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Building a System of Support for Evidence-Based Home Visitation Programs in Illinois: Early Findings from the Strong Foundations Evaluation

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Executive Summary

Introduction

In the fall of 2009, the Illinois Department of Human Services (IDHS), in collaboration with the Illinois State Board of Education (ISBE), the Illinois Department of Children and Family Services (DCFS), and the Home Visiting Task Force (HVTF) of the Early Learning Council began the implementation of Strong Foundations. Funded by the Children's Bureau, Illinois was one of 17 grantees in 15 states to receive funding for 5-years to support the implementation, scale up, and sustainability of evidence-based home visiting programs for the prevention of child maltreatment. Each grantee is expected to conduct local implementation and outcome evaluations, along with an analysis of program costs, and contribute information to a national cross-site evaluation conducted by a research team from Mathematica Policy Research and Chapin Hall at the University of Chicago (MPR-CH). Another research team at Chapin Hall was contracted to conduct the local evaluation of Strong Foundations.

Strong Foundations is based on the assumption that a well-functioning and effective infrastructure at the state level will be reflected in, and supportive of, a well-functioning and effective local system and the successful operation of program sites. It is further assumed that if programs operate successfully, they will produce long-term positive outcomes on maternal life course, child development, and the prevention of child maltreatment similar to those observed in randomized controlled trials of these evidence-based programs. Following these assumptions, the two overarching goals for Strong Foundations are to: (1) implement activities to strengthen the infrastructure of supports for home visiting programs in Illinois and (2) ensure that programs operate with fidelity to their model and are supported with necessary training and resources.

Research Questions and Methods

For the purposes of the evaluation, we were asked to concentrate on three models of evidence-based home visiting programs in Illinois—Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP). The primary research questions were:[1]

- State system: To what extent do state partners in the Strong Foundations' initiative collaborate and implement an effective state infrastructure to support evidence-based home visiting programs, for example, with respect to governance, training and technical assistance?
- Community partnerships: How are communities supported and assisted by the state infrastructure in selecting evidence-based home visiting programs to meet the needs of families and in delivering services effectively? Are home visiting programs integrated into the full array of services and supports for families with young children in the community?
- Program quality and fidelity: Are home visiting programs being implemented and delivered in a way that is faithful to their program model, for example, with respect to staff selection, training, and supervision; engagement, participation, and retention of families; intensity, length, and frequency of services; and links to other community services?

To address these questions, the evaluation includes (1) a process evaluation to assess the implementation of the state system, local infrastructure, and the operation of local programs and (2) an administrative data study of program performance, capacity, and fidelity.

Drawing primarily from interviews with state-level informants, interviews with program directors and supervisors at 15 local programs, focus group interviews with home visitors, and staff surveys, this preliminary report offers some early findings and recommendations on aspects of the state level structures and supports for evidence based home visitation services, as well as program implementation and quality.

Early Findings and Recommendations: Building a Strong Foundation

Findings from the first year of Strong Foundations indicate several important strengths of the state system for home visiting programs. These include a growing emphasis on evidenced-based practices, a range of forums for staff training and development, structures to facilitate communication and collaboration (e.g., the Early Learning Council, the HVTF, cross-agency initiatives such as Strong Foundations), and an increased openness to blend funding for services.

[1] The original local evaluation plan also included data collection from program participants about their home visiting experiences, but funds for this portion of the study were cut.

At the same time, informants at all levels of the system identified several weaknesses in the system and challenges for system-building. Home visiting programs in Illinois are working in communities struggling with complex issues. Programs are currently operating in a climate of limited resources at both the program and community levels. The multiple needs of families as well as a growing lack of resources for families facing unemployment, unstable housing, lack of family support, and transportation problems make it more difficult to engage families and keep them involved in home visits.

Although preliminary, these findings point to several conclusions and recommendations for building the supports for home visiting programs and, in turn, the capacity of programs to meet the needs of their communities with high quality services. These fall in the following areas:

- **Staff development and training**: The state system has considerable capacity to provide basic training for a range of home visiting staff but has less capacity to provide more comprehensive and deeper training and training targeted to the diverse needs of staff and cultural and regional differences in the communities in which programs operate. There also appears to be a need for follow-up assistance in bringing new knowledge back to the program. Thus, when faced with uncertainly about funding, the decision of the Strong Foundations' leadership to focus on enhanced training for staff in specific family risk factors was sound. This is one strategy that should continue and expand.
- **Local system-building**: There appears to be growing momentum to continue to foster local collaborations and partnerships. Thus, the importance of the Strong Foundations-supported community systems development work cannot be overstated. As indicated by our informants as well as experts in the field, the effectiveness of home visitation as a strategy to improve family functioning and child development depends in part on communities' capacity to offer high quality programs that meet the diverse needs of their families. It also depends on their connection to other services and systems, including health and mental health care and early care and education programs. Staff of local programs also expressed a desire for more knowledge of and connections with other service providers to increase their capacity.
- **Monitoring, program performance, and quality assurance**: Another important part of the infrastructure is the ability to collect common data across home visiting programs. Although Strong Foundations lacked resources to continue development of a monitoring and quality assurance strategy this past year, there are new incentives and resources from the federal level for building data systems. There is also greater interest among agencies to share data across systems. Illinois is making technological progress in integrating data from different systems in a form that can be used by multiple agencies. Data sharing and developing common systems for collecting data are critical to building a system and being able to show its impacts, and we urge that Strong Foundations continue

to explore ways to develop a system of common data elements for all home visiting programs in the state. In this effort, care should be taken to develop means for tracking families throughout the system, in order to know when referrals are made but also to track the outcomes of referrals.

- **Communication structures:** A key challenge in any complex system is communication. Our interviews suggested that communication between the state and local communities and programs is not as strong as the communication between state agencies and advocates. Although structures and processes exist to facilitate communication across agencies and across levels of the system, it cannot be assumed that they work equally well at all levels. Participants at the higher levels of the system, in particular, need to be mindful of, and perhaps more intentional about, the way they reach out to and share information with those at the practice level, including front-line staff and families.

In conclusion, several challenges confront Illinois's efforts to strengthen the system of supports for home visiting programs and improve program quality. Somewhat paradoxically, as the reach of home visiting programs and other early childhood services have expanded, the difficulties of coordinating them and maintaining communication networks have multiplied. Bringing quality services to all communities in a large state—making efficient use of all the available resources and sources of talent; ensuring consistent quality of service; reaching the full range of racial and ethnic groups, and focusing particular attention on the most underserved families and regions—is a large strategic, organizational, and logistical task.

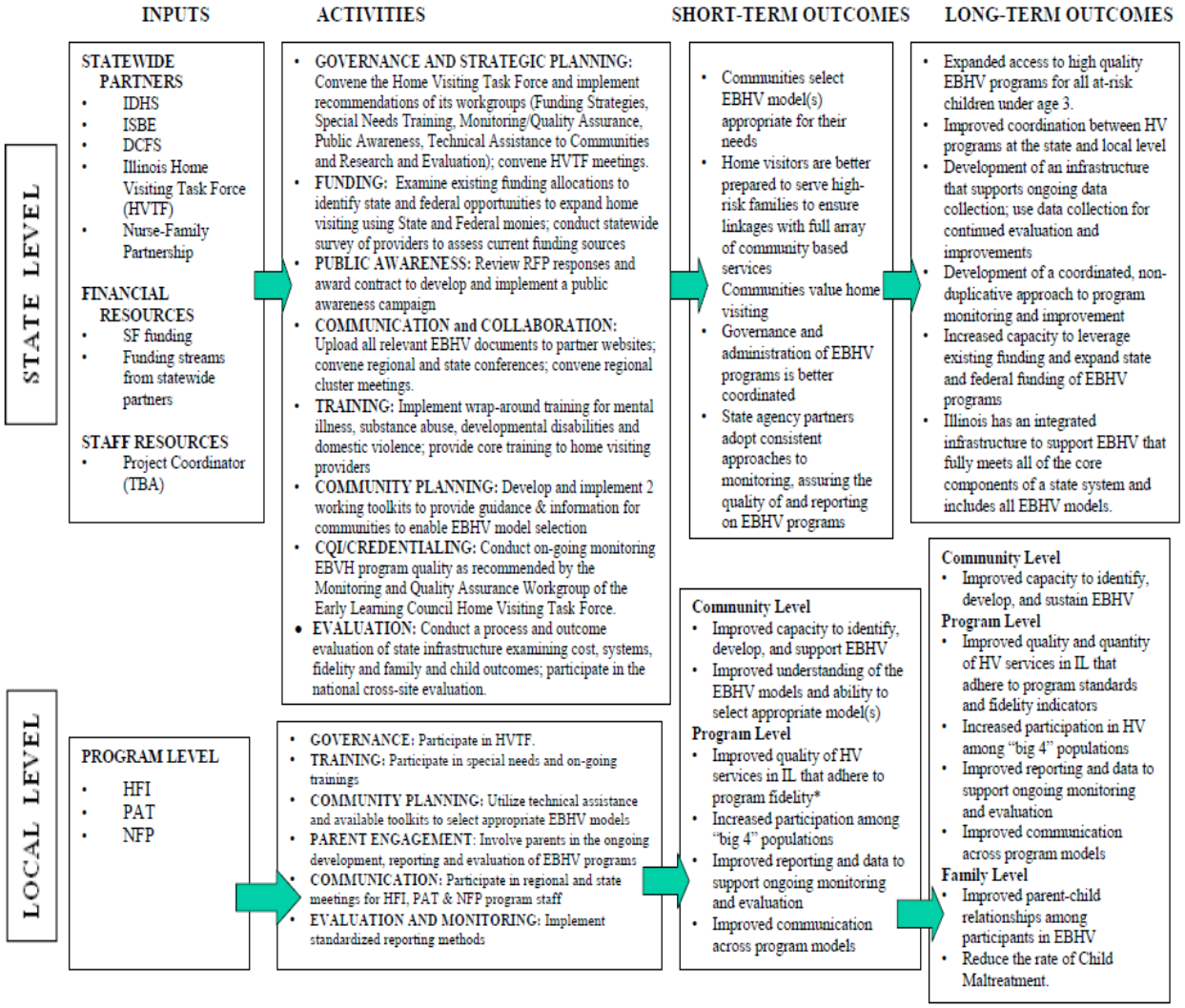
Yet, despite these complexities, the emerging infrastructure in Illinois has several strengths that increase program quality and effectiveness. These include strong advocacy organizations, leadership through the ELC and HVTF and other collaborative initiatives, emerging collaborations at the local community level, as well as sustained participation by a wide range of stakeholders. A number of challenges lie ahead, particularly in the current economic climate, and these are likely to exist for the long term. At the same time, the evidence suggests that Illinois has a good foundation to build its capacity to meet and respond to these challenges in an effective and sustainable way.

Introduction

In the fall of 2009, the Illinois Department of Human Services (IDHS), in collaboration with the Illinois State Board of Education (ISBE), the Illinois Department of Children and Family Services (DCFS), and the Home Visiting Task Force (HVTF) of the Early Learning Council, began the implementation of Strong Foundations, an initiative funded by the Children's Bureau. Illinois was one of 17 grantees in 15 states to be awarded funding from the Children's Bureau to support the implementation, scale-up, and sustainability of evidence-based home visiting programs for the prevention of child maltreatment. These grants were 5-year cooperative agreements intended to support a year of planning followed by 4 years of implementation. Each grantee was expected to conduct local implementation and outcome evaluations, along with analysis of program costs, as well as contribute information to a national cross-site evaluation conducted by a research team from Mathematica Policy Research and Chapin Hall at the University of Chicago (MPR-CH). Another research team at Chapin Hall was contracted to conduct the local, grantee-specific evaluation of Strong Foundations.

The goal of Strong Foundations was to enhance and strengthen the infrastructure of supports for evidence-based home visiting programs in Illinois. As shown in the logic model in Figure 1, the initiative was based on the assumption that the development of a well-functioning and effective infrastructure at the state level would be reflected in, and supportive of, a well-functioning and effective local system and the successful operation of program sites. Furthermore, if the sites operate successfully, it is assumed that model programs would produce the same sort of long-term positive outcomes on maternal life course, child development, and the prevention of child maltreatment that have been observed in randomized controlled trials of these evidence-based programs. Following these assumptions, the two overarching goals for the Strong Foundations initiative are (1) to implement activities to strengthen the infrastructure of supports for home visiting programs in Illinois and (2) to ensure that these programs operate with fidelity to their model and are supported with necessary training and resources.

Figure 1. Original Logic Model for Strong Foundations (June 2009)



In turn, the goal of the evaluation was to assess the home visiting infrastructure in Illinois and the changes in state infrastructure and program quality that result from the implementation of Strong Foundations. For the purposes of the evaluation, we were asked to concentrate on three models of evidence-based home visiting programs in Illinois—Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP).

As outlined in Figure 1, Strong Foundations was designed to strengthen a number of infrastructure components. These included funding strategies; training for home visiting staff to strengthen their skills in working with families affected by domestic violence, mental health problems, substance abuse, or developmental disability; technical assistance to communities in selecting evidence-based programs to meet the needs of their families and coordinating services; monitoring and assuring the quality of

services; use of data for evaluation and program improvement; and public awareness. During the planning year of the grant, which ran from October 2008 through September 2009, the HVTF established six work groups to develop implementation plans for each of these areas.

The planning, implementation, and evaluation of Strong Foundations were originally expected to last 5 years. However, in December 2009, funding for the initiative was unexpectedly and substantially reduced in a congressional budget reconciliation process. Although the Children's Bureau began an effort to obtain alternative funding, it appeared that the initiative could end in the fall of 2010. In response, IDHS and the HVTF scaled back the implementation plan, and the Children's Bureau and the cross-site evaluation team revised cross-site evaluation activities to focus largely on the system and fidelity domains. Consistent with these changes and mindful of a very short time frame for data collection, Chapin Hall modified the grantee-specific evaluation plan to focus on the following three areas:[2]

- *State system*. To what extent do state partners in the Strong Foundations initiative collaborate and implement an effective state infrastructure to support evidence-based home visiting programs, for example, with respect to governance, training, and technical assistance? What are the strengths and weaknesses of the infrastructure? What factors affect implementation of the state infrastructure?
- *Community partnerships.* How are communities supported and assisted by the state infrastructure in selecting evidence-based programs to meet the needs of families and in delivering services effectively? Are home visiting programs integrated into the full array of services and supports for families with young children in the community?
- *Program quality and fidelity*. Are home visiting programs being implemented and delivered in a way that is faithful to their program models, for example, with respect to staff selection, training, and supervision; engagement, participation, and retention of families; intensity, length, and frequency of services; and links to other community services? What factors affect the fidelity of program implementation?

To address these questions, the evaluation includes (1) a process evaluation to assess the implementation of the state system, local infrastructure, and the operation of local programs and (2) an administrative data study of program performance, capacity, and fidelity. Some of the information collected as part of these activities will be shared with the national cross-site evaluation. These activities are briefly described below and summarized in Table 1. Copies of interview, focus group, and survey protocols used in data collection can be found in Appendices A and B.

[2] At the time of this report's publication, a good part of the funding for the initiative has been restored. The primary change in the local evaluation plan was the elimination of plans to collect data directly from program participants about their home visiting experiences; despite the restoration of funding, resources are not sufficient to conduct primary data collection with clients.

Table 1. Overview of Strong Foundations Evaluation Activities

Year	Data Collection/ Analysis Phase	Activities for Illinois Strong Foundations Local Evaluation Domain			Activities for National Cross-Site Evaluation (System, Fidelity, Outcomes, Cost,)
		State Infrastructure	Local Infrastructure/ Program Fidelity	Client Characteristics, Service Experiences, Performance Indicators	
10/2008-9/2009 (Year 1)	**Evaluation Planning**	*Note: Information gathering, site selection, protocol development, IRB reviews, data sharing agreements for administrative data, work with cross-site evaluation team—no data collection*			
10/2009-9/2010 (Year 2)	**Year 1 Data Collection/ Analysis and early findings report**	• IRB submissions • Key informant interviews • Review of program documents and data systems • IDHS Funding survey	• IRB submissions • Interviews with program administrators • Focus groups with frontline staff • Survey of program supervisors and frontline staff • Collection of administrative and secondary data	• Analysis of administrative data on EBHV program participants at selected time points prior to and during Strong Foundations	• Collect data for online program and participant variables for assessment of fidelity and child maltreatment outcomes • Assist with 2010 site visit • Grantee meeting
10/2010-9/2011 (Year 3)	**Year 2 Data Collection/ Analysis and year 2 progress report**	• IRB submissions • Key informant interviews • Review of program documents and data systems • Provider change surveys to assess "special needs" training	• IRB submissions • Interviews with program administrators • Survey of program supervisors and frontline staff • Administrative and secondary data collection	• Analysis of administrative data on HFI, PAT, and NFP participants after implementation of Strong Foundations • Collection of DCFS data	• Collect data for online program and participant variables for assessment of fidelity and child maltreatment outcomes • Grantee meeting
10/2011-9/2012 (Year 4)	**Year 3 Data Collection/ Analysis and year 3 progress report**	• IRB submissions • Key informant interviews • Review of program documents and data systems • Provider change surveys to assess "special needs" training	• IRB submissions • Interviews with program administrators • Focus groups with frontline staff • Survey of program supervisors and frontline staff • Administrative and secondary data collection	• Analysis of administrative data on HFI, PAT, and NFP participants after implementation of Strong Foundations • Collection of DCFS data	• Collect data for online program and participant variables • Assist with 2012 site visit • Grantee meeting
10/2012-9/2013 (Year 5)	**Data analysis and final report**	*Note: Administrative and other secondary data collection might continue into the fifth year, but no primary data collection is planned.*			

Design and Methods

Process Evaluation of Systems and Programs

The process evaluation involves the collection and analysis of both primary and secondary data. To gather information on the state system and the early implementation of Strong Foundations, during the planning

year, we began observing meetings of the HVTF and its work groups and collecting meeting minutes and other documents distributed at these meetings.[3] In February 2010, we began a series of semi-structured interviews with state-level informants about the state system, local programs, and community partnerships. Each interview lasted between 30 and 60 minutes. To date, we have conducted in-person or telephone interviews with 17 representatives of public and private state agencies and advocacy organizations involved in the implementation of Strong Foundations.

In addition, we recruited 15 home visitation programs—two NFP, six HFI, and seven PAT programs—to provide in-depth information on agency operations, the home visiting programs, community collaborations, and relations with state agencies and national program offices. We selected these programs to represent the range of communities served by these three models of evidence-based home visitation programs, which are the focus of the evaluation. Of the 15 programs, five are located in different areas of metropolitan Chicago; five provide services in three of Chicago's suburban or collar counties; and five programs serve families in seven downstate counties.[4]

As of this writing, we have completed primary data collection at all of these sites. This included individual, hour-long interviews with program administrators and supervisors, and focus groups lasting approximately 90 minutes with home visitors. Across the sites, a total of 83 program staff members, 58 home visitors, 16 program supervisors, and 9 program managers or agency administrators have participated in interviews or focus groups. Seventy-six program staff members—all of the program supervisors and all but one of the home visitors—also completed a survey about their qualifications, experience, and other background characteristics. In addition, we asked administrators to supply additional program records and other secondary data (e.g., funding applications) to support our analysis of program fidelity. Site visits to conduct these interviews and focus groups occurred between April and early July 2010. Home visitors received a cash incentive for participating in these data collection activities. Local programs taking part in the evaluation also received an incentive in the form of age-appropriate children's books and toys for their programs' participants.

The interviews and focus groups were recorded, with the permission of the respondents, and transcribed; or, if respondents requested not to be recorded, written interview notes were taken and summarized. The resulting transcripts and summaries were the primary data for this report, with additional information

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[3] Other secondary data include descriptions and evaluations of training for home visiting staff, technical assistance manuals for communities, and program reviews.

[4] Currently, there are only 2 NFP programs in the state, 58 HFI programs, and approximately 194 PAT programs. Because of the closing of some programs during the past year, it has been difficult to get precise counts of PAT programs in particular. The vast majority of programs are located in urban and suburban counties. Additional information is available in a recent needs assessment conducted for Illinois (Daro, Hart, Bell, Seshadri, Smithgall & Goerge 2010).

coming from secondary documents such as meeting minutes, course evaluations, and products developed by Strong Foundations work groups. After transcription, we organized the interviews in a database by case identifier, subgroup (state-level informant, program manager/supervisor, and home visitor), program type, and region. We used a process of simultaneous deduction and induction to code and analyze the data. Although the interview topics provided an initial list of codes, we also looked for other themes and meanings to emerge using the "grounded theory" approach (e.g., Glaser & Strauss, 1967; Miles and Huberman, 1994; Patton, 2002).[5] As we identified concepts, we compared and contrasted them with previously identified concepts; grouped similar concepts together in categories; and documented relationships among concepts and categories and emerging ideas and patterns. Additional information on primary data collection and analysis is available from Chapin Hall.

Administrative Data Study

The evaluation also includes a study of the characteristics of families participating in NFP, HFI, and PAT programs and indicators of program performance and capacity. The purpose of this part of the study will be to assess the capacity, quality, and fidelity of implementation of selected evidence-based home visiting programs, and the characteristics and needs of the current population of families served by these programs. We have established data-sharing agreements with the appropriate state or national agencies to obtain statewide HFI, NFP, and PAT data electronically and are currently in the process of collecting these data. Depending on the availability of historical data, we plan to collect information over several years to describe changes over time in program and client characteristics.[6] (Additional information on the administrative plan can be found in Appendix C.)

The National Cross-Site Evaluation

As indicated above, Strong Foundations is also part of the MPR-CH national cross-site evaluation that includes 16 other grantees. The goal of the cross-site evaluation is to identify successful strategies for adopting, implementing, and sustaining high-quality home visiting programs for the prevention of child maltreatment. MPR-CH conducted a partnership survey and telephone interviews in the spring of 2010 with selected agency directors, other state-level participants, and home visiting program staff. The Chapin Hall local evaluation is also contributing selected data from the local sites on home visiting services and staff characteristics.

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[5] A qualitative data software program, Atlas.ti, was used to facilitate the systematic analyses and coding of the interviews.

[6] If new funding for Strong Foundations and its evaluation is obtained in the future, we will also establish an agreement with DCFS, the state child welfare agency, to collect and analyze data on child maltreatment.

Overview of this Report

This is an early findings report, which is being completed to supplement a state needs assessment being conducted for an application for funding from the Maternal, Infant, and Early Childhood Home Visitation Program within the new federal Patient Protection and Affordable Care Act as well as to inform the HVTF's strategic planning process. It is the result of a selective and limited analysis of the data collected to date, which are relevant to the capacity of the current home visitation system to adequately meet the needs of families and communities, particularly those more at-risk for poor maternal and child health outcomes. Although we have completed most of the primary data collection for the first year of the study, we are still collecting additional, secondary information from local programs and state administrative data bases. The administrative data are particularly relevant to our analysis of some aspects of program fidelity, such as caseload sizes and service delivery, as well as to our ability to provide a comprehensive assessment of the state system. (See Appendix C for a few examples.) Thus, we remind the reader that particularly with regard to the operation and quality of local programs, the results presented here are based on a very small sample of home visiting programs in Illinois. We will be able to provide a more complete picture after additional analysis of these data and the administrative data we are currently collecting.

This report, then, draws primarily from interviews with state-level informants, interviews with program directors and supervisors at 15 local programs, focus group interviews with home visitors, and staff surveys. It begins with perspectives on the state system and then turns to a discussion of local programs, with a focus on four main topics: the characteristics of the communities and programs participating in the evaluation; training and supervision of home visitation staff; program quality and fidelity; the ability of programs to meet family needs; and the availability of—and linkages to—other community services and resources.

State Context and System for Evidence-Based Home Visitation Programs

In this chapter, we provide a brief overview of the state infrastructure that supports evidence-based home visiting programs, respondents' perspectives on the strengths and weaknesses of the current system, and a description of two enhancements to the state system funded by Strong Foundations. It is beyond the scope of this early report to provide a full history of the development of the system or the current state context. However, it is important to note that, as described in the Strong Foundations proposal (IDHS, 2008) and implementation plan (IDHS, 2009) and other secondary data gathered for this evaluation (e.g., Birth to Five Project Report, 2008), Illinois has a strong record of working collaboratively at the state and local levels to build a comprehensive system of early childhood services. The three lead state agencies in the Strong Foundations initiative—IDHS, ISBE, and DCFS—and other public and private stakeholders—the Ounce of Prevention Fund, Voices for Illinois Children, and Prevent Child Abuse Illinois, among other providers and advocacy groups—built on this history in developing the proposal for Strong Foundations and its implementation strategies:

> All of these key stakeholders have a long history of working together on home visitation and other child and family services. There is a very high level of trust among these organizations that has built up over a long period of time and has become the culture within which Illinois' early childhood system operates. This culture of mutual respect is well established and has transcended time and/or individual relationships. Because of this, the key stakeholders at this level do not consider interagency agreements or memoranda of understanding to be necessary in order to establish or formalize working relationships for Strong Foundations (IDHS, 2009).

Moreover, for much of the past decade, Illinois has enjoyed a political climate supportive of the development of the early childhood system. This is evidenced, for example, in the creation in state statute of the Early Learning Council (ELC) in 2003 to guide the development of a statewide early childhood education and care system to ensure that young children at risk for school failure and their families experience high-quality programming and services necessary for healthy child development, and the subsequent passage of legislation to create the Preschool for All program in 2006. In fall 2009, at the recommendation of the ELC, the governor created the Office of Early Childhood Development (OECD) within the Governor's Office to solidify Illinois's efforts to establish a comprehensive, statewide early childhood system.

Other illustrations include the creation of the All Our Kids (AOK) Early Childhood Networks nearly a decade ago to improve the organization and delivery of services for young children at the community level; the development in 2003 of the Children's Mental Health Partnership, which includes an early childhood committee; passage of legislation authorizing a set-aside funding stream in the Early Childhood Block Grant for infant-toddler services (which now stands at 11%); and, in 2007, the establishment of the Birth to Three Training Institute with funding from multiple state agencies. These accomplishments came at a time when other human services were experiencing funding cuts and were partially the result of efforts by early childhood professionals and advocates to engage and educate the governor and legislators about the importance of home visiting for at-risk children. Both 2007 and 2008 saw an extremely long and challenging legislative session and state budget process, and early childhood advocates devoted significant efforts to maintaining the support of some key groups of state representatives and senators during this period. A significant result, in 2008, was a $1.8 million increase in funding for home visiting through IDHS and the Ounce of Prevention Fund, and a request from the governor for a comprehensive plan to expand home visiting statewide for all high-risk families.

At the same time, it has also been acknowledged that despite the legislative successes and growing collaboration across different state agencies serving young children and their families during the past decade, a number of gaps and challenges remain to meet the goal of a unified infrastructure. Funding for local programs comes through several agencies, with the largest coming from ISBE through the Early Childhood Block Grant, which, as mentioned earlier, includes an infant/toddler set-aside that ensures that a percentage of funding will be spent on programs and services for infants and toddlers. The majority of the ISBE-funded programs are home visiting programs, and most of them are PAT programs, although not exclusively; ISBE also supports a few HFI and other programs. Further major funding flows through IDHS to support HFI programs and the Ounce of Prevention Fund's Parents Too Soon programs.

Other than the federally funded Early Head Start and Head Start home-based programs, most of the other funding streams are relatively small and, according to our informants, cannot help to support a comprehensive, intensive evidence-based model of home visiting. Each of the aforementioned agencies has its own governance and administration, data collection, standards, quality assurance, and technical assistance (IDHS, 2008). Thus, the Strong Foundations grant was viewed as an important opportunity to provide the state the resources it needs to meet these challenges and create a common, integrated infrastructure to coordinate resource allocation, community-capacity building, training, data collection, monitoring, and technical assistance across the three state agency partners and an existing network of close to 250 home visitation programs.[7]

In 2008, the ELC created the Home Visiting Task Force (HVTF) under its auspices to support the development of a coordinated, high-quality system of home visiting programs. The HVTF adopted a broad, "big tent" approach that recognizes that several high-quality models of home visiting programs exist. Comprised of a diverse group of stakeholders, the HVTF includes representatives from national home visiting models, state administering agencies, program providers, researchers, parents, and advocates. The HVTF was charged with expanding access to quality home visiting programs for all at-risk children; improving coordination among home visiting programs at the state and local level, as well as between home visiting and other publicly funded services for mothers, infants, and toddlers; planning for potential new state and federal funding; and making recommendations about the infrastructure needed to support a comprehensive home visitation system in Illinois. The HVTF collaborated in the development of the Strong Foundations proposal, and one of its first responsibilities was to serve as an advisory body for the initiative. The full HVTF has met six times since its initial meeting in January 2009, sponsored six work groups, and held a leadership retreat in December 2009, all of which were dedicated to planning the implementation of Strong Foundations.[8]

As mentioned above, however, shortly after the start of the first year of the Strong Foundations implementation phase, the state was informed that funding for Strong Foundations would either cease or be severely reduced at the end of the year. This resulted in a significant scaling back of plans for implementation. Specifically, initiative leaders and the HVTF decided to focus on two strategies most

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[7] Estimates of the total number of programs in the state vary. This number is based on our most recent data on the number of PAT (194), HFI (58), and NFP (2) programs; more accurate data will be detailed in a forthcoming state needs assessment (Chapin Hall, 2010, in preparation). This estimate does not include other home visiting programs; the forthcoming needs assessment, for example, reports that approximately 10,000 children are served in home-based Early Head Start and Head Start programs across the state.

[8] The six work groups encompass the key components of the infrastructure addressed by the Strong Foundations initiative. These are Financing Strategies, Community Systems Development, Special Needs Training, Program Monitoring and Quality Assurance, Research and Evaluation, and Public Awareness.

likely to contribute to system-building and to benefit local programs and communities in a short period of time: (1) specialized training for home visitors on how to approach issues of domestic violence; developmental disabilities; substance abuse; and/or mental illness encountered in the home, and (2) technical assistance to foster the development of community systems to support communities in choosing and implementing the evidence-based home visitation model(s) that best fits their needs.

Below we first discuss the perspectives of our key informants on the current infrastructure of supports for evidence-based home visiting programs in Illinois. We then briefly describe the early implementation of these strategies to enhance two aspects of the system: training and community system development.

Perspectives on the State System

In this section, we report perspectives of state-level informants and some of the program managers and supervisors about the status of home visiting programs in the state and the system of support for evidence-based programs, as reported in interviews conducted in the spring of 2010. Although we also asked home visitors for their views, their knowledge was limited to their local programs and communities.

State Goals for Home Visiting

Most of our respondents recognized that state agencies, advocates, and other stakeholders working across the state have common goals with regard to home visiting programs and the infrastructure of support for these programs. They mentioned goals such as improving quality, providing an integrated system of early childhood services that includes home visiting programs, and increasing the number of programs to reduce service gaps. They also agreed on the goals and expected benefits of programs, noting that although different models focus on different areas; most are aligned with the overarching, longer-term goals of preventing child maltreatment and ensuring children are ready for school. Some also mentioned improved pregnancy outcomes, child health and development, engaging parents in their children's health and education, and parent economic self-sufficiency as intermediate outcomes of these programs.

A few of our respondents also mentioned goals related to early childhood system-building. For example, one respondent told us that "A lot of good thinking has gone into the existing home visiting structure in Illinois." Another said, "We are working toward a more systemic approach to home visiting and providing funding for home visiting programs [so that] they'd be connected to a system of services for children ages birth through five that ends in school readiness." At the same time, they did not convey a sense that an overall state plan yet exists for home visiting programs. Some respondents believed the lack of a plan reflects that home visiting is not a priority for the state, or that public awareness of the purpose and value of home visiting programs is not as high as it should be. Others believed that the state has made

a committed effort to home visiting and creating common standards for home visiting programs, but does not have enough staff and other resources to support efforts such as monitoring or training.

Availability and Quality of Home Visiting Programs

There was general agreement that there are not enough high-quality home visiting programs to meet the needs of families. Some respondents noted regions of the state where programs do not exist or are inadequate in number; for example, some of the midstate and downstate rural areas. Others mentioned populations with particular risk characteristics for whom there are insufficient services; for example, families who do not speak English, teen mothers, and parents of children with special needs. According to another informant, there might never be enough home visiting programs to meet all needs, but that does not mean that some needs could not be met in other ways; nonetheless, a number of families with multiple risks are not being reached because they are harder to engage:

> The availability is always going to be not enough. That does not mean we have to have three times as much money for there to be enough. There're a variety of types of services that could help to meet a family's needs, not just intensive home visiting. But even so, philosophically, there still are huge wait lists of families that truly are falling into those categories of greatest risk that would really benefit from the intensity of a home visiting model. So availability continues to be an issue.

Another informant pointed out that whether or not families with high levels of need are served also depends on the ability of programs to engage them. Specifically, when families are experiencing one or more of a particular set of risk factors—the presence of substance abuse, domestic violence, a developmentally disabled parent, or mental health problems—they are very difficult to recruit or engage in home visiting. Even if they do enroll, they are often difficult to retain because of the structure of the home visiting program model and the need for families to be organized and available to receive visitors regularly. Additionally, it is difficult for home visiting programs to engage families who are experiencing homelessness or transiency.

A few informants also pointed out that access and availability are also related to program eligibility criteria, which can be restrictive; as well as to identifying the needs of families and matching them with the most appropriate program—assuming there are choices of services—to meet their needs. Helping communities to develop the services their families need and the infrastructure to coordinate programs and refer families to the right services are two goals of the Community Systems Development Work Group; thus, state leaders recognize that system-building is necessary at the local community or county level as well as at the state level.

When asked about the general quality of programs in the state, several informants noted that given the wide range of programs, they did not feel they had enough information to venture opinions about their

quality. Yet, there was also a general sense that use of an evidence-based model results in better quality. Moreover, in addition to the particular program model or curriculum, they noted that quality depends on a number of other factors: the presenting needs of families; the type and frequency of staff supervision; whether or not programs are required to be credentialed; the frequency of program monitoring; whether or not on-site monitoring occurs; and financial security of the program. One individual who believed the quality of programs is "beyond expectations" acknowledged that the current fiscal climate has had a negative impact on quality.

Indeed, some informants saw lack of funding leading to a reduction in staffing and, in turn, a reduction in frequency of visits as a threat to model fidelity. Others, however, suggested that when faced with cuts in funding and staffing, changes were made that did not affect fidelity. For example, programs stopped providing transportation and baby care supplies for their clients or funding childcare for parents attending monthly family support groups. Some programs were able to negotiate reductions in caseloads or adjusted the criteria for which families would receive services, resulting in fewer families being served but not reducing service quality. As one informant explained, "With the reduction in funding there is a reduction in the number of families being served. The curriculum is still implemented, that doesn't affect the numbers that are being served, but the number of families being served and the number of staff have been reduced."[9]

Funding and Financing Strategies

It is no surprise that the topic of funding was addressed in nearly all of our interviews. First, the growing enormous deficit in the state budget, the 10 percent cuts in the budgets of the two major funding streams for home visiting programs—as well as a host of other social service programs—in both SFY 2010 and SFY 2011, and the lack of a solid, long-term plan for generating revenue for services in the future was at the forefront of everyone's mind. There was concern that the fiscal issues would not only hurt the availability of services to families and service quality, but also threaten the stability of the infrastructure support for home visiting programs.

At the same time, informants at the state level were generally aware that one of the goals of the Strong Foundations initiative is to leverage existing funds, plan for potential new state and federal money, and prepare for the future challenges of using multiple funding streams.[10] Toward those ends, they believed it

[9] An early analysis of some data from the Cornerstone system on HFI programs indicating a drop in home visits during the summer of 2009 supports the impact of budget cuts on numbers of home visits, although we cannot yet assess their impact on other aspects of service delivery (see Appendix C).

[10] Although a funding survey was conducted during the Strong Foundations planning year, the response rate was too small to provide enough information to develop a strategy to improve financing.

was promising that developing the HVTF and the Strong Foundations initiative has brought "everyone to the table" and that there seems to be more flexibility in funding sources and more openness to blending funding. For example, according to one informant, ISBE is now "dipping its toes" into Healthy Families. Although this work had been recommended by the Early Learning Council and was in process prior to Strong Foundations, in the words of another informant, the grant process was "the catalyst to move it forward."

Although the use of multiple funding streams was seen as a positive thing in most respects, a few program managers expressed concern about the different reporting requirements of individual funders. One described a range of reports her program is required to prepare, as follows:

> Quarterly, we submit reports to DHS, and they kind of reflect how many participants were determined eligible, and they ask questions about how many people were discharged, and [so on]. And then there is doula reporting on a quarterly basis, too, to the Ounce of Prevention with specifics about doula clients, and that's very specific about demographics, and dates and services; and all sorts of specific things we have to share with them, like screenings and parent workshops. And then the local funders, bimonthly, we send them some numbers on hours of service provided by town. And then the agency, it wants participant numbers too.

From this and descriptions from other program managers, there appears to be considerable overlap in the information that different funders require, but it does not seem possible to develop one comprehensive report that would satisfy the requirements of multiple agencies. A state-level informant summarized the challenge for local programs in the following excerpt:

> The biggest struggle that programs face is overlapping and duplicative monitoring that requires them to collect information in a variety of ways, reporting it on different timelines to different sources in different formats. The desire for accountability overtakes the practical functions of the program, and so too much time, anywhere from 20 to 30 percent of a program's time, ends up having to be spent on data collection and reporting of some sort. The percentage has grown as programs combine or try to integrate funding streams, which is sort of what they're supposed to do. Every funder says, 'We can't do it all. You have to connect and coordinate, collaborate together,' but no funder wants to pay for that part, so they're all paying because the funders are not coordinated. That parallels the process down to the communities.

Training and Technical Assistance

A number of state-level informants and program managers and supervisors singled out training for home visitors as a particular strength of the state infrastructure. The Birth to Three Institute at the Ounce of Prevention Fund offers trainings in different regions of the state on a variety of topics, and in recent years, there has been an increase in the availability of online training to help meet the needs of program staff who find it difficult to travel to in-person trainings. In addition, professional development opportunities

are available in the state through quarterly regional cluster or networking meetings that are model-specific and specific to the needs of communities and families in those areas.[11] To help set the agenda for training, the Institute also conducts an annual training needs assessment and solicits other feedback from course evaluations and provider cluster meetings. "The Ounce actually on an annual basis will ask, 'what are your training needs?'," a program manager reported, "And sometimes we'll talk about it as a group, and I'll report back."

Many respondents were also positive about the quality of the available training. For example, according to a program supervisor, "The quality is good. Some of the facilitators aren't the best, but the quality is good. It gets the information across." Another told us, "They are keeping up with the issues that our population is having, putting things together according to the needs of the population. Others used words like "really good," "very adequate," "really helpful," and "wonderful" to describe the training they experienced through either the Ounce of Prevention Fund or ISBE.

On the other hand, some respondents felt that even though professional development for staff is available, consistent, responsive to needs, and of good quality, it is not a system that responds well to different levels of education and experience of staff or to cultural differences in program participants. A program supervisor commented, "I've been doing this for 11 years; they're the exact same trainings I did 11 years ago." Another echoed her view:

> The trainings are basic introductory-level trainings that are offered again and again, and there's not a lot of depth to them. My staff have been here a long time. They just went to the one on domestic violence as a part of Strong Foundations. It wasn't a bad training if you didn't know anything about domestic violence, but they're in the trenches and they've all been with us a really long time; my newest employee's been here 5 years. So they crave not so much "what is it" and "what things do I need to know" but "what do I do." They don't get a lot of that on any of those issues—substance abuse, mental health—and we've been trying the last couple of years to seek out more things on our own that aren't so basic. We don't fault the trainers, but as home visiting has been so established in Illinois, that really is an issue 'cause we're not the only program that keeps their staff forever.

Thus, program managers and supervisors—especially those with experienced staff—also emphasized a desire for higher-level, advanced trainings as well as education in special topics.

With regard to special topic areas, mentioned most often were those identified in the Strong Foundations initiative: mental health, substance abuse, domestic violence, and adult developmental disabilities. They also included topics relevant to other needs of families that home visitors encounter in the families they

[11] These are organized and facilitated differently for different programs; for example, PAT cluster meetings are organized by the Ounce of Prevention, while HFI cluster meetings are facilitated by Prevent Child Abuse Illinois.

serve: adolescent development, working with teen parents, behavioral issues, and autism. According to one of our informants,

> Staff are just thrilled to have that [specialized] training. Until they were able to come to the Ounce [Birth to Three Institute] and get training for working with adolescents, I think that was something they could get through the PAT National Center, but at a cost, and these programs don't have a lot of money. So they have money for that initial training and some for professional development, but not for the wrap-around training. So anything around those special needs, they're not getting that in their basic core training.

Some respondents also pointed to a need for more information and training in ethical issues, mandated reporting, and setting boundaries in their work with families.

Finally, a few informants, including a state administrator and a home visitor, also mentioned another needed area of training in the current fiscal climate: ways to collaborate and blend resources with other service providers. In the words of one individual, "Everyone is in panic mode and yes, they are communicating with one another as far as they are doing. As far as sharing resources, I think that is happening as when a program is going to fold and asks to transition clients to another program." However, additional support and direction "on how to collaborate and how to blend their resources" would be helpful to providers. In this regard, at least one supervisor and some of the home visitors we interviewed thought it would be helpful for staff to know more about public support programs. One told us, "There are a lot of issues with public aid if they're in the TANF program, the childcare subsidy program, and the applications for those." Although some programs are connected to case managers who handle this responsibility, apparently not all are.

Management Information Systems, Monitoring, and Evaluation

Respondents viewed the capacity for program monitoring, research, and evaluation as an important component of the infrastructure for tracking program performance and ensuring program quality and model fidelity. Online data systems developed during the past decade have increased the availability and use of data for monitoring. In addition to the annual reports that all of the Strong Foundations evidence-based models prepare for both their national program offices and state administrators, they also collect and enter data on clients, home visits, and other services on a more frequent basis. Programs funded through IDHS, the Ounce of Prevention Fund, or NFP enter data into an electronic reporting system, and data are returned to program managers on a quarterly or some other regular basis. PAT programs vary; some use a database developed by the national office, while others use an internal computer database or paper records.

Even though one respondent expressed concern about the diminishing frequency of on-site monitoring, state-level informants and program managers appreciated the importance and usefulness of data from electronic systems. As one program manager stated, "It gives me a clear understanding of exactly what I should be doing and how I should be doing it, and whether or not I am doing it right because a lot of times you're delivering services but it's not working for the model." Another manager told us,

> I like Healthy Families because they are going to tell us that we have to be in with the families of different levels so many times a month, or a week. And they are going to monitor that and if the state sees that we're slipping, they contact us and say, 'Hey, what's going on here?' and everything. They send us out quarterly reports that show where we're at with everybody else. I like that idea because it makes us stay dedicated to tracking the people down.

A few home visitors offered contrasting views, however, noting that they spent more of their supervisory time reviewing their caseloads, numbers of visits, and so on than on the content or quality of their work. One noted that during the last two years, the increasing emphasis on collecting data was changing the culture of the program for her:

> [The last few years] it has felt that the whole concept of [the program] was changing and for the first time in many, many years I started to feel as a productive machine rather than a facilitator of support, learning, and growth. It just became about the numbers and [our supervisor] tries with all her heart to balance it and cover it up and make it look as [if it's not just that], so that we don't feel that way.

These comments suggest that although data are useful to managers, as they become more ubiquitous in the life of home visiting programs, front-line staff might need more information and support to adjust to them and understand their purpose. Information on caseloads and number of visits might be a tool to inform supervision but should not take the place of supervision. The comments of one supervisor we interviewed reflect this idea well:

> As a supervisor, I need to make sure that I'm meeting the needs of the program, but it's also very important for me to make sure that I'm meeting the needs of my staff and I'm able to support them where they are. So, I'm always looking at the program, but to me it's an equal balance because I have to make sure that my staff are okay. I call it strengths-based.

As indicated earlier, monitoring and reporting can be complicated, particularly for programs in larger agencies or those that have multiple funding streams. Although reporting requirements are similar, there is no common form to satisfy multiple agencies. Similarly, although documentation and monitoring within agencies has improved, the concept of cross-agency or cross-program monitoring is just coming to the fore. Thus, state level respondents also pointed to the need for common quality standards and monitoring of home visiting programs:

> We've had discussions in Illinois about Birth to Three program monitoring in general. It's very complicated. We had a work group that talked through the programs across agencies and the current monitoring situation with each of those programs and tried to find the commonalities and think about how we could engage in some sort of super monitoring project that would not get down so specifically as models of fidelity perhaps, but look at indicators that we would expect to find in a high-quality home visiting program whatever the model.

In addition to indicators of quality, some respondents also expressed a need to think more broadly about monitoring practices. As one state administrator reasoned, "In many instances that could possibly be accomplished in a more coordinated [and less time-consuming] way so that same information could be shared across agencies and if that was going to meet their needs." In her view, this is all about coordination, collaboration, and system-building: "A lot of it does really have to do with what we're asking of each agency and of our local programs; and to look at it from what we're asking them to invest in terms of human resources beyond the direct services they're providing."

Communication, Connections, and Collaboration

This brings us to another important support for home visiting programs: structures to facilitate state-local, cross-system, and cross-agency communication and partnerships. In a later section we discuss the efforts of the joint Community Systems Development Work Group to develop and implement a statewide technical assistance strategy to assist local communities in selecting home visiting programs that best fit their needs and help them coordinate and deliver these and other services in an efficient and effective manner. Here we present the perspectives of state-level informants and program managers on the current status of communication and collaboration at the state and local levels.

State System

Again, Illinois has long been known for working collaboratively across state agencies through a variety of mechanisms and initiatives, such as the ELC and Birth to Five Project, as well as state support for local collaborations (e.g., the AOK Networks, fostering state-local communication and joint training through the Birth to Three Institute and regional cluster and networking groups). Several informants reinforced this perception, pointing to these and other examples of state-level structures that support communication and collaboration. Respondents also referred to a range of interagency and intra-agency online information and communication sites that have been developed at the state level as ways to increase communication between the state and local programs, as well as make local collaboration easier. In the words of one informant, "All of the programs are part of a myriad of local, regional and statewide networks; they regularly use those bulletin boards and email list-serves for that purpose."

As noted in the earlier discussion of funding, according to our informants, the larger state agencies and systems that support home visiting are more open to a wider range of program models than they were in the past. Moreover, programs and agencies today are more likely to have the support of several different funding streams. For example, the Prevention Initiative funded through the Early Childhood Block Grant allows for the implementation of several different evidence-based models under one funding umbrella. As one state administrator explained,

> So an agency might have a home visiting program that's funded by the State Board of Education and by Maternal and Child Health and the Department of Human Services. So in many instances, that's how the collaboration works, building on whatever structure is already there and using additional funding from possibly another agency to expand those services.

Respondents frequently mentioned the AOK Networks, of which there are currently 13 across the state, as a good example of a state-level mechanism to foster local system-building:

> We found with AOK funding that none of these programs had or could write into their budget a collaboration mechanism and a planning mechanism. And so AOK funds can be used by the entity that receives the AOK funding itself without a requirement for an actual caseload and direct service to families. It can actually serve as the coordinating mechanism for multiple programs and funding streams in agencies within a certain geographic area.… It's a joint application [between two agencies, which] contains the signatures of the agency administrators that are going to be in partnership; the money goes to one entity, but it really is an application that reflects everybody's participation.

At the same time, most of our informants acknowledged that progress in developing real and sustainable interagency communication and collaboration at the state level has been complicated, and not all agencies are equally represented in collaborative efforts. Some respondents believed that despite the best efforts of state agencies and advocates, home visiting and other services for children ages birth to three are still not as visible in the work of the ELC. Furthermore, the mechanisms that are currently available do not reach all areas of the state—for example, some noted that southern regions and smaller, rural communities are not as well integrated into the system or reached by technical assistance opportunities. Although RFP processes were mentioned as another potential means to encourage service agencies within a community to come together to plan and collaborate, it was also noted that such opportunities are likely to be fewer in the current economic climate.

One informant told us she thought there was good communication among the advocates and state leaders. However, she worried about the quality of communication about policy issues between the state leadership and local program sites. In her view, local programs still feel isolated and do not perceive that they are part of a statewide network:

> The families and the folks working in the programs are the heart of this [system-building effort], and how do you keep communication going from them to the policy leadership and back again in an effective way where everyone sees they're part of something bigger than themselves. I believe that the collaboration and the momentum collaborations can build is what is going to ultimately get us to sustainability. And if we don't have that going on, the advocates can do all they want, but without the communities and the families and the providers engaged in it, you're not going to be as effective.

She went on to mention that communication and collaboration with families is another level that is often overlooked. Furthermore, because there are multiple levels of communication, a system needs to develop a range of communication strategies: "It takes different strategies to communicate effectively and involve the families themselves. And it takes another set of strategies for communication to do it at the policy and advocacy level, and another means of communication with your broader community partners that you need to serve the families that are in the home visiting programs."

Finally, one other challenge to strengthening system connections that both state-level informants and local program staff frequently mentioned is the lack of resources to refer families with special needs—particularly in less populated regions of the state. The funding cuts over the past two years have affected not only home visiting and other early childhood programs, but also services in other parts of the system. In this regard, mental health services were singled out as perhaps the most important need. In addition, respondents noted that across the state there is evidence of gaps in services for specific populations, including homeless families, un-emancipated minors, and children with autism and other developmental delays. Some informants also noted that underserved populations include those of Asian and Arab descent as well as Hispanic populations and that the services that are available to these groups need to be more culturally appropriate.

Local System

Coordination among the various community agencies and programs that support early interventions for children and their families is essential to the success of a home visiting program. Whether for purposes of referrals, sharing resources, or other mutually beneficial functions, collaborating with existing programs can help strengthen the model in its local implementation. At least two-thirds of the program managers at our local sites indicated their agency is active in local collaborations around the issue of early intervention or services for infants and young children and their families, which reflect their understanding of the benefits of working with existing local providers. The most common activity in which these managers participated with other community service providers in the past year was geared toward improving service collaboration. All of the managers indicated that they participated in an activity focused on such improvement, and five noted that they had played a leadership role in the activity.

The other activities in which a majority of the program managers had participated in the past year focused on developing shared training across staff and sharing resources, including physical buildings and locations. With limited budgets providing scarce resources, improving the collaborative nature of services delivered to at-risk families will make programs more efficient and the local service infrastructure more sound. With universal common goals—to deliver services that aid in the healthy development of infants and children and to educate the parents on how to make this happen more easily—developing mechanisms to enhance referrals among agencies, train staff members and share information, and share these scarce resources are paramount to making the local model a successful one. These are the main facets of collaboration among the program managers at local agencies who we interviewed.

Referrals

Programs in our sample vary in how they manage referrals. An HFI site is able to employ an outreach coordinator whose primary responsibilities are to connect with the community and service providers, making sure the hospitals and providers are aware of their program for referrals. In lieu of creating waiting lists for programs, one suburban county has developed a unique approach to ensure families receive the services they need. Any expectant or parenting mother applying for a medical card at the county health department is offered home visiting services. The health department then allocates all of the applicable cases among the different home visiting services available in the county as appropriate (part of the intake process includes filling out a referral form, which gives consent for referral to one of several PAT, HFI, and NFP programs within the county). For example, one of the suburban home visiting sites only takes in teen parents, so the county health department distributes the screens of teen parents to this program or to other home visiting programs in the area that take teen parents. Other sites in the same county mentioned their ability to refer families to other county programs when they are unable to accommodate them. When a site gets a referral, the staff work to engage the family. However, if the program cannot enroll the family, staff refer the family to other, local programs. The ability to "send them in the right direction," instead of placing them on a waitlist or turning them away without guidance, is a strength of the infrastructure in this county.

As noted by a downstate provider, the current economic conditions have had differential impacts on the referral process among county health departments. For example, whereas one county has weathered the storm and continues to provide its referrals consistently, another county's health department has endured layoffs, and that loss of staff impacts its ability to collaborate across the board. The department has less time to partner and do referrals, and remaining staff have to pick up additional knowledge and skills that former staff had in working with the home visiting programs.

Training and Information Sharing

Several sites noted that a strength of the local system is the ability for supervisors to attend regular community-wide agency meetings to learn what services are available in the community, and then bring that information back to share with the program staff. A PAT site within a collar county mentioned the ability to attend other programs' trainings, as well as invite other programs' staff to attend their own training. "There's a lot of collaborative training that happens in our communities…I've had, like, one thing that isn't being offered," the supervisor interviewed mentioned. She continued, "Now they have the tool kits, and they're starting to share it. So I think it's a really good way to get the information out there." In addition to extending invitations to other programs' staff, some community programs, such as the Chicago area HFI sites, attempt to get together on a regular basis to share information,.

The ability to connect clients with local resources indicates a local infrastructure that supports the development of the early childhood system. An urban program supervisor noted her program's ability to facilitate opportunities, through the staff's relationships with local providers, for their clients to take GED courses, connect with vocational opportunities, and in general make "sure that the client has the appropriate benefits and that they're accessing community resources." A suburban site discussed its county's monthly meeting for all human services' programs, which helps participants keep each other informed of the local services available. The home visitors who attend the monthly meetings benefit by staying abreast of the resources that could be advantageous for their clients. A downstate site manager mentioned her program's efforts to track referrals to ensure that families have been connected and are receiving the needed services from that resource. Another downstate site reported sending a lot of referrals to WIC and DHS, in addition to local food banks, homeless shelters, schools, and the like. However, the rural character of many downstate sites presents a challenge in providing needed resources. The closest clinic or shelter can be two hours away, a logistical nightmare and virtual barrier impeding most families from ever receiving these services.

As evidenced by the program managers' survey, improving service collaboration is a top priority among many home visiting programs. One approach to such improvement is underway in a suburban county that developed Memorandums of Agreement intended to improve the collaboration among county agencies and programs, raise awareness of available services, improve communication among agencies, and look for joint funding opportunities, among other things. One supervisor within the county noted the macro-level benefits that result from this collaborative work, "They are not just networking for their own good as home visitation programs; they are actually helping with system development."

Strengthening the System: Perspectives on Strong Foundations

Results presented thus far indicate that, overall, our informants perceived both strengths and weaknesses in the current system of supports for evidence-based home visiting programs. Their perspectives also differed depending in part on their positions and roles in the system. Now we turn to a discussion related to specific enhancements of the state system implemented under the Strong Foundations initiative. With the exception of some of the program directors, most of the program-level staff had only cursory information about the initiative. Thus, this section is based primarily on interviews with state-level informants. Some of these individuals were involved in the writing of the proposal, and most—but not all—were involved in regular meetings of the HVTF or one of the work groups.

At the time of our spring data collection, state informants were very much aware of the cut to funding for Strong Foundations that occurred in December 2009 and the uncertainty of funding beyond the current year. Thus, all mentioned with regret the loss of the funding for Strong Foundations. However, they differed in their views about what the experience of writing the proposal and developing the implementation plan meant for the state's infrastructure. That is, about a third of the respondents believed that little had been accomplished during the short life of the initiative, except to provide a limited amount of new training. Moreover, without the funding and opportunity for the high-level collaboration it would have provided, they were pessimistic about the state's ability move forward and implement planned enhancements to the infrastructure. Another third, however, believed that the Strong Foundations application and planning processes had been very helpful in strengthening interagency communication and establishing goals and a plan for the state system to deliver home visiting services in, as one informant stated, "the most effective and efficient manner possible." A few respondents also pointed to examples of small but specific steps being taken by agencies to explore ways to share funding or apply funding in more flexible ways. For example, in the words of another informant,

> Everybody's at the same table. There's now a Home Visiting Task Force, and each of the funding systems is open to funding more than just the model it began with. So, DHS, in the beginning, only funded Healthy Families and didn't fund Parents as Teachers or NFP, and so they've looked at their allocation, and the state budget is now being opened to any of those models. I think ISBE now has at least dipped their toe in the water of Healthy Families, when before it was pretty much [limited to] PAT. So, there's some openness—although it's just begun to involve funding other programs—to becoming familiar with other programs, developing expertise in kind of their implementation.

Other findings related to Strong Foundations included perspectives on the leadership of the initiative and the extent to which the appropriate program models, coordinating agencies, and state-level departments were participating in Strong Foundations—and whether other stakeholders should be involved. Again, views differed somewhat. A majority had no complaints about the leadership and management of the

initiative, although one individual commented, "I'm not sure who is in charge but they're doing a good job."

A few informants, however, were critical of what they perceived as weak or inconsistent leadership of the initiative, and one informant admitted finding the management structure of the HVTF and its several work groups "confusing." These difficulties likely stemmed, in part, from ongoing budget problems at the state level, which kept the project from hiring a state-level project coordinator until the end of the first year. The lack of the coordinator, the multiple dimensions of Strong Foundations, the complexity of participating in a national initiative and a national cross-site evaluation process, coupled with the added layer of uncertainty about the long-term funding for the initiative itself just a few months into the first year of implementation, left state leaders "stretched thin," in the words of one informant.

A majority of our respondents believed there was a broad range of public and private agencies and other partners involved in the initiative, as well as state and local stakeholders—including a few parents. At the same time, a few wished they had been consulted more in the process or asked for their opinions and expertise in planning the initiative. At least two people we interviewed questioned whether the three lead state agencies were really sharing leadership when the grant money and responsibility for coordinating the initiative fell under only one agency. In addition, some of our informants mentioned other partners that might have been included—or should be included in future efforts to strengthen the state infrastructure, such as representatives from the health-care sector, the courts, law enforcement, and local community members. It should be noted that Strong Foundations' leaders made a concerted effort to include parents, and one or two attended meetings of the HVTF; however, in the short time of the initiative they did not have an opportunity to play a very active role.

Most of our respondents also agreed that the three models of evidence-based home visiting programs selected for Strong Foundations had the strongest research base and were the appropriate ones to promote under this initiative. However, a few respondents expressed concern that other models, particularly Early Head Start and Baby Talk, were not part of the initiative from the beginning.[12] With regard to Early Head Start, it was noted that it was not only another model with a research base, but also a significant funding stream for home visiting in the state:

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[12] It should be noted that during the planning year, the HVTF decided to include Baby Talk and EHS in the "big tent" of home visiting models in Illinois with a research base, although for the purpose of the evaluation, it was decided to focus on the three models originally selected. In addition, the HVTF continued to support the decision made early on by the Strong Foundations Planning Team to take a "big tent" approach to the development of one, inclusive, state-level infrastructure for all home visiting programs in Illinois.

> One of the big oversights of Strong Foundations was to not really fully think about Early Head Start as a substantial part of our home visiting system and really think about how they fit in. I think it's more challenging when you're trying to coordinate state funding streams with federal funding streams, but it's no less important…. Strong Foundations is really about a state system for home visiting and shouldn't have been focused on any one funding stream. It should really be focused on building an infrastructure for everything home visiting in the state.

Finally, although the long-term future of Strong Foundations was uncertain at the time of our interviews, we asked our informants for recommendations about which of the initiative's components should continue or where remaining resources should be directed. There was general consensus among the respondents supporting the HVTF's decisions in response to the funding cut to continue to provide support for community system-building and training focused on developing staff skills in working with families experiencing mental health problems, domestic violence, substance abuse, and developmental disability. Another recommendation was to continue the work of the Program Monitoring and Quality Assurance Work Group to develop a common information system for home visiting programs in the state as well as standards for high-quality programs and indicators for measuring quality across program models.

Enhancements Supported by Strong Foundations

Below we describe the implementation of planned enhancements in two areas of the state infrastructure: staff training and support for community system-building. As indicated above, initiative leaders identified these two areas as having the most promise in terms of impact on program quality and system-building. These strategies were not implemented early enough in the year for many of our informants to be able to comment on them. However, each element had an evaluation process that provided some initial feedback on its implementation, which we summarize here.

Training for Program Staff[13]

In the spring, Strong Foundations' funding supported several trainings for home visitors in two of the four identified risk areas: domestic violence and perinatal depression. The two trainings were each offered four separate times, once in each of four identified regions in different parts of the state, and were free of charge. The trainings aimed to provide home visitors with the tools and knowledge needed to detect the signs and symptoms of these two risk factors. The goal of both trainings was that upon completion, home visitors would be able to describe characteristics indicating that one or both parents in a family are

[13] Secondary sources of information for this section include the Strong Foundations proposal (July 2008) and implementation plan (June 2009), minutes from HVTF and Special Needs Training Work Group meetings, and course evaluations for Perinatal Depression and Domestic Violence trainings.

affected by one of the risk factors. They also were expected to be able to describe appropriate actions and precautions to take (or not take) in working with families who are affected by that risk factor and identify appropriate community referral resources and procedures to ensure that families who are affected by such risk factors are appropriately and effectively informed of or linked to these resources.

Perinatal Depression

The Perinatal Depression: Screenings and Strategies training addressed the types, symptoms, and frequency of depression that many home visitors encounter among the mothers on their caseloads and strategies for addressing it. Children of depressed mothers are at risk for developmental and behavioral problems and may be predisposed toward developing depressive disorders themselves. Therefore, early identification of and response to this issue is critical. In addition to the overview of perinatal depression and the opportunity for home visitors to discuss their experiences, the training taught home visitors how to administer the Edinburgh Postnatal Depression Scale (EPDS).

The first two trainings in perinatal depression were held in early March in Chicago and late April in Dixon, in the northwest area of the state; the next two occurred in early June in Springfield, in the middle part of the state, and in downstate Carbondale. Across the four trainings, there were a total of 89 participants; 83 were from either IDHS or Ounce of Prevention Fund/Prevention Initiative (PI) programs, and 6 were from other, unspecified programs. Overall, most participants gave the training above average marks and said they would recommend it to others. They noted several strengths of the training, which included information on identifying and assessing depression and a "useful tool" for assessment. One respondent specified the "interesting application of how depression affects infants."

At the same time, some respondents noted a need for "more interaction" in the approach to the training, and a couple suggested that videos would be a helpful addition. In terms of content, several participants also asked for more detailed information and instruction on specific cultural differences in families whom home visiting programs serve. For example, comments included the need for "more information pertaining to my population," "generational issues working with new moms," "more coverage about social cultural stigma," and "ways to reduce stigma."

Domestic Violence

The Domestic Violence: Strategies for Identification and Getting Help trainings were intended to define the problem of domestic violence for home visitors and examine the underlying causes and symptoms of such violence. The appropriate training and ability to respond to domestic violence are crucial due to the compromised care in which children are placed when an environment of violence or abuse is allowed to continue in a home. In the absence of a safe, secure, and stable environment, children's early

social/emotional development often suffers. Therefore, the training also provided strategies for responding to victims effectively and in a supportive manner.

Like the perinatal depression trainings, the domestic violence trainings also took place in different regions of the state—two trainings were held in April—one in Chicago and one in Springfield—and two were held in May, one in Dixon and one in Carbondale. Evaluations were administered at all four trainings and completed by a total of 81 respondents from either IDHS or Prevention Initiative programs. Evaluations from all four sessions reported above average marks, overall, for the training. They were generally very positive about the information provided, particularly the "safety plan," although some thought too much time was spent on defining domestic violence and not enough on talking about higher-level information. A few respondents suggested that because their clients are primarily teens, the trainings could offer "more about teen dating violence." One participant suggested that future trainings address ways to begin a conversation when domestic violence is suspected. In terms of the approach to training, as with the perinatal depression training, a number of respondents wanted more interaction in the session or the use of role plays to reinforce concepts.

In summary, participants were positive about the trainings provided in two areas—mental health and domestic violence—to address the special needs of families served by home visitors. A majority of participants believed the information would be applicable to their daily work. On the other hand, several course evaluations suggested a need for more advanced, in-depth information on these topics, particularly with regard to working with parents of different ages (i.e., teens) and parents from different cultural groups. Some of the comments regarding the training method utilized also indicated a desire for more interaction among training participants and the instructor, and the use of media, both of which might help to reinforce and implement key concepts. Finally, it is noteworthy that the trainings were held in different parts of the state to make them accessible to a broad audience. At the same time, it appears that most of the participants represented one of two models of home visiting program. Thus, one issue to pursue in developing future training and to track in future data collection will be the extent to which the current professional development system for home visitors reaches staff across all home visiting programs in the state.

Support for Community Systems Development[14]

One of Strong Foundations' goals was to develop a technical assistance strategy for communities to implement the home visiting model that best fit their local needs or to help the communities work with their multiple home visiting models so that they were available to families in a coordinated and efficient manner. This was the primary charge of what became known as the Community Systems Development Work Group (CSDWG). Members of the group—originally named the Technical Assistance Work Group—began working in collaboration with the CSDWG of the ELC's Infant Toddler and Oversight and Coordination committees and the Government Interagency Team of the state's Birth to Five Project. The CSDWG's overall goal is to create recommendations regarding community partnerships to support a coordinated system of services, including home visitation programs, for young children and their families across the state.

During the first year and a half of the Strong Foundations' initiative, the joint CSDWG met eight times. During that time, the primary activity was to create and distribute two community toolkits, *Community Systems Development Resource Toolkit: Supporting Local Communities in Collaboration and Partnership Building* and *Resource Toolkit for Communities Considering and Implementing a Home Visiting Strategy: Identifying Program Models to Meet Community Needs*. As each toolkit complements the other, the decision was made to package the two toolkits together to help communities develop and sustain partnerships and become familiar with research-based home visiting models and with the existing infrastructure and support in Illinois to implement the models. The toolkits are available to assist interested communities with the process of assembling a collaborative local planning team, assessing community needs and resources, identifying potential funding sources, developing a strategic plan, and selecting the home visiting model or combination of models that best meets the communities' needs.

The work group recommended two levels of outreach to local communities to disseminate the toolkits. The first phase, Awareness Level Outreach, is broadly focused to disseminate information on building community partnerships and home visiting to new or existing community partnerships, home visiting providers, and state agencies (e.g., IDHS, ISBE, Head Start). The second phase, Implementation Level Outreach, will provide additional information, training, and support to facilitate the use of the toolkits to interested communities.

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[14] Secondary sources of information for this section include the Strong Foundations proposal (July 2008) and implementation plan (June 2009), minutes and documents from HVTF and CSDWG meetings, December 2008 ELC Infants and Toddlers Workgroup Chart FINAL.doc, the two toolkits, and the Positive Parenting DuPage Collaboration and Systems Building Technical Assistance Evaluation Report compiled by researchers at Northern Illinois University, Center for the Study of Family Violence and Sexual Assault, June 2010.

In May 2010, with funding from Strong Foundations, Positive Parenting DuPage led seven regional Collaboration and Systems Building Technical Assistance sessions. The objectives for these training sessions were to learn characteristics of the continuum of local collaborative systems; understand how to use the Community Systems Development Resource Toolkit; discuss local coordination of programming and how to utilize evidence-based home visiting models; and learn about ongoing technical assistance opportunities. A total of 150 representatives from a wide array of early childhood systems and programs (e.g., Head Start, Department of Children and Family Services, health departments, mental and behavioral health services) attended the sessions.

At the conclusion of the sessions 138 (92%) of the participants completed evaluation surveys, which provide some insight into the perception of local collaborative efforts. (A copy of the "Positive Parenting DuPage Collaboration and Systems Building" report appears in Appendix D.) For example, despite more than two-thirds of respondents indicating that they "currently work collaboratively," when asked to rate their level of engagement in community collaboration on a scale from 1 to 5, with 1 being "fully engaged" to 5 being "not connected in any collaboration," the responses varied widely. Almost half of the respondents answered with a 1 or a 2 for an overall average of 2.7. This raises an interesting question about the level of connectedness and engagement among collaborative participants and supports a need for technical assistance on how to improve existing partnerships to increase levels of engagement. Session participants also answered questions on their "most pressing needs around advancing collaboration and cross system training." More than half of the participants identified money as a pressing need; almost 45 percent indicated a need for structure to build collaboration; more than a third responded there was a need for community leadership; and, almost 25 percent identified the need for technical assistance in some form. Over 81 percent of participants indicated that their communities would take advantage of collaboration supports in areas such as cross-system competency building, resource availability, collaborative work without duplication of services, and collaborative work across a range of community stakeholders. More than 75 percent of participants indicated that they could "identify a research-based home visiting model" and knew where to access information on a research-based home visiting programs.

Summary: System Strengths and Challenges

Results presented in this chapter indicate that overall, state-level informants and program managers perceived both strengths and weaknesses in the current system of supports for evidence-based home visiting programs. Although they agreed in many areas, their perspectives also differed depending in part on their positions and roles in the system. Another factor was the timing of our interviews, with most of the interviews with state-level informants occurring in early spring—just a few months after the announcement of diminished funding for Strong Foundations. Thus, several respondents were pessimistic

about the current state of the infrastructure or its ability to grow. On the other hand, others noted that the application and planning process for Strong Foundations resulted in several promising developments. These include a new logic model and action plan for developing programs and improving program quality, and the outline of a plan for a common system for monitoring and quality assurance. They also include the new training developed to improve the skills of providers working with families experiencing issues such as poor mental health, domestic violence, developmental delay, or substance abuse and improved screening and assessment tools, making it more likely that families with one or more of those issues would be referred for services.

When asked about the strengths of the current system, those we interviewed at the state level mentioned the mechanisms for advocacy, communication, and collaboration most often. Although they acknowledged the imperfections in these areas, they also believed that the state and local communities benefit from the work of the ELC and HVTF, the many other opportunities to share information and collaborate across agencies, and the growing openness to blend funding for services. A number of our respondents also highlighted the fact that there are a number of evidence-based programs now operating in the state. Although their goals are similar in terms of improving family functioning, parenting practices, and child well-being and development, they have different strengths in their approaches and models, and these differences increase the state's capacity to serve families with diverse needs. Among the system strengths are also the multiple forums for training. These include the Birth to Three Training Institute, which is seen as providing a solid foundation to span the diverse delivery of services, but also the growing awareness of the need for training—and availability of training in some areas—to meet the different needs of families in a culturally competent way.

Several weaknesses in the current system and challenges for system-building also emerged in the analysis of our interviews. State-level respondents identified challenges at several levels, including the systems level, the program level, and at the level of individual families. At the system and program levels, funding was mentioned most often. Funding cuts result a reduction in technical assistance and other services that the state can provide to programs. Cuts also result in the reduction of the number of families programs can serve and inhibits the ability of programs to meet existing needs in the community. Budget crises and funding cuts are difficult for program staff as they wait to hear whether their program will remain open or be closed. These impacts are demonstrated in current capacity and enrollment statistics. In the view of some but not all of our informants, budget cuts also impact the quality of programs and services. Another challenging aspect to funding is coordinating, managing, and reporting to multiple funders.

The gaps in both home visiting services and other needed community resources pose another challenge. State respondents indicated that home visiting programs are unevenly provided across the state, and there

are areas where no services are available. Communities also lack resources, especially in the areas of domestic violence assistance, mental health services, infant mental health services, and substance abuse assistance. In addition, they noted evidence of gaps in services for specific populations, including homeless families and specific ethnic groups—Hispanic, but also Asian and Arab populations—and a need to increase the cultural competency of service delivery. Recently, there also have been requests for more help and resources for working with younger teen parents and children with autism.

Respondents often noted lack of transportation systems as a barrier to accessing the other available services. Some interviewees stressed the needs of specific geographic regions, rural communities, for example. The greater distances clients have to travel, lack of bilingual services, lack of available matching funds for programs, and general lack of resources were cited as challenges specific to rural communities. Rural communities also appear to receive less technical assistance from the state.

The variety and depth of family needs are another level of challenge for the state system. Families struggle to meet basic needs such as housing, food, and health care in many areas of the state. Mental health needs often cannot be addressed with available resources. Failing budgets make delivery of domestic violence and substance abuse services difficult. Families with multiple needs or more serious levels of need—for example, those with domestic violence issues, substance abuse issues, parental developmental disabilities, or mental health issues—also tend to be the most difficult to engage. These families are often lost once recruited, or cannot be recruited at all. Teen parents and homeless families can also be more difficult to engage in visits on a regular basis, and trust can take longer to build. In summary, informants participating in the state system identified a number of strengths in the current system but also weaknesses and challenges to building the system. Both have an impact on the operation and quality of local programs. In the next chapter, we discuss this topic from the perspectives of staff—agency or program managers, supervisors, and home visitors—in a sample of home visiting programs from around the state.

Program Implementation and Quality

In this chapter, we present findings related to the operation, quality, and model fidelity of a sample of home visiting programs in the state drawn from individual and group interviews with home visitors, supervisors, and program managers and surveys of home visitors and program supervisors. As described earlier, our goal was to select programs representative of the three evidence-based models that are the focus of Strong Foundations from various regions of the state. We begin with an overview of the sample of local communities from which we recruited program staff to participate in the evaluation. We then discuss the characteristics of these local programs, their staff, the services they provide, the families they serve, and their connections to other community resources.

Community and Family Characteristics

The programs participating in the Strong Foundations evaluation are located in three distinct regions of Illinois: urban Chicago, suburban/collar counties, and rural/downstate areas. In addition to Cook County, the programs serve families in three suburban and seven rural (downstate) counties. Outside Chicago, these counties range in population from approximately 14,000 to 700,000 (U.S. Census Bureau State and County Quick Facts). As is common in rural areas, five of the seven counties have shown decreases in population over the last decade (Johnson, 2003). A program manager from a rural community described a "repetitive history of boom and bust" and a county where "they've had mining, they've had the railroad, they've had the oil industry, then other factories have come and gone." She went on to say, "Those who can leave, do leave, follow the work….The families who can't leave and still aren't employed aren't able to provide for themselves."

The rural and suburban counties tend to be predominantly white (80–97%), while the Chicago area is approximately 42 percent white, 37 percent African-American, and 26 percent Hispanic (U.S. Census Bureau State and County Quick Facts). However, community demographics are changing. A suburban program manager described changes in the community: "The school used to be about 10 percent Latino students and now it's 85 percent, and according to the city, they are talking about 36 percent of the community is Latino." People living below the poverty line range from about 14 to 23 percent in the rural counties, 6 to 9 percent in suburban counties, and approximately 20 percent in the urban Chicago area.

These basic demographics illustrate the very different contexts in which home visiting programs across Illinois operate. During our focus groups, the home visitors highlighted the community context as it relates to their work. In the rural counties, small communities necessitate contacts with clients outside of the home visit. They describe a community where "everybody knows each other," and they run into clients at the gas station and Wal-Mart. One home visitor explains, "You just run into them. And if they want to talk, you talk." In some of the urban areas, there are definite geographic boundaries to consider when attempting to access resources safely. Home visitors at one program described an educational workshop for which they provided transportation for the young mothers who chose to participate. At first, the clients appeared apprehensive when they learned that the workshop was in a different neighborhood, but they were reassured by the staff and transported from door to door.

Program Demographics

The home visiting programs in our sample serve primarily low-income families. The Chicago programs report that approximately 50 percent of their clients are teen mothers without a high school diploma or GED. Almost 100 percent are low-income and WIC eligible, approximately 40 percent are unemployed, and about 30 percent speak a primary language other than English. Programs located in suburban counties also serve primarily low-income, single-parent families, about 70 percent of whom do not have a high school diploma or GED. About 40 percent are teen parents, 40 percent are unemployed, and 40 percent speak a primary language other than English.

The programs serving the more rural downstate communities look a little different in terms of client demographics. Like their urban and suburban counterparts, downstate programs serve predominantly low-income, single parent families. However, only about 25 percent lack a high school degree or GED, and less than 4 percent are non-English speaking. Approximately 60 percent are unemployed and are teen parents.

Family Needs and Challenges

Both program managers/supervisors and home visitors presented a similar picture of the families served by the home visiting programs in our sample and their service needs. These needs also overlap with those

identified by state-level informants. Those mentioned most often involved mental health issues, unique challenges for teen mothers, inconsistent transportation and housing, and domestic violence. Additionally, low levels of education achievement coupled with high levels of unemployment, especially in the current economic climate, and inconsistent family support round out the major areas of family need identified in this report. The budget constraints and realities all programs face magnify the challenge to adequately provide services to meet these needs.

Mental Health

Home visitors from all three regions spoke about recent increases in the number of clients with mental health issues and the lack of appropriate resources and support services available to them. Program supervisors and managers cited the same lack of resources available to support clients with mental health issues. Supervisors also estimated that 20 to 30 percent of their clients have mental health issues. A downstate program manager commented, "Every other person we get, it seems like, is bipolar or is on medication already or needs to be on medication." Another in the same region added, "More people are diagnosed, more people are on medications, but we get really high-risk clients in terms of their mental health issues." A manager of a suburban program similarly noted, "Mental health has really gone up because we see a lot of bipolar and mental health issues just gone up. Every other referral that I pick up has got mental health issues and depression. And I'm thinking, 'Why is a 15-year-old depressed?' It's hard to get them into counseling."

Home visitors and their program supervisors report that the lack of available services is a challenge for their programs as well as for the families they serve. The lack of sufficient mental health services in all three regions results in clients who have nowhere to turn for services or who must endure long waiting periods before receiving services. A supervisor of a program in Chicago told us, "Sometimes we don't even have some place they can go. There may be—they can get services in terms of a hospital or something, but they're not really getting, say, the real services that they need."

Sometimes providers are available but they are not located in the same community as the client and transportation is not available. Even if services are more accessible, it is often difficult to persuade those with mental health issues to seek or follow up on services. A downstate provider described her frustration with a client with a serious psychiatric disorder who habitually missed appointments with her therapists who were only 10 minutes from her home. After the client resumed taking her medication she wanted to resume her therapy, but the local provider refused to re-accept her and referred her to another mental health provider two hours away. Several home visitors in Chicago and suburban counties noted that the lack of insurance coverage or medical providers who will accept Medicaid also pose challenges:

"Probably the biggest issue that we struggle with is helping our families find mental health services that are nonexistent or do not take the medical card."

Teen Parents

Home visitors in Chicago and the suburbs said that they noticed that the mothers they serve seem to be getting younger. A Chicago home visitor commented, "I'm getting them younger and younger now. It started in 2008, but now this year, it's just like most of my girls are, like, 15 and 17. My population is anywhere from 21 and under. So, we can get them as young at 13, 12. I mean, I have had cases of 9-year-olds." This change in the age of client demographics creates challenges for home visitors. Chicago home visitors report the difficulties in locating appropriate and affordable supports and services for teen mothers. As one home visitor explained,

> We're pretty good at handling what we get, but my frustration comes when helping minors. If they want to get out of that situation there's no shelter where you can accommodate them. The second problem is resource availability for a minor if there is some domestic violence or if the person doesn't have documents. [Resources are] very limited, and it's very hard to help them get out of that situation. The majority of the teen shelters are full. Every time you call there's a waiting list. I had a client who had three kids and they wouldn't take her because she had that third child and she ended up having to go to an adult shelter—which may be too much for her—versus going to a shelter of her peers, where there are more teen moms.

As another respondent, the manager of a Chicago program, described it, "These young women are just in limbo. They're just in this no-person's land because until you're 18, your options are so limited."

Home visitors also reported issues specific to working with adolescent mothers and the challenges presented when trying to help these mothers understand their parental role. A home visitor from Chicago told us, "You'll be surprised how many teen moms don't know that reading a book is good for the baby, talking to the baby, holding the baby closely, building relationships." Another said, "We're working with teen moms, who are kids themselves, and teaching them how to be good parents and prevent child abuse, and teaching them proper ways, because some of their parents are on drugs or have substance abuse issues or are not involved, so they have no idea on how to raise their child." A home visitor from a downstate program said she sometimes has to remind herself how young her clients are: "They're not really sure sometimes how they even got pregnant. Or even the real young ones if they're not mentally handicapped, if they're just really young. You have to—I have to remind myself to talk in terms that I think would just be understood."

Another topic raised during the focus groups was the changing manner in which young people communicate and learn and adjusting to that change as a home visitor. "These girls text everything, but it's so much harder even now doing a visit than it was when I was here before," a downstate home visitor

reported. “We used to have so much wonderful stuff that we did on a visit to hook them. Some of them didn’t have TVs; we brought in videos, we videotaped the babies, we showed films on labor and delivery. Now, they’ve got it all on TV, the internet, their cell phones. They’re like, ‘I don’t want to do that. I see that every day on TV’.”

In the view of another home visitor in a downstate program, paradoxically, teen mothers are “very disconnected socially.” Although they are connected through the Internet, texting, and cell phones, “they can’t interact personally.” She went on to explain:

> They are so disconnected personally that it presents huge issues with parent-child relationships because you can’t text your baby. And when you go into their home—they want to talk to you all day on the phone, or by texting, but they don’t want you in their home. I’ve got one girl now that will say 10 words during a visit, but as soon as I round the corner, she texts me for a good 20, 25 minutes afterwards.

Housing

Safe, affordable housing is limited in all of the communities we visited. Home visitors and supervisors in all three regions reported that housing is a challenge for their clients. “Housing is always an issue,” a Chicago supervisor noted. “Our girls tend to kind of go from home to home.” During an urban focus group, one of the home visitors was unexpectedly called away from our meeting due to a crisis on one of her cases in which the family was being told they were about to be evicted from their apartment. Another home visitor from a downstate program explained, “Not having jobs allows my families to get thrown out of their low-income housing, so they’ve got to live out here in a trailer.” One supervisor made a distinction between issues of homelessness and unstable housing. She stated, “None of my girls are homeless. They all have a place to sleep at night, but they move around a lot between friends, their mothers, their boyfriends, or their boyfriends’ parents.”

Home visitors in each of program models echoed the transient nature of families. Not only does housing mobility challenge [teen mothers] in providing safe and secure environments for their children, but home visitors struggle to maintain contact with clients who may sleep on a different couch from one visit to the next. Phones are disconnected and addresses change, and clients often fail to notify their home visitor. A home visitor in Chicago said she always tries to find out her clients’ plans:

> Because they’re constantly moving, and unsure of themselves and where they might be staying. I had a mom just recently that was kicked out like two days before she gave birth. And then, just craziness, she gave me a location to go visit her. I go there, they told me “No, no, she left. She’s at blah, blah’s house,” and I go over there and she’s not there. So, I’m chasing after these kids sometimes, these young moms…. I’m doing a little bit of running around. But it’s part of the job, and we’re doing it to ensure that these moms take care of their babies properly.

Another home visitor told us that sometimes the teen mothers are told to leave by their mothers:

> Some of the times their mothers kick them out, so they're out on the street, and basically they're at an aunt's house, or an older sister's house. The majority of them go to the FOB's [father of baby's] house. They live with the mother-in-law and their family, and they're cramped up. And then we have some girls that are old enough, like they're between 18 and 21, where they're able to get some public assistance or TANF where they're able to obtain an apartment.

As indicated above, the lack of housing resources is a critical factor that impacts early childhood development and familial relationship building. Home visitors in one of the suburban programs that serves a number of clients from area homeless shelters discussed some of the challenges in trying to connect with families who are contending with large-scale issues, such as housing. For example, "There's so much emotional impact on these families right when they move into the shelter that they're not really knowing how to pay attention to their children." Programs in more rural areas face increased scarcity in resources and, specifically, in access to homeless shelters. A supervisor of a downstate program remarked, "One of the sad things is we really don't have homeless shelters locally, so, we do try to help them find what there is out there, but that means going miles away, and those are typically full."

Transportation

Home visitors and supervisors in all three regions reported that transportation is a barrier to services as well as a risk factor for their families. Rural areas lack public transportation, and family circumstances (such as poverty) often prevent them from having their own, reliable transportation. "Transportation is hard. Most of them have one vehicle, and usually somebody's working, so it's hard to get to places," a home visitor in a program in a collar county reported. A downstate program manager declared, "Transportation is a huge barrier for many families that we work with. [This community] is the economic and social service center of the region, but you don't have good public transportation, especially within different counties, traveling from one county to another." This can keep young parents from accessing a range of resources from education (e.g., GED classes) to health care and food assistance (e.g., the WIC program): "If they don't have a car, there's nothing. And it's rural, so it's so far away because we're in a rural area which hugely affects, a lot of times, them getting prenatal care." Although transportation is more available in urban centers, it can involve leaving safe neighborhoods and familiar settings. Thus, a Chicago-based home visitor maintained that, "Transportation is a predominant risk factor affecting our families."

Domestic Violence

Domestic violence is another issue that affects home visiting clients across the programs and the geographical regions represented in our sample. A suburban program manager described the problem this way:

> We have a large percentage of families with domestic violence, and, in fact, this past year, we've probably had more calls related to domestic violence then we've ever had before, so, I don't know if that, in turn with the economy, is making people stressed out and putting their wives and their children at risk because there's so much stress and tension there, so domestic violence is a big challenge for the families.

Several programs have developed partnerships with local domestic violence shelters where the home visiting staff have received training. According to one provider, "[The local] domestic violence shelter offers training for all of our workers for free. I think it's 40 hours, and they tailor it to us, which is home visiting, because their role over there at the shelter is different than a home visitor's role."

However, programs located in suburban and rural parts of the state also report a lack of available services that address domestic violence. According to a program supervisor of a suburban program, "There's not adequate [domestic violence] services here." Another suburban program supervisor reported, "Both of our domestic violence shelters are close to closing down because of the state funding."

Downstate programs differed about the seriousness of the domestic violence issue in their areas. One home visitor reported the following: "A few have dating violence issues, but it's more like 'what is a healthy relationship?' 'Is my boyfriend obsessively jealous because he loves me, or is he obsessively jealous because he's trying to control me?' It's not a huge problem; but it is an issue."

However, a program manager suggested that her clients might not be accessing services because they are denying their issues as much as anything else:

> Domestic violence is pretty common. We have a very good domestic violence shelter located in [this community] that serves that entire region [but] it's really hard to get people to access services. We have a lot of struggles getting families to acknowledge that that's going on. It's a denial about their issues or they move out of one domestic violence relationship and into the next one.

Employment, Education, and Basic Needs

Home visitors and supervisors emphasized the lack of employment opportunities and low education as risk factors for many of their clients. According to a home visitor in Chicago, "They need jobs. This is always the most important thing. But more important than that is education." A downstate home visitor maintained, "The biggest thing is illiteracy. Sometimes you figure out that there's a family that can't read or doesn't read well." Although unemployment is high in all areas of the state in which programs in our

sample operate, the opportunities seem particularly limited in the southern region. "This area doesn't have many jobs," a home visitor reported. "Even the program Put Illinois to Work, it's hard to get the employers here to take in and hire even though it's a federally funded program. I have 12 of my participants that put in for it and only two got called so far." To help address the need to develop job skills, a downstate program manager reported, "We're doing a lot of job skills stuff right now because they can't find jobs."

The lack of employment and general high levels of poverty cause many families to struggle for basic infant and household items. As one program manager from the Chicago area stated, "Oh, my goodness, the biggest [challenge] is just being able to provide for their children the basic necessities." Programs are finding they are making more referrals for basic needs, such as food assistance, than for other needs. For example, a suburban program manager reported, "We've connected more families than before with Food Stamps. Before, some families were on Food Stamps, but now the majority opt for them. It seems that everyone is on Food Stamps." A suburban home visitor noted that even food pantries are reducing their services: "Food pantries have become harder to refer to in recent years due to the economic downturn; families can only access the food pantry once a month." An example of how home visiting programs try to respond to the decreasing availability of resources to meet basic needs comes from a home visitor in Chicago:

> I have a girl right now that's 15, and she's living in her own apartment, because the FOB [father of the baby] is like 18 or 19 and he's providing her with a little studio. And my mission in life right now is to get her furniture, because she has nothing. I'm asking by word of mouth for donations, and I'm getting good responses.

Additionally, programs attempt to provide incentives, like books and other small gifts for the baby or vouchers for transportation, for participating, which can multiply a family's resources and help provide some of their basic needs. However, many programs have had to curtail or cut these incentives completely for funding reasons. According to a home visitor in a suburban program, "The staff would like to be able to give incentives to their families again. They used to be able to give diapers to their families about once a month or so, but the diaper donations have stopped. They used to have a lot of incentives to bring to the families, but with the economy these have all ceased."

Family and Community Support

Home visitors report that, many, though not all, of their clients lack traditional family supports that can be so vital as new parents learn about their child's growth and development. "I think often if they don't have a lot of family support, they need the information," a program manager at a suburban site told us. "They need that support from someone and maybe they don't have a parent or someone that's there." A home

visitor from another suburban program similarly noted, "A lot of them don't have their mothers around or, whatever, somebody showing them or telling them, giving them advice." Home visitors further commented that other sources of informal support—friends and neighbors—are also less available than in the past. As a result, a manager concluded, "We may be their only contact outside of the spouse, so they are here on their own, no family in the area, no friends. Isolation is huge."

Substance Abuse

For the most part, we were surprised to find that the home visitors did *not* report substance abuse as being a major challenge for the families they serve. Some of the home visitors commented that they might suspect same random marijuana usage, but overall, all clients with substance abuse issues were largely absent from their caseloads. We hypothesize that those families with serious substance use and abuse issues do not choose to enroll in voluntary home visiting programs. Some of the comments state-level respondents made—that individuals with substance abuse issues are difficult to recruit and engage—support this hypothesis.

Family Strengths

Although the families engaged in home visiting programs face plenty of challenges and may lack basic necessities, according to the program staff in our sample, they also exhibit strengths. For example, in their experience, parents desire to improve their lives and be good parents, and some have family members who are also able and willing to be part of the home visiting program. Staff at an NFP site commented that they have some girls who "totally have it together. They are going to school all day long and then working a part-time job. They are taking care of their child…." More than one home visitor in downstate programs noted the willingness of their families to learn and to want to be a better parent. The parents acknowledge that they were not raised in an environment they want for their own child and recognize that they can be better parents than those they had growing up. "They want to be a better parent. They know that maybe what they had wasn't what they want," commented one home visitor. "And they want to give babies a good life, better than what they had," added her colleague.

Programs in each region also acknowledged paternal involvement in home visiting services at some level. At least one program manager in each region mentioned the presence of fathers in their children's lives and in the home visiting program, and one downstate program manager estimated that up to 75 percent of the fathers in their program are involved in the program. Another downstate program currently engages roughly 10 fathers, and 2 of the 10 are the primary caregivers of the target child and the only parent involved in the program. When a father is involved in his baby's life but cannot participate in the program meetings due to work or school, some programs are still able to leave handouts behind for him. One program manager commented,

> We made sure we have different videos, you know, really, from the father's perspective, for the father's perspective. We have written materials, printed materials. [Our model] has information specifically tailored to the dads. We help them feel comfortable in playing with their children differently, different activities, different ways of playing than the moms necessarily would, to really support them. They're important, and the way they interact is important, as well.

In addition to paternal involvement, some programs encourage and facilitate the engagement of grandparents as well. One downstate HFI program offers a grandparent group specifically for the mothers of the teen mothers in the program. "So, the parents of the teens come together with me [at] the same time that the teens are with the other family educators," that program's manager told us. This support from fathers and other family members helps the mother continue with the program and raise the child in a network of care. "We encourage family involvement, because the more support the client has the better," concluded another program manager.

Program Characteristics

As indicated in the section above, the communities where our sample of programs are located have a number of characteristics and risk factors that might be addressed through home visiting and other services. The section above also alludes to a few of the ways individual home visiting programs try to meet their needs. Below we discuss the characteristics of the programs in the sample and the services they provide. We begin with staff and their backgrounds and training, followed by the supervision they receive, and then turn to a description of the service delivery process.

Staff Characteristics

Demographics

All but one of the home visiting staff in our sample and their supervisors completed a paper survey distributed to all home visitors who participated in the focus groups as well as to their supervisors.[15] Of the 59 home visitors who completed the surveys, 42 percent represented HFI programs, 39 percent were from PAT programs, and 19 percent were from NFP programs (see Table 2). Program representation was a little different for supervisors: almost half were at PAT programs, just over a third at HFI, and 18 percent of the supervisors were at NFP programs. All of the respondents were female. With regard to the age of the supervisors, most (47%) reported that they were 30 to 39 years of age, followed by another 24

[15] As of December, 2010, 76 Strong Foundations surveys had been completed at the on-site interviews and focus groups or in three cases, were completed and sent to us after the on-site interviews and focus groups; and all 76 were entered into SPSS for analysis. With regard to the 17 supervisors, a total of 8 respondents reported being supervisors and an additional 9 reported being both supervisors and home visitors.

percent who reported that they were 50 to 59 years of age. More than a third (36%) of the home visitors in the sample, across the board, were 40 to 49 years of age, followed by another quarter (25%) who reported being 30 to 39 years of age. The home visitors in the NFP program tended to be slightly older than those in the other two models, with 46 percent reporting that they were 50 to 59 years of age.

Table 2. Characteristics of Staff in Study Sample by Position and Program Model

Age Range	Supervisors (%) (*N*=17)	Home Visitors (%) PAT (*n*=23)	HFI (*n*=25)	NFP (*n*=11)	Total HV (*N*=59)
Program					
Healthy Families Illinois	35	—	—	—	42
Parents as Teachers	47	—	—	—	39
Nurse-Family Partnership	18	—	—	—	19
Age					
Under 20 years of age	0	0	8	0	3
20–29 years of age	12	22	20	0	17
30–39 years of age	47	26	24	27	25
40–49 years of age	18	44	32	27	36
50–59 years of age	24	9	12	46	17
60+ years of age	0	0	4	0	2
Race/Ethnicity[a]					
Black, African American	18	44	24	9	30
Asian/Pacific Islander	0	0	0	0	0
White, non-Hispanic	53	35	28	82	40**
Hispanic/Latina	24	22	52	9	32*
Other	6a	0	0	0	0

[a] Note: Respondents could select more than one race/ethnicity but just one respondent did so. "Other" is Southeast Asian/Indian
Chi-square tests indicate differences are statistically significant at *p<.05, **p<.01, or ***p<.001.

One question of interest with respect to the characteristics of program staff is the extent to which they are similar to or different from the families they serve. In our sample, over half (53%) of the supervisors self-identified as being white, while the home visitors were fairly evenly divided among black, white, and Hispanic. Almost half (44%) of the PAT home visitors self-identified as being black, just over half (52%) of the HFI home visitors self-identified as being Hispanic, and well over three-quarters (82%) of the NFP home visitors self-identified as being white. In addition, a large majority (88%) of both supervisors and home visitors reported that they either are currently parenting or have parented a child.

Staff Selection and Education

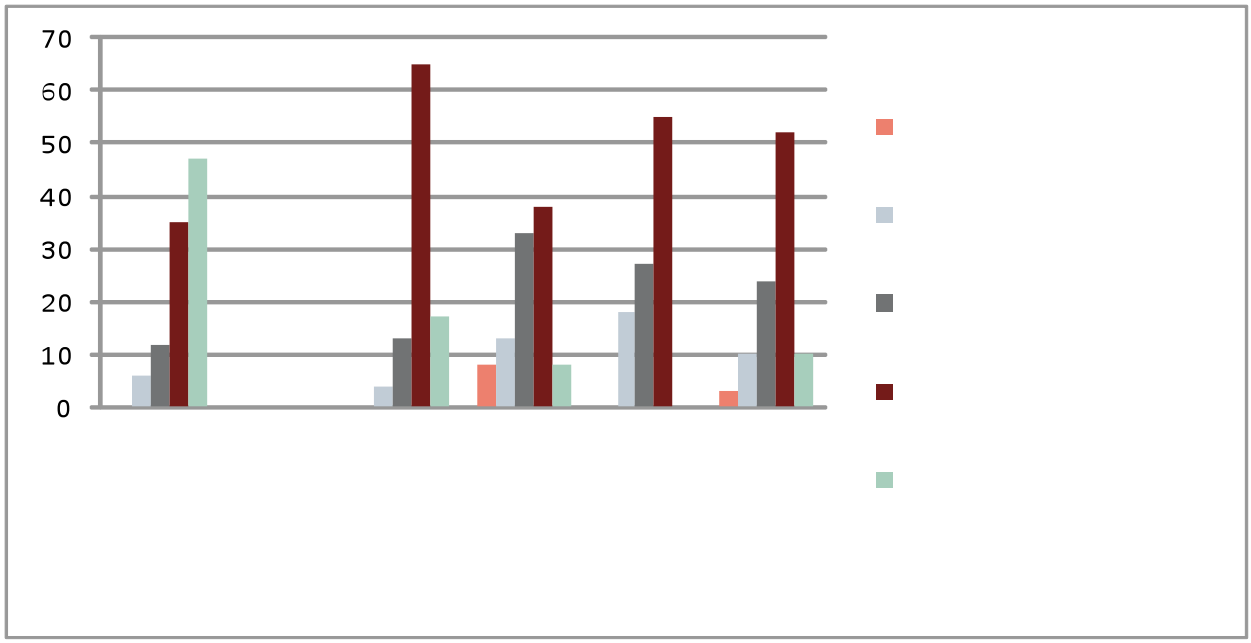
Next we describe the characteristics of the home visiting staff and program supervisors in our sample and then discuss other criteria program managers use in hiring. The three program models require different kinds of educational qualifications, which are reflected in our sample. In addition, however, program managers said they also look for other characteristics when selecting staff, including the ability to build relationships with clients but also the ability to respond appropriately to crisis situations and, in the words of one informant, "an ever-changing set of circumstances."

All of the survey respondents have, at a minimum, a high school diploma or a GED. Among the supervisors, over three-quarters reported having a bachelor's degree (35%) or a master's degree (47%). Slightly more than half (52%) of all home visitors have a bachelor's degree; by program model, this represented 65 percent of PAT staff, 38 percent of HFI staff, and 55 percent of NFP home visitors (see Figure 2). The fields in which the respondents hold their degrees are rather diverse (see Table 3). Almost half (47%) of the supervisors selected "other" when presented with a list of six possible fields of study. For the eight supervisors who selected "other," the majority noted business as their field of study. Larger proportions of PAT home visitors reported that their degrees are either in early childhood education/education (35%) or psychology (30%). The largest proportion of HFI home visitors noted that their degrees are in child development (40%), and almost all (91%) of the home visitors in the NFP program have degrees in nursing.

Very few of the supervisors hold a license or certification; just 18 percent are registered nurses, and just 6 percent are Licensed Clinical Social Workers (LCSW). As for the home visitors, 73 percent of the NFP home visitors are registered nurses, and none of the home visitors in the PAT or HFI programs are. A quarter of the home visitors in each of the program models noted that they have some type of certification, the most often mentioned being education/teaching certificates, FAW/FSW training, and PAT certification.

Very small percentages of supervisors (13%) and home visitors (19%) were seeking further education at this time. Of the two supervisors who were seeking to further their education, both were taking college classes, but not toward a degree. The majority (64%) of the home visitors who were furthering their educations were working toward a master's degree. Everyone was studying something highly relevant to their current work: psychology, social work/social welfare, therapy, counseling, or nursing ($p<.05$).

Figure 2. Highest Educational Degree of Staff in Study Sample by Program Model



Chi-square tests indicate differences are statistically significant at *p<.05, **p<.01, or ***p<.001.

Table 3. Field of Study for Highest Degree of Staff in Study Sample by Program Model

Current Field of Study[a]	Supervisors (*N*=17)	All Home Visitors			
		PAT (*n*=23)	HFI (*n*=25)	NFP (*n*=11)	Total HV (*N*=59)
Child development	0	26	40	9	29
Early childhood education/Education	18	35	12	0	19*
Psychology	6	30	20	0	20
Social work/Social welfare	24	22	24	0	19
Nursing	18	0	4	91	19***
Other	47b	13	12	9	12c

[a] Note respondents could select more than one field of study.
[b] Other fields of study included child and family services, business/business administration, criminal justice, political science and sociology, public administration, public health.
[c] Other fields of study included business/business administration, child life education, Christian education, doula, nursing, sociology.
Chi-square tests indicate differences are statistically significant at *p<.05, **p<.01, or ***p<.001.

In selecting staff for their programs, managers and supervisors in our sample were quite clear that they look beyond educational qualifications. Sometimes it is a need for someone who is bilingual. Sometimes it has to do with what they are able to offer in terms of salary. As a Chicago provider said, "It's a balance between finding somebody who has got the ability to learn without necessarily having the education, or the degree, or the experience, especially given the salary." At the same time, she looks "at their

commitment to learn, to be able to follow the curriculum, being able to kind of take the curriculum and go with it and be creative within it." A downstate provider described a similar set of characteristics:

> Someone who could interact well with our youth; who understood the barriers that they face; who just has the skill sets in early childhood to deliver the knowledge without being, you know, "Oh, I know everything." You know, "I've got all the answers and you don't know anything." But just to engage them respectfully. And I don't think she needs quality training, she needs the motivation.

An NFP program noted that although the national program model requires a bachelor's level nurse, it is difficult to find nurses with that level of education to work for the salary they are able to provide: "In this area, that's a dream." Thus, staff "have to have an active RN license." In addition, the program also looks for experience in a setting other than a hospital: "We really do look for experience—like if they've been a nurse in a Head Start program, they have some experience. Some of the community health department, they've had that, and then sometimes we do team interviewing."

A suburban program manager with a large Spanish-speaking clientele noted that she requires Spanish-speaking staff, but in hiring, she also looks for "people who are able to build good relationships with families, people who are knowledgeable about the culture and people who want to serve their target population." Finally, a provider with a PAT program noted that although her program has more of an educational emphasis than the other models, if she were hiring, she would favor staff with a background in social services based on her experience with both:

> I have degrees in both, a teaching certification and a school social work certification. They're two very different approaches. I would only hire social workers. There was an example of a family educator who wasn't a social worker, didn't know where some of the resources were and didn't have the connections in the social work world that everybody tends to know everybody and what's available and here and there. And I think it's easy for the social worker to become a teacher. It's harder for that teacher to get down and really understand why you're doing some of those things, or why are you empowering them? Just get it done, and that's harder for them.

Staff Experience and Training

Staff in the study sample had a range of experience in their current home visiting models, with a majority of staff across the programs having 5 years of experience or less. The 17 supervisors reported that their years of hire ranged from 1994 (n=1) to 2008 (n=1). PAT home visitors reported dates of when they began working in the program ranging from 1978 to 2010, with the largest number of home visitors reporting a start date in 2008. The reported years of hire for HFI home visitors in the sample ranged from 1994 to 2009; the largest number of home visitors began in 2009 (n=6). Finally, depending partly on when their programs opened in the state, NFP home visitors reported years of hire from 2001 to 2009, with the largest number of home visitors beginning in either 2003 or 2007.

While the training and certification requirements differ by each evidence-based home visiting program in Illinois, all of the supervisors and home visitors in our sample have completed their model-specific training or certification.

Parents as Teachers

When the PAT programs first hire home visitors, they are enrolled in a week-long PAT certification course. The home visitors cannot work with families until they are certified. The PAT certification training focuses on child development as well as tools needed during the home visit, such as delivering the PAT curriculum and using the PAT materials. All 23 of the PAT home visitors in our sample reported the dates when they completed their model training or certification. The completion years ranged from 2005 to 2010, with most having completed in 2005 or 2008. In addition to the PAT certification trainings, the PAT model requires that each home visitor acquire additional training or pursue professional development through their employment. One home visitor noted that they are required to earn 20 hours of professional development training the first year of their employment, 15 hours the second, and 10 hours their third and fourth years.

Focus group interviews with home visitors in PAT programs also revealed opportunities for additional training in the following areas: working with teen parents, infant massage, diversity training, domestic violence, sexual violence, creating an individualized family service plan, hearing and vision screening, completing the ASQ screening instrument, prenatal to 3 development, 3 to 5 development, and racial justice. These trainings are offered by a variety of agencies including the Ounce of Prevention Fund, Child and Family Connections, TouchPoints, ISBE, colleges and universities, and additional local entities.

Despite the number of existing training opportunities, some internal and logistical barriers exist that prevent all staff from attending any desired meeting. One downstate PAT home visitor commented that even though the PAT national trainings are in St. Louis, Missouri, ISBE does not permit out-of-state training attendance. “You know, that’s huge when the PAT National Center is right there, and they have a wonderful conference right in St. Louis every year.” By not being able to attend the National PAT Conference, home visitors have a harder time acquiring all of the training hours needed for the year, which has a negative impact on their professional development. Additionally, since some of the state-funded agencies have not been paid, they recently have been unable to offer trainings. As the state cannot help to fund training expenses, the opportunities to attend trainings have declined.

The PAT home visitors in our sample did suggest some trainings that would help them perform their jobs more effectively and successfully; as with the training opportunities noted above, these suggestions varied by region. Some of these include working with fathers and involving fathers in home visits, counseling,

building confidence, mental health, working with DCFS, empowering families, nutrition, post-partum depression, and more Zero to Three trainings. One home visitor in an urban program suggested having a "training on what to do about the lack of linkages and the lack of resources. Or if there's a resource, there's a waitlist."

Additionally, despite efforts in certification training, several home visitors mentioned they need more training on what a home visit actually looks like, things that can be read about in a curriculum or guide book. "I felt like I was tossed into the water and told to swim, when you don't know what you're doing," commented one Chicago home visitor. (In this regard, as noted below, one home visitor talked about receiving just this kind of training when she was part the HFI program.) A handful of urban and suburban programs also suggested trainings for the well-being of the home visitors themselves. Topics for these trainings would include taking care of themselves, addressing boundary issues between workers and families, and personal safety. Another home visitor, from a downstate program, noted that she had attended the domestic violence training, but wanted to learn more about domestic violence in home visiting: "If you know you're dealing with it, how to keep your information secret and not out there and safety measures that not only you should take when you're visiting, but how to keep supporting that person and not blame the victim kind of [thing]—I think that they need more of that."

PAT home visitors in our sample felt that the formal training they received allowed them to learn from not only the trainers, but from other home visitors as well. The PAT home visitors stated that the Ounce of Prevention Fund has great trainings. However, one home visitor in a downstate program who had worked at and been trained through both Healthy Families and PAT acknowledged that "the best training that I got from the Ounce of Prevention Fund was when I went through my Healthy Families training for HFI, and I think PAT does a good training as far as curriculum and what to do when you get into home visit, but Healthy Families laid the foundation for what a real home visit would be like." And despite the certification process that is generally viewed as helpful training, and the extra trainings offered by the program, some home visitors felt the additional trainings need to be strengthened. Another home visitor noted that, "what's frustrating with PAT [is] they're just not coming up with anything new. They might tweak something here or there, but it's pretty much the same old information just the different spin on it."

Healthy Families Illinois

Every HFI home visitor we interviewed attended the initial 40-hour Core Training and then an additional 40-hours of training during their first 6 months with HFI. All 25 HFI home visitors provided the year in which they completed their models' training or certification. The completion years ranged from 1994 to 2009, with the most having completed in 2008 and 2009. The HFI home visitors noted that trainings are an ongoing process which helps them add to the knowledge that they already have. One home visitor in a

downstate program stated that while her agency does not have any training requirements, she is able to attend "at least one or two trainings every other month." On the other hand, another downstate home visitor noted that she believed that the home visitors simply had not had enough trainings. The trainings that the HFI home visitors have attended have been provided by the Ounce of Prevention Fund, AOK, and Strong Foundations. Programs noted that Strong Foundations had recently provided the domestic violence and perinatal depression trainings. One suburban program noted that its local domestic violence shelter provides a free 40-hour domestic violence training tailored to the needs of the home visiting staff. For another program, a psychologist provides trainings on medication and the mentally ill. Others reported that their host agency, the local university, and ISBE all provide some trainings. One supervisor noted that the Ounce of Prevention Fund does ask annually what the home visitors perceive as their training needs, and this feedback appears to be taken into account in future trainings.

The HFI home visitors reported attending a variety of trainings, but a few did comment on domestic violence training. One HFI home visitor working in an urban program stated that she attended an intensive 40-hour training in domestic violence—not to be confused with the recent short training sponsored by Strong Foundations—which she described as "really an awesome training; that one really helped me understand and how to help these women out who have been violently abused." Additionally, the HFI home visitors reported having attended trainings on domestic violence, depression, intergenerational issues, cultural competency, working with fathers past sexual abuse, substance abuse, mental illness, mental health, medications, and drug interactions. One HFI program noted that its host agency provides CPR training for adults and babies, trainings around culture and diversity, and trauma training.

Some HFI program staff in our sample felt the existing trainings being offered could be improved. In this respect, they mirrored the comments of some of our state-level informants and program managers. For example, a home visitor in Chicago told us, "Once you do Core then you have to relate the service to the training and they don't always remember to do that. They're not always culturally relevant and they're not always connected to the here and now." The home visitors and supervisors in the downstate region reported that more local trainings would be appreciated. For some programs, regardless of how accessible or beneficial a training might be, the cost may inhibit the home visitors from attending.

HFI home visiting staff would like to see trainings that go beyond some issues currently addressed. For example, in the domestic violence trainings, they said they would like to see less time spent defining domestic violence and more time on real-life situations the home visitors may encounter; or training that will help home visitors teach, in the words of a downstate staffer, "the mothers that domestic violence is not okay. Because the ones that are living in it don't [know]." Like the PAT home visitors, many HFI

home visitors in our sample emphasized that additional trainings in mental health issues are increasingly needed. Home visitors in all regions seem to agree that trainings on how to better understand and better serve families with mental health issues would be beneficial. One suburban home visitor stated "I think there can always be training on that because it's every person who I've had, mentally ill, sometimes the diagnosis is different for each one. We've been to some mental illness and mental health trainings. But most of it has come from my experience with just working with people and other clients who have had similar issues and so on."

Other home visitors have training needs specific to the families on their caseloads. One home visitor in a downstate program noted that some of her teen mothers had recently lost their own mothers "so [training on] the grieving process of an adolescent who has just become a mom, that impact" would be helpful. As with home visitors working in the PAT model, HFI home visitors expressed a need for additional trainings. These training needs varied by region and included topics on developmental delays in parents, immigration, children with autism, children's behavioral issues, child discipline, and working with families involved with child welfare. Home visitors and supervisors across all regions agree that additional trainings that benefit the home visitors directly, such as refresher courses in safety issues and how to deal with issues of the home visitor's own grief, would help them function more effectively in their roles. Helping staff take care of themselves will also help to avoid burnout.

Nurse-Family Partnership

The NFP home visitors reported that they have very specific trainings requirements. One home visitor reported, "The way it works, in the beginning, is you do an online module before you go to Denver [for on-site nurses training] and then you do the Denver training and then there's ongoing training that does happen; some of it is web-based. Of course, the supervisors have their own set of training as well, if you have a new supervisor." The online modules include trainings on Core trainings, pregnancy, infancy, and toddler. Another home visitor noted that, "The first year was very intense. I mean, trainings every week. I mean every month and week at a time sometimes." All 11 NFP home visitors in our sample completed their model's training/certification, and eight provided the years in which they did so. The completion years ranged from 2003 to 2009.

In addition to the initial training that all of the NFP home visitors received in Denver, the home visitors also noted that they have received training in domestic violence as well as some HFI training. One home visitor noted a specific training on working with the so-called millennial generation about which she said "…[the presenters] went through all this stuff that I was having all this trouble with and I literally was sitting there going, 'oh my God, that's so true'." In addition to the trainings provided by the national NFP

program office; the home visitors received some trainings at the Ounce of Prevention Fund in Chicago and Springfield.

The NPF home visitors noted a few areas in which additional trainings would be helpful. For example, trainings on TANF and the childcare subsidy systems—specifically what these programs entail and how to complete the applications for these programs—would help home visitors with the populations they serve. Other needed training topics included working with people with development disabilities, substance abuse, and mental health issues. As one home visitor noted, "Because…our clients have those issues, so, it would be helpful to provide that type of training. But I think mental health is the high priority." Another home visitor stated a need for trainings on gangs, domestic violence, and education. Finally, home visitors in both NFP programs reported a need for trainings on legal matters such as how a minor can become emancipated, visitation, and paternity issues. As one home visitor acknowledged, "That's a lot of stuff we kind of have to search and find on our own because we don't really have trainings or guidelines for those things. Yeah, probably legal stuff, training on legal issues would be nice to have."

Training Needs in Specific Family Issues

We also asked staff who responded to the survey to indicate their comfort level with their knowledge of the four issues identified by the Strong Foundations leadership as having an impact on the families they visit: domestic violence, substance abuse, adult developmental disabilities, and adult mental health issues. The survey respondents were provided with a 4-point scale ranging from 1 ("very comfortable") to 4 ("very uncomfortable"). As shown in Table 4 below, supervisors indicated they felt "comfortable" with their knowledge in all four topic areas. They were most comfortable with their knowledge of domestic violence and adult mental health problems (with a mean score of 1.9) and least comfortable with their knowledge of adult developmental disabilities (with a mean score of 2.2). The home visitors were also comfortable with their knowledge of the four topic areas; they were most comfortable with their knowledge of domestic violence (with a mean score of 1.8) and were least comfortable with their knowledge of adult mental health programs (with a mean score of 2.3). The HFI home visitors showed a little more comfort with their knowledge of all four topic areas than did the home visitors in the other two program models.

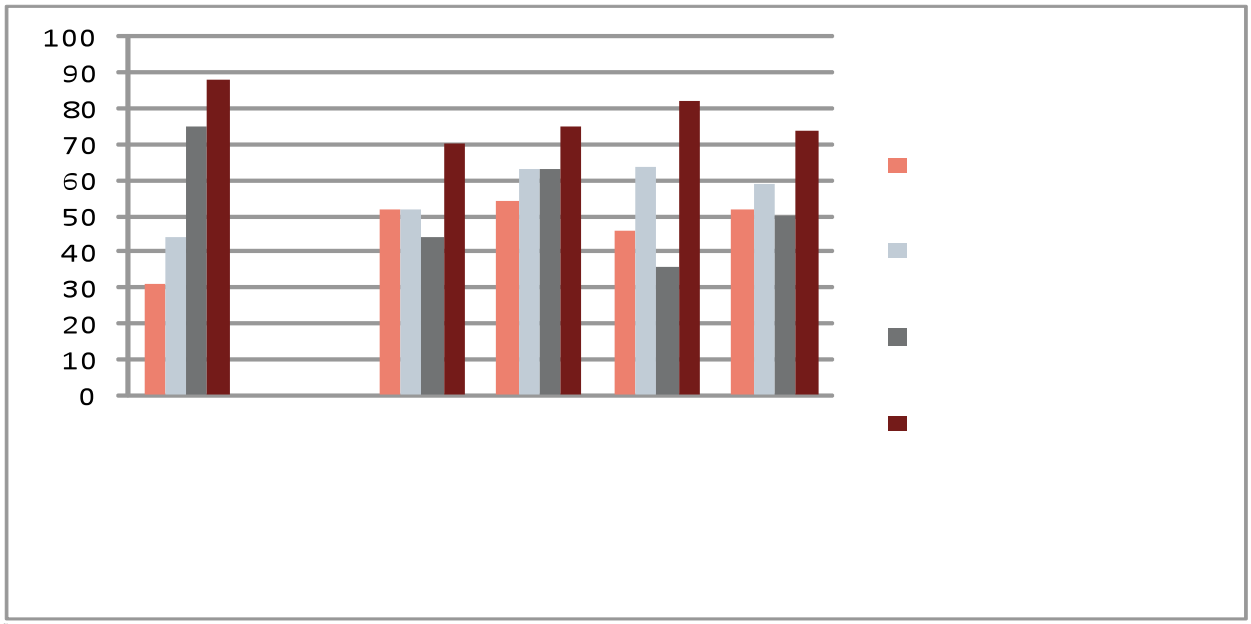
Table 4. Respondents Comfort Level of Knowledge about Family Risk Factors

Risk Factor	Supervisors (*N*=17)		All Home Visitors							
			PAT (*n*=23)		HFI (*n*=25)		NFP (*n*=11)		Total HV (*N*=59)[a]	
	% Very Comfort-able	Mean Comfort Score[b]	% Very Comfort-able	Mean Comfort Score[b]	% Very Comfort-able	Mean Comfort Score[b]	% Very Comfort-able	Mean Comfort Score[b]	% Very Comfort-able	Mean Comfort Score[b]
Domestic violence	29	1.9	30	1.7	33	1.8	9	1.9	28	1.8
Adult mental health problems	29	1.9	0	2.6	21	1.9	0	2.6	9**	2.3***
Substance abuse	18	2.1	5	2.2	35	1.8	9	2.4	18	2.1*
Adult develop mental disabilities	6	2.2	5	2.4	29	1.9	9	2.3	16	2.2*

[a] Between 1 and 3 home visitors skipped various items within this series of questions.
[b] Means are based on a 4-point scale (1=Very comfortable; 2=Comfortable; 3=Uncomfortable; 4=Very uncomfortable); standard deviations for means are not included in the table for ease of reading but are available from Chapin Hall.
Chi-square tests indicate differences are statistically significant at *p<.05, **p<.01, or ***p<.001.
Oneway ANOVA tests indicate differences are statistically significant at *p<.05, **p<.01, or ***p<.001.

As shown in Figure 3, both supervisors and home visitors desired more training in addressing domestic violence issues, substance abuse issues, adult developmental disabilities, and adult mental health problems. However, the area in which more respondents across the board noted they would like more training was in addressing "adult mental health problems." The home visitors in the NFP programs specifically were more likely to indicate that they would like more trainings in "adult mental health problems" than the home visitors in the other two programs.

Figure 3. Areas in which Staff in Study Sample Desired More Training by Program Model



[a] One supervisor skipped various items within this series of questions.
[b] Between 1 to 3 home visitors skipped various items within this series of questions.
Chi-square tests indicate differences are statistically significant at *p<.05, **p<.01, or ***p<.001.

Supervision

Supervision is a key component of quality, evidence-based home visitation services. How home visitors view the supervision process and its benefits depends largely on how supervision is provided. One of the state-level informants who is quite familiar with many of Illinois' home visiting programs across models indicated her strong belief in "reflective practice"—the idea that people operate in and change through relationships. She explained:

> Reflective practice is about the supervisor being self-aware, knowing that how she is with the staff and how the staff is with parents are parallel practices—how the supervisor is with the home visitor [parallels] how the home visitor is with the mom, which [parallels] how the mom is with the infant. So, in reflective practice you have to have reflective leadership. You have to lead through relationships and be open with your staff. You understand your staff issues; you have to be aware of what you're bringing to the relationship and if you are helping the relationship or hurting it. Then there are these core things about reflective supervision, that you meet once a week for supervision, but within that you talk about the "hows" of the home visit, how many you've seen, how many immunizations, it can be about those administrative things, but it also has to be reflective about the work.

Some of the programs do adhere to reflective supervision and it appears to be well received by the home visitors. For example, a staff member of a downstate program reported, "The model that we follow is Reflective Practice so we can call [supervisor] in, reflect on what's happening with our caseload, as well as each other, and we try to build that relationship with these families." Similarly, a home visitor from a suburban program listed supervision among the major strengths of her program: "The supervision, the support that home visitors get is unlike any other in my opinion. I don't see it in too many other models. We have a 2-hour weekly minimum supervision."

In comparison, home visitors were less likely to view less reflective and more task-oriented supervision as beneficial. A home visitor from a suburban program commented:

> I think of supervision as reflective supervision, but, also, maybe, some training or coaching. The supervision with her is not so much. I guess we're getting that more from peer-to-peer....Because she's (the supervisor) not doing home visiting. She's in the office, writing grants or paperwork, so we don't have anyone.

In another example, a downstate home visitor viewed supervision as taking time away from her other responsibilities. She reported:

> Supervision doesn't help you work with your families. The only thing you're doing is telling [the supervisor] about what you did at your visit, how long you were there, what was the mom doing, what was the baby doing, and [the supervisor is] writing what you already have written. She's already

> got the [case] sheet. She's writing down what you already have on paper, so I think it's double work. I shouldn't have to spend two hours telling [the supervisor] what I already done and already got it written down. It's two hours of your day that you could be doing something [else].

Among the home visiting programs participating in this evaluation, formal individual supervision ranges from weekly, 2-hour meetings to once a month meetings. As part of the survey administered to program supervisors, 16 of 17 supervisors across the three home visiting models noted the average amount of time they spend in direct one-on-one supervision each month. All 17 supervisors who completed the survey reported that they currently supervise one to eight home visitors, with an average of 3.5. On average, supervisors reported spending a total of almost 16 hours on supervision per month, with a range of 1.5 to 50 hours based on the number of staff. Based on widely varying reports, we estimate that supervisors dedicate an average of 5 hours of direct one-on-one supervision per staff member each month.[16]

In addition to one-on-one supervision, the majority of programs also conduct at least monthly group meetings. Some programs utilize group meetings to invite other service providers or speakers to share information with the home visitors. Home visitors in one of the suburban programs described the mental health consultation services they receive as part of a grant as a strong, positive component of their regular supervision. In addition to being available for specific questions, the consultant could accompany the home visitors on home visits to observe the family. The consultant is also a part of at least some of the home visitors' regular group meetings.

In addition to these formal supervision practices, many of the home visitors and their supervisors spoke about the great benefit of also having informal supervision, in which a home visitor can just drop by the supervisor's office and talk about a family on an as-needed basis. As one home visitor noted, "We have a set time with supervision each week, but if there's a crisis happening right now—my time is Thursday at 8:00—my crisis is not going to wait till Thursday at 8:00. And we can just go in there." In several of the programs, supervisors and home visitors share office space and, as a result, are readily available to support and consult with one another.

There appears to be less of a formal supervision process for those supervisors who also carry a caseload. At one downstate program, when asked who the supervisor turns to in times of crisis on her cases, the program manager responded, *"*If [the supervisor] has a crisis such as that, my bet is that she's talking to the Health Department. She's also very comfortable talking to [our state program administrator]*."* In

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[16] One NFP home visitor noted that she spent 140 hours per month in direct one-on-one supervision. Her response was excluded from this analysis. It also should be noted that the data on staff supervision is based only on estimates reported in the spring staff survey. Going forward, programs will be reporting time spent in supervision on a monthly basis as one measure of fidelity.

another example, an urban program manager with a small caseload noted that while she can talk informally with the program supervisor about her cases, she talks to "outside people" when necessary about her families. In two of the suburban programs, the supervisors with caseloads also do not have formal supervision, but reported feeling comfortable with their peer-to-peer support. For example, a home visitor told us, "One of the strengths of our program within our coworkers is that we all work as a team. I feel like we're always bouncing ideas off with each other, so if we do have a bad day or we need to talk to somebody, there's always support there for you."

Service Delivery and Intensity

The intensity in which families are seen by their home visitors is determined, at least in part, by their home visitation model. NFP requires that programs enroll families prenatally up until the mother's twenty-eighth week of pregnancy. Home visitors begin by visiting families weekly for the first 4 weeks the family is involved in services. After that initial 4-week period, the home visitors reduce the number of visits to every other week until the baby is born. Once the baby is born, weekly visits resume for the first 6 weeks and then return to bimonthly visits until the child is 21 months old at which point the visits taper to monthly visits.

PAT requires that each family receive two home visits per month and that each visit includes three components: child development, parent education, and a parent/child activity. The bimonthly level of intensity does not change for families who may be involved prenatally—although few PAT providers mentioned serving any prenatal clients—and remains consistent from the time that a family begins with the program until their graduation.

HFI has a more complicated system to help determine how frequently families are visited. The HFI model involves a maximum of 8 levels of service: Level E (engagement), Level P (prenatal), Level 1 (weekly visits), Level 2 (every other week visits), Level 3 (monthly visits), Level 4 (quarterly visits), Level X (creative outreach), and Level S (suspension). Not all programs utilize all of the different levels. For example, one program's home visitors noted that they are phasing out Level 4 because they feel that not much is accomplished at the visits after they catch up with the families as to what had happened during the previous quarter. Families in that program would stay at Level 3 as the least intensive service level. As described by some of the HFI programs, families are placed on Level E when they first agree to participate in the program. Then they are assigned either to Level P or Level 1 when they meet with their home visitor. It can take approximately 2 weeks to move from Level E to either Level P or Level 1.

Moving from one level to another depends on the Healthy Families criteria and where the family and baby fall within those criteria. If the decision is made to place a family on Level X, the HFI home visitor attempts to reconnect with the family through weekly phone calls, letters, text messages, or unannounced

visits. Level X can last for up to 3 months, and if the family remains on Level X for all 3 months, the case is closed and cannot be reopened. One home visitor offered that, in some instances, she felt that 3 months is too long to remain on Level X and that weekly outreach efforts are too burdensome on the home visitors and on the families:

> Usually Level X are families that you have had a hard time with home visits since the beginning. When you try to engage them, they're [saying], "Oh, I'm gonna be busy." "Oh, I have a doctor's appointment." "Oh, but I have to go…." I mean, 3 months to me is a long time that we're trying every week to engage the family. That means that we have to call them. We have to send them information, and sometimes we have to stop by their house. It's like instead of helping them you are pushing them. So I don't think it's necessary. It's like calling, calling, calling, leaving messages. I feel like I'm a stalker sometimes.

However, other discussion during that same focus group maintained that, in some instances, 3 months is not long enough to keep a family on Level X. One home visitor gave the following example: "I had a family that I worked with for 2 years, and she was all the time very consistent. All of a sudden her boyfriend came out of jail. Obviously, she was spending time with her boyfriend…so I lost contact. I chased her, I chased her. Three months was not enough, but I'm sure that she's coming back one day and she's going to say, 'Why haven't you missed me?'"

NFP and PAT home visitors also attempt to re-engage inconsistent clients through similar means (e.g., unannounced visits, calls, mail). PAT programs can keep inactive families for up to 2 months. However, they can also re-engage a family regardless of how long the family is inactive. According to a Chicago home visitor:

> [The families] can even come back. I had one parent who had one child and we started meeting, and then it got so her life was just too busy and I had to exit her out. Then, maybe 6 months later, she came back with that same baby, and I readmitted her. Then, she still got busy, I had to exit her again, and then she had another child and she came back again.

Home Visitor Caseloads

As indicated in the introduction to this report, some areas of program operation and model fidelity cannot be easily described or assessed without data from program administrative records. Although the staff survey and interviews provide some basic information on caseload sizes, we will be able to talk about these topics in more depth in our next report. Appendix C provides a brief overview of the kind of information that will come from analysis of administrative data. For example, initial analyses of statewide HFI program performance from data in the Cornerstone system indicates a drop in the number of program participants and the number of visits per participant during the summer of 2009, when there was considerable uncertainty about the extent of budget cuts.

In our sample of local programs, home visitors across the three models reported very similar average caseload sizes. At the time they were surveyed, PAT home visitors reported carrying an average caseload of 17 families with a range of 5 to 25 families. HFI home visitors reported an average caseload of 16, with a range of 7 to 25 families. Caseloads for NFP home visitors ranged from 7 to 22 families, with an average of 16. In addition, 7 of the 16 supervisors in the study sample reported carrying a small caseload in addition to their supervisory responsibilities. The average current caseload size for these supervisor/home visitors is around six, with a range of 1 to 11 families.

A large majority (86%) of the home visitors in our sample work full-time, or more than 35 hours a week, although a quarter of NFP workers reported working less than 35 hours at the time they were interviewed. Thus, the average caseload of 16 to 17 families is somewhat lower than what most of the program models expect of their full-time staff and might reflect the difficulties in retaining families and maintaining usual caseloads resulting from the state funding situation. At the same time, as the ranges in caseload size indicate, there is considerable variation among the staff that were surveyed. Indeed, a few home visitors who found their hours reduced because of budget cut-backs complained that they are still expected to carry the caseload of full-time workers.

Distribution of Program Activities[17]

The staff survey asked both supervisors and home visitors to estimate the percentage of their time spent on home visiting activities, supervising activities, and other duties. Responses suggest some variables across the three models but considerable variability within each of the models. With regard to supervisors, 6 of the 17 supervisors who carry a small caseload reported spending between 2 and 85 percent of their time home visiting, with an average of just over 42 percent. The 17 supervisors reported allocating between 10 and 100 percent of their time to supervising, with an average of 76 percent. Finally, 7 supervisors reported allocating between 5 and 40 percent of their time, or an average of 20 percent, to "other duties." These other responsibilities were not always specified but include other agency activities, operational duties, staff meetings, and supervising other programs.

All of the home visitors, on average, spend more than three-fourths of their time on home visiting activities versus other responsibilities, with NFP staff reporting a slightly higher average than PAT and HFI staff. PAT home visitors reported spending an average of 79 percent of their time on home visiting with a range of 20 to 100 percent. HFI home visitors reported spending a similar amount of time on home

[17] We assume confusion on the part of the respondents over the questions regarding time allocated to home visiting, supervising, and other duties, as well as over the question on average number of hours spent in direct one-on-one supervision activities each month. Where home visitors allocated or indicated spending time in supervision activities, we assume they mean toward their own supervision and with their supervisor.

visiting—an average of 77 percent—with a range of 15 to 100 percent. NFP nurse home visitors reported spending between 50 and 100 percent of their time on home visiting, or an average of 85 percent.

A number of the PAT and HFI home visiting staff who responded to the survey also reported allocating a percentage of their hours worked each week toward supervising. This included 10 (43%) of the 23 PAT home visitors and 11 (44%) of the 25 HFI home visitors. Estimates of their time spent on supervision varied from as little as 1 or 5 percent to almost 100 percent, with an average of 19 or 20 percent. None of the NFP home visitors noted allocating any of their time to supervising.

Eighteen (78%) of the 23 PAT home visitors indicated spending an average of 23 percent of their time on "other duties," with percentages for individuals ranging widely from 2 to 100 percent. Their "other duties" include driving a bus, case management, data entry, group meetings, meetings, paperwork, trainings, and working in other programs. Sixteen (64%) of the HFI home visitors reported devoting between 5 and 70 percent of their time on "other duties," with an average of 27 percent. They listed other activities that include administrative responsibilities, writing case notes, working the delivery room, doing family assessments, coordinating groups, and paperwork. Seven of the 11 NFP home visitors in our sample reported allocating an average of 24 percent of their time to other responsibilities—with responses ranging from 17 to 50 percent. These other tasks include cross training, immunizations, labor and delivery, and paperwork.

Cultural Competency of Services

Cultural competency is considered an important component of program quality, and each of the models represented in our study sample advocate for cultural competence in service delivery. This includes selecting staff that have similar characteristics to program participants, when available; providing services in a family's preferred language; and adjusting the model to be respectful of participating families' cultural norms and practices. Thus, we addressed this topic in our interviews and focus groups with program staff; in the staff survey, we asked home visitors about cultural and linguistic diversity within their client populations.

Most (83%) of the supervisors who carry a caseload reported just 10 percent or less of their caseload is foreign-born and over half (55%) of the home visitors also reported that 10 percent or less of their caseloads are foreign-born (see Table 5). The majority of supervisors (71%) and home visitors (83%) reported that they speak enough English to be able to conduct home visits in English. Thirty-one percent of the home visitors also reported that they speak enough Spanish to be able to conduct home visits in Spanish comfortably (see Table 6).

Table 5. Percentage of Caseload Who Are Foreign-born of Staff in Study Sample

Percentage Foreign-born	Supervisors (*n*=6)	All Home Visitors			
		PAT (*n*=23)	HFI (*n*=22)	NFP (*n*=11)	Total HV (*n*=56)
10% or less	83	61	46	64	55
10–25%	0	13	9	0	9
25–50%	0	0	14	9	7
50–75%	0	4	18	18	13
75–100%	17	22	14	9	16

Chi-square tests indicate differences are statistically significant at **p*<.05, ***p*<.01, or ****p*<.001.

In interviews and focus groups, program staff also provided examples of their capacity to work with families from diverse backgrounds. The home visitors and supervisors at the PAT programs noted that the PAT curriculum is available in both Spanish and English: "We have materials in Spanish that staff can give to clients and some of my staff, because they're bilingual as well, so, they use the materials, they speak and use it in Spanish." There is a larger Spanish-speaking population in Chicago and in the collar counties than there currently is downstate, and thus many caseload families in Chicago and the suburbs are either bilingual or primarily Spanish speaking. One Chicago PAT program noted that it was a "challenge in finding staffing to work with these [Spanish-speaking] families." One supervisor noted that the majority of the caseload families are Spanish speaking and that her staff is all Spanish speaking as well. Another program noted that they had had a bilingual home visitor, but she is no longer with the program. Her departure resulted in the program no longer trying to recruit Spanish-speaking families.

Table 6. Foreign Language Skills of Staff in Study Sample

Languages Spokena	Supervisors (*N*=17)	All Home Visitors			
		PAT (*n*=23)	HFI (*n*=25)	NFP (*n*=11)	Total HV (*N*=59)
English	71	83	84	82	83
Spanish	29	22	48	9	31*
Other language	6a	4	4	0	3

[a] Indicate languages staff reported speaking fluently enough to use in conducting home visits. Other languages include sign language, Urdu, Hindi, and what was described as "some Spanish, not fluent."
Chi-square tests indicate differences are statistically significant at **p*<.05, ***p*<.01, or ****p*<.001.

Other programs do not have bilingual staff, and they find the home visits challenging when the mother speaks one language and the child speaks another. A supervisor in an urban program noted a challenge of having both English- and Spanish-speaking staff; the supervisor indicated that she has two programs; "a Spanish-speaking program and an English-speaking program, so, how do you blend the two programs

together? How do you do it separate and still have the impact, and the staff resources to do that? And so we're struggled that way."

Like the PAT programs, the HFI programs also have higher proportions of Spanish-speaking families in Chicago as well as the surrounding collar communities. Downstate HFI programs do not face the same language issues that the other locations do. In Chicago and the surrounding suburbs, the HFI programs noted that their staffs are predominately bilingual. One supervisor reported, "…and so they go in [to the families] speaking the language, that's the main thing, and then talk to them at a level that they understand." Supervisors also said that their caseload families tend to be undocumented so the home visitors also have to work hard to gain the family's trust on this issue before home visits can begin. One supervisor in a Chicago program noted, "…and I think on the Hispanic side sometimes you will not capture the client possibly initially because of fear of 'who knows you're here'."

Since Illinois NFP sites in our sample are located only in the suburban and downstate communities, only the suburban communities noted any cultural differences. One home visitor at the suburban site estimated that approximately 75 percent of her caseload families are Hispanic and that many of these are likely to be undocumented, which echoes what PAT and HFI programs also reported. The downstate programs reported a very small percentage of their caseload families being Hispanic and none of those families were Spanish speaking.

As noted above, the evidence-based home visiting programs participating in our study acknowledge that their programs are operating in culturally diverse communities. This diversity, however, is not limited to Spanish-speaking families. Programs in our sample are serving families from a variety of ethnic backgrounds, and, as exemplified by the following two excerpts from our interviews, are committed to doing so. A provider from a Chicago program noted how happy she was to be working with an "Ethiopian family, and then corrected herself to say the family was "Eritrean," adding "[the mother] would be so mad if said that [she was Ethiopian]." She then went on to describe her work with another immigrant family: "I am currently working with a Palestinian family which is just amazing. I speak a little Arabic now because there are some behavior problems and I needed to know some key words and mom gave them to me and we're putting them on practice."

The following excerpt is another example of ethnic diversity that can occur in programs in the southern region of the state:

> We occasionally get an international family through the university. We have one now that's from Nepal. It's always a different kind of home visiting to do because, typically, educationally, they're at a higher level than a lot of our clients. They usually qualify for the program and are interested in the program because the moms are socially isolated, so this mom that we have right now, her husband is

> in grad school at the university and she lives in family housing at the university, and she's just had her first baby and her family is in Nepal. She doesn't have any friends and—this is always the case, too—she wants to know how Americans parent.

In addition to these examples, our site visits gave evidence of programs that are looking comprehensively at the cultural competency of their program. An HFI site manager shared a copy of a recent Cultural Sensitivity Review that they completed on their program. As she explained, "The Cultural Competency Survey is how the families feel about our services, how well we handle the cultural differences because every family had their own culture. So we want to be the most respectful about their culture because parenting is different in every single culture."

Knowledge of Community and Family Context

Staff's familiarity and knowledge of the community in which their clients live is another aspect of cultural competency. One regional difference that emerges in our interviews and focus groups with downstate programs home visitors who work with families who live within their community and how encountering their clients at the local store or gas station can impact their relationship. Those home visitors spoke about having to establish boundaries in a way that differ from the boundaries needed in Chicago or the suburban areas where home visitors are not as likely to come into contact with their clients outside of work. As shown in Table 7, home visitors who live and work in downstate Illinois are more likely to live in the same community as their caseload families, as 47 percent of the home visitor respondents in the downstate communities reported that "all or almost all" of their families live in the same community as they do. The home visitors in Chicago and the suburban communities are less likely to live in the same community as their caseload families. Forty-eight percent of the home visitors in the Chicago programs and 56 percent of the home visitors in the collar county programs reported that "none or almost none" of their caseload families live in the same community as they do.

One of the downstate home visitors gave an example of having a client who is also a relative of her coworker. Another downstate home visitor has a client who is employed at the local grocery store. The home visitor frequents the store and almost always has her own daughter with her. That relationship seems to make an impression on the client, who always goes out of her way to "make a big deal out of my little girl."

Table 7. Proportion of Staff in Study Sample Residing in Same Community as Program Participants

Percent Caseload Living in Your Community	Supervisors (*N*=6)	All Home Visitors*			
		Downstate (*n*=15)	Chicago (*n*=23)	Collar (*n*=18)	Total HV (*n*=56)[a]
None or almost none (0–10%)	0	20	48	56	43
A few (10–25%)	17	7	9	17	11
Some (25–50%)	33	20	4	0	7
Most (50–75%)	0	7	13	0	7
All or almost all (75–100%)	50	47	26	28	32

[a] Three home visitors did not answer this item.
Chi-square tests indicate differences are statistically significant at *p<.05, **p<.01, or ***p<.001.

Working with Families: Recruitment, Engagement, and Participation

Eligibility and Recruitment

As described in the Strong Foundations Implementation Plan, the commitment of state resources to support the existing array of programs is not enough to serve all of the families in need of home visitation services. Relying on eligibility criteria helps programs identify and engage the highest-risk families. All of the programs within our sample, except for one, operate under a range of eligibility criteria. The one exception relies only on geographic boundaries to determine service eligibility. That particular program's supervisor described the program's target population as "essentially any pregnant or parenting person, any male or female, with a child prenatal to three, who agrees to participate in the program and is in our geographical catchment areas." One home visitor from that program, for example, explained that grandparents who are newly raising their grandchildren are enrolled in the program.

All of the other programs within our sample use income level in addition to geographic boundaries to help determine need. Another demographic measure in the urban and suburban home visiting regions is the parent's age. For example, three-fourths of the urban programs in our sample reported that they direct their services to young parents under 25, with some programs limited to teens or parents under 21. None of the downstate programs, however, identify their program's target population by the parent's age.

Other eligibility criteria are set by the particular evidence-based model. NFP and HFI have more stringent eligibility criteria than PAT. For example, NFP requires that women are identified and enrolled by their twenty-eighth week of pregnancy, and HFI's compliance expectation is that clients are enrolled prenatally or within the first few weeks of the birth of the baby. In comparison, some PAT programs can enroll families as long as the target child is under 3 years old. Consequently, PAT programs appear to be the least restrictive regarding their target populations. While the majority of the PAT programs determine

eligibility through income level and geographic boundaries, at least one PAT program also requires that families have an educational need (e.g., parent has less than a high school diploma) as an eligibility factor. One PAT program director noted that there can be unintended consequences in limiting services to at-risk families. Based on her experience in going from a program that provides universal services to one that serves only at-risk families, she expressed concern about the attitudes of families who are no longer eligible because of income or other requirements, but would like home visiting services: She suggested, "It is probably a bit better to fly under the radar to keep people who would like to participate but are not high-risk from feeling like they are being kept out."

In addition to determining a parent's eligibility based on demographic characteristics, HFI programs utilize a screening tool to further identify those families who are experiencing the stressors associated with an increased risk for maltreatment. The HFI programs within our sample reported using a recently modified DHS-developed screening tool. One program manager described it as a two-level system with primary and secondary risk factors. If a parent is identified as having one of any six primary risk factors (i.e., history of domestic violence, history of alcohol or substance abuse, late prenatal care, sought abortion for current pregnancy, or mental health concerns), she is automatically eligible for home visiting services. A parent can also be eligible for services if she has two or more secondary risk factors (e.g., parent is employed or underemployed, parent has trouble paying for basic living expenses, partner is unemployed, family has unstable housing, mother is isolated, no phone or transportation, support system is inadequate, relationship or family problems, parent has less than a high school diploma).

HFI programs also recently changed their screening process by eliminating separate Family Assessment Workers. Although the greatest impact of this change seems to occur in relation to how families are engaged with the programs, one program indicated that this practice shift has also led to a change in the types of families being accepted into the program. This program's home visitors reported that the assessment had been utilized as a prescreening tool; if a family did not score 25 on the assessment, they were not eligible for the program and would be referred elsewhere. Now, the newly cross-trained Family Support Workers (FSW) have 45 days after the family is enrolled to complete the assessment. Consequently, they are seeing a broader spectrum of clients. One home visitor shared, "We are seeing more families enroll who don't necessarily score [high enough], but I mean, could always use the support, but we probably miss a lot of the higher-risk clients because we don't do the assessment prior to anymore. They say the tool balances it out, but for me it doesn't seem like it balances out."

Recruitment

Recruitment is, of course, an issue common across all program models and regions. How programs recruit the families with whom they work impacts the entirety of the program and the relationships between

program staff and families. All of the programs engage in some type of recruitment, from flyers at area hospitals and WIC offices to individual recruitment methods. However, it is the strong collaborative partnerships with health departments, hospitals, shelters, and other area home visiting programs that result in healthy streams for recruitment. Programs that lack such strong partnerships face uphill challenges in serving families within their communities. One supervisor in a program with a strong hospital connection noted collaborative partnership as one of the major strengths of her program, describing her program as "lucky not to have to go fishing around for clients." In contrast, staff at programs in which the home visitors serve as the major source for recruitment emphasized their dissatisfaction with that aspect of their programs. One home visitor described her recruitment process as getting some referrals from hospitals, but also conducting individual outreach at the supermarket and local nail salons, referring to the process as "ground-pounding." Another program supervisor explained that she was aware that her staff "hates this type of recruitment," but it is now necessary for them to start going "door-to-door." A home visitor from that same program commented about the pressure to increase recruitment: "We've been told recently that we're going to start getting written up if we don't have the amount of families we're supposed to have, and if we don't get those families to do [the expected number of home visits] each month."

While there is a general negative consensus among programs in which home visitors are responsible for recruiting their own families, there are some regional differences, most notably in the urban programs. Home visitors at several of the urban sites pointed to their recruitment efforts as infringing on the amount of time they have to spend with their already engaged families. At one program in which each individual home visitor is responsible for recruiting her entire caseload, the home visitors discussed the lack of affiliations and their desire to have more formal connections with area hospitals and other programs or departments that could be referral sources. Another issue that came up in the urban settings is the notion of competition for clients. While discussing local collaboration, one home visitor relayed a story in which she attended a local meeting and felt that other attendees used the meeting to find out about her potential clients to recruit for their own programs. She recounted, "They were trying to steal my clients from under me because they had my caseload list. They were trying to convince my parents that I had worked so hard to recruit, because, like I said, I was new to the [area]. So I had to go [do] all that work for you to come and try to, you know, snipe, I guess, my parents. They were telling them they'll give them incentives if they come here they'll give them baby clothes and all that."

Successful collaboration can serve to ameliorate issues around competition, as demonstrated by the suburban programs within our sample. The majority of these programs spoke about the collaborative nature of their recruitment process. All of the programs that operate within the same county are members of a Home Visitation Collaborative. As such, they each agree to participate in a home visitation referral

and linkage system for that county's pregnant and parenting clients who are eligible for services. (See Appendix E for a copy of the collaboration agreement used in this network.) For example, because one program can only initiate services within a pregnant population up to a certain gestation level, that program refers other pregnant or parenting individuals who are interested in home visiting to the other area programs. Likewise, another program has a strong connection to a medical provider that results in referrals of potential clients to other area programs. Another program outside of that county, which is not a member of the collaborative, also reported strong partnerships with its local area programs. That program's director remarked upon the strength she feels she gets from the community in support of her program's efforts. For example, the director of an area homeless shelter frequently speaks to new residents prior to the home visiting program meeting with the clients.

Engagement

Time and time again throughout our focus groups and interviews, the home visiting staff conveyed their commitment and dedication to the families and communities with which they work and their personal sense of pride when families achieve their goals. Most often this occurred as the home visitors discussed the development of their connection with the families with whom they work and the impact that they see it has on the children's early development. This process starts with the first efforts to engage families. It continues through the home visiting process and the work to ensure families are linked with medical homes and other community resources. The following sections highlight the work to establish and maintain connections with families, the work done to effectuate a successful home visit, and the challenges and opportunities to connect families to appropriate community service providers. As above, some of the information we learned crosses all regions and all of our sample's home visitation models, while other information is more closely linked to a specific model or geographic region.

Staff from across the models and regions spoke about the need to be nonjudgmental, open, and respectful when engaging families. Sometimes there is a misunderstanding, especially at the beginning, about the role of the home visitor. For example, one informant told us the following:

> Parents think we are DCFS at first. When they hear home visits, they think we're looking for something, that they're going to be in trouble. When I work with young—either teens or girls that are still living at home—there's a lot of time spent trying to convince the other family members that it's okay; that we're here as a resource and support for the family and all that. Like I said, a lot of times it's hard to get in there.

Another common theme we heard across the state is the need to engage not just the parent(s) of the baby, but also other family members, most often the grandparents of the baby. In the words of one informant:

> There's basically more communication with the grandparents of the baby than with the participant sometimes. That is very important upfront, when bringing in the grandmother, or whoever else is in the home, kind of inviting them in on the first or second visit or so, because when it's just the mom who knows what we're there for, you don't know what you're walking into. So, you've got one person who knows you're coming and everybody else looking at you like, 'Why are you here?'.

Staff also discussed the importance not only of having communication with other family members but also building trust and relationships with them. As one home visitor explained,

> Sometimes grandparents feel threatened by us at first, I think. I remember one of my first clients when I started, [the grandparents] scared me because she was bigger, and he was kind of a really big guy. She was a nurse and she told me that she knew everything about raising kids. And I'm like, 'Oh, that's good. Could you help me?' And then after that, I was going in every week and I would talk to her and show her respect, and they send me birthday cards now.

The home visitors also spoke about how they set out to engage families. An NFP provider described it as follows: "I think just we start out by showing them brochures and talking about the program and explaining how long it's been going on, and the research results they found over the years and then getting them involved right away. I show them the menu book right away. And I say these are some of the things we're going to be talking about." Some of the PAT home visitors described similar experiences. For example, according to one PAT educator, it is important to "legitimize yourself as much as possible." She described her process of engaging a family as follows:

> We have an initial kind of discussion, so I say, 'You know what? It's up to you, but would you like just to get together? Let's just sit and talk about where you are, the goals you have for your family, and I'll tell you what we're about, and just see if it's a match. If it is, great, and if it's not, at least you have some information about some support out here in case you want to in the future, or tell other people.' So, we have this initial interview (that we can't even count to go toward our numbers of times we've seen the family), and we just try and make it as informal as possible.

Another PAT staffer stressed the importance of making a new family feel comfortable and unpressured to participate:

> I think the more comfortable they are with us, just the time we spend with them. We just keep leaving the information with them and keep that open door policy, like, okay if you need anything, just give me a call. And usually when that time comes when they do think of us and we give them the information they need, they know they can count on us.

HFI programs recently changed to a "one-step eligibility" enrollment process. According to individuals familiar with the decision making, HFI sought to change the enrollment practice for a number of reasons. Through consultation with a national HFA administrator about the trends observed through the

credentialing process, DHS learned of a growing issue with the transfer of information from the Family Assessment Worker (FAW) to the Family Support Worker (FSW). It was felt that having the same person conduct the initial assessment would improve the development of the individualized service plans with the families. DHS started a task force with providers from across the state to address the best practices for instituting this type of change. Seventeen agents across Illinois piloted one-step eligibility before being adopted by all HFI programs. Because several of the HFI programs with which we met had just recently implemented this change, the home visiting staff was still acclimating to the new process. Several of the home visitors spoke to how the changes impact their daily work; for example, "When FAW was separate from FSW I didn't know how easy I had it. The FAW did all of the chasing. All I had to do is go in to the first home visit and complete the orientation." At another focus group, the staff had much more to say about this change and how it affects their initial work to engage the families:

> With the FAW they type up the assessment and you can go back and read it before you enter this home. And now it's like you don't know what's going on. You're walking in cold. Last week, I had an example, and the family was, like, 'What are you doing here?' That's the part where the job of the Assessment Worker was huge because she sold the program. By the time we met with them, the families already knew what they were getting into; they knew about the commitment; they knew how often. And this way it's harder for the intake; it's harder to sell the program. After you sit down for an hour with a complete stranger and tell them your whole life story, it makes it a lot easier for us to come in—as opposed to being that initial contact. Since we don't have that process with her anymore, everything happens at that initial visit. 'You want the program? All right. Here's the stack of papers. Sign here, sign here, and sign here.'

Length of Services and Program Retention

When families enter services and how long they remain depend on both family characteristics and program factors. As with some of the other areas of model fidelity, we will have more to say about the frequency and length of services after we collect and analyze administrative data. Here we can note that the three programs in our sample vary in terms of the child's age at which families are usually terminated from services. Across the three models, families have the option of remaining with the program until the target child is either 3 or 5 years old, depending on the program. Some of the program managers in our sample reported reducing their age limit from 5 to 3 because they find it becomes more difficult and less critical to conduct home visits if the child is enrolled in preschool programs.

However, every voluntary home visiting program contends with the issue of attrition. In the suburban and downstate regions, the home visitors reported an increasing number of people leaving their programs because the families are moving out of the area due to the lack of jobs. Sometimes families stop communicating with their home visitor suddenly. One home visitor described it this way, "There may be

something that's going on in the house where the person's living. And even though your client is not participating in the drugs or whatever, you've had five great visits, you've got this great relationship going, and suddenly they don't return your calls anymore. And you can only surmise that there's—because of our experience—something's going on there, and they see you're coming in and might pick up from something that would be reportable. So there's just suddenly no contact." Clients often do not have consistent or reliable telephone services, so home visitors attempt to re-engage families by corresponding through the mail, making unannounced visits, and leaving notes in mailboxes. Different programs have various policies regarding how long families can be placed on an outreach status, ranging from no formal time limit to 3 months. In the majority of the programs, home visitors must make at least one attempt weekly to reconnect with the client.

Home Visiting Services

As described earlier in this report, one of the primary goals for each of the three evidence-based home visiting programs is to improve the family context to promote positive parenting and child development and prevent child abuse and neglect. Although each model approaches this goal somewhat differently, each expects home visitors to focus on providing support to parents and fostering parent-child interactions and child development. In addition, each of the models—whether intentionally or unintentionally—seems to allow some flexibility in services, so that home visitors can respond to the needs of individual families. Below we share some of the descriptions staff provided of their work with families.

Parental Support and Education

Building trusting, supportive relationships with new mothers is the first step home visitors take in helping parents develop the skills and knowledge they need to care for their children. A visitor from an urban PAT program recalled, "So, it's going in, building relationship with the parents, modeling an activity, talking about the value of it for the child's development, and then encourage the parent to participate in the activity with the child, and it's also just encouraging the parent, so building confidence in the parent so that they'll do it when you're not around." In presenting parenting information, another provider said she liked the flexibility of the PAT curriculum: "You can kind of modify it. You don't necessarily have to use exactly what's there, but like, you can kind of outline. What I said before, kind of outline what things to do and like target points—like she said—those target points that they should get developmental milestones."

Several home visitors emphasized the value of focusing on and listening to the parent as an important component of their work: "They love to have that time where they can just focus on themselves, and a lot of times, I think the strength of the program is you're just there to listen and it alleviates a lot of parental concerns," a staff from a suburban program told us. Another said, "I usually go in and I start just asking

how their day is, talk about if they did the follow-up activity that I gave them. 'How's it been going?' 'What's the challenge with that?' Then we start getting into that activity." A downstate provider presented a similar view in her description: "The first thing I'd do is how have things been since the last time I seen you and then they'll begin to tell me. Then I ask, 'how's baby been doing, how about work?' We talk about that, so we get the little things out of the way and this also breaks the ice, that mom is feeling more at ease and comfortable."

Home visitors also described the importance of being able to modify their models' curriculum to fit the needs of individual families. For example, according to a downstate program supervisor, "So the model allows for the home visitor to tailor—it doesn't have to be every other week. If there's a crisis you can have more intensive intervention." A home visitor in a Chicago program stated:

> We follow the [program model] guidelines for the visits. But the service plan, that kind of can go—like if you have a 17-year-old, you want her to work on goals of staying in school. If you have a 30-year-old without a GED, hers would be GED or housing or employment. So the service plan kind of gives us room for that.

We mentioned earlier in this report the ability to incorporate other family members, especially fathers, into home visits. A downstate home visitor noted that her program has "a good number of the fathers who are involved—possibly even up to 75 percent." She went on to describe the printed and other kinds of materials used to engage fathers, including "videos from the father's perspective, for the father's perspective." Moreover, when working with fathers, she and her colleagues are mindful of differences between mothers and fathers in their interactions with their children: "We help them feel comfortable in playing with their children differently, different activities, different ways of playing than the moms necessarily would, to really support them. They're important, and the way they interact is important, as well."

Another aspect of model modification is helping parents to develop individual goals and service plans. As one home visitor described, "We also ask the parents if they have any goals— goals for themselves, educational goals, goals for their children or as a family— and we help them work towards reaching those goals." Another noted, "We also do Individual Family Plans, so we help families to make goals and monitor them if they're reaching the goals or how can we help you or what can we do together."

Parent-Child Interactions

Fostering positive parent-child interactions is another focus of home visiting activities across all the evidence-based models included in our sample. In most cases, home visitors provide the materials and demonstrate the behavior they are trying to encourage in the new mothers. A home visitor in a suburban program described her approach this way:

> I usually do it first and then I'll say, 'Mom, you want to try it,' and then usually the kid will go right with the mom, and they'll try it, and then we'll observe that visit, so [I ask the mother] 'what things did the child respond to well? Good job, mom, doing this.' I always try to give them the positive part of the visit. Then we'll talk about the visit, and I'll give them a follow up activity for the next time I see them.

Staff of programs in Chicago and downstate reported similar strategies for fostering positive parent-child relationships: "Well, the first thing we do, we go out—our first concern is the baby, how is the baby—you know, how has the baby been doing?," a Chicago provider explained. "We'll do some activities with the baby and then we bring hand-outs and show Mom some activities she could do with the baby." A downstate provider summarized her typical visits in the following way: "We go in the home and talk about how baby's developing and watch them bond and teach them how to bond with baby and play with toys."

Child Development

Sharing information about child development is an integral part of developing positive parent-child relationships and developmentally appropriate parenting practices. As a home visitor with a Chicago program nicely summarized her job, "We tell them why and show them how." Part of this is helping new parents to understand what is developmentally appropriate for their baby. When parents understand what appropriate behavior is for their child they are better equipped to develop strategies to handle the daily challenges of parenting. A home visitor from a suburban program talked about working with parents on developmentally appropriate guidance and discipline strategies for children as they become more mobile and independent—in other words, "just exploring, getting into everything":

> They [want to say] "no, no, no," all the time instead of create a safe environment, [and] yell at them. [So] we're modeling all the time, modeling what we want them to do, so [we] do it first and show them how to do it so they can see and then they can do it and see how it's supposed to be done. A lot of them just turn on the TV and let the TV do the entertaining. A lot of it is just getting the kids on the floor because they all just sit in the bed all day long, and they don't understand how important it is to get the child on a firm surface on the floor so they can explore. A lot of them don't have their mothers around or whatever, somebody showing them or telling them, giving them advice, so we can give them a lot of information.

Providers use screening instruments to facilitate parents' understanding of child development. According to a home visitor with a Chicago program, "We do developmental screenings so that we're watching the development." Likewise, a suburban provider reported, "We do developmental screenings at key times when those children should be achieving their developmental milestones."

Other Family Services: Referrals and Case Management

Two program models, HFI and PAT, provide opportunities for families to meet with home visitors and other families outside of the home. These programs provide group activities for parents and their children. Groups may be offered weekly or monthly; they often include parent-child activities, or focus on parenting skills. A home visitor with a downstate program described her program's group work:

> We have groups every Friday; every other Friday is 'bring your child.' And when the kids are here, we just provide like child-friendly snacks and activities that are age appropriate and then on the other Fridays when it's just the moms, we'll do a parenting topic. But we also cook. The moms all cook a meal. We have a prenatal group that we run, and that's usually on a Wednesday, and we do one in the morning for like an hour and a half and then we'll do one in the afternoon for an hour and a half cause some kids come in the morning, some come in the afternoon. And then Friday groups, how we set it up is we have a group either at age 11 [months], or 12 [months] to 3 [years]. But we'll break it down to if you're a creeper/crawler, this is the group you come to.

These group activities provide families with an opportunity to engage with other parents and their children in a healthy, learning environment. The focus and content of the group activities vary and include parenting skills, workshops, and nutrition. In some cases, the groups are simply an opportunity for families to come and have fun, as described by a home visitor from a suburban program: "Our program, we do groups so they're able to come to play groups, so sometimes the food will pull them in. It's fun because we do have those play groups that are interacting with other families."

In addition to supporting families in the context of the home and facilitating group activities, the home visiting programs in our sample focus on providing linkages to a wide array of services in their communities. One Chicago home visitor described the work, "Another aspect [of my job] is helping parents to use their resources, so giving them referrals to different resources…refer them to mental health counseling." Another home visitor in a suburban program stated, "The focus is making sure that we get in there and work with families, especially at-risk families that wouldn't otherwise have services or know about other services in the community." In particular, the HFI programs make sure their clients are connected to a medical home.

As well as providing resources to families, many home visitors are active in connecting families to services. For example, a home visitor with a downstate program said, "If they're trying to get benefits, I go with them. I may have to call someone, a caseworker, like now I got one whose car needs repair. She has a full-time job, but she can't get her gas mileage because her odometer doesn't work, so I've got to call and talk to a caseworker about that to see if there are any funds that'll get her car repaired." Home visitors in Chicago programs described accompanying clients to appointments, medical visits, and WIC offices; providing carfare or bus cards when needed. Home visitors also provide direct services outside

the home. A home visitor in a suburban program described her work: "I do parent education at the shelters; I do a play group at the shelters one time a month." These additional activities don't always take place during traditional business hours, as one program supervisor downstate stated, "My staff is on-call 24/7, and so they're readily available to the families, even in the middle of the night, weekends."

While connecting families to resources and ensuring that families get the services they need, home visiting programs are also working to help families become independent and access what they need on their own. A home visitor with a Chicago program reflected, "We also do community resources, we pass on the community resources and we basically—anything they ask me to look for, I'll look for them. I'll try to help them any way I can. And we try to make them advocate for themselves." These efforts to help families become independent pay off, as one supervisor from a downstate program noted, "We provide transportation to families on a limited basis, less now than ever before, I think, because staff are doing a better job of empowering families about accessing Medicaid transports and things like that."

The importance and frequency of the linkage work that home visiting programs engage is evidenced in the results of a survey conducted as part of a state needs assessment (Daro, Hart, Bell, Seshadri, Smithgall & Goerge, 2010), which included eleven of the local programs in our sample. When asked how frequently (*rarely, occasionally*, or *often*) their programs refer families to a variety of community support services, 86 percent of the eleven providers reported *often* referring families to services for basic infant and household items, and 78 percent of the eleven providers reported that they *often* refer families to primary health care services. In addition, 64 percent reported *often* referring families to childcare services; 57 percent said they *often* refer clients to mental health services for parents; and 57 percent *often* refer to income maintenance services.

Assessing Parent Satisfaction with Services

Programs were asked about how they solicit feedback from their clients and how that information is utilized. Of the 15 programs that participated in the data-collection process, 21 percent implement parent satisfaction forms at the completion of each home visit; 43 percent ask parents to complete satisfaction surveys upon their termination from the program; all 15 programs (100%) conduct annual parent satisfaction surveys. Programs use the feedback in a variety of manners. Forty-three percent of programs reported that the feedback impacts the training of home visitors; 64 percent reported that the surveys impact the topics and content covered during home visits; and another 64 percent indicated that the information learned from the surveys affects their referrals and the linkages their program has with other local providers. Just one program noted that the impact of the feedback is too minimal to have any impact. Three programs, however, noted that the feedback they receive may not have been relevant to training, topics/content, or referrals/linkages, but they did not suggest how the feedback impacts their program.

Summary

The individual and group interviews we conducted as well as the surveys completed by the home visitors and supervisors focused on examining the quality and fidelity of 15 evidence-based home visiting programs. These 15 programs are representative of the three evidence-based models that are the focus of the Strong Foundations initiative: PAT, HFI, and NFP. We asked home visitors, program managers, and program supervisors about program implementation, including staff selection, training and supervision; the engagement, participation, and retention of families; and the types of services and resources provided by their home visiting programs.

Community Characteristics

The evidence-based home visiting programs are operating in three distinct regions of the state: urban, suburban, and rural. While each of these regions represents a very different context in which to situate home visiting programs, the current economic climate in Illinois creates communities across the state that struggle with similar issues of poverty and unemployment. Programs cited a number of needs and challenges faced by the families they serve. Home visitors described community-level issues such as a lack of mental health services, transportation, housing, and unemployment as being challenges for the families they are serving. These challenges are evident across program model and geographic region. Respondents also noted family-level challenges such as mental health issues, domestic violence, and adolescent parenting as impacting their clients. Taken together, these issues and challenges impact communities and influence the context in which home visiting programs are operating.

Program Implementation

Through the surveys, interviews, and focus groups we learned about program implementation: staffing, training, and family engagement and retention. These factors influence how well the programs can be put into practice across the three regions.

Most home visitors in our sample have some formal education beyond a high school diploma or GED, usually in the fields of early childhood education or social services. Program supervisors emphasized that education is only part of what they look for when hiring new staff. The ability to work with specific populations and be true to the program model are also important characteristics to search for in hiring new staff, as well as to cultural sensitivity. Supervisors and managers acknowledged the importance of hiring bilingual staff to respond to the needs of their community's specific populations.

All three of the evidence-based program models included in this study require that home visitors complete a specified training sequence prior to conducting home visits. The home visitors and supervisors all indicated that they had completed their model-specific training, the exact content and timing of which

differs slightly by model. Additional professional development and other trainings are offered by a variety of agencies, including the Ounce of Prevention Fund and ISBE. When asked about the need for new or additional training content, respondents from all parts of the state recommended more in-depth trainings. Home visitors and program managers expressed a need to learn more about how to better support families with mental health issues. Those respondents from downstate programs also expressed a desire for trainings to be offered regionally.

The three program models have various client eligibility requirements; most are based on age of the mother. All programs work to engage families in services and have a variety of outreach methods available to them. Recent budget cuts and reduced funding streams resulted in several of the programs reducing the services they provide to families. For example, programs cut home visitors' work hours, limited or stopped group activities, reduced case loads, or were more selective in the families they engaged in services.

Program Services

Although the three models that are the focus of this evaluation vary somewhat, the actual work that takes place during the home visit focuses largely on strengthening parenting skills, fostering positive interactions between parents and their babies, and helping parents understand their children's development. When asked about the work that they do while in the home, staff described efforts to engage parents in the act of parenting and to educate new moms about their children's development and appropriate parenting behaviors. Home visitors described modifying their model's curriculum to better meet the needs of individual families.

As described by all the home visitors with whom we met, the actual home visit is only a part of their job. Another important role is to connect their families with community services and resources. To accomplish this work, home visitors need to be connected to the local resources and services available in their community. These connections take a variety of forms, including participating in a local community resource collaborative and connecting with local health departments, health care providers, and WIC offices.

In conclusion, the results presented here suggest that evidence-based home visiting programs in Illinois are working in communities struggling with complex issues. Programs are currently operating in a climate of limited resources, at both the program and community levels. We heard about the challenges home visitors face meeting the needs of their families, but also about the dedication with which they approach these challenges.

Summary and Conclusions: Building a Strong Foundation

This report has presented early findings from the evaluation of Strong Foundations, an initiative to strengthen the infrastructure of supports for evidence-based home visiting programs in Illinois. The focus of the evaluation falls into two main areas: the state system, including support for local service collaborations and system-building; and program implementation, quality, and model fidelity. Evaluation methods include a process study of the state system, local infrastructure, and a sample of programs using primary and secondary data; and an administrative data study of program performance, capacity, and fidelity. As we are still collecting and analyzing administrative data, data for this report were drawn largely from interviews, focus groups, and surveys with three groups of informants. Seventeen were state-level informants, including administrators of state funding agencies, trainers, and advocates; 25 were either managers or supervisors of a sample of 15 home visiting programs; and 59 were home visitors in those programs.

Home visitors are fully aware and knowledgeable of how their own work, program, and clients fit into their community's system of support, especially when trying to find other community resources for their clients, or when dealing with the impact of a funding shortfall that changed their work hours, caseloads, and job responsibilities. They, however, seem to be less aware of or know how their work or the supports for their work fit into a broader system of supports or how they might play a role or have an impact on the system. Thus, most of our understanding of the system of supports for home visiting programs comes largely from our interviews with state-level informants and program managers. Below, we summarize their perspectives on the current system, including its strengths and weaknesses.

State-level informants and program managers mentioned several important facilitators of communication and collaboration, notably, the ELC and HVTF, cross-agency initiatives (such as Strong Foundations),

and the growing openness to blend funding for services. Although they did acknowledge that none of these is perfect, they are a start. A number of our respondents also highlighted the fact that there are a number of evidence-based programs now operating in the state. Although their goals are similar in terms of improving family functioning, parenting practices, and child well-being and development, they have different strengths in their approaches and models, and these differences increase the state's capacity to serve families with diverse needs. Another strength of the current system is the range of forums for training, including the Birth to Three Training Institute, which is seen as providing a solid foundation to span the diverse delivery of services. There is also a growing awareness of the need for training—and availability of training in some areas—to meet the different needs of families.

Respondents also identified several weaknesses in the system and challenges for system-building. Decreased funding for direct services and staff training was mentioned most often as a significant barrier to improving service access and quality and local system-building. Funding cuts also result in the reduction of the number of families programs can serve and inhibit the ability of programs to meet existing needs in the community. Other weaknesses are the gaps in both home visiting services and other needed community resources. State respondents indicated that home visiting programs are unevenly provided across the state, and no services are available or accessible in some areas. In addition, communities lack other resources, especially in the areas of domestic violence assistance, mental health services, infant mental health services, and substance abuse assistance, that support or extend the benefits of home visiting programs. In addition, they noted evidence of gaps in services for specific populations, including homeless families and specific ethnic groups—Hispanic, but also Asian and Arab populations—and a need to increase the cultural competency of service delivery.

State-level informants also emphasized the variety and depth of family needs as another level of challenge for the state system. They noted that families struggle to meet basic needs such as housing, food, and health care in some areas of the state. As noted above, mental health needs often cannot be addressed with available resources. Failing budgets make delivery of domestic violence and substance abuse services difficult. Additional trainings are needed in the areas of parent education and mental health. Families with multiple needs or more serious levels of need—for example, those with domestic violence issues, substance abuse issues, parental developmental disabilities, or mental health issues—also tend to be the most difficult to engage.

Our interviews and surveys with program managers, supervisors, and home visitors reinforced these views. That is, they were particularly mindful of the lack of community resources—especially mental health services—for the families they serve and the growing need for such resources for families facing unemployment, unstable housing, lack of family support, and transportation problems. The greater level

of need of families for basic necessities in many communities is making it more difficult to engage and keep them involved in home visits. At the same time, programs are also struggling with budget cuts, reduced staffing, fewer service hours, and smaller caseloads—in other words, lower capacity to meet the needs of families. At the same time, during our data collection, we were impressed with the commitment home visitors and program managers expressed toward their clients and their communities, their positive ways of building relationships with the families they are able to engage, and their desire to improve their abilities to work with high-risk families through additional training.

Because our data collection and analyses are not complete, we view this report as preliminary. Nonetheless, the early findings presented here point to a few conclusions and recommendations for building the system of supports for home visiting programs and, in turn, the capacity of programs to meet the needs of their communities and deliver services with fidelity to their evidence-based models. These fall in the following areas:

- **Strong Foundations enhancements**. First, with respect to the strengths, weaknesses, and challenges identified by our informants at different levels of the home visiting system, the decision of the Strong Foundations leadership at the beginning of the year to focus on enhancements in training for staff in specific risk factors affecting family functioning and community systems development is sound. These two strategies, initially implemented in the spring of 2010, were well received by those who participated in them. During our data collection as well, staff of local programs also indicated a strong desire for more in-depth training on the issues of mental health, domestic violence, and developmental disabilities. They also expressed a desire not only for more connections with other service providers to increase their capacity, but simply for more knowledge of public benefits available to their clients. In brief, findings suggest that these strategies—and ongoing evaluation of the strategies—should continue and expand.
- **Staff development and training**. With regard to training, it appears that the state system has considerable capacity to provide basic training for a wide range of home visiting staff, especially new home visiting staff. It has less capacity, according to our informants, to provide more comprehensive and deeper training, to target training to diverse needs of staff and incorporate cultural and regional differences in their trainings, or to provide follow-up assistance in bringing new knowledge back to the program. Respondents from downstate programs also expressed a desire for trainings to be offered regionally, as the Strong Foundations trainings were. Training might be a resource that could be shared across and within systems beyond the formal opportunities provided through the Birth to Three Institute. For example, one program desiring more advanced training for its staff is trying to

contract individually with an external trainer. This kind of resource might be shared and supported by more than one agency in a community.

- **Local system building**. There appears to be growing momentum to continue to foster local collaborations and partnerships. Thus, the importance of the Strong Foundations-supported community systems development work cannot be overstated. As described by the providers we interviewed for this report as well as a number of experts in the field (e.g., Daro, 2006, 2009; Johnson, 2009), the effectiveness of home visitation as a strategy to improve family functioning and child development depends in part on communities' capacity to offer high-quality programs that meet the diverse needs of their families. It also depends on their connection to other services and systems, including health and mental health care and early care and education programs.

  A point to keep in mind is that communities likely differ in their capacity to communicate and collaborate. The second phase of the joint CSDWG was to include individualized technical assistance to community groups to address issues such as this one; and we hope there will be a way to implement this next phase. Just as individual staff members have different capacities to benefit from training in the professional development system, communities are likely to have differing capacities to make use of and benefit from the community development toolkits and other information. It is also possible that the planned technical assistance for the community toolkits will not be sufficient. As DelGrasso and Daro (2009) point out, integrating home visitation programs into local service networks can be complicated and take time. It requires attention to multiple components of the system, including collaborative planning, workforce development, funding, communication, public awareness and support, and capacities for monitoring and quality assurance.
- **Monitoring, program performance, and quality assurance**. During the period of Strong Foundations, a plan was developed for a common data-collection system across all home visiting programs in the state. Although resources were not available when the plan was first developed, there are new incentives and resources from the federal level for building data systems and indications of a greater willingness for agencies to share data across systems. Illinois is making technological progress in integrating data from different systems in a form that multiple agencies can use. Data sharing and developing common systems for collecting data are critical to building a system and showing its impacts, and we urge that the efforts to develop common indicators for program monitoring and quality assurance continue. As part of this effort, care should be taken to develop means for tracking families throughout the system, for example, to know when referrals are made but also to track the outcomes of referrals.
- **Communication structures**. As mentioned above, home visitors in our sample are not as aware of or knowledgeable about how their work fits into a broader system of supports, although they know when

their program is part of a local collaboration. Some of our state-level informants and program managers also mentioned the challenges of communication in a complex system with multiple players. A program administrator suggested that communication between the state and local communities as well as between state agencies and local programs is not nearly as strong as that at the level of state agencies and advocates. This is a key challenge for Illinois' system-building efforts. Although many structures support clear, open, and consistent communications across agencies and across levels of the system, it cannot be assumed that they are working well at all levels—or that strategies that work well at one level will work for another. Participants at the upper levels of the system, in particular, need to be cognizant and perhaps more intentional in how they reach out to and share information with those at lower levels, including frontline staff and families.

In conclusion, we have identified several challenges facing Illinois' efforts to strengthen the infrastructure of supports for home visiting programs and to improve program quality. Somewhat paradoxically, as the reach of home visiting programs and other components in the early childhood system continues to grow, the difficulties and complexities of coordinating them and maintaining communication structures and networks multiply. Bringing service to most or all of the communities in a large state—making efficient use of all the available resources and sources of talent; ensuring consistent quality of service; reaching the full range of racial and ethnic groups; and focusing particular attention on the most underserved families and regions—is a large strategic, organizational, and logistical task.

Yet, despite the complexity of providing high-quality, effective supports for young children and their families, the emerging infrastructure in Illinois has several strengths that increase program quality and effectiveness. These include strong advocacy organizations; leadership through the ELC, HVTF, and other collaborative initiatives—for example, the Birth to Five Project and the new Illinois Project LAUNCH—emerging collaborations at the local community level; as well as sustained participation by a wide range of stakeholders. As discussed here, a number of challenges lie ahead, particularly in the current economic climate, and these challenges are likely to exist for the long term. At the same time, the evidence suggests that Illinois has a good foundation and is building its capacity to meet and respond to these challenges in an effective and sustainable way.

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Appendix A: Year 1 Consent Forms and Interview and Focus Group Guides

Consent for State Level Respondents, including Coordinating Agencies

Informed Verbal Consent

Chapin Hall at the University of Chicago is an independent policy research center whose mission is to build knowledge that improves policies and programs for children and youth, families, and their communities. Researchers at Chapin Hall at the University of Chicago are evaluating Strong Foundations, an initiative to strengthen the infrastructure for home visiting programs, for the Illinois Department of Human Services. We are interviewing selected staff of state and local agencies and of selected home visiting programs to learn about their activities and experiences with and perceptions of home visiting programs and supports for them in Illinois. We might contact you again during the next year about completing additional interviews. We will be asking questions about the state's progress in implementing these supports, their strengths and their challenges, and unmet needs. We are interested in learning your perspectives on how decisions and plans for achieving the state's goals are made and who is involved in the process. We are also interested in knowing what you think are the biggest challenges in providing services for parents of young children in Illinois and how well the state has done to address these challenges.

Before we begin, I need to provide you with information about the study and obtain your consent to be interviewed. This process is called informed consent. You may ask questions about the study or process at any point.

This 2-year study is being done to find out how Strong Foundations supports three home visiting programs and helps them work more effectively with families: Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP). The study will examine how Strong Foundations is working, learn how home visiting programs can improve, and determine how these programs affect parent-child interactions. We are interviewing between 50-100 individuals from state and local agencies whom we selected to represent their organization and who are willing to talk with us about the Strong Foundations initiative.

The only risk to you for participating in the interview is the possibility that someone else will learn what you have told us. However, to prevent this from happening, we will take the following steps.
If you agree to be interviewed, we will keep all of your answers private and confidential. Your name or other identifying information will not be shared with other agency staff or used in any communication or written reports about the study. The information we collect from you and other partners will be used to write reports for the state and other collaborators in the initiative, in which we will summarize responses from many people. General things we learn from the study may also be presented at conferences or professional meetings, and in written articles.

It is possible in these reports and data presentations that we will use quotes from your interview to illustrate common themes that emerged in the analysis of the data. If we choose to quote from your interview, we use only general terms to describe you (for example, "an administrator at a state-level agency.") We will not include any information that identifies you or your agency (for

example, your name, title, age, or race, or your agency name, type, or location). However, you may request that we not use quotes from your interview.

Audio-taping our interviews will provide a more accurate record of our conversations. However, you may be interviewed without audio-taping. You may also ask the interviewer to stop recording at any point in the interview. If you agree to have your interview recorded, the recording will be erased one year after we complete our summary or transcript of the interview. The interview will take about one hour to an hour and a half. Whether or not you choose to participate will have no impact on your employment.

Now I will review each of these conditions and answer any questions you may have.

□ You will be one of 50-100 agency and program representatives being interviewed.
□ You are agreeing to an interview that will be completed now and take between one hour and an hour and a half.
□ Whether or not you choose to participate will have no impact on your employment.
□ Your participation is voluntary and refusing to participate or to answer any question will not result in any consequences or penalties.
□ Everything you say in the interview will be kept confidential to the extent allowed by law as described above, and will not be shared with anyone outside the research team.
□ Your identifying information will be destroyed at the end of the study.
□ The information collected for the study will be destroyed in five years after the study is completed.
□ If you agree to be audio-recorded, the recording will be erased within one year of transcription.
□ You may refuse to answer any question, request to stop the audio-recording, or to end the interview at any time without consequence.
□ You will not be compensated for the interview.
□ If you have any questions about the study, contact the study director, Julie Spielberger, at the Chapin Hall at the University of Chicago, 1313 East 60th Street, Chicago, IL 60628; 773-256-5187 or 1(800) 508-6023, julies@uchicago.edu.
□ If you have any questions about your rights or are upset in anyway about the study, you can call: (773) 834-0402 or write: Anita Goodnight, IRB Coordinator, School of Social Service Administration, University of Chicago, 969 E. 60th Street, Chicago, IL 60637, or email: abg@uchicago.edu

□ Do you agree to participate?
□ Do you agree to have the interview audio-taped?
□ Do you agree to use of quotes from your interview if we do not include information that identifies you or your agency?

Interview Guide for State Level Respondents, including Coordinating Agencies

Thank you for participating in our study. This study is being done to find out about the implementation of Strong Foundations, a state-wide plan to strengthen the infrastructure of supports for home visiting programs. It is focusing on three evidence-based programs: Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP). The study will examine how the infrastructure is working, whether the current array of evidence-based programs in Illinois is meeting the needs of communities and families, and learn about any needed improvements in the operation and effectiveness of local programs. Today, I would like to talk with you about your perceptions about home visiting in Illinois and the Strong Foundations initiative. I'll ask you a series of open-ended questions to which you may respond. Your participation in this study is voluntary. If you have any questions for me or do not feel comfortable answering any questions, please let me know. We can skip anything that you don't feel comfortable answering. After we complete this interview, I might contact you again to schedule a follow-up interview. Do you want to ask me anything before we begin?

[Note to Interviewer: The following questions are a *guide* to a semi-structured conversational interview. Sub-questions are included as possible probes to use if the respondent does not mention these topics; you are not expected to ask all sub-questions but should try to address each topical area. Because state informants vary, not all questions will be appropriate for all respondents. New relevant topic areas may also emerge during the course of the interview.]

First, we will ask you about home visiting in general and then move more specifically to talk about Strong Foundations:

Background

1. What is your position and title?
    a. How long have you held this position?
    b. What is your role in relation to home visiting programs in Illinois?

Home Visiting in Illinois

[This section looks at the "Big Picture" of home visiting in Illinois. Before I ask some specific questions, is there anything you would like to say about home visiting in Illinois?]

2. Please describe the current state of home visiting in Illinois.
    a. What is the quality of home visiting services in the state/your region? What are their strengths? What are their weaknesses?
    b. What challenges does the state face in implementing and supporting evidence-based home visiting programs? How has the state responded?

3. What are the state's goals for home visiting programs? How are decisions and plans made for achieving these goals? Who decides the goals and how they are to be achieved? Are the state's goals in-line with what you think?

4. How are communities supported and assisted by the state in selecting evidence-based programs to meet the needs of their families? In what ways could they be better supported?

5. What types of supports are available to home visiting programs? Are they well-supported in the state? Why/why not?
    a. Several different agencies provide home visiting services. What is your view of how home

visiting programs are coordinated at the state level?
   b. What is your view of the way services are coordinated and delivered at the local level?
   c. How could the system for home visiting services be improved to better support local programs?

6. What factors affect the implementation of home visiting programs in local communities?
   a. How do providers respond to funding uncertainties for home visiting services? (For example, do they look for opportunities to collaborate or share resources with other agencies? What changes do they make in staffing, caseload size, and caseload mix; and what are the reasons for their decisions?)
   b. What infrastructure supports do providers need in times of uncertain funding?
   c. How are communities and families affected by funding instability?
   d. What kinds of programs are better able to withstand uncertainties in funding?

7. To what extent do communities adapt the national program models to their target population and local service delivery context?

8. How well are home visiting programs connected to other services and supports for families with young children in the community? How are the families who access home visiting services in Illinois connected to other community services including medical services?

9. How well do you think local programs reach and serve those families most in need?
   a. Are you aware of if programs have had to make any changes to their referral processes or to how they engage or serve families during the last 18 months?
   b. How do they engage at-risk families who are hesitant about receiving home visiting services?
   c. Are there gaps in services, e.g., areas of the state or types of families that are not well-served?

Areas of Focus in Strong Foundations Initiative

Note to interviewer: The topics in this section may already have been covered within the previous topics listed above. You should only ask about topics not already discussed.

[We've already touched on quality in general; these next questions cover certain aspects of home visiting that might affect quality.]

Monitoring, Quality Assurance, and Fidelity

10. Do the home visiting programs that are the focus of the evaluation operate with fidelity to their evidence-based models?
    a. How is fidelity measured? Are monitoring and reporting requirements for programs adequate?
    b. Please describe how the current fiscal climate has impacted programs' quality and fidelity to their models.

11. How do programs collect and use data for program improvement and evaluation? How could this be improved?

12. Are families actively engaged in the planning, operation and/or evaluation of local programs? What strategies are used by local programs to involve parents in these activities?

Information, Communication, and Collaboration

13. Please describe how information is shared and how local programs communicate and collaborate with each other.

a. What kind of communication is there among local home visiting programs? Are resources (e.g., information about various community services) shared or referrals made across programs? How could local communication and collaboration be improved?
b. How is information about home visiting shared at the state level (e.g., between IDHS and ISBE) and between the state and local levels? How could communication and collaboration at the state level be improved?

Staff Characteristics, Training, and Supervision

14. What is the quality of staff skills in the three programs that are the focus of the evaluation (NFP, PAT, and HFI)? What is your understanding of the type of training and technical assistance provided to home visiting programs? What is the quality of the training like? How could it be improved?
    a. Are there any areas of training or technical assistance that service providers need but are not able to get? If so, what?
    b. What steps have been taken to ensure that programs effectively serve families affected by domestic violence, substance abuse, mental illness, or developmental disability?

Strong Foundations Management and Implementation

15. How familiar are you with the Strong Foundations initiative? What is your current role in the development of Strong Foundations? Has this role changed since the beginning of the initiative?

16. What do you view as the primary mission and goals of Strong Foundations? What implementation challenges have been encountered and how has the initiative responded?

17. What is your understanding of the management and administrative structure used to develop and oversee Strong Foundations? How effective has this structure been? How could it be improved?

18. In your view, have the appropriate program models, coordinating agencies, state level departments, and other stakeholders had a voice in the development of Strong Foundations? If not, who else should be or should have been represented?

19. What is the role of partnerships in the implementation of Strong Foundations? Who are the Strong Foundations partners? How effective are the partnerships? What challenges have been experienced in developing partnerships to implement Strong Foundations? How have partnerships changed over time?

20. [Prompt: Are you aware of the current status of the grant for Strong Foundations?] Given the shortened timeframe and budget, on what do you think Strong Foundations should focus? What are your current expectations for the impact of Strong Foundations on local programs?

Wrap-Up

We appreciate your time in talking with us. Is there anyone else you think we should make sure to interview? Is there anything else you would like to say regarding home visiting in Illinois or Strong Foundations?

Thank you!

Consent for Managers and Supervisors in Local Home Visiting Programs (HFI, PAT & NFP)

Informed Verbal Consent

Chapin Hall at The University of Chicago is an independent policy research center whose mission is to build knowledge that improves policies and programs for children and youth, families, and their communities. Researchers at Chapin Hall at the University of Chicago are evaluating Strong Foundations, an initiative to strengthen the infrastructure for home visiting programs, for the Illinois Department of Human Services. We are interviewing selected staff of state and local agencies and of selected home visiting programs to learn about their activities and experiences with and perceptions of home visiting programs and supports for them in Illinois. We might contact you again during the year about completing additional interviews. We will be asking questions about the state's progress in implementing these supports, their strengths and their challenges, and unmet needs. We are interested in learning your perspectives on how decisions and plans for achieving the state's goals are made and who is involved in the process. We are also interested in knowing what you think are the biggest challenges in providing services for parents of young children in Illinois and how well the state has done to address these challenges.

Before we begin, I need to provide you with information about the study and obtain your consent to be interviewed. This process is called informed consent. You may ask questions about the study or process at any point.

This 2-year study is being done to find out how Strong Foundations supports three home visiting programs and helps them work more effectively with families: Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP). The study will examine how Strong Foundations is working, learn how home visiting programs can improve, and determine how these programs affect parent-child interactions. We are interviewing between 50-100 individuals whom we selected to represent their organization and who are willing to talk with us about the Strong Foundations initiative.

The only risk to you for participating in the interview is the possibility that someone else will learn what you have told us. However, to prevent this from happening, we will take the following steps. If you agree to be interviewed, we will keep all of your answers private and confidential. Your name or other identifying information will not be shared with other agency staff or used in any communication or written reports about the study. The information we collect from you and other partners will be used to write reports for the state and other collaborators in the initiative, in which we will summarize responses from many people. General things we learn from the study may also be presented at conferences or professional meetings, and in written articles.

It is possible in these reports and data presentations that we will use quotes from your interview to illustrate common themes that emerged in the analysis of the data. If we choose to quote from your interview, we use only general terms to describe you (for example, "an administrator at a community-level agency.") We will not include any information that identifies you or your agency (for example, your name, title, age, or race, or your agency name, program type, or

location). However, you may request that we not use quotes from your interview.

Audio-taping our interviews will provide a more accurate record of our conversations. However, you may be interviewed without audio-taping. You may also ask the interviewer to stop recording at any point in the interview. If you agree to have your interview recorded, the recording will be erased one year after we complete our summary or transcript of the interview. This interview will take about one hour to an hour and a half. Whether or not you choose to participate will have no impact on your employment.
Now I will review each of these conditions and answer any questions you may have.

- □ You will be one of between 50-100 agency and program representatives being interviewed.
- □ You are agreeing to an interview that will be completed now and will take between one hour and one hour and a half.
- □ Whether or not you choose to participate will have no impact on your employment.
- □ Your participation is voluntary and refusing to participate or to answer any question will not result in any consequences or penalties.
- □ Everything you say in the interview will be kept confidential to the extent allowed by law as described above, and will not be shared with anyone outside the research team.
- □ Your identifying information will be destroyed at the end of the study.
- □ The information collected for the study will be destroyed in five years after the study is completed.
- □ If you agree to be audio-recorded, the recording will be erased within one year of transcription.
- □ You may refuse to answer any question, request to stop the audio-recording, or to end the interview at any time without consequence.
- □ You will not be compensated for the interview.
- □ Information you provide during the interview may benefit IDHS and its partners.
- □ If you have any questions about the study, contact the study director, Julie Spielberger, at the Chapin Hall at the University of Chicago, 1313 East 60th Street, Chicago, IL 60628; 773-256-5187 or 1(800) 508-6023, julies@uchicago.edu.
- □ If you have any questions about your rights or are upset in anyway about the study, you can call: (773) 834-0402 or write: Anita Goodnight, IRB Coordinator, School of Social Service Administration, University of Chicago, 969 E. 60th Street, Chicago, IL 60637, or email: abg@uchicago.edu

- □ Do you agree to participate?
- □ Do you agree to have the interview audio-taped?
- □ Do you agree to the use of quotes from your interview if we do not include information that identifies you or your agency?

Interview Guide for Managers and Supervisors in Local Home Visiting Programs (HFI, PAT & NFP)

Thank you for participating in our study. This study is being done to find out about the implementation of Strong Foundations, a state-wide plan to strengthen the infrastructure of supports for home visiting programs. It is focusing on three evidenced-based programs: Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP). The study will examine how the infrastructure is working, whether the current array of evidenced-based programs in Illinois is meeting the needs of communities and families, and learn about any needed improvements in the operation and effectiveness of local programs. Today, I would like to talk with you about your perceptions about home visiting in Illinois and the Strong Foundations initiative. I'll ask you a series of open-ended questions to which you may respond. Your participation in this study is voluntary. If you have any questions for me or do not feel comfortable answering any questions, please let me know. We can skip anything that you don't feel comfortable answering. After we complete this interview, I might contact you again to schedule a follow-up interview. Do you want to ask me anything before we begin?
[Note to Interviewer: The following questions are a *guide* to a semi-structured conversational interview. Sub-questions are included as possible probes to use if the respondent does not mention these topics; you are not expected to ask all sub-questions but should try to address each topical area. Because local home visiting program managers vary, not all questions will be appropriate for all respondents. New relevant topic areas may also emerge during the course of the interview.]

First, we will ask you about home visiting in general and then move more specifically to talk about Strong Foundations:

Background

21. What is your position and title?
    a. How long have you held this position?
    b. What services does your agency provide? How many staff do you have?

Your Home Visiting Program [○ HFI○ PAT○ NFP]

22. Please describe your home visiting program.
    a. What are some of its strengths? What are some of its weaknesses?
    b. What is the target population for your program? Is your program meeting its caseload targets?
    c. Is your program at or near capacity?
    d. In your experience, what have been the biggest challenges your program faces in serving families? What kind of assistance have you received, and from whom, to meet these challenges?
    e. How is your program funded?
    f. How has your program responded to the current climate of funding uncertainties for home visiting services? (E.g., Have you looked or do you plan to look for opportunities to collaborate or share resources with other agencies? What changes have you made in staffing, caseload size, and caseload mix; and what are the reasons for these decisions?)

23. How available and accessible is your home visiting program to families who could benefit from it?

a. How and when are families referred to your program? How are they screened and assessed? In the past 2 years, have there been changes in how families are referred to your program or their willingness to enroll?
b. How does your home visiting program meet the cultural and language needs of families in your program?
c. Typically, what is the desired length of time for families to participate in services? How is that determined? Does the intensity of services offered change over that period of time?
d. How receptive are they to enrolling in your program and receiving services? How does your staff work with at-risk families who are hard to engage or hesitant about receiving home visiting services?
e. During the past 2 years, have there been changes in the risk levels, presenting issues, or other characteristics of families served by local programs?
f. Is your home visiting program integrated with or does it make referrals to other services (including medical services) and supports for families with young children in the community? How well do families understand the reason for these referrals and how likely are they to follow-up? Are you able to follow-up to find out if families who are referred actually get the services they are referred to?
g. How do parents let you know how they feel about your program? How is that feedback used? Are parents actively engaged in the planning, delivery, or evaluation your program? What strategies are used to involve parents in these activities?

Areas of Focus in Strong Foundations Initiative

Note to interviewer: The topics in this section may have been covered within the previous section. You should only ask about topics not already discussed.

Monitoring and Quality Assurance

24. As an evidence-based home visiting program, how does your program monitor fidelity to the national model? Is your program accredited/credentialed or seeking accreditation/credentialing (from your national program model)? Why or why not?

25. Has your agency discussed changes to service implementation in response to the current economic and political climate (prompt: such as, providing the services in groups or at the site or other typical cost effective strategies that differ from the model, but allow services to continue)?

26. If such changes have occurred, have you communicated them to your funder or national model? If so, what was their response – have they provided any response or technical assistance regarding these changes (or planned changes)?

27. What type of data does your program keep/collect?
    a. What reports do you provide to your funder and to your program model? If yes, are these reports similar? Are there shared reports?
    b. How is information used for program improvement and evaluation?

Staffing/Training/Supervision

28. How many full and part-time home visitors do you have on staff?

29. What do you look for in terms of education, training, and interpersonal skills when hiring staff?
    a. How does the staff reflect the racial, ethnic, cultural and linguistic diversity of the families served by the program?
    b. What is turnover like at your agency? What are some reasons for staff turnover?
    c. How does your staffing reflect the national program models suggestions for staffing?

30. What is the caseload size per home visitor?
    a. How is caseload size determined?
    b. How have financial realities impacted the overall caseload of the program?
    c. How have financial realities impacted the home visitors' caseloads?
        ⇨ If there was staff reduction, was a process for this reduction in force in place prior to it occurring? If there wasn't a RIF, is a plan in place in the event it becomes necessary?

31. What type of training does your staff receive and when is this training offered? (pre-service and on-going trainings?)
    a. Do you feel that this training has prepared you/them for working with issues related to culture or at-risk populations?
    b. During the past 2 years, have there been changes in staffs' perceptions of their professional skills and training needs?
    c. Are there other training areas you feel would benefit your staff or agency?
    d. Who gets the on-going training? All staff or just one staff who then shares what s/he has learned?

32. Please describe supervision at your agency.
    a. How frequently do home visitors meet with supervisors? How is supervision conducted?
    b. Are their opportunities for staff members to exchange ideas with other home visitors, supervisors or other service providers in the community/region/state?

Home Visiting Programs in Illinois

Now I'd like to talk generally about home visiting in Illinois, or the "big picture."

33. Please describe the current state of home visiting in Illinois.
    a. What is your view of the quality of home visiting services in Illinois? Do you think home visiting services are available and accessible to families who can benefit from them? How well do home visiting services meet the cultural needs of families in the state? How well do home visiting services meet the needs of the high-risk population?

34. Are you aware of how decisions and plans are made for implementing home visiting in the state? Is there a management and administrative structure that is used to oversee home visiting programs in Illinois? If so, how does it work?

35. Do you think home visiting programs are supported in the state/your region? How could they be better supported?

a. Several different agencies provide home visiting services in the state. What is your view of the way services in general are coordinated and delivered?
b. Are you aware of any trainings and/or technical assistance offered to all home visiting programs at the state level *(clarify that this is separate from training received through the individual program)*? What is your experience with this kind of training or technical assistance? What is your view of the quality of training and technical assistance provided to programs at the state level?

36. What factors affect the implementation of home visiting programs in local communities? To what extent do local communities adapt national models to their target population and local service delivery context?
37. How would you describe the level of collaboration among home visiting programs in Illinois?
    a. What about sharing of resources and information? Are referrals made across programs?
    b. Please describe the structure and quality of communication, partnerships, and collaborations with other service providers at the local or regional level to improve the referral process and families' connections to other community-based services?
    c. Do you believe that interagency agreements or memoranda of agreements (MOAs) are necessary to establish or formalize working relationships to improve the network of services?

38. How aware are families and other community members of home visiting programs? Do you think they support them? Why or why not?

39. Are you aware of whether home visiting programs collect and use similar data for program improvement and evaluation? If so, is this information ever shared among different types of programs?

Strong Foundations

40. How familiar are you with the Strong Foundations initiative? [If not familiar at all, move to wrap up] Did you have a role in developing it?

41. What do you view as the primary mission and goals of Strong Foundations? How would you define success for the initiative?

42. Are you familiar with other collaborative efforts in Illinois similar to Strong Foundations?

43. Do you think the appropriate program models, coordinating agencies, state level departments and others involved with home visiting had a voice in developing Strong Foundations? If not, who else should be represented?

Wrap Up

We appreciate your time in talking with us. Is there anyone else you think we (the local evaluators) should make sure to interview? Is there anything else you would like to say regarding home visiting in Illinois or Strong Foundations?

Thank You!

Consent for Home Visitors of HFI, PAT, NFP Programs

Informed Verbal Consent

Chapin Hall at the University of Chicago is an independent policy research center whose mission is to build knowledge that improves policies and programs for children and youth, families, and their communities. Researchers at Chapin Hall at the University of Chicago are evaluating Strong Foundations, an initiative to strengthen the infrastructure for home visiting programs, for the Illinois Department of Human Services. We are conducting focus groups with home visitors from about ten home visiting programs in Illinois. A focus group is a small group of people brought together to participate in a guided discussion of a specific topic. These focus groups will help us learn about the activities and experiences of home visiting program staff, as well as the supports available to these staff in Illinois. We will be asking questions about the state's progress in implementing these supports, their strengths and their challenges, and unmet needs. If you participate in the focus group, we will also ask questions about your home visiting program and how families are recruited or referred to your program.

Before we begin, I need to provide you with information about the study and obtain your consent to be interviewed. This process is called informed consent. You may ask questions about the study or process at any point.
This 2 year study is being done to find out how Strong Foundations supports three home visiting programs and helps them work more effectively with families: Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP). The study will examine how Strong Foundations is working, learn how home visiting programs can improve, and determine how these programs affect parent-child interactions. We are conducting between 6 to 10 voluntary focus groups with 6-8 staff members from each of the three aforementioned home visiting program models.

The only risk to you for participating in the focus group is the possibility that someone outside of this group will learn what you have told us. However, to prevent this from happening, we will take the following steps. If you agree to participate in the focus group, we will keep all of your answers private and confidential. We ask you to also adhere to confidentiality provisions and not share today's discussion with others. We will not share your name or other identifying information with other agency staff or use it in any communication or written reports about the study. The information we collect from you and other partners will be used to write reports for the state and other collaborators in the initiative, in which we will summarize responses from many people. General things we learn from the study may also be presented at conferences or professional meetings, and in written articles.

It is possible in these reports and data presentations that we will use quotes from the focus group recording to illustrate common themes that emerged in the analysis of the data. If we choose to quote from a focus group participant, we will describe the person making the state only in general terms (for example, "a home visitor in a program participating in the study"). We will not include any information such as name, age, race, or location that could be used to identify an individual agency, program, or staff member.

The focus group will last for 60 to 90 minutes. We would like to audiotape the discussion to provide a more accurate record. If you do not agree to the recording of the discussion, we will not record the discussion but take notes instead. If we do record, the recording will be erased one year after we complete our transcript and analysis of the focus group.

Your participation in the focus group is voluntary. Whether or not you choose to participate will have no impact on your employment. To thank you for your time, we will provide you with $25 in cash.

Now I will review each of these conditions and answer any questions you may have.

- □ The researchers will be conducting 6-10 focus groups with home visiting staff from PAT, NFP, and HFI. You will be one of six to eight participants in one of these focus group
- □ You are agreeing to participate in a 60-90 minute discussion that will be completed now.
- □ Whether or not you choose to participate will have no impact on your employment.
- □ Your participation is voluntary and refusing to participate or to answer any question will not result in any consequences or penalties.
- □ What you say in the focus group may be quoted in a report or presentation. However, the researchers will keep everything you say in the focus group confidential and will not share it with anyone outside the research team. Your name and other identifying information will not be used in any report or presentation and will be destroyed at the end of the study.
- □ You agree not to share your colleagues' comments with others.
- □ The information collected for the study will be destroyed in five years after the study is completed.
- □ There will be an audio-recording of the focus group. If you do not agree to be audio-taped, the focus group will be conducted without audiotaping. If the discussion is recorded, the audio recording will be erased within one year of transcription.
- □ You may refuse to answer any question during the focus group or leave the group at any time without consequences.
- □ You will receive $25 in cash to thank you for participating in the focus group.
- □ If you have any questions about the study, contact the study director, Julie Spielberger, at the Chapin Hall at the University of Chicago, 1313 East 60th Street, Chicago, IL 60628; 773-256-5187 or 1(800) 508-6023, julies@uchicago.edu.
- □ If you have any questions about your rights or are upset in anyway about the study, you can call: (773) 834-0402 or write: Anita Goodnight, IRB Coordinator, School of Social Service Administration, University of Chicago, 969 E. 60th Street, Chicago, IL 60637, or email: abg@uchicago.edu

- □ Do you agree to participate?
- □ Do you agree to have the interview audio-taped?

Focus Group Guide for Home Visitors of HFI, PAT, NFP Programs

We really appreciate your taking time to talk with us.
Before we get started I must get your agreement to participate in the study and make sure you understand your role in the study.
[READ OVER CONSENT FORM AND CHECKLIST. EACH PARTICIPANT SHOULD FILL OUT THE COPY OF THE CHECKLIST ON PAGE 2 AND RETURN IT TO THE GROUP FACILITATOR.]

HAVE **ALL** RESPONDENTS PROVIDED VERBAL CONSENT?
YES ⇒ GO TO NEXT BOX
NO ⇒ ANY INDIVIDUAL WHO DOES NOT CONSENT WILL BE ASKED TO LEAVE THE GROUP

RECORD THE FOLLOWING INFORMATION:

DATE: _____

NAME OF AGENCY: _____

NUMBER OF STAFF PRESENT: _____

MALES: _____ FEMALES: _____

DID **ALL** RESPONDENTS CONSENT TO AUDIO RECORDING?
YES ⇒ START INTERVIEW AND RECORDING
NO ⇒ INFORM THE GROUP THAT THE INTERVIEW WILL NOT BE RECORDED AND START INTERVIEW WITHOUT RECORDING

Thank you for participating in our study through this focus group. This study is being done to find out about the implementation of Strong Foundations, a state-wide plan to connect three local parent support programs for home visitation: Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP). The study will examine how Strong Foundations is working, learn about any needed improvements in the operation and impact of local programs, and determine the impact of the new state-wide plan on parent-child interaction and the occurrence of child maltreatment.
Today, I would like to talk with you about your perceptions about home visiting in Illinois and Strong Foundations. This focus group will help us learn about your activities and experiences, as well as the supports available to you in Illinois. We will be asking questions about the state's progress in implementing these supports, their strengths and their challenges, and unmet needs. Your participation in this focus group is voluntary. You may refuse to answer any questions during the focus group. After we complete this interview, I might contact you again during the next year or 2 years to schedule a follow-up focus group. Does anyone have any questions before we begin?
The purpose of this interview is to learn more about your home visiting program, your experiences with the program, and your opinions about the program. We hope you will tell us any ideas you have for

improving the program to better meet the needs of families you serve. We also are interested in learning about training you receive from your agency or another source and your ideas for improving the training. We want to make sure we cover specific topics and give all of you the opportunity to share your opinions; consequently, we may need to cut short some answers or topics in order to finish the discussion in our allotted time.

To begin, we would just like to know a little about you—please introduce yourself and indicate how long you have been working in home visiting and how long you have been with this agency.

Possible Focus Group Questions:

1. Please describe your home visiting program.
    a. What are some of its strengths?
    b. What are some of its weaknesses?
    c. How are families referred to your program?
2. Overall, how is this program helping families?
3. How available and accessible is your home visiting program to families who could benefit from it?
4. How are families referred to your program?
5. How do you get assigned to the families with whom you work?
    a. What is the average caseload size? Do you feel this size is appropriate?
6. Typically what is the length of time parents are engaged in services?
    a. What is the intensity of services offered over that period of time?
    b. Do you increase or decrease services as needed?
7. How do you typically spend your time during a home visit?
8. How do you work with at-risk families who are hard to engage or hesitant about receiving home visiting services?
9. How do you connect the families with whom you work to other community services including medical services?
10. Tell us a little about the families with whom you work. What are the biggest challenges? What are the biggest strengths?
11. What type of supervision do you receive? How often?
12. What type of training have you received?
    a. Do you feel that this training has prepared you for working with issues related to culture or at-risk families?

b. Are there any state-level trainings or technical assistance services that have been offered to you? If so, have you participated?

c. Are there other training areas you feel would be of benefit to your or your agency?

13. How would you describe the attitudes toward home visiting in your community?

a. Are parents or guardians who could benefit from home visiting services aware of their availability?

14. How does your home visiting program meet the cultural needs of the population?

15. Do parents provide feedback about your program? If so, how is that feedback used?

16. Are you familiar with other home visiting programs in your community?

a. Have you had the opportunity to collaborate with any of the other programs in your community? If so, how?

17. Do you have any concerns about the program or your training that we haven't talked about?

18. Is there anything you would change to improve the program?

19. Prior to today, had you heard of the new state initiative called, "Strong Foundations?"

a. If so, what was your understanding of the goals of Strong Foundations?

20. Is there anything else you would like to say regarding home visiting in IL or Strong Foundations?

Thank you for your time. If you have any questions or comments later, you may contact us at the toll-free number provided.

Appendix B: Program Supervisor and Home Visitor Survey

Program Supervisor and Home Visitor Survey

Dear Home Visiting Program Staff Member:

I am writing to ask you to complete a short survey about your home visiting program and your background. This survey is part of an independent study of Strong Foundations, a state-wide plan to strengthen the infrastructure of supports for home visiting programs. The study will examine how the infrastructure is working, whether the current array of evidence-based programs in Illinois is meeting the needs of communities and families, and learn about any needed improvements in the operation and effectiveness of local programs. This study is being conducted by Chapin Hall for the Illinois Department of Human Services. It is also part of a national evaluation of systems to support evidenced-based home visiting programs being conducted by Mathematica Policy Research for the Children's Bureau.

As part of our effort to learn more about local programs, we plan to survey approximately 50 home visitors and program supervisors. Basic information about the survey appears below:

- The survey asks questions about your demographic characteristics, your education and work experience, and your job satisfaction.
- Completion of the survey is voluntary and should take no more than 15-20 minutes to complete.
- You are not required to answer any questions that you do not wish to answer.
- All of your answers are confidential. They will become part of summary reports in which no individual home visiting program or person is identified.
- We have assigned you an ID number to help us keep track of the surveys, but only research staff will have access to your answers. Chapin Hall data files are password-protected, and any information that identifies you will be destroyed 2 years after the end of the study.

It is very important to have responses from all staff so we understand everyone's point of view. There are a few ways to respond. You may send your completed survey directly to Chapin Hall in the enclosed self-addressed stamped envelope or fax it directly to me at (773) 256-5393. If you have any questions or comments about this study, please contact us at (773) 256-5193. If you have questions about your rights or feel you were not treated fairly, you may also contact the University of Chicago's Institutional Review Board Coordinator at 773-834-0402 or irb@ssa.uchicago.edu .

Thank you for helping with this important study.

Sincerely,

Julie Spielberger, Study Director

HOME VISITIOR/HOME VISITOR SUPERVISOR DEMOGRAPHHIC AND EMPLOYMENT CHARACTERISTICS FORM

Date form completed: __ __ / __ __ / __ __ __ __

Home visiting model that this home visitor/supervisor is working in: (*Check one only*)

☐ Parents as Teachers (PAT) ☐ Healthy Families America (HFA) ☐ Nurse Family Partnership (NFP)

SECTION I: Demographic Characteristics

1. Sex:
   ☐ Male ☐ Female

2. Age:
   ☐ Under 20 years ☐ 40-49 years
   ☐ 20-29 years ☐ 50-59 years
   ☐ 30-39 years ☐ 60 or older

3. Race/Ethnicity: (*check all that apply*)
   ☐ Black/African American ☐ American Indian/Native American
   ☐ Asian/Pacific Islander ☐ Hispanic/Latina
   ☐ White, non-Hispanic ☐ Other (*specify*) _____

4. Have you completed high school or a GED?
   ☐ Yes, completed high school
   ☐ Yes, completed GED
   ☐ No

5. Have you completed education or vocational training other than high school/GED?
   ☐ Yes
   ☐ No ⟶ **Go to Question 8.**

6. What is your highest degree obtained?
   ☐ Vocational/technical training program
   ☐ Some college, no degree
   ☐ Associate degree
   ☐ Bachelors degree
   ☐ Masters degree (MA, MS, MSW, MFT, etc.)
   ☐ Professional degree (for example: LLB, LD, MD, DDS)
   ☐ Doctorate degree (for example: PhD, EdD)

7. Field(s) of study:
   ☐ Child development ☐ Social work/social welfare
   ☐ Early childhood education/education ☐ Nursing
   ☐ Psychology ☐ Other (*specify*) _____

8. Please indicate if you have any of the following licenses or certifications:
   - ☐ RN
   - ☐ LCSW
   - ☐ Other (*specify*) _____

9. Are you currently enrolled in any kind of school, vocational or educational program or pursuing a higher degree?
   - ☐ Yes
   - ☐ No ⟶ **Go to Question 11.**

10. Please indicate the degree/credential sought and the field of study.

a. Degree/Credential Sought:

- ☐ Vocational/technical training program
- ☐ Some college/no degree
- ☐ Associate degree
- ☐ Bachelors degree
- ☐ Masters degree (MA, MS, MSW, MFT, etc.)
- ☐ Professional degree (for example: LLB, LD, MD, DDS)
- ☐ Doctorate degree (for example: PhD, EdD)

b. Field of Study:

- ☐ Child development
- ☐ Early childhood education/education
- ☐ Psychology
- ☐ Social work/social welfare
- ☐ Nursing
- ☐ Other (*specify*) _____

11. Are you a parent or have you ever been the primary caregiver for a child?
   - ☐ Yes
   - ☐ No

SECTION II: Employment Characteristics

12. Date on which you began working in this home visiting model:
   __ __ / __ __ / __ __ __ __ (mm/dd/yyyy)

13. Have you completed model specific training or certification?
   - ☐ Yes Date training/certification completed __ __ / __ __ / __ __ __ __ (mm/dd/yyyy)
   - ☐ No

14. Your role in the home visiting model:
   - ☐ Home visitor
   - ☐ Supervisor
   - ☐ Both

15. Do you usually work more than 35 hours per week? If no, please include number of hours worked in a typical week.

☐ Yes
☐ No ⟶ **# of hours worked in a typical week: __ __**

16. Of the hours you usually work, what percentage is allocated to home visiting and what percentage is allocated to supervision in a typical week? If this home visitor/supervisor does only one activity (home visiting or supervising), enter 100% for that activity.

a. Percent allocated to home visiting: __ __ __ %
b. Percent allocated to supervising: __ __ __ %
c. Percent allocated to other duties: __ __ __ %

Please specify other duties:

_____
_____

17. What is the average number of hours you spend in direct one-on-one supervision activities each month? _____ hours

18. Before this job, did you have prior experience delivering home-based interventions to families?

☐ Yes
☐ No

19. How many years of prior experience did you have? _____ years

20. **For Home Visitors**: What is your current caseload? _____ families

21. About what proportion of your caseload are foreign-born?

☐ 10% or less
☐ 11-25%
☐ 25-50%
☐ 52-75%
☐ 75-100%

22. **For Supervisors**: What is the number of home visitors in the program that you supervised this month? _____ home visitors

23. Are you fluent in any of the following languages, to the extent that you can conduct home visits in that language? (*Check all that apply*)

☐ English
☐ Spanish
☐ Other (*specify*) _____

24. Please rate how satisfied or dissatisfied you are with the following aspects of your job.

	Very Dissatisfied	Dissatisfied	Satisfied	Very Satisfied
a. Your workload	☐	☐	☐	☐
b. The supervision you receive	☐	☐	☐	☐
c. The support you receive from co-workers	☐	☐	☐	☐
d. The quality of training you receive	☐	☐	☐	☐
e. Opportunities for professional development	☐	☐	☐	☐
f. Being valued for your work	☐	☐	☐	☐
g. Cultural sensitivity in your workplace	☐	☐	☐	☐
h. Physical working conditions	☐	☐	☐	☐
i. Salary and benefits	☐	☐	☐	☐
j. Your influence on the program	☐	☐	☐	☐
k. Your interactions with parents	☐	☐	☐	☐
l. Your influence on parent-child interactions				
l. Administrative responsibilities	☐	☐	☐	☐
m. Overall job satisfaction	☐	☐	☐	☐

25. How comfortable do you feel with your knowledge and ability to work with families who have experiences with the following:

	Very Comfortable	Comfortable	Uncomfortable	Very Uncomfortable
a. Domestic violence	☐	☐	☐	☐
b. Substance abuse	☐	☐	☐	☐
c. Adult developmental disabilities	☐	☐	☐	☐
d. Adult mental health problems	☐	☐	☐	☐

26. Which areas would you like to have more training? (*Check all that apply*)

☐ a. Domestic violence
☐ b. Substance abuse
☐ c. Adult developmental disabilities
☐ d. Adult mental health problems

27. What proportion of the families in your current caseload would you say live in the same community as you?

☐ None or almost none (0-10%)
☐ A few (11-25%)
☐ Some (25-50%)
☐ Most (51-75%)
☐ All or almost all (75-100%)

If you have other comments to share about your home visiting program, please add them below or on the

back of this page. Thank you again for your participation in this study.

Appendix C: Administrative Data Plan

Administrative data are an important source of information for both the process evaluation and the indicator study. We have established data sharing agreements with the appropriate national, state, or local agencies to access administrative data from these systems. We are accessing three major data systems to support this evaluation, as well as a number of other data reports and files. These systems are as follows.

- *Cornerstone.* IDHS developed Cornerstone as a centralized database for human services programs at the state level, including Family Case Management, WIC, and Healthy Families Illinois. HFI uses Cornerstone for caseload management purposes, and local sites enter substantial demographic data for participants and a detailed record of enrollments, home visits, worker assignments, level of service classifications, terminations, etc. A subset from Cornerstone of detailed HFI participation from FY2005-FY2010 has been provided to Chapin Hall by IDHS. A second subset, showing basic client engagement in FCM, WIC, and HFI programs is still in process at IDHS and is expected at Chapin Hall immanently.

- *OunceNet.* The OunceNet system is the outcome tracking system for the Ounce of Prevention Fund's Parents Too Soon programs, which also implement some evidence-based home visiting models (mostly PTS). OunceNet reports on 22 local programs. OunceNet tracks a number of variables that are indicators of the outcomes each program strives to achieve. Some of these indicators reflect changing characteristics of participants, while others show changes in the participants' children. OPF has provided a copy of OunceNet to Chapin Hall (current through May 2010).

- *NFP Data and Reporting System.* The NFP Data and Reporting System is a web-based data collection system that local programs are required to use to document services received by clients.

NFP is providing these data directly to the national cross-site study, which will relay the data for the two Illinois NFP sites to Chapin Hall.

- *Other data sources:* We have detailed tracking data created on an ad hoc basis for two of the local PAT sites that we engaged for this evaluation, and hope to receive a few more. Also, we are collecting PAT Annual Performance Record (APR) report that local programs complete for the nation PAT organization, the annual Prevention Initiative Program Record that PAT agencies complete for ISBE, and data from the local applications to ISBE. Also, we expect to link the Cornerstone case information to DCFS child maltreatment reports.

We continue exploring the quality and usefulness of data that exist in administrative records. At a minimum, we hope to address many of the program fidelity issues, including maintenance of appropriate home visiting schedule, size of staff caseloads, child assessment activity, and medical service linkage. However, we know that not all data categories of interest exist in data systems for all three program models. By far, our most comprehensive data source is Cornerstone, which provides information on all IDHS supported HFI programs in the state (see Table below). The second most comprehensive information is from OunceNet. For the most part, description of other PAT sites will have to be either on an illustrative site-by-site basis or on an annual aggregate level.

HFI Data Elements Available though IDHS Cornerstone Database

Data Element	Description
Personal (family):	Client ID number, names, date of birth, race/ethnicity, gender, marital status, household size, employment status, education, household income language.
HFI enrollment:	Clinic ID Home visit worker, id and dates (if changes).
HFI activity:	Service plan intensity level, with dates Prenatal supports Home visits, with dates HFI termination, date and reason
Related birth event:	Date of child birth event, pregnancy outcome, number and gender of births, birth weight
Related activity:	Well-child visits, Developmental Screening,
Linkable (non-DHS):	DCFS child maltreatment investigations: date of event, alleged harm code, relation of alleged perpetrator to alleged victim, finding of investigation (indicated or not), identity of alleged victim, identity of alleged perpetrator, age and gender of victim. Foster care placement events: date of removal from home, date(s) and type(s) of placement, reason for removal, permanency goal, end date of substitute care, closing reason
Other DHS services:	Enrollment in any of the following programs: Family Case Management (FCM) Healthy Families Illinois (HFI) Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

Analysis of Administrative Data

Some details about the specific data items that we anticipate using during the course of this evaluation project still remain to be fully understood, as we are still learning about the capacities of the management information systems that are used to track home visiting activity. We are now starting to observe and document shifts in the client populations, agency caseloads, and other trends in home visiting in Illinois. At the end of this Appendix, we provide a first look at the types of information that can be produced from the administrative databases. The five tables show monthly measures for each local HFI program, as well as the statewide totals. Measures include home visiting caseload sizes, average number of visits per month for each case, the proportion of scheduled visits that are completed, and the average numbers of well-child medical contacts and DD screening assessments. These are included for illustrative purposes. There are many more analytic possibilities in these data.

We expect to analyze administrative records for the complete universe of home-visiting participants in HFI, NFP, and PAT programs in Illinois, which will entail near-universal program tracking across the state. The individual-level data that can support more detailed investigation is fundamentally available for all HFI programs and those PAT programs in OunceNet.

Administrative Data Analysis on all HFI, NFP, and PAT Clients

In order to examine home-visiting activity statewide, we will use basic individual-level administrative records and case tracking data for all women (and children) who participate in home visiting programs through HFI. These records have been organized into a single statewide HFI client-level event history dataset, which can be subdivided into local program-specific datasets to look at variability between programs and specific local implementation. The events that are included are mother's birth, children's birth(s), HFI enrollment, HFI level-of-service classification and changes, worker assignment and changes, home visits, EPSDT visits, DD screens, and HFO case terminations. Data at the case/individual/event specific level provides building blocks for many analytic approaches. This monitoring information is reported only in the aggregate (at the local program level or higher). Client identifiers (ID numbers only, not names) are used to organize and inter-relate the information, but no reported information will be attributable to individual clients.

The basic constructs we expect to track with these data include the number and geographic distribution of home-visiting clients, the composition of the client population (age, race/ethnicity, education, occupation, household status, identified stressors, etc.), the characteristics of their home visiting case episodes (duration, number of visits, number of workers, reason for termination), and agency characteristics relevant to program fidelity such as worker caseloads. These constructs support creation of program fidelity measures; for example, whether the program is serving its targeted population, whether services

are provided with the frequency and level of intensity recommended by the program model, whether families are being retained in services, and whether they are receiving medical care and other services.

Additionally, we hope to monitor enrollment of HFI participants in other community-based services, such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the state-funded Family Case Management program through the Cornerstone management information system. This information will address one of the objectives of the initiative, which is to ensure families are linked with the full array of community-based services. We also plan to link to DCFS maltreatment records, to provide overall suggestions as to the levels of child/abuse and neglect experience by those in the home visiting caseloads.

Early Analysis of Reports from Cornerstone

The information below is from an early approach to individual level data records for HFP participants from Cornerstone. Two things must be emphasized about this information. The first is that these results are intended for illustrative purposes, and have not been fully checked for accuracy. The second is that the analytic constructs used here are likely different than those used in standard HFI reporting.

These tables and graphs begin to convey information about recent trends and conditions in HFI programs in Illinois. For example:

- HFI programs vary widely in size.
- Some HFI programs first appear during the past 18 months, while other disappeared during this time period.
- For those HFI cases where home visits are happening, an overall average of 2 visits per month seems very stable.
- During the height of the state fiscal crisis in summer 2009, there was a noticeable decrease in the number of cases receiving visits and in the average numbers of visits per month for those being visited.
- HFI children are receiving EPSDT/well-child medical visits, and they are receiving developmental screens. The levels seem relatively high, but have been decreasing slowly over the past 18 months.

These findings must be considered as tentative, but they demonstrate some of the capacity of this analysis approach.

Table C-1. HFI Active Home Visiting: Monthly Caseload by Individual Program Site

HFI Program	Jan 2009	Feb 2009	Mar 2009	Apr 2009	May 2009	Jun 2009	Jul 2009	Aug 2009	Sep 2009	Oct 2009	Nov 2009	Dec 2009	Jan 2010	Feb 2010	Mar 2010	Apr 2010	May 2010	Jun 2010	**Monthly Average**
All Sites	**1,377**	**1,389**	**1,421**	**1,418**	**1,413**	**1,389**	**1,183**	**1,092**	**1,119**	**1,207**	**1,252**	**1,295**	**1,330**	**1,328**	**1,370**	**1,341**	**1,263**	**1,183**	**1,298.3**
1	27	27	27	29	29	27	23	23	23	24	23	25	27	27	26	26	25	22	**25.6**
2	15	16	17	17	17	19	17	12	10	11	11	12	11	12	12	12	12	10	**13.5**
3	53	55	56	59	63	61	58	55	58	57	58	57	57	60	63	64	61	65	**58.9**
4	19	17	17	18	17	17	17	17	19	19	19	19	19	19	19	20	20	19	**18.4**
5	28	28	28	29	27	27	25	24	24	26	24	25	26	26	25	27	27	26	**26.2**
6	33	34	38	37	33	30	18	13	13	15	16	19	21	23	24	29	29	29	**25.2**
7	13	15	18	17	18	18	16	9	0	0	0	0	0	0	0	0	0	0	**6.9**
8	15	14	15	16	17	15	15	13	0	0	0	0	0	0	0	0	0	0	**6.7**
9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.0**
10	53	51	50	48	50	50	33	33	40	46	48	49	53	55	58	59	60	63	**49.9**
11	18	18	18	20	18	18	18	17	17	17	18	14	21	23	26	27	27	27	**20.1**
12	36	38	36	36	35	33	22	19	15	14	16	21	22	31	32	29	30	28	**27.4**
13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.0**
14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.0**
15	61	60	63	58	56	53	50	48	49	53	60	63	65	68	64	64	65	63	**59.1**
16	1	1	1	1	1	1	1	1	1	1	2	5	10	16	25	28	26	24	**8.1**
17	44	43	45	44	44	43	41	35	35	36	37	36	39	37	39	40	35	28	**38.9**
18	42	41	44	43	44	41	25	25	31	28	34	36	39	40	43	44	43	44	**38.2**
19	30	30	31	33	36	38	36	37	33	34	34	32	31	31	32	34	34	37	**33.5**
20	14	13	14	14	15	15	15	18	17	17	19	22	23	23	27	27	26	21	**18.9**
21	62	62	63	63	66	62	36	30	30	30	30	36	37	40	42	41	40	30	**44.4**
22	36	36	35	33	32	34	31	27	33	32	34	41	42	42	39	40	35	29	**35.1**
23	6	6	6	6	6	6	5	5	5	5	5	5	5	5	5	5	5	5	**5.3**

24	45	46	48	45	43	41	41	41	44	44	44	44	43	45	49	50	49	47	**44.9**
25	91	95	98	98	101	101	95	90	90	90	92	92	92	90	86	49	0	0	**80.6**
26	1	1	1	1	2	3	4	5	12	73	73	70	73	74	77	68	66	55	**36.6**
27	11	10	10	11	11	11	10	11	9	11	11	11	11	11	10	9	10	9	**10.4**
28	3	4	4	3	3	1	2	2	7	9	8	5	6	6	6	6	5	3	**4.6**
29	25	26	26	27	27	26	26	25	25	27	27	26	26	27	27	25	26	25	**26.1**
30	11	13	15	12	12	11	11	9	9	9	10	10	12	14	13	12	11	10	**11.3**
31	54	52	56	55	49	49	48	48	53	56	59	62	63	64	66	68	62	63	**57.1**
32	82	80	78	79	77	77	77	72	70	71	75	80	81	75	70	67	71	70	**75.1**
33	36	37	35	34	35	38	34	31	31	31	31	31	30	30	41	46	47	44	**35.7**
34	10	10	11	12	11	12	11	12	14	14	14	12	13	13	14	15	15	15	**12.7**
35	53	53	52	52	47	44	41	34	34	35	38	40	39	39	41	42	41	31	**42.0**
36	16	16	15	17	16	15	14	15	16	19	20	20	20	20	20	18	19	20	**17.6**
37	16	15	16	18	19	18	17	14	15	17	18	20	18	19	19	18	17	17	**17.3**
38	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.0**
39	20	22	26	26	26	26	14	4	3	4	5	5	7	6	7	9	10	9	**12.7**
40	25	25	24	22	24	24	20	9	12	15	15	14	18	16	17	15	14	15	**18.0**
41	4	4	4	4	4	4	4	2	2	2	1	1	1	1	2	3	3	3	**2.7**
42	41	41	41	45	45	43	38	38	39	37	35	36	35	35	37	37	34	35	**38.4**
43	49	47	49	47	44	42	18	18	20	19	20	23	21	21	25	30	30	25	**30.4**
44	12	13	13	13	13	15	15	14	13	14	14	14	13	14	16	18	15	8	**13.7**
45	55	56	55	54	56	54	19	16	19	19	26	30	31	34	29	30	30	30	**35.7**
46	22	25	25	25	29	30	29	29	32	33	34	32	30	0	0	0	0	0	**20.8**
47	32	34	40	41	37	35	32	28	30	28	27	29	28	26	24	21	21	21	**29.7**
48	53	55	53	52	55	58	59	63	66	64	66	70	70	69	72	69	66	57	**62.1**
49	4	4	4	4	3	3	2	1	1	1	1	1	1	1	1	0	1	1	**1.9**

Source: Chapin Hall analysis of IDHS Cornerstone data.

Status is draft/provisional. Do not cite without consulting authors.

Table C-2. HFI Average Number of Visits per Month for Active Home Visiting Participants

HFI Program	Jan 2009	Feb 2009	Mar 2009	Apr 2009	May 2009	Jun 2009	Jul 2009	Aug 2009	Sep 2009	Oct 2009	Nov 2009	Dec 2009	Jan 2010	Feb 2010	Mar 2010	Apr 2010	May 2010	Jun 2010	**Monthly Average**
All Sites	**2.0**	**2.1**	**2.2**	**2.1**	**2.0**	**2.1**	**1.5**	**1.5**	**1.8**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.2**	**2.0**	**2.1**	**2.3**	**2.0**
1	1.2	1.7	1.3	1.2	1.4	1.5	1.4	1.8	1.8	1.5	1.8	1.4	2.0	2.1	2.7	2.0	1.7	2.2	**1.7**
2	2.5	2.3	2.5	2.4	2.4	2.2	2.2	2.0	2.0	2.5	2.5	2.3	1.8	1.9	2.1	2.4	2.2	2.4	**2.3**
3	2.0	1.7	1.8	2.1	1.8	2.1	1.9	2.1	2.4	2.1	2.2	1.9	1.6	1.8	1.9	1.8	2.0	1.8	**1.9**
4	2.2	2.2	2.6	2.2	2.1	2.6	2.1	1.9	2.5	2.2	2.2	2.1	2.3	1.9	2.3	2.2	2.9	2.6	**2.3**
5	2.1	2.0	2.1	1.8	1.8	1.9	0.2	0.1	0.6	1.7	1.8	2.2	2.2	2.3	2.3	2.1	2.1	2.0	**1.8**
6	2.2	2.3	2.5	2.2	2.4	2.3	0.7	1.8	2.2	2.3	2.2	2.4	1.9	2.0	2.4	2.0	2.5	2.7	**2.2**
7	1.9	1.9	2.5	2.4	2.3	2.4	2.1	2.0	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**2.2**
8	2.7	2.8	3.1	3.3	2.9	3.8	2.7	1.2	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**2.9**
9	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
10	2.2	1.8	2.4	2.3	2.4	2.1	0.8	0.9	1.7	1.9	1.8	1.7	2.0	2.0	2.3	2.2	2.3	2.8	**2.0**
11	2.3	2.7	2.4	2.3	1.8	2.6	2.2	2.7	2.0	2.0	1.6	1.8	1.5	2.0	2.0	1.9	2.4	2.5	**2.2**
12	1.3	1.9	2.3	2.6	2.5	1.3	1.3	2.1	2.8	3.4	3.1	2.7	2.7	2.5	1.8	2.6	2.6	2.7	**2.3**
13	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
14	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
15	1.8	1.7	2.3	1.9	2.0	1.8	1.1	0.8	0.7	1.8	1.6	1.8	1.8	1.9	2.2	2.1	2.0	2.4	**1.8**
16	0.0	0.0	1.0	2.0	1.0	0.0	0.0	0.0	0.0	0.0	0.5	1.8	1.5	1.5	2.0	2.3	2.6	2.8	**2.1**
17	2.2	2.0	2.6	2.5	2.3	2.4	2.0	1.3	2.1	2.2	1.8	2.0	1.8	1.9	2.3	1.7	1.7	2.4	**2.1**
18	2.6	2.9	2.4	2.4	2.1	2.4	1.5	1.8	2.2	2.1	2.3	2.3	2.1	2.0	2.3	2.4	2.3	2.7	**2.3**
19	2.2	1.9	2.0	1.9	1.8	2.0	2.0	1.7	2.0	2.2	2.1	1.9	1.9	2.4	2.6	2.2	1.9	2.0	**2.0**
20	2.1	3.0	2.9	2.5	2.5	2.5	2.2	2.1	1.9	2.2	1.6	1.6	2.4	2.4	2.3	1.9	2.4	2.7	**2.3**
21	2.0	1.6	2.0	2.1	1.9	1.7	0.4	0.5	1.0	1.2	1.3	1.8	1.6	1.7	1.6	1.8	1.5	1.8	**1.6**
22	2.9	2.9	3.2	2.2	2.0	2.8	1.0	0.7	2.7	2.8	2.3	2.5	2.2	2.4	3.1	2.4	2.3	2.9	**2.4**
23	2.3	3.0	2.8	2.3	2.0	1.8	0.4	0.0	0.0	1.8	2.4	2.6	2.2	2.2	2.0	2.0	1.8	2.0	**1.9**

24	2.4	2.4	2.3	2.5	2.0	2.2	2.2	2.3	2.2	2.2	2.2	2.1	2.4	2.3	2.4	2.6	2.4	2.3	**2.3**
25	2.6	2.8	2.4	2.8	2.6	2.6	1.5	1.5	2.1	2.4	2.3	2.6	2.4	2.4	2.6	1.0	- - -	- - -	**2.3**
26	0.0	0.0	0.0	0.0	0.5	1.0	0.3	0.2	0.8	2.2	2.0	1.2	1.8	1.7	1.9	1.9	1.8	1.9	**1.8**
27	1.3	1.4	1.7	1.5	2.0	2.2	1.7	2.2	2.1	1.8	2.3	1.9	2.1	1.5	1.9	1.6	1.4	1.8	**1.8**
28	1.3	2.3	2.8	1.7	1.3	5.0	2.0	0.5	1.7	2.1	1.6	2.4	1.3	2.2	2.2	2.3	1.4	3.0	**2.0**
29	2.2	2.4	2.8	2.1	2.4	2.7	1.0	0.7	2.5	2.2	1.9	1.9	2.0	2.4	2.3	2.2	2.0	2.0	**2.1**
30	1.8	2.0	2.1	2.6	2.1	2.8	1.8	0.2	1.4	2.4	2.5	2.6	2.3	1.9	2.4	2.1	1.9	2.1	**2.1**
31	1.6	1.8	1.9	1.6	1.5	1.6	1.6	1.8	1.8	1.9	1.9	2.3	1.6	1.8	1.9	1.9	2.0	2.1	**1.8**
32	2.1	2.1	2.0	2.1	1.8	1.9	2.0	1.7	1.9	1.9	2.0	1.9	2.0	1.9	2.0	2.1	2.0	2.0	**2.0**
33	2.1	2.2	2.5	2.1	2.3	2.8	0.5	0.1	0.2	0.8	1.8	2.5	1.9	2.2	2.1	2.4	2.4	2.5	**1.9**
34	2.3	2.1	2.5	2.6	2.3	2.4	2.2	2.0	2.1	1.9	2.5	2.7	2.2	2.1	1.8	2.1	2.0	1.7	**2.2**
35	2.1	2.0	2.3	1.6	1.6	1.8	1.7	1.8	2.0	2.0	1.8	2.0	2.1	2.0	2.1	2.2	2.2	2.3	**2.0**
36	1.6	1.7	2.5	2.2	1.9	2.2	2.4	2.3	2.1	1.9	2.3	2.8	1.7	1.9	2.2	1.5	1.5	2.0	**2.0**
37	1.7	1.8	2.5	2.0	2.4	2.4	1.8	1.3	2.3	1.9	1.9	2.3	2.2	2.1	2.2	2.5	2.3	2.5	**2.1**
38	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
39	1.6	1.8	1.8	1.8	1.7	1.8	1.1	1.8	1.3	2.0	2.8	2.4	2.1	2.7	2.7	3.1	2.7	2.8	**2.0**
40	1.4	1.8	1.5	2.1	2.5	2.2	1.8	1.7	2.7	2.5	2.7	3.1	2.1	2.4	2.5	2.7	2.4	2.8	**2.2**
41	2.8	3.0	2.0	1.8	1.8	2.0	0.5	0.0	0.0	0.0	0.0	3.0	2.0	1.0	2.5	1.0	2.0	2.0	**1.7**
42	1.8	1.7	1.9	1.8	1.4	1.3	1.2	1.1	1.3	1.6	1.5	1.9	1.7	1.6	1.7	1.8	1.6	1.8	**1.6**
43	2.0	1.7	2.3	2.1	1.8	1.8	0.0	0.0	1.6	1.7	2.2	1.5	1.8	1.9	1.8	2.1	2.1	2.5	**1.8**
44	1.8	2.1	1.9	2.3	1.7	1.6	1.6	2.1	2.1	1.9	2.0	2.1	2.0	1.9	1.9	1.7	2.0	1.8	**1.9**
45	1.7	1.9	2.4	2.2	2.5	1.8	0.3	0.9	0.9	0.7	1.6	2.5	2.4	1.7	2.7	2.1	2.3	2.7	**2.0**
46	2.2	2.2	2.6	2.4	2.5	2.3	1.7	2.1	2.5	2.7	2.6	2.6	2.1	- - -	- - -	- - -	- - -	- - -	**2.4**
47	1.5	1.5	1.7	1.7	1.2	1.4	1.7	1.7	1.7	1.0	1.1	0.8	1.6	2.5	1.9	2.0	2.0	2.4	**1.6**
48	1.6	1.8	1.7	1.9	1.8	2.0	2.0	2.0	1.9	1.6	1.7	1.8	1.7	1.8	2.0	2.0	1.7	1.8	**1.8**
49	2.3	2.5	2.8	3.0	2.0	2.7	1.0	0.0	0.0	0.0	2.0	2.0	0.0	1.0	2.0	- - -	2.0	4.0	**2.1**

Source: Chapin Hall analysis of IDHS Cornerstone data.

Status is draft/provisional. Do not cite without consulting authors.

Table C-3. HFI Active Participants: Proportion of Scheduled Visits Completed

HFI Program	Jan 2009	Feb 2009	Mar 2009	Apr 2009	May 2009	Jun 2009	Jul 2009	Aug 2009	Sep 2009	Oct 2009	Nov 2009	Dec 2009	Jan 2010	Feb 2010	Mar 2010	Apr 2010	May 2010	Jun 2010	Monthly Average
All Sites	**0.89**	**0.90**	**0.89**	**0.88**	**0.89**	**0.88**	**0.87**	**0.88**	**0.89**	**0.89**	**0.89**	**0.89**	**0.87**	**0.90**	**0.89**	**0.88**	**0.89**	**0.89**	**0.89**
1	0.91	0.94	0.97	0.90	0.95	0.84	0.71	0.91	0.84	0.80	0.87	0.80	0.93	0.88	0.97	0.90	0.82	0.92	**0.88**
2	0.97	0.92	0.93	0.93	0.98	0.95	0.93	1.00	1.00	1.00	1.00	0.90	0.91	1.00	0.96	0.94	0.96	0.96	**0.95**
3	0.85	0.86	0.91	0.87	0.83	0.86	0.91	0.86	0.87	0.89	0.92	0.86	0.85	0.88	0.89	0.82	0.89	0.85	**0.87**
4	0.85	0.95	0.96	0.81	0.92	0.83	0.83	0.84	0.89	0.84	0.87	0.91	0.91	0.90	0.86	0.86	0.97	0.88	**0.88**
5	0.95	0.97	0.87	0.84	0.84	0.87	0.67	1.00	0.60	0.75	0.88	0.93	0.85	0.88	0.83	0.93	0.95	0.88	**0.87**
6	0.83	0.83	0.79	0.77	0.94	0.93	1.00	0.92	0.97	0.94	0.97	0.90	0.89	1.00	0.97	0.94	1.00	0.94	**0.89**
7	0.76	0.81	0.78	0.75	0.75	0.72	0.67	0.90	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**0.75**
8	0.98	0.93	0.96	0.93	0.83	0.92	0.80	0.80	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**0.90**
9	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
10	0.84	0.88	0.88	0.92	0.89	0.85	0.79	0.97	0.93	0.86	0.93	0.91	0.89	0.89	0.90	0.90	0.96	0.97	**0.90**
11	0.98	1.00	1.00	1.00	1.00	0.98	1.00	1.00	0.97	0.97	0.94	0.89	0.97	0.90	0.96	0.88	0.97	0.91	**0.96**
12	0.74	0.88	0.92	0.93	0.88	0.76	0.76	0.68	0.89	0.98	0.94	0.98	0.94	0.97	0.83	0.82	0.86	0.83	**0.87**
13	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
14	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
15	0.87	0.94	0.94	0.87	0.89	0.85	0.90	0.80	0.80	0.86	0.88	0.90	0.80	0.90	0.88	0.91	0.87	0.93	**0.88**
16	- - -	- - -	1.00	1.00	1.00	- - -	- - -	- - -	- - -	- - -	1.00	1.00	0.83	0.92	0.85	0.93	0.94	0.89	**0.91**
17	0.92	0.92	0.92	0.96	0.91	0.95	0.96	0.94	0.96	0.99	1.00	0.99	0.99	0.99	0.97	0.99	0.98	0.99	**0.96**
18	0.97	0.98	0.93	0.92	0.91	0.97	0.90	0.88	0.96	0.98	0.91	0.88	0.87	0.92	0.91	0.94	0.89	0.95	**0.93**
19	0.86	0.83	0.82	0.76	0.82	0.87	0.82	0.80	0.88	0.86	0.85	0.78	0.88	0.92	0.92	0.88	0.83	0.84	**0.85**
20	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.97	0.97	1.00	0.95	0.93	0.97	0.94	0.77	0.90	0.97	**0.95**
21	0.83	0.79	0.78	0.78	0.78	0.78	0.63	0.88	0.74	0.60	0.75	0.75	0.72	0.64	0.73	0.78	0.75	0.74	**0.76**

22	0.99	0.99	0.99	0.94	1.00	0.91	0.97	0.90	0.92	0.97	0.94	0.96	0.97	0.97	0.98	0.94	0.98	1.00	**0.96**
23	0.78	0.86	0.89	0.74	0.71	0.50	0.33	- - -	- - -	0.90	0.92	0.87	0.79	1.00	0.67	0.91	0.90	0.71	**0.78**
24	0.92	0.95	0.95	0.97	0.91	0.97	0.92	0.99	0.96	0.95	0.96	0.99	0.95	0.97	1.00	0.97	0.98	0.99	**0.96**
25	0.95	0.95	0.93	0.95	0.97	0.94	0.91	0.96	0.94	0.93	0.93	0.96	0.96	0.96	0.96	1.00	- - -	- - -	**0.95**
26	- - -	- - -	- - -	- - -	1.00	1.00	1.00	1.00	0.91	0.87	0.87	0.73	0.75	0.83	0.75	0.78	0.82	0.78	**0.80**
27	0.88	0.88	0.89	0.84	0.88	0.96	0.81	0.96	0.95	0.95	1.00	0.88	1.00	0.80	0.90	1.00	0.93	0.80	**0.91**
28	0.80	1.00	0.92	1.00	1.00	1.00	1.00	1.00	1.00	0.95	0.76	0.86	0.80	1.00	1.00	0.82	0.88	1.00	**0.92**
29	0.96	0.89	0.97	0.92	0.83	0.86	0.93	0.86	0.85	0.83	0.79	0.84	0.88	0.84	0.84	0.75	0.78	0.98	**0.86**
30	1.00	1.00	0.89	1.00	0.89	0.97	0.95	1.00	0.87	0.96	0.96	0.90	1.00	1.00	0.94	0.89	0.91	0.84	**0.94**
31	0.82	0.78	0.81	0.73	0.79	0.80	0.91	0.87	0.82	0.84	0.77	0.87	0.72	0.86	0.90	0.85	0.95	0.83	**0.83**
32	0.92	0.90	0.91	0.89	0.91	0.95	0.92	0.86	0.97	0.92	0.94	0.95	0.91	0.92	0.92	0.97	0.96	0.91	**0.92**
33	0.86	0.89	0.83	0.86	0.87	0.91	0.90	1.00	1.00	0.90	0.96	1.00	0.95	1.00	1.00	0.97	0.95	0.92	**0.92**
34	0.92	0.95	0.93	0.84	0.89	0.88	0.86	0.89	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.93	**0.95**
35	0.90	0.86	0.90	0.87	0.80	0.90	0.86	0.86	0.88	0.95	0.85	0.89	0.80	0.92	0.84	0.91	0.91	0.82	**0.87**
36	0.87	0.75	0.78	0.73	0.79	0.85	0.89	0.92	0.89	0.97	0.87	0.89	0.92	0.93	0.83	0.79	0.78	0.87	**0.85**
37	0.73	0.87	0.98	0.90	0.87	0.81	0.86	0.86	0.92	0.86	0.76	0.90	0.78	0.85	0.89	0.92	0.87	0.93	**0.86**
38	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
39	0.86	0.89	0.94	0.98	0.85	0.88	0.71	0.78	0.80	0.80	0.93	1.00	0.83	0.80	0.95	0.97	0.90	1.00	**0.90**
40	0.85	0.87	0.77	0.94	0.94	0.79	0.74	0.83	0.76	0.86	0.73	0.83	0.80	0.79	0.80	0.77	0.85	0.93	**0.83**
41	0.73	0.92	0.80	0.58	0.78	0.89	0.25	- - -	- - -	0.00	- - -	1.00	1.00	1.00	0.71	0.43	0.86	0.67	**0.71**
42	0.86	0.89	0.89	0.82	0.76	0.82	0.92	0.74	0.75	0.87	0.89	0.93	0.81	0.86	0.81	0.72	0.71	0.78	**0.82**
43	0.90	0.90	0.93	0.93	0.93	0.86	- - -	- - -	0.94	1.00	0.93	0.95	0.97	0.85	0.96	0.97	0.87	0.98	**0.92**
44	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	**1.00**
45	0.88	0.85	0.87	0.90	0.91	0.85	1.00	1.00	0.85	0.76	0.84	0.81	0.85	0.86	0.91	0.88	0.83	0.89	**0.87**
46	0.84	0.93	0.88	0.94	0.89	0.84	0.80	0.86	0.79	0.89	0.87	0.78	0.79	- - -	- - -	- - -	- - -	- - -	**0.85**
47	0.84	0.80	0.84	0.86	0.88	0.82	0.81	0.82	0.91	0.82	0.97	0.74	0.79	0.90	0.81	0.79	0.83	0.85	**0.84**
48	0.88	0.89	0.86	0.86	0.92	0.89	0.85	0.87	0.87	0.90	0.81	0.84	0.84	0.89	0.86	0.82	0.79	0.80	**0.86**
49	0.82	1.00	1.00	0.92	0.86	1.00	1.00	- - -	- - -	- - -	1.00	1.00	- - -	1.00	1.00	- - -	1.00	1.00	**0.95**

Source: Chapin Hall analysis of IDHS Cornerstone data.

Status is draft/provisional. Do not cite without consulting authors.

Table C-4. Average N of EPSDT/Well-child Visits per Month for Active HFI Participants

HFI Program	Jan 2009	Feb 2009	Mar 2009	Apr 2009	May 2009	Jun 2009	Jul 2009	Aug 2009	Sep 2009	Oct 2009	Nov 2009	Dec 2009	Jan 2010	Feb 2010	Mar 2010	Apr 2010	May 2010	Jun 2010	**Monthly Average**
All Sites	**0.41**	**0.36**	**0.43**	**0.37**	**0.34**	**0.35**	**0.32**	**0.34**	**0.36**	**0.36**	**0.34**	**0.33**	**0.34**	**0.31**	**0.36**	**0.29**	**0.25**	**0.17**	**0.34**
1	0.63	0.11	0.41	0.21	0.31	0.26	0.39	0.22	0.39	0.29	0.26	0.36	0.30	0.30	0.15	0.15	0.16	0.09	**0.28**
2	0.27	0.31	0.76	0.18	0.53	0.68	0.29	0.50	0.50	0.09	0.36	0.58	0.27	0.42	0.33	0.33	0.00	0.20	**0.38**
3	0.34	0.15	0.27	0.34	0.25	0.26	0.31	0.18	0.47	0.33	0.31	0.28	0.26	0.28	0.14	0.22	0.15	0.05	**0.25**
4	0.21	0.47	0.53	0.22	0.59	0.41	0.24	0.35	0.16	0.42	0.26	0.26	0.58	0.32	0.37	0.30	0.30	0.32	**0.35**
5	0.29	0.36	0.11	0.45	0.22	0.33	0.28	0.21	0.13	0.35	0.13	0.20	0.31	0.15	0.16	0.22	0.15	0.04	**0.23**
6	0.27	0.21	0.50	0.32	0.30	0.43	0.11	0.23	0.46	0.27	0.50	0.32	0.10	0.30	0.21	0.24	0.31	0.41	**0.31**
7	0.15	0.27	0.44	0.29	0.28	0.28	0.25	0.00	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**0.27**
8	0.20	0.29	0.60	0.38	0.29	0.47	0.40	0.15	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**0.35**
9	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
10	0.36	0.35	0.40	0.40	0.32	0.40	0.18	0.21	0.23	0.24	0.25	0.18	0.21	0.36	0.24	0.20	0.17	0.21	**0.27**
11	0.44	0.44	0.56	0.55	0.56	0.56	0.67	0.47	0.71	0.12	0.28	0.43	0.29	0.39	0.31	0.48	0.26	0.26	**0.42**
12	0.33	0.45	0.50	0.31	0.31	0.39	0.36	0.26	0.13	0.43	0.13	0.33	0.36	0.13	0.47	0.31	0.43	0.21	**0.34**
13	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
14	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
15	0.31	0.25	0.27	0.31	0.32	0.21	0.20	0.15	0.33	0.19	0.28	0.17	0.18	0.18	0.20	0.23	0.22	0.13	**0.23**
16	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.20	0.10	0.25	0.32	0.29	0.23	0.13	**0.21**
17	0.50	0.63	0.51	0.39	0.73	0.65	0.27	0.34	0.29	0.11	0.43	0.25	0.26	0.32	0.49	0.08	0.17	0.18	**0.38**
18	0.33	0.39	0.27	0.21	0.39	0.07	0.40	0.32	0.06	0.32	0.38	0.31	0.49	0.20	0.42	0.36	0.23	0.20	**0.30**
19	0.63	0.47	0.55	0.45	0.25	0.34	0.53	0.38	0.64	0.35	0.62	0.38	0.35	0.55	0.44	0.35	0.47	0.27	**0.44**
20	0.14	0.15	0.21	0.29	0.20	0.00	0.33	0.17	0.24	0.18	0.21	0.18	0.22	0.09	0.22	0.04	0.23	0.00	**0.17**
21	0.27	0.23	0.22	0.29	0.27	0.11	0.31	0.43	0.30	0.23	0.53	0.11	0.19	0.38	0.29	0.27	0.18	0.10	**0.25**
22	0.42	0.44	0.57	0.39	0.56	0.47	0.39	0.56	0.33	0.34	0.38	0.32	0.33	0.33	0.38	0.23	0.31	0.21	**0.38**
23	0.17	0.17	0.17	0.33	0.17	0.33	0.00	0.00	0.20	0.20	0.00	0.00	0.00	0.00	0.20	0.00	0.20	0.00	**0.13**

24	0.38	0.28	0.38	0.27	0.26	0.15	0.24	0.49	0.18	0.39	0.16	0.18	0.28	0.27	0.31	0.34	0.14	0.21	**0.27**
25	0.60	0.40	0.62	0.51	0.41	0.40	0.42	0.46	0.44	0.58	0.49	0.37	0.49	0.48	0.44	0.14	- - -	- - -	**0.46**
26	0.00	0.00	1.00	0.00	0.00	0.33	0.25	0.20	0.42	0.26	0.19	0.36	0.26	0.18	0.31	0.34	0.21	0.13	**0.25**
27	0.45	0.10	0.20	0.82	0.45	0.27	0.40	0.36	0.11	0.64	0.27	0.18	0.73	0.27	0.10	0.78	0.10	0.33	**0.37**
28	0.67	0.25	0.75	0.33	0.00	2.00	0.50	0.00	0.00	0.67	0.38	0.60	0.00	0.67	0.17	1.17	0.20	0.00	**0.42**
29	0.40	0.46	0.23	0.33	0.41	0.31	0.19	0.48	0.20	0.30	0.26	0.23	0.27	0.33	0.44	0.16	0.12	0.00	**0.29**
30	0.55	0.38	0.60	0.58	0.33	0.55	0.36	0.44	0.67	0.33	0.50	0.30	0.25	0.29	0.38	0.33	0.45	0.20	**0.42**
31	0.39	0.40	0.21	0.35	0.22	0.29	0.40	0.31	0.43	0.34	0.39	0.24	0.51	0.19	0.50	0.31	0.31	0.22	**0.33**
32	0.56	0.54	0.63	0.34	0.53	0.55	0.38	0.38	0.46	0.44	0.55	0.71	0.47	0.55	0.69	0.61	0.48	0.14	**0.50**
33	0.58	0.49	0.46	0.29	0.29	0.53	0.24	0.26	0.52	0.58	0.48	0.19	0.13	0.23	0.39	0.22	0.30	0.18	**0.35**
34	0.40	0.60	0.64	0.33	0.82	0.33	0.64	0.50	0.71	0.93	0.36	0.58	0.46	0.69	0.43	0.40	0.60	0.33	**0.54**
35	0.34	0.23	0.27	0.31	0.23	0.25	0.17	0.38	0.35	0.40	0.26	0.30	0.38	0.23	0.39	0.17	0.27	0.23	**0.28**
36	0.25	0.44	0.40	0.29	0.19	0.40	0.64	0.13	0.19	0.42	0.15	0.55	0.20	0.20	0.45	0.28	0.16	0.15	**0.30**
37	0.13	0.60	0.44	0.44	0.47	0.50	0.29	0.29	0.53	0.18	0.11	0.50	0.56	0.53	0.58	0.44	0.47	0.59	**0.43**
38	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
39	0.25	0.23	0.46	0.38	0.23	0.42	0.14	0.50	0.33	0.00	0.40	0.80	0.00	0.67	0.57	0.67	0.40	0.33	**0.35**
40	0.36	0.16	0.50	0.32	0.33	0.54	0.20	0.44	0.67	0.33	0.87	0.29	0.83	0.56	0.53	0.60	0.43	0.33	**0.44**
41	0.25	0.50	0.50	0.00	0.25	0.25	0.00	1.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.33	0.00	0.00	**0.22**
42	0.29	0.17	0.07	0.27	0.16	0.12	0.24	0.11	0.21	0.24	0.09	0.19	0.20	0.09	0.08	0.14	0.03	0.09	**0.16**
43	0.49	0.60	0.82	0.45	0.45	0.55	0.39	0.28	0.50	0.53	0.30	0.78	0.57	0.57	0.60	0.70	0.60	0.24	**0.54**
44	0.17	0.23	0.15	0.31	0.08	0.33	0.13	0.21	0.46	0.29	0.36	0.14	0.15	0.21	0.25	0.17	0.07	0.00	**0.21**
45	0.62	0.52	0.58	0.43	0.32	0.22	0.42	0.50	0.58	0.47	0.46	0.50	0.71	0.29	0.55	0.27	0.40	0.13	**0.44**
46	0.36	0.44	0.36	0.72	0.24	0.57	0.38	0.52	0.38	0.64	0.38	0.44	0.53	- - -	- - -	- - -	- - -	- - -	**0.46**
47	0.31	0.38	0.33	0.56	0.19	0.34	0.41	0.57	0.37	0.57	0.33	0.24	0.14	0.19	0.58	0.29	0.14	0.19	**0.35**
48	0.55	0.27	0.49	0.33	0.25	0.31	0.27	0.43	0.30	0.23	0.32	0.20	0.33	0.26	0.26	0.28	0.11	0.02	**0.29**
49	1.00	0.00	0.75	0.25	0.00	0.33	0.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00	1.00	- - -	1.00	0.00	**0.38**

Source: Chapin Hall analysis of IDHS Cornerstone data.

Status is draft/provisional. Do not cite without consulting authors.

Table C-5. Average N of DD Screens per Month for Active HFI Participants

HFI Program	Jan 2009	Feb 2009	Mar 2009	Apr 2009	May 2009	Jun 2009	Jul 2009	Aug 2009	Sep 2009	Oct 2009	Nov 2009	Dec 2009	Jan 2010	Feb 2010	Mar 2010	Apr 2010	May 2010	Jun 2010	**Monthly Average**
All Sites	**0.32**	**0.29**	**0.32**	**0.27**	**0.29**	**0.29**	**0.23**	**0.25**	**0.31**	**0.29**	**0.31**	**0.28**	**0.30**	**0.28**	**0.31**	**0.27**	**0.25**	**0.24**	**0.28**
1	0.63	0.67	0.41	0.41	0.21	0.41	0.52	0.26	0.43	0.33	0.30	0.28	0.30	0.41	0.54	0.27	0.32	0.27	**0.39**
2	0.33	0.38	0.53	0.24	0.47	0.32	0.29	0.25	0.50	0.18	0.36	0.67	0.36	0.33	0.33	0.67	0.08	0.40	**0.37**
3	0.19	0.18	0.27	0.29	0.24	0.16	0.31	0.24	0.26	0.19	0.29	0.32	0.30	0.38	0.29	0.41	0.21	0.18	**0.26**
4	0.47	0.53	0.76	0.56	0.71	0.65	0.59	0.35	0.58	0.11	0.63	0.58	0.84	0.58	0.53	0.45	0.65	0.47	**0.56**
5	0.36	0.50	0.36	0.48	0.33	0.33	0.12	0.17	0.21	0.54	0.25	0.36	0.42	0.46	0.16	0.48	0.22	0.35	**0.34**
6	0.12	0.15	0.24	0.22	0.27	0.30	0.17	0.08	0.23	0.33	0.06	0.21	0.00	0.13	0.04	0.07	0.07	0.07	**0.16**
7	0.08	0.13	0.17	0.12	0.17	0.22	0.13	0.00	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**0.14**
8	0.00	0.00	0.27	0.06	0.12	0.40	0.13	0.00	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**0.13**
9	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
10	0.23	0.24	0.30	0.17	0.26	0.30	0.24	0.21	0.33	0.20	0.25	0.08	0.28	0.20	0.19	0.22	0.17	0.13	**0.22**
11	0.44	0.50	0.22	0.15	0.11	0.17	0.11	0.18	0.06	0.35	0.33	0.07	0.05	0.09	0.12	0.19	0.15	0.07	**0.18**
12	0.28	0.21	0.33	0.17	0.43	0.33	0.41	0.37	0.20	0.71	0.31	0.29	0.23	0.19	0.25	0.17	0.20	0.18	**0.28**
13	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
14	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
15	0.16	0.17	0.13	0.10	0.13	0.25	0.08	0.08	0.22	0.11	0.20	0.21	0.17	0.03	0.23	0.17	0.22	0.25	**0.16**
16	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.04	0.11	0.00	0.04	**0.04**
17	0.20	0.26	0.27	0.05	0.34	0.21	0.17	0.17	0.14	0.11	0.16	0.31	0.15	0.14	0.08	0.05	0.17	0.04	**0.17**
18	0.24	0.20	0.23	0.14	0.36	0.15	0.16	0.32	0.10	0.21	0.41	0.11	0.18	0.30	0.28	0.27	0.33	0.18	**0.23**
19	0.53	0.30	0.55	0.24	0.39	0.32	0.33	0.32	0.39	0.18	0.18	0.38	0.39	0.26	0.34	0.15	0.32	0.14	**0.31**
20	0.21	0.08	0.29	0.00	0.13	0.00	0.27	0.00	0.12	0.06	0.26	0.14	0.17	0.13	0.19	0.22	0.04	0.14	**0.14**
21	0.23	0.10	0.22	0.19	0.15	0.15	0.03	0.10	0.43	0.03	0.47	0.17	0.19	0.30	0.12	0.22	0.08	0.00	**0.17**
22	0.75	0.56	0.71	0.39	0.56	0.41	0.35	0.52	0.42	0.28	0.26	0.29	0.50	0.40	0.56	0.35	0.43	0.45	**0.46**

23	0.50	0.00	0.67	0.33	0.17	0.33	0.20	0.20	0.20	0.60	0.20	0.60	0.20	0.60	0.60	0.60	0.00	0.20	**0.34**
24	0.11	0.41	0.29	0.09	0.33	0.10	0.39	0.22	0.30	0.34	0.32	0.16	0.19	0.38	0.22	0.20	0.18	0.23	**0.25**
25	0.64	0.44	0.57	0.54	0.57	0.50	0.34	0.31	0.60	0.69	0.51	0.52	0.67	0.46	0.72	0.14	- - -	- - -	**0.52**
26	0.00	0.00	1.00	0.00	0.00	0.33	0.00	0.00	0.42	0.30	0.47	0.46	0.33	0.28	0.55	0.31	0.35	0.49	**0.38**
27	0.45	0.30	0.10	0.45	0.27	0.18	0.30	0.64	0.22	0.27	0.18	0.64	0.27	0.18	0.10	0.56	0.40	0.44	**0.33**
28	0.33	0.50	0.00	0.67	0.00	0.00	0.00	0.50	0.00	0.00	0.38	0.00	0.00	0.17	0.00	0.83	0.40	0.33	**0.22**
29	0.36	0.27	0.46	0.41	0.33	0.35	0.15	0.32	0.52	0.33	0.22	0.15	0.31	0.48	0.11	0.08	0.15	0.40	**0.30**
30	0.45	0.15	0.20	0.17	0.25	0.00	0.00	0.11	0.22	0.22	0.30	0.50	0.42	0.07	0.38	0.08	0.36	0.20	**0.23**
31	0.31	0.42	0.20	0.16	0.22	0.20	0.29	0.40	0.21	0.16	0.27	0.15	0.40	0.30	0.29	0.25	0.26	0.27	**0.26**
32	0.16	0.28	0.28	0.24	0.13	0.35	0.19	0.21	0.31	0.30	0.12	0.24	0.22	0.13	0.23	0.39	0.21	0.17	**0.23**
33	0.39	0.38	0.49	0.38	0.34	0.53	0.03	0.06	0.06	0.35	0.68	0.77	0.17	0.53	0.22	0.33	0.38	0.30	**0.35**
34	0.50	0.70	0.55	0.42	0.64	0.33	0.55	0.42	0.43	0.57	0.43	0.33	0.38	0.46	0.29	0.53	0.33	0.47	**0.46**
35	0.51	0.42	0.60	0.23	0.45	0.48	0.24	0.47	0.35	0.37	0.42	0.23	0.49	0.31	0.34	0.33	0.49	0.23	**0.39**
36	0.25	0.19	0.00	0.00	0.06	0.27	0.43	0.27	0.00	0.11	0.10	0.10	0.30	0.30	0.30	0.22	0.16	0.30	**0.19**
37	0.00	0.27	0.44	0.11	0.21	0.22	0.00	0.00	0.60	0.12	0.11	0.20	0.22	0.00	0.37	0.06	0.29	0.24	**0.19**
38	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	**- - -**
39	0.40	0.23	0.19	0.42	0.19	0.38	0.14	0.50	0.33	0.25	0.20	0.40	0.29	0.17	0.43	1.00	0.30	0.33	**0.32**
40	0.20	0.28	0.25	0.41	0.46	0.33	0.20	0.56	0.25	0.53	0.60	0.36	0.39	0.69	0.59	0.80	0.50	0.53	**0.42**
41	0.50	0.75	1.00	0.50	0.00	0.50	0.00	1.00	0.00	0.00	1.00	0.00	1.00	1.00	1.00	0.00	0.33	0.00	**0.43**
42	0.20	0.12	0.15	0.18	0.18	0.12	0.13	0.13	0.05	0.16	0.11	0.06	0.11	0.11	0.08	0.08	0.12	0.03	**0.12**
43	0.33	0.26	0.39	0.17	0.32	0.29	0.33	0.22	0.65	0.26	0.30	0.09	0.48	0.19	0.36	0.47	0.17	0.52	**0.31**
44	0.17	0.08	0.38	0.08	0.00	0.27	0.07	0.07	0.38	0.21	0.14	0.21	0.08	0.36	0.19	0.11	0.07	0.00	**0.16**
45	0.18	0.18	0.13	0.30	0.18	0.17	0.05	0.19	0.05	0.11	0.12	0.20	0.16	0.09	0.10	0.20	0.23	0.10	**0.16**
46	0.23	0.28	0.16	0.36	0.31	0.23	0.21	0.21	0.22	0.39	0.24	0.25	0.13	- - -	- - -	- - -	- - -	- - -	**0.25**
47	0.72	0.26	0.30	0.34	0.22	0.26	0.22	0.21	0.30	0.14	0.30	0.21	0.39	0.42	0.46	0.62	0.43	0.62	**0.34**
48	0.28	0.33	0.19	0.54	0.33	0.26	0.32	0.33	0.33	0.34	0.32	0.39	0.31	0.25	0.33	0.29	0.33	0.23	**0.32**
49	0.50	0.25	0.75	0.00	1.00	0.00	1.00	0.00	1.00	0.00	1.00	0.00	0.00	0.00	2.00	- - -	0.00	0.00	**0.44**

Source: Chapin Hall analysis of IDHS Cornerstone data.

Status is draft/provisional. Do not cite without consulting authors.

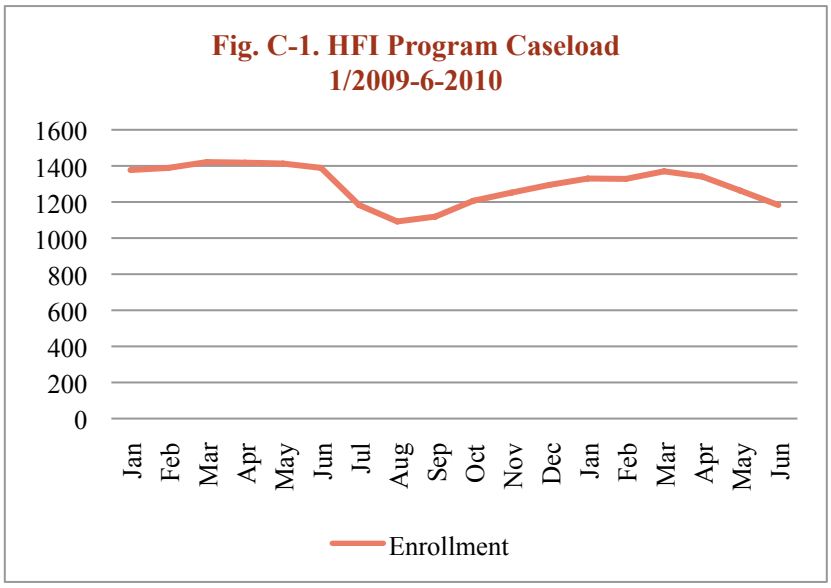


Fig. C-1. HFI Program Caseload
1/2009-6-2010
1600
1400
1200
1000
800
600
400
200
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Enrollment

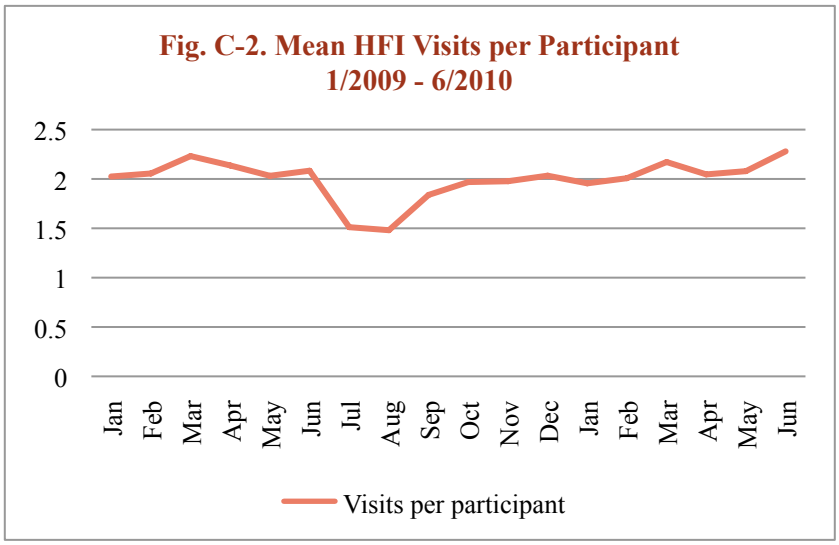


Fig. C-2. Mean HFI Visits per Participant
1/2009 - 6/2010
2.5
2
1.5
1
0.5
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Visits per participant

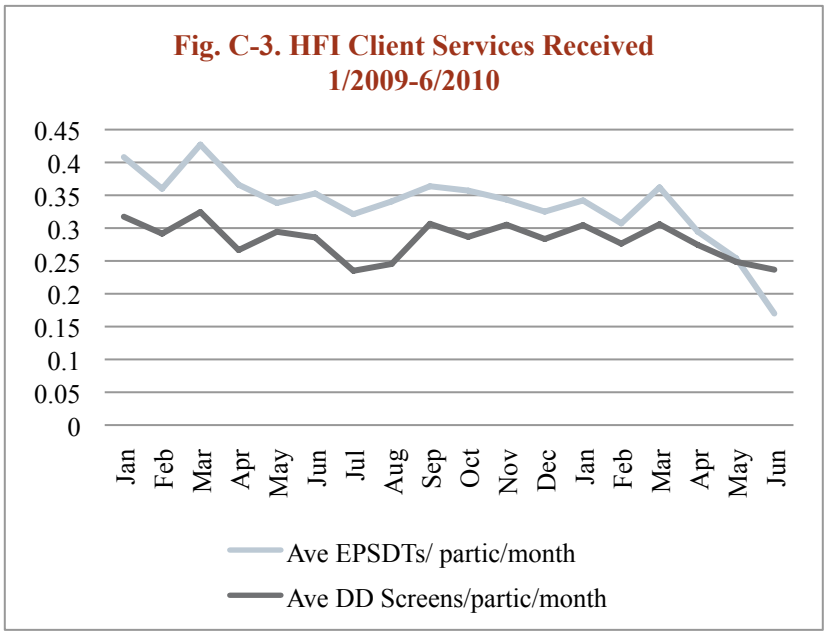
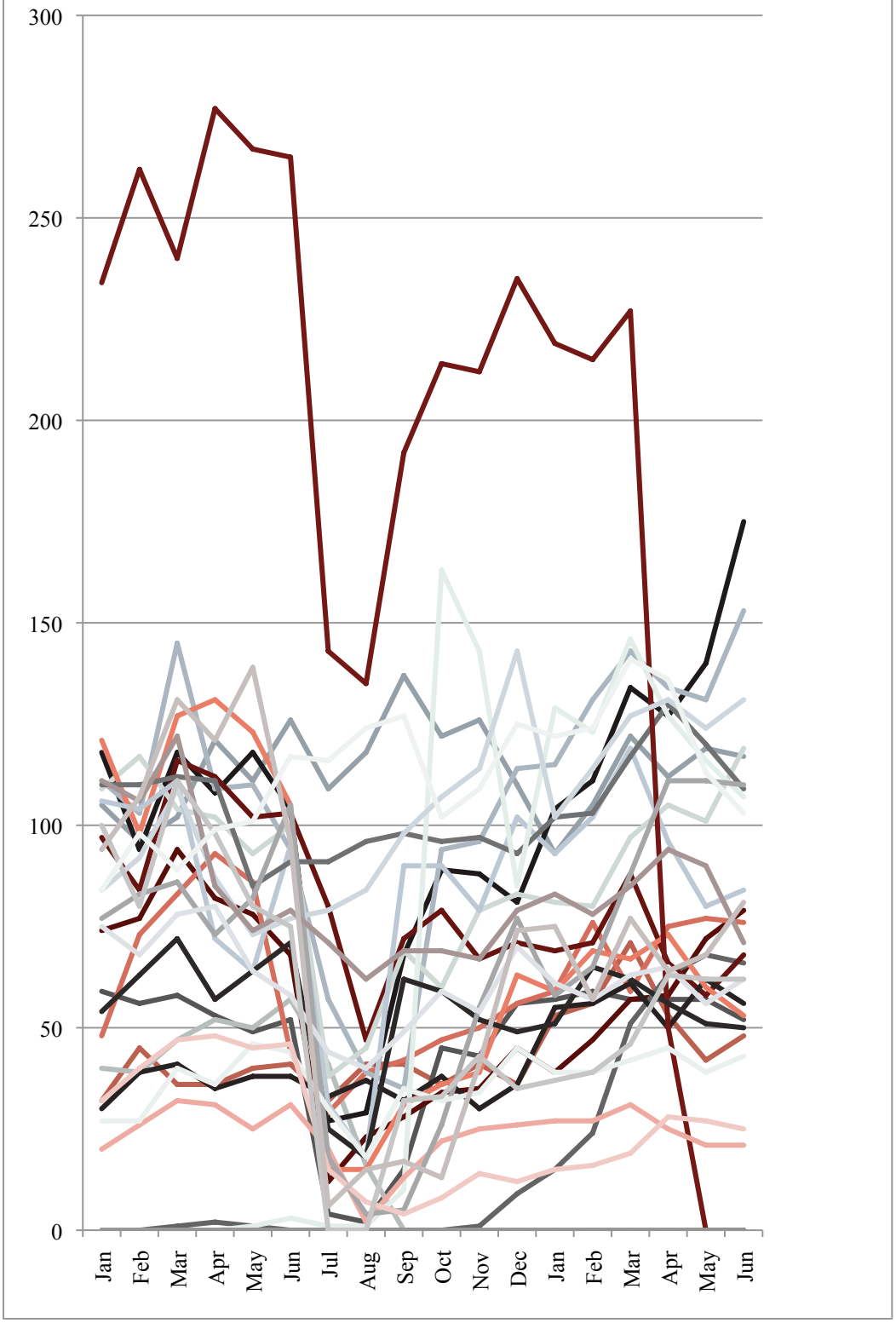


Fig. C-3. HFI Client Services Received
1/2009-6/2010
0.45
0.4
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Ave EPSDTs/ partic/month
Ave DD Screens/partic/month

Fig. E-4. Monthly Caseloads for Selected HFI Programs, 1/2009-6/2010



positive

Positive Parenting DuPage
Collaboration and Systems Building

This report summarizes activities and evaluation data related to the *Collaboration and Systems Building Technical Assistance* sessions sponsored by the Strong Foundation Initiative and led by Positive Parenting DuPage.

The objectives for these training sessions were to:

- Learn characteristics of the continuum of local collaborative systems.
- Understand how to use of the Community Systems Development Resource Toolkit.
- Discuss local coordination of programming and how to utilize evidence-based home visiting models.
- Learn about ongoing technical assistance opportunities.

Training sessions. A total of seven technical assistance sessions were held in various locations around Illinois. Sessions were held in the following cities: Bloomington (10 participants), Galesburg (8 participants), Springfield (23 participants), Mount Vernon (20 participants), DeKalb (15 participants), Joliet (40 participants), and Park Ridge (35 participants).

Participants. The 138 participants who completed the follow-up surveys represented an array of agencies (e.g., Head Start, Department of Children and Family Services, health departments, mental and behavioral health services, etc). Table 1 displays the broad service categories respondents endorsed when asked to indicate what field they worked within.

Current collaboration. When asked to indicate whether they "currently work collaboratively," 69.6% of respondents said "yes." Of the remaining respondents, 10.9% responded "no" to this item, and 19.6% left this item blank.

Participants were also asked rate their level of engagement in community collaboration on a scale from 1 to 5, with 1 being "fully engaged" to 5 being "not connected in any collaboration."

Table 1: Types of services reported by respondents.

Organization	#	%
Social services	57	41.3
Early childhood	37	26.8
Education	18	13.0
Childcare	9	6.5
Health	7	5.1
Government	3	2.2
Other	7	5.1
Total	138	100.0

The average rating across all respondents was 2.65 (*SD* = 1.32). Interestingly, approximately half (49.2%) of respondents rated their engagement in collaborative work below the midpoint of the scale (i.e., less than 3). Collectively, these findings suggest that although most of the participants perceived themselves as currently part of a collaborative effort, nearly half did not feel very connected or engaged in these efforts.

Participants also were asked to indicate what they felt were their "most pressing needs around advancing collaboration and cross system training." A majority (57.3%) of respondents indicated that money was their most pressing need. Nearly half (44.8%) felt they needed structure for building collaboration. Over a third (39.6%) felt they needed community leadership and about a quarter (24.0%) thought they needed some form of technical assistance. Over a quarter (27.1%) of respondents identified other needs related to advancing collaboration in their community, such as time, awareness of resources and agencies, committed partners, buy-in from partners/agencies, etc.

Needs for additional support. Participants also were asked if they thought their community would access additional support related to collaboration building if such were available. Of those that responded to this question, 81% said "yes."

Collaboration and Systems Building

Respondents who answered "yes" to this item were asked to indicate what type of support they thought their community might need. The following are examples of the types of support participants thought their communities might be interested in receiving:

- "help building competencies in collaboration across systems."
- "support in bringing together all community stakeholders, not just early childhood programs (medical, dental, social services, public school systems)."
- "to work with someone to prioritize our work and strategize about engaging people to do systems work in addition to the services work."
- "assistance collaborating with community agencies to provide support for families with preschool aged children who have been identified as being at-risk for academic failure."
- "awareness of resources for children/families who do not meet eligibility requirements for early intervention yet need supports."
- "need funding, ideas, service access to families."
- "help getting money for community statistics."
- "help ensuring that collaborations are working together without duplicating services."

Assessment of training effectiveness: At the close of each training session, participants were asked to complete a post assessment, indicating the extent to which they agreed that they understood and were familiar with the central messages conveyed in the training. As may be seen in Figure 1, the majority of respondents (77% or more) indicated they "agreed" that they understood, had awareness, or possessed skills in each of the areas assessed at the end of the training.

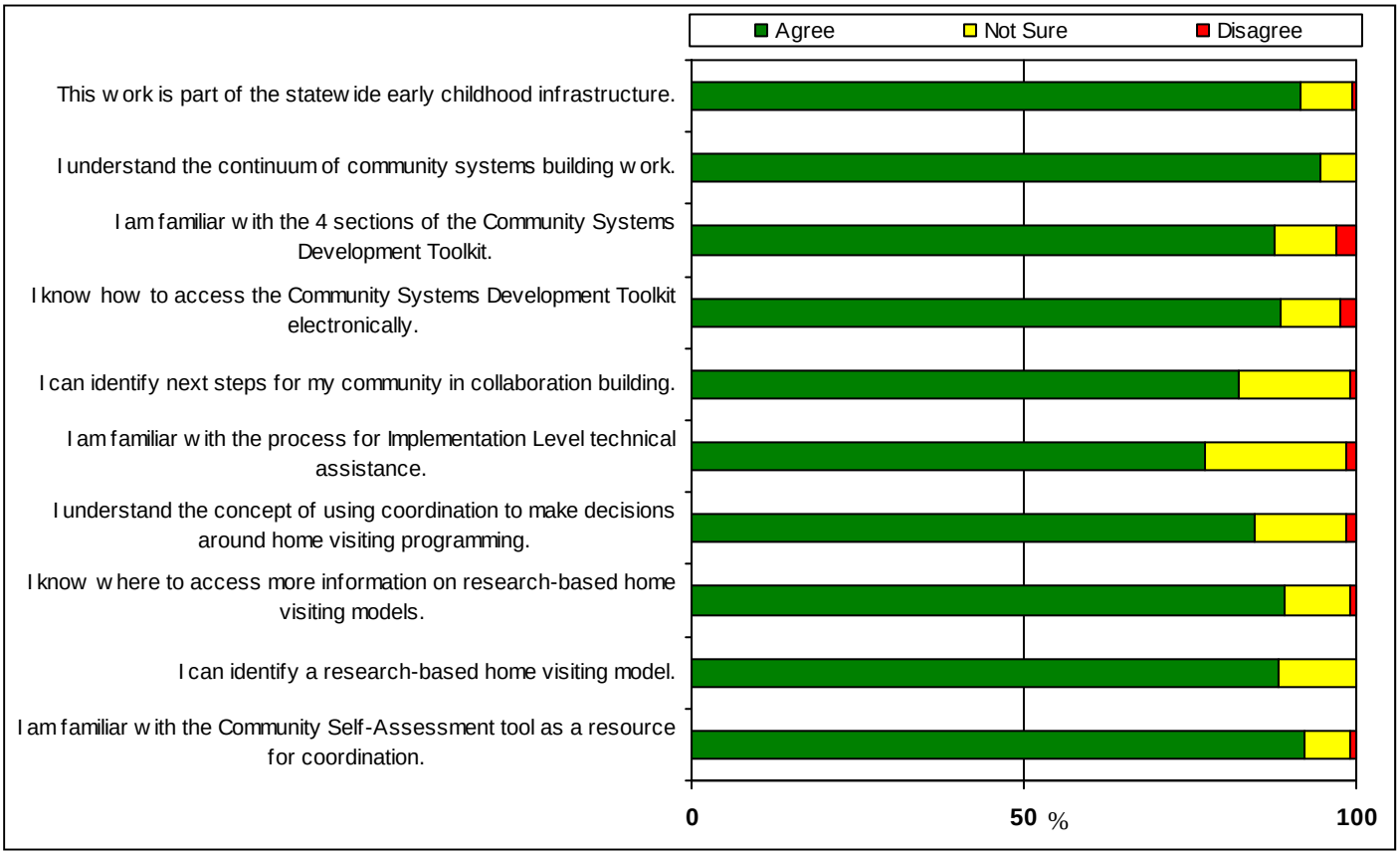


Figure 1: Percentage of respondents (*N* = 132) who endorsed *agree*, *not sure*, or *disagree* across items assessing objectives for the collaboration and systems building training.

Collaboration and Systems Building

Assessment of Key Concepts. As part of the post assessment training, participants also were asked to review seven items and identify which of the items were "key concepts" related to systems building work.

As shown in Table 1, participants were generally very successful (80% or higher) in correctly identifying six of the seven key concepts. One item, however, was missed by approximately one-third of the participants. This item focused on the concept that "geographic boundaries should be natural to those living in the community and the system serving them." Of those participants who missed this item, 13.1% of respondents were "not sure," and 20% responded "no."

Collectively results from the post assessment revealed that participants in the *Collaboration and Technical Assistance* trainings achieved a high level of understanding of the key concepts and skills covered in the presentations. Refinement of the content to help participants grasp the importance of the notion of naturally occurring geographic boundaries would seem warranted; however, all other aspects of the training appeared to be clearly and effectively conveyed.

Table 1: Key Concept Item	% correct
System of interrelated parts working together to ensure collaboration. (agree)	96.1
Communities may engage different collaborative strategies to effect systems change for children and families. (agree)	97.7
Systems building work is referred to only as a coalition in local communities. (disagree)	84.5
Geographic boundaries should be natural to those living in the community and the systems serving them. (agree)	66.9
Participation in systems building work should be limited to civic leaders. (disagree)	86.9
Formal collaborations may have a multi-level governance structure. (agree)	92.3
Expected results for systems building must be linked to the activities of the collaboration. (agree)	86.2

Data analyzed and report compiled by researchers at Northern Illinois University, Center for the Study of Family Violence and Sexual Assault. June 2010

KANE COUNTY HOME VISITATION COLLABORATION AGREEMENT

The purpose of this agreement is to formalize the existing collaboration among the Home Visitation Programs in Kane County. The mission of our collaboration is to assure comprehensive, unduplicated, quality home visitation services to the children and families of Kane County.

All our organizations share a strong commitment to improving and strengthening the families, by providing education and support, to meet the complex needs of our families and community. We are unified in our vision that building relationships with parents and children in their home environment enhances their learning and competence in responsive parenting.

We will continue to support each other in our commitment to continuous quality improvement and ongoing program assessment and evaluation to better meet the needs of the families we serve.

Each agency agrees to:

1. Recognize the existence of the professional services of members of the Collaborative
2. Maintain quarterly contact with regard to changes in service elements present within each member's program
3. Participate in a home visitation referral and linkage system for Kane County pregnant and parenting clients who are eligible for services
4. Obtain signed release of information forms to aid in the transfer of relevant client information and provide feedback to the referring agency regarding client enrollment
5. Collaborate in providing educational workshops for Home Visitors
6. Avoid duplication of services and advocate for additional resources to address unmet home visitation needs of Kane County parents.
7. Encourage the Collaborating agencies to contribute to the enhancement of the maternal-child health system in Kane County through collaboration on the MCH IPLAN and the AOK strategic plan in Kane County.
8. Participate in quarterly meetings through a designated contact person for the purpose of coordination of referral information and other relevant interagency communication.

Kane County Health Department

Director Signature _____ Date_____

Home Visitation Program _____

Director Signature _____ Date _____

About Chapin Hall

Established in 1985, Chapin Hall is an independent policy research center whose mission is to build knowledge that improves policies and programs for children and youth, families, and their communities.

Chapin Hall's areas of research include child maltreatment prevention, child welfare systems and foster care, youth justice, schools and their connections with social services and community organizations, early childhood initiatives, community change initiatives, workforce development, out-of-school time initiatives, economic supports for families, and child well-being indicators.

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