

**Building a System of
Support for Evidence-Based
Home Visitation Programs
in Illinois:**

**Findings from Year 3 of
the Strong Foundations
Evaluation**

**Julie Spielberger
Elissa Gitlow
Carolyn Winje
Allen Harden
Aaron Banman**

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Julie Spielberger, Elissa Gitlow,
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Table of Contents

Executive Summary	i
Introduction	i
Key Findings and Recommendations	ii
Introduction.....	1
Design and Methods	5
Overview of this Report	7
State Context and System for Evidence-Based Home Visitation Programs	8
Perspectives on the State System.....	10
Training through Strong Foundations	37
Big Four Trainings	39
Happiest Baby on the Block	48
Training and Technical Assistance Developments.....	53
Summary.....	62
Program Implementation, Fidelity, and Quality	64
Staff Characteristics.....	65
Program Implementation, Quality, and Fidelity	80
Summary.....	94
Administrative Data Study: Trends in PAT and HFI Program and Family Characteristics	96
Parents as Teachers Annual Program Reports 2008–11	97
HFI Caseloads and Clients, State Fiscal Years 2006–12.....	103
HFI and other IDHS Social Service Programs: WIC, FCM, and EI	115
Links to DCFS Abuse/Neglect Investigations.....	117
Summary of HFI Administrative Data Findings	120
Summary and Recommendations.....	122
State System	122
Bibliography	130
Appendix A: Home Visiting State Systems Development Assessment Tool (HVTF 2009)	133
Appendix B: Ratings of Individual Items on Wilder Collaborative Factors Inventory by State Informants	137
Appendix C: Enhanced Trainings on Domestic Violence, Perinatal Depression, Substance Abuse, and Young Adults with Learning Challenges.....	142

Appendix D: Monthly Data Collection Form	156
Appendix E: Program Supervisor and Home Visitor Survey	161
Appendix F: State Level Informant Consent, Program Supervisor Consent and Interview Guide and Home Visitor Consent and Focus Group Guide	168

List of Figures

Figure 1. Original Logic Model for Strong Foundations (June 2009)	2
Figure 2. Reach of Big Four and HBOB Trainings in Illinois, SFY 2012.....	38
Figure 3. Reach of Big Four and HBOB Trainings in Illinois, SFY 2011 and SFY 2012.....	57
Figure 4. Average Number of Hours Supervisors Dedicate to Supervision over Time by Program Model, July 2010–June 2012.....	72
Figure 5. Average Number of Staff Meetings by Program Model over Time, July 2010–June 2012	74
Figure 6. Average Length of Staff Meetings in Minutes by Program Model over Time, July 2010–June 2012	74
Figure 7. Average Capacity and Enrollment of Families by Program Model over Time, July 2010–June 2012	82
Figure 8. Percent of Programs Indicating a Change in Capacity by Program Model over Time, July 2010–June 2012	83
Figure 9. Percent of Programs Implementing Program Enhancements by Program Model over Time, July 2010–June 2012	85
Figure 10. Average Number of Families Newly Referred, Met Criteria, and Enrolled in Program by Program Model over Time, July 2010–June 2012	88
Figure 11. Average Number of Families Who Left Their Programs over Time, July 2010–June 2012.....	94
Figure 12. Average HFI Caseload, by Region and SFY Quarter.....	107
Figure 13. Number of Completed Home Visits per Month, by Region and SFY Quarter.....	108
Figure 14. Monthly Visits per Child, by Region and FY Quarter.....	109
Figure 15. Entries to HFI Programs, by SFY Quarter and Region	110
Figure 16. Terminations from HFI, by Quarter and Region	110
Figure 17. Net Change in HFI Caseload, by SFY Quarter and Region	111
Figure 18. Enrolled Children in Investigations of Child Abuse and Neglect, SFY 2006–10	119

List of Tables

Table 1. Overview of Strong Foundations Evaluation Activities	4
Table 2. Descriptions of Strong Foundations' Big Four Trainings ^a	40
Table 3. Training Dates and Attendance per Training Location by Training Topic	41
Table 4. Characteristics of Big Four Training Participants.....	42
Table 5. Participant Views on Whether Training Met Objectives	44
Table 6. Change in Participants' Levels of Knowledge and Confidence ^{a,b}	45
Table 7. Participants' Satisfaction with Strong Foundations Trainings.....	46
Table 8. Characteristics of HBOB Participants, 2011–2012 (<i>N</i> = 21)	50
Table 9. Home Visiting Program Staff Views on Effects of HBOB Training, 2011–2012 ^a	51
Table 10. Characteristics of Program Staff in 15 Home Visiting Programs, 2010–12 ^a	67
Table 11. Hours Spent in Supervision This Past Month over Time ^a	71
Table 12. Comfort Level with Knowledge ^a	76
Table 13. Percent of Respondents Wanting More Training ^a	77
Table 14. Percent of Respondents Who Reported Participating in a Strong Foundations Training in SFY 2011 and SFY 2012	78
Table 15. Mean (<i>SD</i>) Satisfaction Levels with Job Aspects over Time ^a	79
Table 16. Race/Ethnicity of Children Served by Illinois PAT Programs over Time	98
Table 17. Nativity of Families Participating in Illinois PAT Programs over Time	99
Table 18. Characteristics of Illinois PAT Families over Time	99
Table 19. Characteristics of Illinois PAT Parent Educators over Time	101
Table 20. Services Provided by Illinois PAT Programs over Time	102
Table 21. Estimated Cost of Providing PAT Services in Illinois over Time	103
Table 22. Healthy Families Illinois Program Components, SFY 2006–12.....	105
Table 23. Characteristics of Clients Entering Healthy Families Illinois Programs	106
Table 24. Type of enrollment in HFI, by Region of Illinois and State Fiscal Year, 2006–12	112
Table 25. Duration of HFI Home Visiting Spells, Percent Distribution of time periods from enrollment to termination, SFY 2006–12.....	113
Table 26. Duration of HFI Home Visiting Spells, by Year of Engagement and Type of Enrollment, SFY 2006–12	114
Table 27. Comparison of All Live Births in Illinois during 2009 with Infants Enrolled in IDHS Programs. Program enrollees from infants born during SFY 2009.....	116

Table 28. DCFS Investigation of alleged Child Abuse and Neglect for DHS program enrollees Children born SFY 2006–10 and enrolled in programs any time during SFY 2006–10	118
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Table 29. Alleged Child Abuse and Neglect as Perpetrators of Victims for DHS mothers in DHS programs during SFY 2006–10.....	119
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Table B-1. Ratings of Individual Items on Wilder Collaborative Factors Inventory by State Informants (Spring 2012) ^a	138
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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 Illinois Early Learning Council (ELC) began the implementation of Strong Foundations. Funded by the Children’s Bureau of the U.S. Department of Health and Human Services Administration for Children and Families, Illinois was one of 17 grantees in 15 states to receive funding for 5 years to support a year of planning followed by the implementation, scale up, and sustainability of evidence-based home visiting programs for the prevention of child maltreatment. Each grantee was expected to conduct local implementation and outcome evaluations, along with an analysis of program costs, and contribute information to a national cross-site evaluation.

The primary of Strong Foundations has been to enhance and strengthen the state infrastructure—governance, funding, monitoring and quality improvement, and training and technical assistance—that supports close to 200 evidence-based home visiting programs in Illinois. Strong Foundations is based on the assumption that a well-functioning and effective infrastructure at the state level will support and be reflected in a well-functioning and effective local system and the successful operation of program sites. Furthermore, 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 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

The evaluation focuses 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 are:

- *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, funding, monitoring and quality assurance, and 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 three primary components, as follows:

- (1) A process evaluation of the state infrastructure using the methods of (a) annual interviews and, in 2012, a structured survey collaboration factors with about 20 state-level informants; (b) annual interviews and surveys of program supervisors and directors of 15 local programs in different regions of the state; and (c) surveys and focus groups with home visitors.
- (2) Surveys and interviews of participants in training and professional development activities sponsored by Strong Foundations.
- (3) An administrative data study of program performance, capacity, and fidelity indicators based on program records of the 15 local programs and state data systems for HFI and PAT.

Key Findings and Recommendations

State System

As outlined below, over the past 3 years of the implementation of Strong Foundations, we have seen growth in the home visiting system in several areas, especially in the areas of leadership, state-level collaboration and partners, and professional development and training.

Leadership, Governance, and Collaboration

State informants were generally optimistic about the growing collaboration among the three main state agencies involved in the development of the home visiting system—IDHS, ISBE, and DCFS. Their optimism reflects progress towards the vision of the original Strong Foundations plan for shared leadership and accountability among organizations in the home visiting system. In the third year, they also emphasized the integration of the Strong Foundations initiative with the new Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program—both of which are administered by the new Strong Foundations Partnership project director in the Governor’s Office of Early Childhood Development (OECD)—as a sign of progress in state system building. At the same time, there is still work to be done to have all of the evidence-based models and funding agencies fully engaged in the state’s system-building effort.

Communication and Decision-Making

A key challenge in any system is communication. Over the 3-year study period, we have observed decreasing concern about how information is shared and the way decisions are made in the system and by whom. Although communication is better, however, there is still room to improve relationships with partners. The structured collaboration assessment indicated that some informants believe that inadequate funding, people resources, and trust among some participants continue to pose barriers to clear communication and transparency in decision-making in a complex system. Given the complexity of the system, communication cannot be taken for granted, particularly between state and local levels, and the effectiveness of communication efforts should be checked on an ongoing basis.

Monitoring Program Fidelity and Quality Assurance

The ability to collect common data across home visiting programs and funding streams is another important component of an effective infrastructure. There is strong interest among agencies in sharing data across systems, and an early HVTF workgroup developed recommendations for a statewide monitoring and quality assurance infrastructure. Although few resources were allocated to address these recommendations as part of Strong Foundations, MIECHV and other federal initiatives have provided new incentives and resources to build a data system for the collection of common indicators or benchmarks of child, family, and community well-being. The data system is a component of the new HVTF work plan and is in its final stages of development at the time of this report.

Despite this progress, key informants for the evaluation noted that many providers supported by multiple funding streams are still subject to burdensome data reporting requirements. It will take time before the state has an integrated system of common data elements for all home visiting programs, which might also link with other existing or developing systems (e.g., the IDHS Early Intervention system, the DCFS

Statewide Provider Database, and the ISBE data system). A more comprehensive, integrated data system will eventually facilitate the tracking of families' service use and outcomes throughout the early childhood system.

Funding and Sustainability

Each year of the Strong Foundations evaluation, state and local informants have highlighted funding as an ongoing threat to the stability of the state's infrastructure. This was most evident at the time of the summer 2010 budget cuts on home visiting programs, which resulted in reductions and reallocations of staff and caseloads. Even with the restoration of some of the funding, it took time for programs to rehire staff and rebuild their caseloads. Staff or families who left could not necessarily be re-engaged. Staff loss occurred at both the supervisor and frontline worker level.

MIECHV funding and strong advocacy during 2011 and 2012 helped to stem proposed cuts to funding for home visiting services, but state and local stakeholders do not feel secure about the current funding context. Even though the new state procurement process appears to be improving, it has slowed efforts in a number of areas and will be an ongoing challenge. The HVTF has created a Sustainability Work Group is well poised to focus on long-term funding strategies, in light of ongoing state budget problems and given the fact that MIECHV funding will only be available for a few more years.

Staff Training and Development

Training is the area of the infrastructure that Strong Foundations has focused many of its resources, and it is the most tangible product from the initiative. Over the past 3 years, Strong Foundations has supported the expansion of training tailored to home visitors and their supervisors the areas of domestic violence, perinatal depression, substance abuse, and adult learning challenges. Growing numbers of home visiting staff are participating in these trainings. Pre- and post-training surveys and participant interviews indicate a very positive response to the quality and content of these trainings, as well as a positive impact on home visitors' confidence in applying their knowledge to their work with families—both immediately after training and 3–6 months afterwards.

An important improvement to the trainings offered during state fiscal year (SFY) 2012 was the addition of a co-facilitator—an educator with home visiting experience who could help participants integrate the content knowledge into their work with families. Strong Foundations has also supported the creation and implementation of Supervisory Learning Communities, recognizing that their training needs are likely to differ from those of frontline staff. These changes address the requests for more comprehensive and deeper training targeted to the diverse needs of different staff articulated by home visitors in focus groups during the first year of the Strong Foundations evaluation.

Other recently added training supported by Strong Foundations include the Happiest Baby on the Block self-study certification program for home visiting staff and Strengthening Families trainings on trauma informed practice and protective factors. Collectively, these developments potentially increase the capacity of the state system to provide training for a range of home visiting staff and foster a “culture for training and learning” among local programs.

At the same time, some home visiting staff continued to identify the location of the trainings as a hurdle. The training infrastructure still does not equitably reach all regions of the state. Barriers to attendance remain for staff working in rural areas of the state, particularly in southern and southwestern regions. This suggests a need to continue to explore other training locations, and other training modalities, as well as to track trends in participation and reasons for low attendance in certain regions or topic areas.

It is too soon to know whether the capacity of Illinois’s home visiting programs to serve high-risk families has significantly increased as a result of the trainings provided in 2011 and 2012. As more home visitors receive training in these topic areas and as more formal systems for sharing and integrating this knowledge into practice are developed, we believe that capacity will increase accordingly. Long-term, it will be important for the Training Institute, the Strong Foundations Partnership, and the HVTF to examine whether these training topics continue to meet the needs of home visiting staff and whether they are able to strengthen other aspects of the system, for example, staff retention, staff interest in obtaining additional training in these and other topic areas, and staff’s ability to engage and retain families with higher risk characteristics in services.

Program Capacity and Local Collaboration

This report has noted both perceived capacity issues and real capacity issues that affect the home visiting infrastructure. Evidence from administrative data and key informant interviews indicate that some HFI and PAT programs are under enrolled and that home visiting staff have to be creative and diligent to recruit families to their programs. Some respondents expressed concern about the need for increased funding to build capacity when current programs are not full or suggested that the state needs to explore which programs are under capacity, the extent to which the programs are under capacity, and the reasons that they struggle. This might entail another needs assessment like the one conducted 2 years ago in preparation for the MIECHV program, as well as a more comprehensive analysis of take-up and retention rates in home visiting programs. Another capacity issue pertains to the lack of available, affordable mental health and other resources for home visiting clients. Community collaborations can help to bridge programs and increase awareness of resources that exist; towards this end, some of our informants highlighted the community systems work that is being piloted through MIECHV as another step towards increasing awareness and collaboration. In addition, the HVTF might explore with the ELC’s System

Integration and Alignment Committee ways to address the current shortage of needed resources and long waiting lists for some types of services.

Program Implementation

An analysis of trends in administrative data on program and family characteristics for the PAT and HFI programs showed modest changes over time. Three years of data on PAT programs showed a decrease in the total number of programs providing data and the number of families served between SFY 2009 and 2011. At the same time, there was a small increase in the percentage of families designated as “low-income” over this period (from 74% to 84%), the percentage of single-parent households (from 35% to 50%), and parents who were teens (from 22% to 27%). This suggests that, collectively, these programs are increasingly serving a higher risk population. Other findings included a small increase in the number of Hispanic families served during this time period, a small decline in the percentage of families starting services prenatally, and a small decline in the number of 2-year-old children who were fully immunized.

Data on HFI programs over a 7-year period beginning in SFY 2006 showed modest variability in the number of HFI programs in any given year, which fell between 40 and 48 programs. The demographic characteristics of families were fairly stable over the period of study: 36 percent of the families were recorded as Hispanic, 30 percent as black, 3 percent as white, and 31 percent as “other.” Just over half of the mothers served were teen mothers and just over half were high school graduates. On average, HFI programs successfully engaged mothers prenatally in about one-half of all cases, while 40 percent were initiated after the birth of the child. Although these patterns were fairly stable, there was a clear upward trend in prenatal enrollments in Chicago, which is a positive trend. A comparison of two groups of families—those who entered prenatally and those who had their first visit shortly after the child’s birth—suggests program retention was greater for prenatal cases.

The proportion of expected home visits that were completed is an important measure of fidelity. For most of the 6 years, it appears that between 75 and 90 percent of the planned home visits took place, with the lower completion levels occurring in programs in Chicago. At the time of the SFY 2009 fiscal crisis (Summer 2009), the completion level in Chicago dropped to its lowest level, 70 percent, although it rebounded to about 85 percent during the final three quarters. In contrast, programs in the other regions of the state showed only a minor shift in completion levels during the same time. In addition, the number of case closings increased considerably in Chicago and downstate regions during the fourth quarter of SFY 2009. All three regions show increased recruitment of new cases during the following months (Winter 2010). Although the final result of these changes is small in terms of the number of clients served, the fluctuations caused by a short period of unusually high terminations followed by a period of active

enrollment reflect instability in the caseload that raises concerns about the system's ability to provide stable services to families.

Data from 14 of the 15 programs in our study sample indicated trends similar to those found in the statewide data. During a 2-year period, SFY 2010 and SFY 2011, enrollment was almost always just below capacity. Although there were small fluctuations from month to month, capacity and enrollment tended to stay fairly stable over time. Engagement and enrollment of new families varied from program to program for a variety of reasons, including differences in family needs, program eligibility guidelines, and program capacity; there also were seasonal and regional variations. Qualitative data drawn from focus groups with home visitors indicate ongoing challenges to keeping high-risk families engaged in services (although they also provided examples of “success”). Home visiting staff most often pointed to their families' transient situations as the major factor that influenced changes in enrollment. Home visitors across all three of the study's geographic regions noted the difficulty of keeping up with some families who moved frequently or “couch surfed” from one home to the next.

Final Thoughts

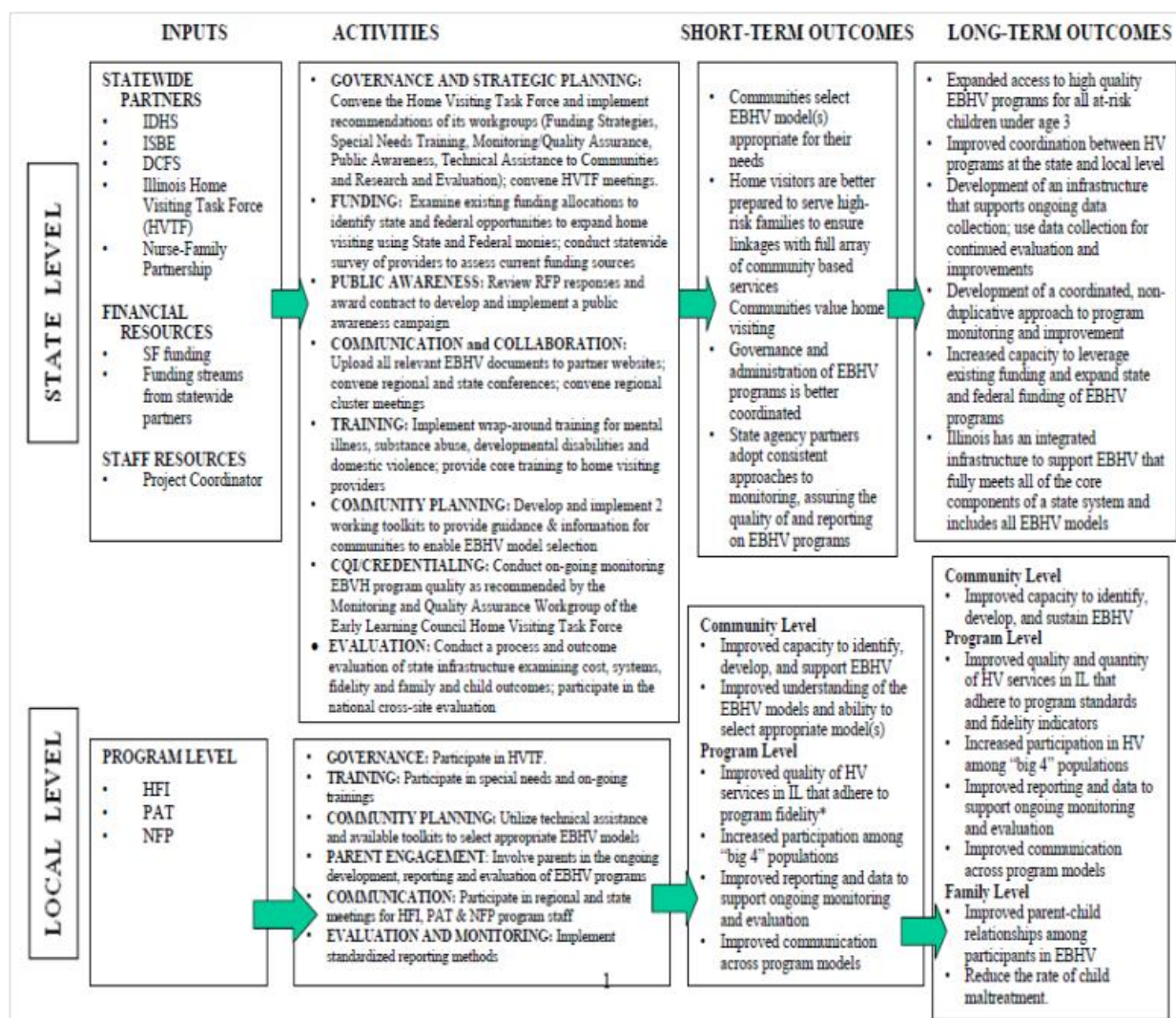
In conclusion, we observed a number of accomplishments that strengthened the training infrastructure, leadership, and administration of the system and partnerships at the state level during the third year of Strong Foundations. The challenges that remain in the state's efforts to strengthen the system of supports for home visiting programs and improve program quality and model fidelity—stable funding, common data collection and monitoring systems, local system-building, and communication across the system—are ones we have discussed before. 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. Despite the challenges, the infrastructure in Illinois continues to be resilient and has strength in a number of areas that affect program quality and effectiveness. These include strong advocacy organizations and growing state-level collaborative leadership that includes public entities—such as the OECD, the new Strong Foundations Partnership, and state agencies—and also the ELC, HVTF, Early Childhood Comprehensive Systems Initiative (ECCS), and other collaborative initiatives. Although the new MIECHV program is focused on a small number of communities, it is providing needed, if short-term, resources to expand home visiting services. As noted by several informants, the integration of Strong Foundations and MIECHV has been a positive development as it recognizes the importance of system building in any effort to improve service quality and access and outcomes for families and children.

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 (ELC), began the implementation of Strong Foundations after a one-year planning period. Illinois was one of 17 grantees in 15 states to be awarded funding from the U.S. Department of Health and Human Services 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, and to 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.

As shown in the original Strong Foundations logic model in Figure 1, the initiative was based on the assumption that the development of a well-functioning and effective state infrastructure 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)



Correspondingly, the goal of the local evaluation is to assess the home visiting infrastructure in Illinois and the changes in state infrastructure and program quality that have resulted 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 Illinois (HFI), and the Nurse-Family Partnership (NFP).

As outlined in Figure 1, Strong Foundations was designed to strengthen a number of infrastructure components. These include 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 disabilities; technical assistance to communities in selecting evidence-based programs that meet the needs of their families and in 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.

As described in our first year's report (Spielberger et al., 2011), Strong Foundations was originally expected to be a 5-year initiative. However, in December 2009, funding for the initiative was unexpectedly and substantially cut in a congressional budget reconciliation process. Although much of the funding was restored the following year, IDHS and the HVTF scaled back the implementation plan considerably. Chapin Hall also had to modify its evaluation plan by eliminating planned data collection with program participants.¹ The revised plan, therefore, focused on the state system and local system building and program quality. Primary research questions for these areas are the following:

- *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 Year 3 evaluation included: (1) a continuation of the process evaluation to assess the implementation of the state system, local infrastructure, and the operation of local programs; (2) evaluations of trainings supported by Strong Foundations on domestic violence, perinatal depression, substance abuse, and young adults with learning challenges and of the Happiest Baby on the Block self-study training; and (3) an administrative data study of HFI and PAT program performance, capacity, and fidelity. Some of the information collected as part of these activities is shared with the national cross-site evaluation. These activities are briefly described below and summarized in Table 1².

¹ The later restoration of funding was not sufficient to restore data collection with families.

² The Year 3 survey protocol can be found in the Appendix E; the interview guide can be found in Appendix F.

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	<ul style="list-style-type: none">• IRB submissions• Key informant interviews• Review of program documents and data systems• IDHS Funding survey	<ul style="list-style-type: none">• IRB submissions• Interviews with program administrators• Focus groups with frontline staff• Survey of program supervisors and frontline staff• Collection of administrative and secondary data	<ul style="list-style-type: none">• Analysis of administrative data on EBHV program participants at selected time points prior to and during Strong Foundations	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• IRB submissions• Key informant interviews• Review of program documents and data systems• Provider change surveys to assess “special needs” trainings^a	<ul style="list-style-type: none">• IRB submissions• Interviews with program administrators• Survey of program supervisors and frontline staff• Administrative and secondary data collection	<ul style="list-style-type: none">• Analysis of administrative data on HFI, PAT, and NFP participants after implementation of Strong Foundations• Collection of DCFS data	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• IRB submissions• Key informant interviews• Review of program documents and data systems• Provider change surveys to assess “special needs” trainings^a	<ul style="list-style-type: none">• IRB submissions• Interviews with program administrators• Focus groups with frontline staff• Survey of program supervisors and frontline staff• Administrative and secondary data collection	<ul style="list-style-type: none">• Analysis of administrative data on HFI, PAT, and NFP participants after implementation of Strong Foundations• Collection of DCFS data	<ul style="list-style-type: none">• 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	Administrative and other secondary data collection, evaluation of training activities, and limited interviews and surveys of state-level informants will continue into the fifth year.			

^a “Special needs” trainings in working with families experiencing domestic violence, perinatal depression, and substance abuse were first implemented in the 2010–11 program year; training in working with young adults with learning challenges and the Happiest Baby on the Block program were added in 2011–12.

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 implementation of Strong Foundations, we have, since the beginning of the initiative, attended meetings of the HVTF and its work groups and collected meeting minutes and other documents distributed at these meetings.³ In the spring of 2010, we conducted a series of semi-structured interviews with state-level informants about the state system, local programs, and community partnerships. These interviews were repeated in the spring of 2011 with seventeen informants representing public and private state agencies and advocacy organizations involved in the implementation of Strong Foundations. Two resources for the interview protocol were the “Healthy Families America State Systems Development Guide” (Healthy Families America, 2003) and the companion “Home Visiting State Systems Development Assessment Tool,” which was revised at the end of 2009 by the HVTF (see Appendix A), both of which have informed the initial plan for and the ongoing development of Strong Foundations. The evaluation team asked respondents a series of questions based on the tools’ system components, which included perspectives on how well the state was doing in that area of the system, if changes were seen in the past year or over the course of the initiative, strengths and weaknesses of the current system, and suggestions for areas of improvement.⁴

In addition, we continued to work with the 15 home visitation programs recruited in 2010—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. 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.⁵

³ Other secondary data include descriptions and evaluations of training for home visiting staff, technical assistance manuals for communities, program reviews, and the MIECHV implementation plan (see: http://www2.illinois.gov/gov/OECD/Documents/HVTF_MIECHVP/MIECHVP/Illinois_MIECHVP_State_Implementation_Plan_FINAL.pdf).

⁴ The eight areas in this section of the interview protocol are: (1) Governance, administration, and strategic planning; (2) Workforce development, training and technical assistance; (3) Collaboration, community planning, and site development; (4) Research evaluation, continuous quality improvement, and credentialing; (5) Communication, public awareness, and outreach; (6) Funding and financing; (7) Evidence-based standards and monitoring; and (8) Innovation.

⁵ It is difficult to get precise counts of programs of different models. The 2010 needs assessment indicated two NFP sites, 42 HFI sites, and 200 PAT sites in Illinois (Daro, Hart, Bell, Seshadri, Smithgall & Goerge 2010). However, according to the PAT website (<http://www.parentsasteachers.org/resources/locations>), there are 226 PAT programs in Illinois; according to the MIECHV Implementation Plan there are 47 HFI programs in Illinois (see: http://www2.illinois.gov/gov/OECD/Documents/HVTF_MIECHVP/MIECHVP/Illinois_MIECHVP_State_Implementation_Plan_FINAL.pdf). Since the 2010 needs assessment, three new NFP programs have opened in Illinois.

In year 1, during the spring of 2010, we visited each of these programs to conduct individual, hour-long interviews with program administrators and supervisors and focus groups with home visitors. We also asked program supervisors and home visitors to complete a survey about their qualifications, experience, and other background characteristics. We asked administrators to supply additional program records and other secondary data (e.g., funding applications) to support our analysis of program fidelity. Home visitors received a cash incentive for participating in these data collection activities. The local programs also received an incentive in the form of age-appropriate children's books and toys for their participants. We used the same procedures in year 2, but did not conduct focus groups with home visitors, to minimize their burden. In year 3, we followed the same procedures as in the first year. That is, in the spring of 2012, we again conducted 15 focus groups with 67 home visitors and individual interviews with 20 program directors and supervisors and sent surveys to all supervisors and frontline staff. The interviews were recorded, with the permission of the respondents, and transcribed; if respondents requested not to be recorded, written interview notes were taken and summarized.

Starting in the second year of the study, 2010–11, we began collecting information from participants in the new Strong Foundations special needs trainings on the topics of domestic violence, substance abuse, perinatal depression, and young adults with learning challenges. We collected the information at the time of training and again several months after training. During the third year, we also conducted surveys of participants in the Happiest Baby on the Block self-study program, which is provided under an IDHS contract with Prevent Child Abuse Illinois. It should be noted that, although not included in the current evaluation report, additional trainings and technical assistance efforts have been implemented as part of Phase II of the Strong Foundations trainings. These include new regional supervisor learning communities, which will emphasize supervision and support for home visiting staff who encounter the Big Four risk factors on their caseloads and two Strengthening Families trainings, “Protective Factors and Understanding Trauma” and “Children Exposed to Violence.”

Administrative Data Study

The evaluation also includes a study of the characteristics of families participating in HFI and PAT programs and indicators of program performance and capacity based on administrative data in the Cornerstone system. The purpose of this part of the study is 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 established data sharing agreements with the appropriate state or national agencies to obtain state-level data electronically and are continuing to collect and analyze data over an extended period of time—which, in the case of HFI programs, began 5 years prior to Strong Foundations—in order to describe changes over time in program and client

characteristics. We also will examine program characteristics in relation to data from DCFS on child maltreatment. (Additional information on the administrative data analyses plan can be found in our year 1 report.)

The National Cross-Site Evaluation

As indicated above, Strong Foundations is also part of the MPR-CH national cross-site evaluation that includes 15 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. In year 3, MPR-CH conducted site visits to each of the 17 grantees and implemented a cost study. The Chapin Hall local evaluation also contributes selected data collected from local sites on home visiting services and staff characteristics of 14 of 15 programs through a monthly data reporting form (see Appendix D) and also recruited four of these programs to participate in the national cross-site cost study.

Overview of this Report

This report draws primarily from interviews with state-level informants, interviews with program directors and supervisors at 15 local programs, focus groups with home visitors at the same programs, surveys of staff, and surveys of participants in training funded by Strong Foundations. In the next chapter, we discuss perspectives on the state system from key informants at the state and local program levels. Because a large part of Strong Foundations and the evaluation focused on improving the professional development component of the infrastructure, we present findings related to the trainings supported by the initiative separately in the third chapter. We then, in the fourth chapter, turn to a discussion of local programs, with a focus on five 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. The fifth chapter provides a statewide overview of two of the evidence-based programs, HFI and PAT, based on an analysis of administrative data. The final chapter offers conclusions about the growth of the system supporting home visiting programs in Illinois and implications for future system-building activities.

State Context and System for Evidence-Based Home Visitation Programs

In this chapter, we discuss the state infrastructure that supports evidence-based home visiting programs, its leadership and administration, and respondents' perspectives on components of, challenges to, and hopes for Illinois's home visiting system. Because training represents such a large component of the state's infrastructure building efforts, Strong Foundations training efforts are discussed in the next chapter. Before discussing the current state system, it is important to describe some of the contextual changes within the state system that have occurred since our last report.

Integration of EBHV and MIECHV

First and foremost is the integration of the Evidence-Based Home Visitation programs (EBHV) grant (the original Strong Foundations initiative) into the larger Strong Foundations Partnership, which also oversees the new federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, established as part of the Patient Protection and Affordable Care Act (2010). As the oversight and governance of these two initiatives has been knitted together, so has the vision for how to take the work of MIECHV to scale through the use of EBHV's foundational work. As described in our Year 2 report (Spielberger et al., 2012), "Strong Foundations has helped to strengthen the system for home visiting in Illinois, as well as the private-public partnership represented by the Home Visiting Task Force (HVTF), both of which have been essential to the state's response to the MIECHV opportunities." As time has passed, certain aspects of Strong Foundations and MIECHV have become even more interconnected. Our interview protocol administered to 21 key, state-level informants acknowledged the difficulty in differentiating certain aspects of the EBHV and MIECHV grants and probed for how the two initiatives

relate to each other, as well as the impact of having both initiatives in Illinois. By and large respondents perceived the two initiatives as sharing a great deal and viewed the overlap positively, as reflected in the following comment from one stakeholder: “It’s not at all troublesome that there is difficulty distinguishing [between the two initiatives] and I think that’s a good thing.”

Informants described the integration of the two initiatives as an indicator of the success of the EBHV work to build and enhance the home visiting infrastructure and capacity as a whole in Illinois. “I actually think it’s a really good thing, a really positive thing that people don’t necessarily see them as different and distinguish between them,” one informant explained. “Because that means we’ve done a good job of integrating, which is ultimately what the work is about.”

The strengthening of Illinois’s Strong Foundations Partnership extends the potential impact of each of the initiatives, as well as future home visitation work in the state. As noted by one respondent,

The fact that they have become so integrated has been valuable to Strong Foundations. The fact that Strong Foundations has essentially almost been kind of a foundation for the MIECHV grant has both increased its utility and value, and, of course, provided great support to MIECHV as well. So I’m not suggesting in any way that they should be any less integrated than they already are. In fact, I think that Strong Foundations became much, much more successful when it was integrated.

There’s always been the recognition among stakeholders that those [MIECHV] outcomes are not going to be attained unless we’re developing the broader system as a whole and focusing on those infrastructure components that were at the heart of original Strong Foundations.

Everything that we think about for [the MIECHV communities], we think about doing it in a way that once we know what we’re doing, it can be scaled up elsewhere—whether it’s how we figure out how to strengthen the community so that the referral network is in place to support the home visitors when they want to help a family broadly, or the community support around policy and fundraising, or budgeting that might support sustainability for home visiting over the long haul. If a community building piece that we’re trying to fund through MIECHV works, then that’s something we can start to carry forward and promote in other places.

In order to build a solid infrastructure, there can’t be a situation of “haves” and “have-nots.” It’s kind of an undercurrent within the MIECHV grant, although we don’t look at it that way at a state level. We look at these [six communities] as pilots. How can we take them statewide? EBHV allows us to continue to reach out to the rest of the state and continue to incorporate the rest of the state into MIECHV, which is something that the MIECHV-specific dollars don’t necessarily allow.

By approaching EBHV as a mechanism to take MIECHV—and other local home visiting efforts—to scale, state stakeholders advance the themes of EBHV within those more localized opportunities, thereby continuing to work towards the original infrastructure goals of EBHV as other initiatives develop.

Leadership and Administrative Changes

Another factor that impacts the context of Illinois's home visiting landscape is the number of changes within key leadership positions at the state level during this past year. The Illinois State Board of Education's (ISBE) long time Early Childhood Division administrator retired at the end of state fiscal year (SFY) 2011, and a new administrator began at the beginning of SFY 2012. The Early Childhood Division has administrative and leadership responsibilities for a range of federal and state grant programs, which include the Birth to 3 Prevention Initiative that manages the majority of the Parents as Teachers (PAT) programs in the state. In January 2012, the Illinois Department of Human Services (IDHS) merged two divisions, the Division of Community Health and Prevention and the Division of Human Capital Development, into the new Division of Family and Community Services (Illinois Department of Human Services, 2012). IDHS funds, either directly or in collaboration with the Ounce of Prevention Fund (the Ounce), 58 evidence-based home visiting programs in the state, which implement the Healthy Families America (HFA), PAT, or Nurse-Family Partnership (NFP) model. In addition to the leadership changes at ISBE and IDHS, the Governor's Office of Early Childhood Development (OECD), which provides overall coordination for the Strong Foundation Partnership, has also experienced leadership change. In April 2012, the first director of the OECD stepped down from her position. The position remained vacant through the end of the calendar year but was expected to be filled in early 2013.

Besides the leadership changes of these key partners in the Strong Foundations Partnership, at the beginning of SFY 2013 the Illinois Early Learning Council (ELC), which includes the HVTF, refocused their strategic planning process "to reduce the number of committees and consolidate their work in addition to creating more formal linkages to key partners such as related State agencies and advisory bodies" (Illinois Early Learning Council, 2012). Over the course of the strategic planning process, the ELC approved four new committees and the continuation of the HVTF. In turn, the HVTF reshaped its committee and work group structure to align with the ELC's changes:

The Executive Committee [of the ELC] recommended and the Council approved the continuation of the Home Visiting Task Force and its revised subcommittee structure given the Task Force's unique role as a strategic planning and advisory body for Illinois's Maternal, Infant, and Early Childhood Home Visiting Program, funded through the Affordable Care Act. In addition to oversight of MIECHV planning and implementation the Task Force will continue to identify opportunities for integrating and aligning their work with that of the other four [ELC] committees (Illinois Early Learning Council, 2012).

Perspectives on the State System

As described above, 2012 brought a number of significant changes that affected the context of home visiting in Illinois. Through all of these changes, home visiting work continued. The ongoing work of

EBHV and MIECHV during these leadership changes and other shifts has helped the state work towards its vision of having a resilient, sustainable infrastructure for home visiting. In this section, we describe respondents' perspectives on aspects of the state system that contribute to the home visiting infrastructure—namely, its partnerships, oversight and administration, challenges, and vision for the future.

Partnerships and Collaborations

Working and mutually beneficial partnerships are a key factor necessary to achieve the state's vision for the home visiting component of its early childhood development system. As one respondent noted, "We can't have a more comprehensive cross-model process without partnerships." During our interviews, many state-level informants expressed the view that even though Illinois has had a rich history of private/public partnerships relating to early childhood, Strong Foundations has developed and realized partnerships in ways not seen before. This is reflected in the following excerpts from two interviews:

Partnerships are absolutely necessary and the backbone of the project. Neither Strong Foundations nor MIECHV would exist as a solo effort by any one entity or agency. And I think that's because the nature of Illinois's home visiting system, as it has developed over the past 30 years, has been a multiagency effort—through the State Board of Education's Early Childhood Block Grant funding, through Healthy Families and Parents Too Soon and IDHS, through Early Head Start and so on. And so I think it's to our benefit that those partnerships have existed and MIECHV and Strong Foundations are opportunities to continue those partnerships.

Strong Foundations has helped the three primary partners that manage all of the funding streams—ISBE that manages the block grant, the Governor's Office that coordinates the MIECHV money, and IDHS which does a big chunk of home visiting and manages the MIECHV money. Strong Foundations took the leadership in bringing those three to sit down at the same table. In the past I don't think they've had experiences to form themselves into a real collaborative group that works together. I just don't think they've had the opportunities to do that, and now they do.

State-level key informants emphasized that coming together in response to these initiatives has reduced the often disparate nature of the various home visiting agencies and funding streams. In the words of one informant, "The coordination at the state level has improved radically. The introduction of federal money that everybody has to share has really pulled all of the stakeholders together." This has, in turn, improved communication and enhanced a cohesive approach among stakeholders. According to another informant, "Strong Foundations helped first to reveal the extent to which silos had been developed between the home visiting funding streams. And then it actually got people talking to each other, in an unprecedented way." As another explained,

It has brought people together in ways that have never happened before. The head of the [IDHS] department changed and the head at ISBE Early Childhood changed, but people have continued to come to the table. It just didn't happen like that before EBHV or the Home Visiting Task Force. It wasn't that people didn't like each other, it's just they weren't coming together that way towards that common goal.

State-level informants provided a wide range of examples of the continuing effect that Strong Foundations has had by “bringing people together to the table.” Being able to approach work through the lens of Strong Foundations has, for the most part, advanced the relationships and collaborations that make partnerships successful. For example, several people noted that a small group of home visiting funders have opted to meet, as necessary, to keep each other informed and work in a unified manner. One person familiar with the group described it as follows:

A by-product of MIECHV [is] knowing that the home visiting agencies implementing MIECHV are funded by one of us, or many of us, for many components of those same programs. It made us know that we needed to work together to support those agencies to make sure that we don't have them in a bureaucratic hell. So we have had meetings, and we haven't called it Strong Foundations or EBHV or anything other than us wanting to get together and support our agencies. We want to make sure we're assisting them to provide comprehensive services in the most efficient manner possible, and they don't spend more time figuring out what we need than they do figuring out what their clients need.

The respondent emphasized that it was the foundation laid by Strong Foundations that enabled these funders to get together to approach their common issues. She said, “We would not have known [a particular funder representative] before. We would not have even been on the same page or even thought we were. And so now we all know each other.” For example, this group recently met to focus on the issue of piloting specialized home visiting services for homeless families and included Illinois advocacy groups to help inform their discussion.

Although the above partnership is informal, stakeholders also described other, formal examples of partnerships that developed through Strong Foundations' work. Several informants spoke about the presence of leaders from different organizations at statewide events. For example, ISBE's Early Childhood Division invited the Strong Foundations Partnership to share in the sponsorship of this year's annual Prevention Initiative conference. The web site promoting the March 2012 event highlighted the shared sponsorship, naming the Illinois State Board of Education Early Childhood Division, TEAM (Together Everyone Achieves More to Strengthen Illinois Families), the Governor's Office of Early Childhood Development and the Ounce of Prevention Fund as partners in the effort.⁶ The following

⁶ The web site promoting the event is <http://events.r20.constantcontact.com/register/event?oeidk=a07e5hipu92facf5bc5&llr=wpz888iab> (retrieved on 10/29/12)

month, the MIECHV kickoff meeting was held and leaders from OECD, ISBE, IDHS, and the Ounce were all present. Several informants pointed to this type of shared presence as evidence of the mutual vision Strong Foundations has brought to fore:

In pulling this ISBE conference together, [ISBE] invited [OECD] to share in the sponsorship of the conference that all Prevention Initiative providers go to. So by name, in public, it was the State Board of Education's conference in partnership with the Governor's Office of Early Childhood, MIECHV, and the Ounce. That was a nice—we have not seen that before.

There was a lot of shared planning with [OECD] around the experience that they wanted MIECHV programs to have coming together. At the MIECHV kickoff, of course, [ISBE Early Childhood] was there. So at the leadership level we have seen a lot of movement of people towards each other.

A representative of ISBE related her appreciation of being part of the MIECHV process and the kickoff meeting.

It [the kickoff] has been really helpful to help me understand how the state is implementing home visiting with [IDHS], MIECHV, and ISBE. It gives me an overview of the whole picture and helps us work together to see how we can inform program improvement; also, it allows me to be a part of MIECHV. [MIECHV] is really piloting some of the practices we hope to be able to take statewide. So to allow me from ISBE, even though MIECHV is funded through the Governor's office and DHS, to be a part of that process is really wonderful because it gives us a role in some of these decisions that we know are going to affect all of us.

In addition to the shared participation in meetings, the developed partnerships have resulted in a more inclusive, coordinated approach to some home visiting components, such as monitoring and access to training. For example, as reported by one respondent familiar with the process, when ISBE set out to revise their parent evaluation forms, they included IDHS and home visiting programs from the different models in the conversation. By calling on the partnership, the process for developing the new parent evaluation forms considered thinking across organizations that formerly worked independently and cultivated a product that conveys a shared message. Likewise, Strong Foundations partnerships are being called upon to improve access to training for home visitors regardless of funding stream. The Ounce of Prevention is helping the OECD facilitate conversations with ISBE and the Chicago Public Schools (CPS) so that home visitors across funding streams are able to take advantage of all appropriate training.

Although many stakeholders highlighted these positive partnership examples, some also took the opportunity to talk about partnerships that they would like to see improve or change. The Illinois Department of Children and Family Services (DCFS) is one of the original three partners on the EBHV/Strong Foundations grant. However, they have been much less involved than their counterparts at

IDHS and ISBE. One informant shared her perspective that the history of home visiting in Illinois offered at least one explanation for DCFS's reduced role.

During the growth of home visiting in Illinois from the late '80s into the early '90s, there was an [assumption] that it should be kept far away from being identified with DCFS because it was a voluntary, prevention service in high-risk communities. Families identified DCFS as extremely frightening and provocative and it [would have] completely changed the image and the meaning of the [home visiting] program. So when EBHV came along and said include your child welfare agency, there was not a lot of interactive history to build on. Strong Foundations didn't necessarily resonate with DCFS because they might not have thought that there was much in it for them. And they have such a burden of responsibility that we probably didn't provide them with a clear role and value-add for having them. [Today DCFS is a partner.] What remains is the challenge and opportunity to figure out more fully what the relationship between DCFS and the MIECHV home visiting initiative is.

Another stakeholder described some of the ways in which DCFS has begun to serve as a partner in the home visiting infrastructure. Home visitors are now using the DCFS statewide service provider database as part of an intergovernmental agreement. There is work underway on what home visiting could mean to DCFS's re-education and intact family services, what restrictions there are on home visiting as it relates to DCFS, and how case management models and home visiting models differ.

Several stakeholders spoke about the Strong Foundations partnership with the Nurse-Family Partnership home visiting model as something that could be strengthened. First of all, there are only a few NFP programs in the state. When Strong Foundations started there were only two NFP programs, although that number has now increased to five. Also adding to the perceived disconnect is the fact that the NFP model is not as closely linked to Illinois's state agencies as the other models in the EBHV grant are. The Ounce of Prevention Fund serves as Illinois's state office for PAT and provides training and technical assistance for PAT programs, most of which are funded by ISBE. The Ounce of Prevention is also the provider of core training for Healthy Families Illinois (HFI) programs, and IDHS and Prevent Child Abuse Illinois provide ongoing support for HFI programs. NFP programs, in contrast, may receive funding from the Ounce, ISBE or IDHS, but their model-specific training and technical assistance is not embedded within an Illinois agency. NFP's National Service Office employs program developers and nurse consultant managers by geographic region to consult with new sites as they write their implementation plans and applications and to provide ongoing technical assistance.

The 21 key informants at the state level who were interviewed for this report included representatives from each model, as well as representatives from the various state agencies and departments. Across the board, from within NFP and outside of NFP, there was an acknowledgment that NFP programs are less connected to the Illinois home visiting infrastructure than PAT and HFI programs are. One informant

representing the NFP model noted that NFP providers “feel kind of separate from the other models within Illinois, [and] I don’t know necessarily how we can change that. We aren’t as large as the other models.” Another told us:

For us being the kind of the new kid on the block, we haven’t really been included in a lot of the conversations. And we do participate and show up to the various work groups and things like that, but we don’t have the same relationship that a lot of the other people have with the history and long-term relationships. We just want to continue to participate and collaborate in the process.

An informant not connected with NFP observed that “it really is unfortunate, but I don’t see [NFP] as being really as much of a partner,” and added that the lack of connection may stem more from the way the program operates nationally than the way it is implemented locally. “[The funders] may fund an NFP program and from that perspective we include them as part of us, but in terms of their national NFP office, not as much.”

Overall, respondents both in and outside of NFP acknowledged that it would be good if NFP was a “full” partner; however, they seemed unsure of how to make that happen. Some informants also hinted at underlying historical issues that may have slowed the current effort to develop a more solid partnership with NFP programs. At least two informants referenced an NFP-produced marketing sheet disseminated when the NFP model was first implemented in Illinois, which highlighted NFP’s outcomes as being more favorable than the outcomes of other programs.

There’s not a big presence of people who live in Illinois who are involved with NFP, so they [were] often not at the table. So we are trying to make sure they have some representation on the HVTF and on some of the other forums. The NFP folks we are working with now really do see the big tent, but historically there has, I think, been some strain within the home visiting community because NFP has marketed themselves as better than the other models, and that hasn’t completely gone away.

On the other hand, an informant affiliated with NFP expressed concern that the wrong information about NFP eligibility guidelines or program focus sometimes gets circulated by other providers.

As another example of areas in which partnership or communication could be strengthened, a small number of respondents expressed concern about inequity when it comes to setting the state’s home visiting agenda and decision making. The HVTF is a large body of the ELC, and its work is advanced through its executive committee, new priority work areas, and ad hoc groups. During each year of the Strong Foundations evaluation, we have heard comments from some stakeholders about a lack of transparency and inability to participate fully in the process. There continues to be a sense among several of our informants that, in the words of one, “a lot of decisions get made among the smaller group of people and they then bring these findings out to a larger group and ask for their comments.”

At least one informant, speaking about the complexities of planning and implementing a large-scale, statewide grant and the steps needed to be inclusive while moving forward, addressed these concerns.

When you have a federal grant and are developing it, as the requirements change, having more people at the table brings good news and bad news. You cannot have a pure collaborative process and actually execute a set of work plan objectives. There has to be a moment when you agree or you close discussion. And all you can do, I think, is just make that public. Yes, all of these perspectives are valid and we've considered them all, and now we're closing the discussion. And some of that happens from the power relationships of the funding agency and the state agency interacting with the funding agency.

The challenges to partnerships, communications, and decision making discussed above reflect some natural tensions. In the case of partnerships among programs that represent national models, partnerships may work better at one level (e.g., state or local) than at another (e.g., national), and what happens at one level affects what happens at other levels. As illustrated by the quotes above, it is sometimes difficult to ensure that people at all levels of the system are involved equally in communication and decision making, particularly when working on a complex initiative with specific goals and timelines.

An Assessment of State-Level Collaboration Factors

Despite the aforementioned challenges, overall, results of interviews with key state-level informants indicate improved collaboration across the multiple agencies that implement and monitor home visitation policies and practices in Illinois and support local programs. In addition to participating in interviews, we also asked state-level informants to respond to the Wilder Collaboration Factors Inventory, a structured survey, to assess aspects of their collaboration. In the spring of 2012, this online survey was sent to 19 individuals identified by IDHS as participants in the state-level infrastructure, including members of the HVTF Executive Committee. Seventeen (89%) of these individuals completed the survey.⁷

The Wilder Collaboration Factors Inventory is made up of 40 items grouped into 20 factors associated with successful collaboration (Mattesich, Murray-Close, & Monsey, 2001). Respondents use a Likert-type scale ranging from 1 (“strongly disagree”) to 5 (“strongly agree”) to rate the items. It should be noted that the inventory is not intended to provide a total collaboration score. Rather, it offers a set of descriptive factor scores that the members of the state collaborative group—in this case, state-level participants helping to build state infrastructure for home visiting programs in Illinois—can use as indicators of strengths and areas needing improvement in their work together.

⁷ There was some variation in the number of responses to each of the items in the survey; of the 17 respondents, between 14 and 17 responded to the individual items.

Table 2 presents the mean ratings of the 20 factors; the individual items that make up each factor can be found in Appendix B. As shown in the table, the self-assessment of the state collaborative group touched on a number of different dimensions. Those that were evaluated most favorably are listed first in the table and can be considered strengths of the group at baseline, while those listed near the bottom of the table can be considered areas for improvement to be addressed in further development of the ELC. Because there was no opportunity for the members who completed the survey to help us interpret the assessment, we reviewed data from our key informant interviews to assist in the processing of the baseline assessment. Below we discuss some of the strengths and areas for improvement in the assessment with reference to findings from the interviews.

Areas of Collaborative Strength

Respondents to the survey very much agreed that the work of Strong Foundations would not be possible without collaboration. The mean rating of the factor “unique purpose” was high and due to agreement with both of the statements that make up this item: “What we are trying to accomplish would be difficult for any single organization to accomplish by itself” and “No other organization in the [state] is trying to do exactly what we are trying to do.” Respondents also agreed that the collaborative effort to build the state infrastructure was in their self-interest, meaning that their organization would benefit from their involvement.

At the time of the survey, state agency heads and advocates were also convinced that participants in Strong Foundations have a shared vision of what they want to accomplish. Of the two statements that make up this factor, there was more agreement with the statement “the people in this collaborative group are dedicated to the idea that we can make this project work” than with the statement “my ideas about what we want to accomplish with the collaboration seem to be the same as the ideas of others.”

Respondents also agreed that participants in the state-level system have “established informal relations and communication links.” They indicated that communication “happens both at formal meetings and in informal ways” and that, as individuals, they also participate in informal conversations with others about Strong Foundations.

Survey respondents also generally agreed that the following factors applied to the Strong Foundations state-level collaboration: “skilled leadership”; “adaptability,” meaning an ability to adapt to changes in funding, leadership, or political climate; a shared “stake in both process and outcome”; “concrete, attainable goals and objectives”; and “favorable political and social climate.”

Table 2. State Informants' Self-Assessment on Wilder Collaboration Factors Inventory^a

Factor	<i>N</i>	Mean^b	<i>SD</i>
Unique purpose	14	4.5	0.62
Members see collaboration as in their self-interest	17	4.4	0.51
Shared vision	14	4.1	0.47
Established informal relationships and communication links	16	4.1	0.65
Adaptability	16	4.0	0.34
Skilled leadership	14	4.0	0.39
Members share a stake in both process and outcome	17	4.0	0.58
Concrete, attainable goals and objectives	14	4.0	0.70
Favorable political and social climate	17	4.0	0.75
History of collaboration or cooperation in the community	17	3.9	0.81
Collaborative group seen as a legitimate leader in the community	17	3.7	0.47
Appropriate cross-section of members	17	3.7	0.58
Appropriate pace of development	16	3.7	0.81
Development of clear roles and policy guidelines	17	3.6	0.66
Open and frequent communication	16	3.5	0.76
Flexibility	17	3.5	0.89
Mutual respect, understanding, and trust	17	3.4	0.71
Ability to compromise	17	3.4	0.87
Sufficient funds, staff, materials, and time	14	2.9	0.98
Multiple layers of participation	17	2.7	0.56

^a Several items reference “the community.” Respondents were directed to “think of the community as all of the statewide partners involved in Strong Foundations.”

^b Based on a 5-point scale ranging from 1 (“strongly disagree”) to 5 (“strongly agree”). Individual items that correspond to each of these factors can be found in Appendix B.

At the same time, there was variability in the ratings of some of the individual items that make up these factors. For example, with regard to the factor “members share a stake in both process and outcome,” respondents were less likely to agree that organizations in the collaborative were investing the right amount of time in the effort than they were to agree that there was a high level of commitment among participants and a desire for the project to succeed. With regard to the factor of “concrete, attainable goals and objectives,” respondents were more likely to agree that they as individuals “have a clear understanding of what [their] collaboration is trying to accomplish” but less likely to agree on whether other members in the collaborative group knew and understood the goals and had reasonable expectations for the initiative .

Areas of Concern

The lowest-rated factor was “multiple layers of participation,” which includes statements about members having time to confer with their organizations about major decisions and having the authority to speak for

their organizations. Both of these items had mean ratings lower than 3. Responses to the “multiple layers of participation” factor suggest that some participants in the current collaboration do not feel that they were able to speak for their entire organization or that there is not enough time for participants to report back to their colleagues and discuss with them matters to be decided upon.

The other area of collaboration that was rated below 3 was the factor “sufficient funds, staff, materials, and time.” Both of the indicators that make up this factor were rated 2.9, reflecting that more respondents disagreed than agreed with the statements “our collaborative group had adequate funds to do what it wants to accomplish” and “our collaborative group has adequate ‘people power’ to do what it wants to accomplish.”

Additional concerns were reflected in some of the indicators that make up factors that were rated above 3 overall. For example, the factor of “mutual respect, understanding, and trust” was rated, but ratings of the individual components of this factor suggest that although most of the respondents to the survey “have a lot of respect for the other people involved in this collaboration,” they disagreed on whether people involved in the collaboration “always trust one another” (see Appendix B).

Oversight and Administration

Administrative structure is another key component of a resilient, effective home visiting infrastructure. According to the “Healthy Families America State Systems Development Guide” (Healthy Families America, 2003), a centralized administrative structure that provides leadership and management while planning for sustaining and expanding home visiting models is critical for system development. Since the beginning of the Strong Foundations initiative those individuals and entities that provide leadership for the home visiting infrastructure have had a number of challenges to overcome, not the least of which was learning, in the middle of the first year of implementation, that funding for Strong Foundations would either cease or be severely reduced at the end of that year. It is interesting to reflect on the changing landscape within the initiative’s administrative structure over the past few years.

Planning Year and Implementation Year One (10/2008–6/2010)

As written in the initial EBHV implementation plan, the management structure for Strong Foundations was “visualized as four ‘levels’ or concentric circles, each a part of the layers that lie outside of it, with communication and collaboration taking place in all directions” (Illinois Department of Human Services, 2009). IDHS functioned as the lead agency for Strong Foundations and thus composed Level 1 of the management structure. The Child and Adolescent Health Bureau chief served as the initial Strong Foundations project director and was responsible for collaborating with the HVTF to ensure all project

stakeholders were involved with decision making.⁸ However, the initiative was without a project coordinator to assume day-to-day responsibility for the initiative. Constraints imposed on hiring within state government resulted in the project coordinator being hired contractually through the Ounce of Prevention Fund at the end of September 2009 (Implementation Year 1).

Key stakeholders accounted for Level 2 of the project's management structure. These included ISBE, DCFS (both of which were named as collaborators with IDHS on the project), the Ounce of Prevention Fund (which serves at the PAT state office and provides training for HFI and PAT program staff), the NFP National Service Office, Voices for Illinois Children, Prevent Child Abuse Illinois, and the Chapin Hall evaluator for the project. Given the partnership discussion earlier in this report, it is interesting that the revised implementation plan specified that given the "very high level of trust" among these organizations and the "culture of mutual respect," the stakeholders did not consider interagency agreements or memoranda of understanding necessary to formalize their working relationships for Strong Foundations (Illinois Department of Human Services, 2009).

Level 3 of the management structure was comprised of the chairs of the six initial HVTF work groups (Special Needs Training, Technical Assistance to Communities, Public Awareness, Financing Strategies, Program Monitoring and Quality Assurance, and Research and Evaluation). The group was to meet on a bimonthly basis (or more often if needed) to provide effective management and overall direction for the project.

The membership of Level 4 of the management structure rested with the HVTF.⁹ Comprised of a diverse group of stakeholders, the HVTF included representatives from national home visiting models, state administering agencies, program providers, researchers, parents, and advocates. 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.

Complicating the oversight of the initiative was the creation of the Office of Early Childhood Development (OECD) within the Governor's office, at the recommendation of the Early Learning Council, in the fall of 2009 (Year 1 of Strong Foundations Implementation). The OECD was created to provide overall coordination and policy leadership for Illinois's early childhood development system (including home visiting) and collaborate with state and federal agencies to successfully implement ELC

⁸ In 2008, the ELC created the 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 recognized that there were several high-quality home visiting program models.

⁹ There were approximately 80 participants in the HVTF at that time, compared to over 150 in 2012.

recommendations. However, the Governor's office could not hire the OECD director until October 2010 (SFY 2011, Implementation Year 2).

On December 3, 2009, representatives of the HVTF (Level 2 of the management structure) held a Strong Foundations Strategic Planning Retreat and plans were discussed for moving the initiative forward. However, less than two weeks later Congress failed to re-appropriate EBHV funding in that year's reconciliation bill. In response, IDHS and the HVTF scaled back the project's implementation plan. The uncertainty around the federal funding, coupled with the state's own ongoing budget problems, and the inability to hire a state-level Strong Foundations project coordinator added layers of difficulty for the leadership of the initiative. An informant for the Year 1 Strong Foundations report described the state as being "stretched thin" at that time.

Also during Implementation Year 1, in March of 2010, the Patient Protection and Affordable Care Act passed and created the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). MIECHV is a program that makes federal grants to states to support implementation of evidence-based home visiting services for at-risk children and families. There was strong support by the HVTF's Executive Committee for the MIECHV grant to be housed in the Governor's office for central management and strong interagency components. In Illinois, the MIECHV grant became known as the Strong Foundations Partnership. As with the EBHV grant, IDHS functioned as the lead agency. However, MIECHV was housed in the Governor's OECD and would be managed by a Strong Foundations Partnership project director, who had yet to be hired.

Implementation Year 2 (7/2010–6/2011)

The "human capital challenge" posed by the delay in hiring the Strong Foundations Partnership project director (SFPPD) continued to test the governance structure during Implementation Year 2. Until that position could be filled, an "ad hoc Management Team," as one informant described it, was created to "keep things moving forward." Thus, the HVTF Executive Committee was designated as an interim decision-making body of the HVTF. In forming the Executive Committee Management Team, members chose not to include representatives of specific evidence-based home visiting models. At the time of the management team's formation, it was not known which models would be included under the new federal home visitation initiative (MIECHV). Members of the HVTF Executive Committee did not want to create conflicts of interest at the point of community selection. Thus, the broader representation that was included in the original Level 2 management structure (and present at the September 2009 strategic planning retreat) had less of a role in the oversight of and decision making for home visiting efforts as the state moved towards MIECHV.

The primary charge of the HVTF Executive Committee during Year 2 was to guide the development of the three different MIECHV proposals, an implementation plan for the first application, and the completion of the statewide needs assessment.¹⁰ These tasks also entailed the development and implementation of a process to receive and review applications from local communities, as well as choosing a small number of communities in which to implement MIECHV-funded projects. As described in the MIECHV implementation plan¹¹, the Strong Foundations Partnership supports and is supported by the HVTF, led by its Executive Committee which serves as the convening, policy-setting, and decision-making body for the Strong Foundations Partnership (Illinois Department of Human Services, 2011).

The full start-up of the OECD, the hiring of its director (October 2010), the resignation of the Strong Foundations (EBHV) project coordinator (April 2011), and the subsequent hiring of the Strong Foundations partnership director (May 2011) all occurred during this same time period. All of these activities brought considerable change in a fairly short time. Understandably, therefore, there were times when decisions had to be made without full discussion or review by the full HVTF and, as a result, some state and local stakeholders felt uncertain about how decisions were being made.

Implementation Year 3 (7/2011–6/2012)

During SFY 2012, the various entities involved with oversight and administration seemed to coalesce under the new leadership of the SFPPD, who was hired in May 2011. In addition, all of the home visiting work done under the auspices of Strong Foundations (EBHV) and the Strong Foundations Partnership (MIECHV) were officially brought together under the Health Resources and Services Administration (HRSA) as of January 1, 2012 (Nolan, 2011). Originally a grant program of the Administration for Children and Families (ACF), EBHV grant funds were continued through ACF's collaboration with HRSA under the state's MIECHV formula grant; all legal and fiduciary responsibility was transferred from ACF to HRSA.

For Illinois, this transition was logical. IDHS remained the recipient of the federal funds and the Strong Foundations Partnership expanded to include the EBHV grant. Having the SFPPD coordinate the work of both initiatives ensured that the work of each complemented the other, and that the implementation had the highest level of support within the executive branch. This structure also helped Illinois maintain its “big tent” approach in supporting evidence-based and promising approaches to home visiting, as well as

¹⁰ On 6/8/11 Illinois submitted its MIECHV FY10 Implementation Plan to HRSA. That same week HRSA released the MIECHV FY11 Competitive Grant (MIECHV2), which was due by 7/1/11. On 6/21/11 HRSA then released the MIECHV FY11 Formula Grant (MIECHV 3), which was due on 7/21/11.

¹¹ MIECHV Implementation Plan (http://www2.illinois.gov/gov/OECD/Documents/HVTF_MIECHVP/MIECHVP/Illinois_MIECHVP_State_Implementation_Plan_FINAL.pdf).

coordinate policy development and program management across agencies responsible for home visiting programs in Illinois.

In conducting the key informant interviews for this report, there was consensus on the leadership skills and style of the SFPPD among the respondents who worked with her. This is not to diminish the ever-present work of the various agencies and divisions, the HVTF, or its committees and work groups that have had a role in the advancing the home visiting landscape through the work of the Strong Foundations Partnership, but, as stated by a respondent, “Partnerships have to be nurtured and facilitated.” There has to be a driving force to steer the collaboration and cultivate these partnerships or “you can kind of get lost in the process.” Another respondent noted, “Having that new role in the Governor’s office was something that was really important to bring together these different funding streams to ensure their integration and coordination.” The SFPPD began serving as the OECD liaison to the HVTF alongside the HVTF co-chairs in the spring of 2012,¹² which was described by a respondent as “a really good thing, because that was a piece that was missing—the idea of someone from the state being in a leadership position on that task force.” According to our informants, the SFPPD is now seen as the staff leader for the grant. The role of the Executive Committee, in turn, is now to be responsive to information and needs that the SFPPD identifies.

[The Executive Committee] meets about every other month or so and the agenda formation is a joint process of the HVTF co-chairs [including the SFPPD]. The meetings always include project updates from her, but there are also larger, broader discussion topics that are jointly agreed upon. The Committee talks about what needs to be figured out that is in flux, decision points, and how the group can be useful.

As illustrated in the following representative excerpts from our interviews, respondents familiar with the history of the EBHV grant and its oversight were universally pleased with this new administrative structure:

[The SFPPD] has been more able to express and to plan the implementation work to a point where there’s just a greater capacity for the work to move forward in a comprehensive fashion where there’s great communication. She has been, I think, a nexus, an exceptionally strong leader of all this work. I think she’s a very collaborative person. So I have great respect for her.

She has just been a phenomenal, phenomenal director of this set of interlocking projects. There’s no question. We wouldn’t be where we are today if it weren’t for [the SFPPD]. She deserves enormous credit and recognition for her capacity to think it through, her capacity to engage critical players who

¹² Please note that some respondents reported that the Strong Foundations Partnership project director was a new cochair of the HVTF’s Executive Committee, while others reported that she was OECD’s liaison to the Executive Committee. With either title, it was clear from the interviews that she had a leadership role.

are often very challenging to engage due to their roles, and to work within the challenges of the current set of systems and around the mechanics, if you will.

The SFPPD reports to the Governor's chief of staff; however, the HVTF, its Executive Committee, and the Early Learning Council each serve in an advisory capacity to the SFPPD and for the Project. Many respondents highlighted the changing role of the Executive Committee as it has worked in collaboration with the SFPPD. The Executive Committee is comprised of the SFPPD; the acting chief of IDHS's Bureau of Childhood Development; the cochair of the HVTF; the director of IDHS's Division of Family and Community Services; the director of IDHS's Division of Alcoholism and Substance Abuse; the ISBE's Early Childhood Division administrator; and the U.S. Department of Health and Human Services' (DHHS) Region V Office of Head Start program specialist. One informant explained that, as a private-governmental partnership, the Executive Committee "serves as our most direct advisory body [and] a lot of decisions can be made at that level." Other informants familiar with the Executive Committee also commented on its changing role since working with the SFPPD as follows:

[The SFPPD] has used the [Executive] Committee differently, in an appropriate way. [The home visiting projects] were struggling before because the HVTF and its Executive Committee was not being used in its most appropriate fashion. I think there was a little too much management on the part of the Executive Committee. I think that the Executive Committee should serve as a board does in that it should not be involved in the day-to-day management. It should be involved in strategic thinking and strategic planning and it should be there to insure that the goals and visions are executed, not to make operating decisions. That was the way it was always envisioned. We struggled for a long time until we had the capacity in the OECD to have that really happen. I believe we're sort of there, but we're not fully staffed in MIECHV and that's still a challenge for Strong Foundations.

The role of the Executive Committee is to bring together a leadership team that includes the state agencies, Region V [of DHHS because of Head Start, and the advocacy leaders. The leadership team comes together to oversee the direction—"Are we moving in the right direction? Are we moving towards our stated goals and purpose? How do we do that?"—and to shape the use of the Task Force. It's more than an advisory group. It really is the intersect between what are we trying to do, how do we think about implementing it, and how do we hold ourselves collectively accountable for it. I think we've gotten better at it over time. The other key thing, of course, is the staff that leads these efforts on behalf of the government are key players in the Executive Committee. The leadership of [the SFPPD] has been remarkable.

Home Visiting Task Force

As mentioned above, the HVTF is part of Illinois's ELC. Its role as part of the ELC, changes to its committee structure, and how it has advanced the work of the Strong Foundations Partnership were all topics of discussion during our informant interviews. In 2008, the ELC created the HVTF under its auspices to support the development of a coordinated, high-quality system of home visiting programs.

The HVTF was designed in anticipation of the need to have a planning group and structure in place to respond to national initiatives. It was also intended to be inclusive of all home visiting stakeholders, a “big tent” under which any home visiting stakeholder was welcome. The HVTF has met those goals with ease and been, as described by one informant, a “barometer” as the state responded to the federal EBHV and MIECHV applications and moved into implementation. Further, there are approximately 150 participants on the committee now, as compared to the 80 or so that were involved during the first year of Strong Foundations. There are representatives from national home visiting models, state program administering agencies, program providers, researchers, parents, and advocates. Having such a broad group brings opportunities for learning new and/or different perspectives and for facilitating connections. According to one informant, “Strong Foundations helps shape the Home Visiting Task Force and the Home Visiting Task Force, in a sense, gives shape and future to the goals and objectives of Strong Foundations.” Another described it as “our sounding board, our barometer for asking pertinent questions and helping us think about issues from our very different perspectives.” And a third commented on its growing representation of local stakeholders not previously engaged in the home visiting system:

The Home Visiting Task Force has always had really good representation from different agencies and communities. And I have noticed at the last few meetings that there have been a lot more representatives from individual programs around the state calling in, which is really nice. I think Strong Foundations has encouraged that and I think it’s been helpful.

However, some respondents described a certain set of challenges arising from having such a large committee:

It’s such a huge committee that it’s more than a bit unyielding. I think the question of how we address that is one that we honestly have not yet figured out. I think we made it as “Come one, come all—a ‘Big Tent!’” and that’s probably a good thing, but at some point that doesn’t really work when you are considering, “What does it mean to be on a committee of the Early Learning Council?” and “How are you making things happen?” So there is a question of how to use the entire task force and how and when to use committees. So I do worry about the Home Visiting Task Force, its size and its structure.

Much of the work of the HVTF is accomplished through its committee structure. As mentioned earlier in this report, the HVTF’s initial committee structure included six work groups. As part of the revised implementation plan that was drafted following federal budget cuts to the Evidence-Based Home Visiting (EBHV) grant, the Public Awareness and Financing Strategies Work Groups were placed on hiatus. Ad hoc work groups were added as necessary; for example, in October 2010 a Parent Perspectives Work Group and an Innovative Strategies Work Group were created to help inform the MIECHV application.

Similarly, a more focused Public Awareness group began meeting at the beginning of 2012 to develop an outreach strategy targeting MIECHV communities.

In June 2012, the ELC completed an extensive strategic planning process that resulted in a new committee structure, an updated vision, and a set of guiding principles. Although the ELC created four new standing committees, the HVTF remained in place but with some structural changes.¹³ Like each of the new ELC committees, the Task Force has two cochairs and an agency liaison. This leadership structure is intended to strengthen communication and align the Task Force's efforts with the priorities of state government to advance the shared goals of the early childhood development system. As part of the ELC strategic planning process, the HVTF reviewed and revised its own structure and established new priority work areas: Sustainability, Universal Screening, Research and Evaluation, and Health Connections. In the case of Health Connections, the decision to include that as a focus under the HVTF came largely in response to the MIECHV grant application and a need to bolster Illinois's efforts in that area. There were discussions about retaining Monitoring and Community Systems as priority work areas, but ultimately those areas were not included. One stakeholder explained this process as follows:

One of the things we wanted to do with this redesign was not duplicate efforts or create parallel processes. If you review the new ELC [committee structure chart], you see Monitoring, but it's no longer free standing to us [HVTF]. This doesn't mean we aren't concerned about it or thinking about it; our Task Force will be represented on those committees and focused on how to improve monitoring.

For example, the community systems work, which had been spearheaded by the Community Systems Development Work Group as a joint work group of the HVTF, Infant-Toddler Committee, and Oversight and Coordination Committee, was moved under the ELC's new System Integration and Alignment Committee. Members who served on the work group under the HVTF will continue to serve under the new structure. As explained by one member of the HVTF,

The new priority work areas are the actual work groups that exist currently. Others that were there previously, like Monitoring and Training, aren't there now. That's does not mean that the Task Force isn't concerned with training or monitoring. It's just that the [work groups] are meant to represent the work that is actively taking place right now. That's not to say that there's not work to be done, but that it is done at the interagency, advisory-level committee perspective; the "thought work" has been done and now it's a question of implementation. That's what's tricky about representing things on a chart like that because it certainly isn't meant to exclude.

¹³ As approved on 6/19/12, the ELC's standing committees are: Programs Standards and Quality; System Integration and Alignment; Data, Research and Evaluation; and, Family and Community Engagement.

As one state agency representative noted, “The work groups of the Home Visiting Task Force advise and inform us on a state level and help us to put processes in place to support the local levels.” Another stakeholder referred to the priority work areas as “problem solving committees”—the place where you take aspirations, such as coordinating child health with home visiting or developing a universal screening tool, and figure out how to roll out the efforts across the state.

Challenges to Creating Comprehensive Infrastructure

There is a definite need for “problem solving committees.” To state the obvious, developing and implementing systems is complicated. As part of our state level interviews, we asked key informants what they thought the state’s biggest challenges were in implementing and supporting evidence-based home visiting programs. Responses varied and are described below, but there was consensus about the obstacles faced as a result of the state’s current procurement process.

Procurement

To meet the challenge of cleaning up state government and putting integrity back into the procurement process, Illinois passed new procurement standards and procedures that went into effect in SFY 2011. Even though the new procedures were intended to ensure that taxpayer dollars are spent in the most efficient and effective way possible and with integrity, the implementation of these changes created additional complications and timing challenges. Navigating these complex, labor-intensive laws has challenged the ability to move initiatives forward, including the work being done through the Strong Foundations Partnership. Several informants highlighted this issue, as indicated by the following excerpts from three different interviews:

The issue of procurement hangs over *everything* that the state is doing. It’s clearly been an enormous challenge in this work. There’s no question that it has negatively affected both the pace of the progress, but also, frankly, the content, because at this point it slows the process down to such an extent. People like [the Acting Chief of IDHS Bureau of Childhood Development] have done heroic work in the context of just a ridiculous system. I don’t see any way to overcome it. I don’t think that we’re missing something that should be done. It’s just a challenge that we have to address.

If somebody says, “What is the single system that impacts your program the most,” instead of saying, “communities,” the answer is “procurement.” I think that we need the weight and the strength of the Home Visiting Task Force, the Executive Committee particularly, but the Home Visiting body at large because it reaches so many people, and also the Early Learning Council to say that the reactionary laws that have been passed in response to [former Governor] Blagojevich’s reign have completely seized the system. But as much as we can put pressure on [them], you know at some point the systems are locked; it’s the law.

It has been a constant fight. We would be farther ahead in our programs in our entire system if we didn't have procurement to face. And I mean that on every level: with systems integration, with partnerships, with paradigm shifts, with development, with everything. There is no other piece that exhausts me more. At least 50 percent of my time is spent on procurement, as opposed to program building and system building, which grieves me greatly.

Additionally, due to the budget deficit, the state implemented periodic furloughs that resulted in procurement staff turning over in large numbers statewide as people left government or shifted to other jobs. In the last year, the procurement process has improved somewhat as those involved became better acquainted with the procurement system and staff levels stabilized. However, ongoing challenges—for example, in providing training for new MIECHV home visitors and implementing a comprehensive data system to collect data on MIECHV outcomes—demonstrate how procurement has slowed progress. These issues indicate that the procurement process remains difficult and is a sticking point for early childhood systems work.

Funding Silos

Another challenge in the creation of a comprehensive, cross-model support system for home visiting stems from the state's disparate funding streams and the different requirements of each. The individual funding streams' requirements impact numerous system components: training, data collection, monitoring, and reporting. Although progress has been made, as noted above, in terms of partnerships and working together towards a shared vision, there are still real barriers and work to be done. Respondents were candid in sharing their perspectives on this challenging aspect of system building.

It's not a coordinated and integrated state system. One thing that I would want to have constantly at the forefront is that every conversation ends with a check of if we've created, or eliminated, or lessened a barrier for families and home visitors, because most of what we're doing is still not accomplishing that. We have big goals and everybody nods their heads, but the work needs to continue to be pushed out. And it's a parallel process. It flows from all the public funders who just add on their requirements. That is the final frontier—the funding agencies must coordinate their contracting, monitoring, and reporting. Until that day comes, we are just giving lip service to the idea that the infrastructure that we're building supports the home visitor. That's why everybody focuses on the training, because the training is that one thing where the experience is free to the programs because it's funded.

The differentiated funding streams continue to make it difficult to implement a comprehensive but uniform data monitoring system for the home visiting system.

I don't think that non-MIECHV home visitors should be compelled to enter data into Social Solutions [the Efforts to Outcomes (ETO) database] because those home visitors are funded by a different funding source. We want to figure out how to make data collection seamless for the agencies, which is

what led us to start meeting with [the funding agencies]. For example, [home visiting program A] has DHS-funded staff and Ounce-funded staff or CPS-funded staff. Some of them enter into Cornerstone; some of them enter into OunceNet; some of them will enter into ETO because they have to do benchmark collection. So it's kind of like what kind of nightmare are we creating for them?

One state leader familiar with the issue of multiple data systems added, "It's a disappointing situation and hard on the workers, but we are listening to them and hope, by [our continuing work], we will make it easier."

Even as funders move closer to agreement on the need to coordinate their systems, achieving that goal is a complicated process filled with logistical quandaries and decisions, the slightest of which impacts home visitors' work with families. One respondent noted that decisions made, for example, in the elements of a data table could either support or interfere with the home visitors' work with families, potentially for years to come. There are procedural questions as to how many visits have to be made and by when, at what point in the home visitor/family relationship certain paperwork is completed, how often data are collected, where and how data are entered, whether home visitors have to return to their offices to use a certain computer, and whether families can respond to online surveys. Other respondents also emphasized other aspects of the complexity of shared data collection. One respondent said:

It's just becoming apparent about how complex this whole data collection system is in our state, because we have so many different funders for home visiting. I think the impact on the field is going to be pretty hard. There was this communication gap between what is the crosswalk, if you will, between the systems. For one thing the terms across the systems, the definitions, are different. It's not as simple as trying to migrate data to feed into a shared database. One program refers to an enrollment date, but is that enrollment date the same as the date another program first engages the family member? Is it the date of a first visit or the first signed consent?

Another example is the relatively new requirement that all ISBE Prevention Initiative program participants must be entered into the ISBE's Student Information System (SIS) information system. We learned during our site visits about a mismatch between the SIS database and the Prevention Initiative programs. For example, SIS data are entered by school year; children in Prevention Initiative programs are 0 to 3 years old and their enrollment status doesn't necessarily change at the end of a given school year. Despite that, the children and families have to be closed by school year and then re-entered. One stakeholder spoke about the impact of this mismatch on Prevention Initiative doula programs:

[SIS] is designed as if you were enrolling everybody at the beginning of the year. So we got notes in February saying, "Oh, you're only half full." Well, that's because we are not done enrolling people yet. And there's another problem—you can't enroll pregnant participants, you have to wait until the baby is born. But we are servicing pregnant women, so we always look under enrolled to them.

Even with these challenges, this stakeholder emphasized that it's a work in progress adding, "But it's a step in the right direction. I mean they have something to build on."

These issue and questions are but a few of the many in front of policymakers and funding agencies as they contend with supporting quality, evidence-based home visiting programs in the state in a coordinated manner. As one respondent opined, "I think we're going to have to make progressive steps and be satisfied with that." Another echoed this view:

Everybody is still funded in silos, which means monitoring and data reporting are also still in silos. But if we keep working on this, eventually, the priorities, just like we're starting with data systems, should start to line up, so that there is more consistency across the board in terms of not so much what they want, but there will be less emphasis on who is paying for what?

It is promising, then, that this issue is being looked at as part of the Strong Foundations Partnership work.

Equity

Another challenge raised during our interviews was the issue of equity. From the outset, there has been a concerted effort to build and enhance the home visiting infrastructure through a "big tent" lens. The EBHV grant focused on the PAT, HFI, and NFP home visiting models, although the Strong Foundations trainings were open to all home visitors. However, whenever there is funding for expansion and enhancements to only some programs or communities, as is the case with the MIECHV funding,¹⁴ issues of equity hover around the work. The challenge is how to contend with those equity issues. Respondents offered their suggestions, such as viewing the MIECHV work as a pilot for the rest of the state:

In order to build a solid infrastructure, there can't be a situation of "haves" and "have-nots." It's kind of an undercurrent within the MIECHV grant, although we don't look at it that way at a state level. We look at [the MIECHV communities] as pilots. How can we take them statewide? So, that being said, the EBHV grant allows us to continue to reach out to the rest of the state and continue to incorporate the rest of the state into MIECHV, which is something that the MIECHV-specific dollars don't necessarily allow.

Another respondent suggested that local collaboration can foster equity among programs:

At the community level, I'm hearing that we are going in a direction where there is now more kind of a turf thing. Like with the MIECHV training, "Oh, the MIECHV workers get to go to this training or that training." And that flies in the face of what local community [collaboratives] are trying to do, regardless of who funds them, for example, having coordinated professional development that is accessible to more than just a single audience because more than just one audience needs mental health training. This isn't rocket science. That's why local [collaboratives] exist, because

¹⁴ Note that MIECHV funding is not limited to the three models in the EBHV grant.

[collaboratives] think about more than one audience that can gain value from going to training with their peers and will build those informal networks.

Although collaboratives can play a substantial role, even the perception of inequity among programs can lead to a fracturing within collaboratives and weaken infrastructure. One respondent described a situation in which she had learned, while at a state-level meeting, of a situation in which home visitors from Program A were advocating their services as superior to Program B's services to Program B's clients. By the time Program B's director was aware of the issue and planned to address it with Program A's director, the community and home visitors had already learned about the alleged disparity between the programs. Program B's recruitment efforts suffered. The informant noted that such situations create "system shifts" in the community. Such shifts lead to capacity issues, another example of a challenge to growing infrastructure.

Capacity Issues

As in the earlier example of the Prevention Initiative doula programs appearing under enrolled because services are provided to pregnant women who cannot be entered into the database, there are both perceived capacity issues and real capacity issues that affect the home visiting infrastructure. As will be discussed later in this report, some programs are under enrolled and home visiting staff have to be creative and diligent to recruit families to their programs. Some respondents noted that they, along with program staff, question why programs are not full "because there are plenty of families to go around." They expressed concern about the disconnect between the need for more funding to build capacity when current programs are not full.

How do we demonstrate the need for more programs when most of the programs we have aren't full? That's due to a number of reasons. We may not be mining the fields, but I also think that maybe we didn't look strongly enough at areas in the state where there were no programs. Also, maybe we are making incorrect assumptions about the size of a population that will engage in a voluntary home visiting program. I think that looking ahead, especially if we're going to be making the case to the federal government if MIECHV sticks around that we need more money, that we should do another needs assessment and analyze retention rates and acceptance rates more.

Another capacity issue pertains to the lack of available, affordable resources for home visiting clients. There are two aspects to this issue: awareness of resources and access to resources. Community collaborations can bridge programs and increase awareness of resources. As one respondent noted, "The home visiting provider, the mental health provider, and the domestic violence shelter all need to work together, otherwise there is no place to send your families to for services." Some respondents pointed to the community systems work that is being piloted through MIECHV as another step towards increasing awareness and collaboration.

[The idea behind having] a community systems development person in each of the six [MIECHV] communities is to build those early childhood networks, disciplines, organizations, or programs that an at-risk family may need in order to be successful. It is about making sure that those entities are coordinated and working together to support families in a comprehensive and connected way.

In addition to the six community systems staff positions in the MIECHV areas, the Chicago (South) MIECHV area is working with the Children's Home and Aid's early learning network, which has a model of service delivery that looks at families with children from prenatal to college age and how to bring them together to provide seamlessly connected services for the best interest of the community. As described by one respondent,

We asked [Children's Home and Aid] to write up the model that they've developed in the Englewood area, the challenges, the frustrations, the successes, and how they went about engaging people in this very fractured community. We want to learn what it could tell us about taking [this model] to other communities such as East St. Louis, that is very fractured at this point, or into Thornton that was having some difficulty bringing some people together, but was among the neediest of the communities.

Through such efforts, should additional MIECHV or other funding become available, the state will have a stronger foundation laid to advance community systems, build partnerships and increase local capacity. However, collaboration does not adequately address the dearth of affordable providers—for example, domestic violence shelters for teens or mental health providers—in some regions of the state. Under MIECHV, Illinois is piloting efforts to improve mental health services in home visiting programs through the Illinois Children's Mental Health Partnership. To that end, one Prevention Initiative home visiting program in each of the six MIECHV communities receives the full Infant Mental Health consultation model, while the other MIECHV agencies receive support and consultation in reflective supervision. Although this will help home visitors in those communities who work with families with mental health issues, the issue of access to resources remains a huge challenge in the state.

Sustainability

A large part of the aforementioned resource issue is the state's continuing budget crisis. Last year's Strong Foundations report (Spielberger et al., 2012) cited news reports that said as of September 2011, Illinois had 5 billion dollars of unpaid bills. News reports from November 2012 indicated that the state's unpaid bills totaled 8 billion dollars at the end of the fiscal year in June.¹⁵ As a result, programs have been forced to make difficult decisions; many have had to close. As one informant said:

¹⁵ Reuters. "Illinois governor eyes bonds to pay off growing bill pile." Reuters.com 15 Nov. 2012 <http://www.reuters.com/article/2012/11/15/illinois-bills-idUSL1E8MFIZ620121115>

Sustainability, to me, is the number one challenge. What's harming sustainability right now, is that the small programs disappeared, quit. A whole bunch of ISBE programs just completely refused to apply again, because the state was up to ten months behind in payments. What are they going to use? These little programs, they don't have boards that have endowments. Even in Springfield, the Family Service Center went out [because of late payments by the state]. They were 25 years old and went belly up this year. It's an absolute scandal. Our state is in the middle of a scandal and in pain.

Addressing this core challenge to the infrastructure is critically important, and it is a challenge state-level stakeholders are well aware of, as evidenced by the new Sustainability priority work area of the HVTF. Much work has been done during this past year to maintain public investment. For example, state advocates fiercely fought proposed home visiting budget cuts. Consequently, legislators rejected cuts which would have required Illinois to pay back \$19 million in federal funding and render the state ineligible for an additional \$29 million in SFY 2013 federal home visiting dollars. Our informants were also mindful of the precarious state of the state budget for home visiting but also the short-term nature of the current federal funding, as illustrated by the following excerpts from two of our interviews:

With state funding for home visiting programs being threatened each year, there is no security that those programs will still be there tomorrow, in a month, in a year. It's caused a lot of stress in staff and programs. The issue can't be understated. You have to acknowledge that one of the fundamentals of infrastructure is to cure funding so that there is a steadiness and a belief that this will be there year in and year out. And that has not been anywhere near the case in the last several years.

The most salient issue is that the MIECHV money runs out in 2015 and we have, at this point, no [concrete] plans beyond that. So for me one of the most important things for the Sustainability group is to figure out what's going to happen with those programs when the MIECHV money runs out. Figuring out how to get nongovernment money involved in the home visiting system would be wonderful. We've been sort of at the mercy of the economy the last few years, and good programs have closed down. Other programs have chosen to close down because there have been payment delays. If there were some private money to help stabilize that, it would be a good thing.

Discussing the issue of sustainability, some respondents again pointed to the MIECHV pilot work with community systems development as part of a larger sustainability strategy. In selecting staff to fill the MIECHV community systems position, for example, one of the requirements is individuals who have the connections or the capacity to bring nontraditional as well as traditional partners to the table. That is, as one informant explained, "CEOs and COOs and decision makers who can make a community impact."

Respondents also raised the salaries of home visitor staff as another aspect of sustainability that needs to be addressed as part of infrastructure building:

How do we sustain knowledge within the home visiting workforce? I have been trying to promote giving home visitors a better salary, a better wage so that they can live day-to-day and still work in

home visiting. Home visitors have traditionally been lower paid than child welfare workers, which I think is a travesty, because the knowledge that home visitors have is just as specialized as the knowledge that child welfare workers have. And if you look at what home visitors do, they go into [the same homes] as Intact Family Services. I think anytime you work with intact families, whether it is child welfare or home visiting, those are the families that have the greatest risk.

Having reviewed respondents' perspectives on the state systems that contribute to the home visiting infrastructure, its partnerships, oversight and administration, and challenges, we turn in the next section to respondents' vision for the future.

Successes and Future Vision

As part of our interviews, we asked our informants to think about the successes of Strong Foundations and their hope for the future vision of Illinois's home visiting infrastructure as a result of the Strong Foundations' work. Not surprisingly, most of the responses highlighted the training (which will be described in the next chapter), expanded and improved partnerships, leadership and coordination at the state level, and the work being piloted under MIECHV. As noted above, maintaining the state funding for home visitation was highlighted as a success but also a goal for the future. Interestingly, for the most part, people's hopes for the future of the home visiting infrastructure corresponded well with the current challenges described above. Respondents expressed hope to integrate the work of the different funding silos, increase capacity and access, and increase public awareness. Given that, these hopes for the future of home visiting can also serve as a roadmap for ongoing and future work.

Streamlining Procurement

Given the strong feelings about the state's current procurement process, it is no wonder that a more streamlined process was also among respondents' hopes for the future. As one respondent stated, "My vision for the future is some way of moving out some of the bureaucratic challenges or mechanics that just cause us to lose enormous amounts of time." However, given the current laws on the books there is only so much that can be done to improve the procurement process. Continuing to learn about the specifics of the system and how to work within it are crucial to advancing the work under the Strong Foundations Partnership.

Coordinating and Monitoring within Funding Silos

For many respondents, a mainstay of the future home visiting infrastructure is a system with improved coordination across funding streams to unburden home visiting programs. This work has started and could impact training, data collection, monitoring, and reporting. "I would love to see the state advance on shared monitoring across the different funding agencies and stop driving the local programs insane," one informant told us. "They express interest in different kinds of monitoring, but you would need to make

some substantial changes and trust each other's monitoring and accept that." Another presented the following vision: "In 5 years I would like to see that there are meaningful differences at the state level in terms of the efficiency with which we are operating. The data system is up and running. Monitoring is up and running. Training is improving, as always."

In arguing for the need for an integrated data system, another stakeholder reminded us of the importance of keeping the relationship between home visitors at the center of all system-building efforts, including monitoring:

To me, the most important aspect of all the systems building work is keeping the individual encounters between the home visitor and the family at the center. The system that we build should support and surround that parent-child relationship, the larger family, and the home visitors rather than building a set of burdensome responsibility. And that to me that can be a very, very fine line. Everybody says, "Oh, yes, of course," but then they turn around and you have Home Visitor A, who has to enter data into three different systems.

Some stakeholders spoke about their hope that data will help demonstrate outcomes that will inform policy.

If you haven't done longitudinal research, your program doesn't look so good because a lot of the savings aren't realized until after the child has left the program. So one of the potential benefits for [entering the children in] SIS is that down the road we'll be able to say, "Well, here are kids who were in a home visiting program when they were a year old." If public policy is going to be shaped by showing what saves money, I think we need to do more of that.

Raising Public Awareness

If the system is going increase its capacity to serve families and have a shared data and monitoring system to demonstrate the positive outcomes of home visiting programs to policy makers and the public, it needs to also have a broader public awareness campaign. Some respondents shared their dissatisfaction with the fact that home visiting is not very well known and their hope that Illinois's future system addresses that. They made several suggestions for strategies to increase awareness and enrollment.

I think there needs to be more ongoing awareness of the importance of Birth to Three and home visiting, and just sort of the crucial time period for these children in terms of their development.

People don't understand what home visitors do. I'd like to see home visiting better defined so that people don't say, "What do you do?" when they learn you are a home visitor. They aren't wondering if you are bringing people soup on Sundays. So I hope that Illinois becomes a leading state, not only in bringing stability to the home visiting workforce, but in giving it definition.

I'd like to see the home visiting system provide a basic understanding to the public by giving the home visiting vocation a stronger definition.

At a policy level, I'd like to see more acknowledgment of the value of home visiting. We've spent so much time talking about the research that I'd just like to see more people buy into it conceptually and understand the value of home visiting.

Increasing Capacity

As discussed above, communities can build their resources and improve access for families through collaboration. Respondents shared their hope that the future home visiting infrastructure would include stronger collaborations and expanded access to services.

I hope that home visiting programs can play a key role in cross-sector community system efforts. The more work that I do in terms of systems building, the more I am struck by how important integration and collaboration are at the community level. That's where the state needs to really move beyond talking about how they'd better support those local community systems efforts, and really do it in a more collaborative way.

In terms of service access, several informants highlight the need for mental health services. "I would like to see mental health in all the [geographic] areas," one stated. "I would really like to see that become the norm rather than the exception."

Increasing staff qualifications, salaries, and training was also considered as an important part of building capacity for professional development and that was also included in respondents' vision for the future. As one informant put it, "Home visitor salary and qualifications is one of the issues I would like to see in my dream ten years from now. I would like it to be more professionalized with higher salaries so people stay longer." Another told us, "I hope that we will have a strengthened and consistent set of professional development that goes across the models and supports the implementation of fidelity to the models and innovation."

This aspect of our informants' visions for the future brings us to the topic of professional development. As mentioned above, a discussion of Illinois's home visiting infrastructure would be incomplete without a consideration of the training offered through Strong Foundations and its impact on home visiting staff. Because training represents such a large component of the state's infrastructure building, we dedicate the next chapter to the evaluation of Strong Foundations' efforts to enhance training for program staff.

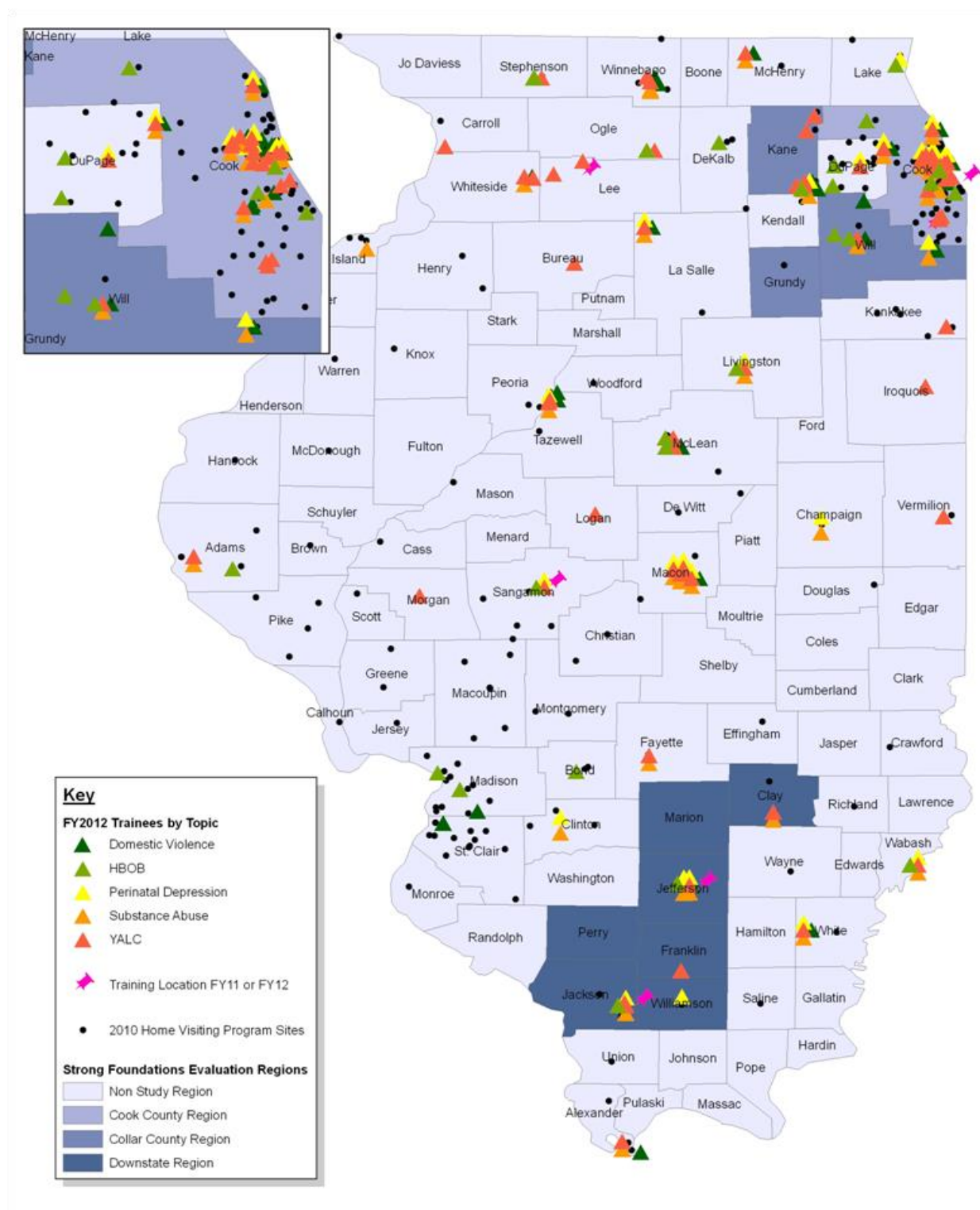
Training through Strong Foundations

Training is an important, heavily utilized, and highly praised support for home visiting programs in Illinois. Accordingly, a significant aspect of the Strong Foundations initiative has been to bolster the state's home visiting training and professional development infrastructure. To that end, Illinois has expanded home visiting training topics, methods, and locations. Strong Foundations training opportunities for home visiting staff began with trainings known as the Big Four, which cover the topics of domestic violence, substance abuse, perinatal depression, and parental learning disabilities. They currently also include supervisory network meetings, which provide additional support to supervisors on the Big Four topics and provide a venue for networking; Happiest Baby on the Block (HBOB) training, which is a self-study program on an infant soothing technique; and, Strengthening Families trainings on protective factors, designed to deepen the understanding between protective factors and prevention, and on trauma informed practice, which looks at the relationship between exposure to trauma and child development and parenting.

This chapter presents findings from our evaluations of the past year's Big Four and HBOB training activities (see Figure 2).¹⁶ We also report on how new funding initiatives, such as MIECHV, have advanced knowledge to home visitors who serve children and families with complex needs. This growth fits into Strong Foundations' overall plan and goals by providing a more comprehensive and effective system of training supports for home visiting providers. In the next section, we discuss findings related to the Big Four trainings. We then discuss evaluation findings for the HBOB self-study program.

¹⁶ Although we could not collect data on the Supervisory network meetings for this evaluation report, the data will be included in next year's report. Data from the Strengthening Families trainings are not being collected as part of the Strong Foundations evaluation.

Figure 2. Reach of Big Four and HBOB Trainings in Illinois, SFY 2012



Big Four Trainings

Through Strong Foundations, the Ounce of Prevention’s Training Institute (the Institute) has been able to implement new trainings and supports specifically tailored for home visitors and their supervisors. The Institute developed the training topics in response to specific needs identified through research and by home visiting staff. These trainings, known as “the Big Four,” cover the topics of domestic violence, substance abuse, perinatal depression, and parental learning challenges and are facilitated by a content expert and a home visiting expert. Table 2 provides a brief description of these trainings.

Chapin Hall evaluated the addition of the Big Four trainings as an enhancement of the state’s home visiting infrastructure through multiple methods: pre- and post-surveys at the time of training, follow-up surveys and phone calls, and in-person interviews at the Strong Foundations study sites. In SFY 2012, Big Four trainings were offered between December 1, 2011 and June 14, 2012 (see Table 3) Beginning with the January 26, 2012 perinatal depression training, surveys were implemented prior to and immediately after the day’s training. Participants who completed the day-of surveys between January 26, 2012 and June 14, 2012, as well as all attendees who signed in for SFY 2012 Big Four trainings that were held prior to January 26th, were e-mailed follow-up surveys approximately 3 months after their training date. Additional data was collected during site visits by asking home visiting staff at each of the 15 study sites about their perspectives and satisfaction with the training and training system in Illinois, including the Big Four trainings. Finally, state-level respondents were asked about their views on the training system and its role in the state’s infrastructure. Findings in this section are based on surveys from 268 duplicated home visiting participants at baseline (97 percent of all trainees completed pre- and post-surveys), 199 duplicated follow-up surveys (nearly 60 percent of those returning pre- and post-surveys), interviews with staff of 15 home visiting programs (including 66 home visitors and 18 supervisors), as well as interviews with 21 state-level respondents.¹⁷

Table 3 below summarizes the dates and attendance of trainings across each of the training topics by location. The new Young Adults with Learning Challenges (YALC) training topic was offered most often and involved the largest number of participants, while the perinatal depression and domestic violence trainings had fewer attendees. As would be expected, there were more attendees at the Chicago trainings than those at rural locations. This is partially explained by the higher concentration of programs near the Chicago training location and a larger number of initial sign ups. However, attendees located near the

¹⁷ 73 participants who attended training from December 2011 through January 2012 were not given pre- or post-surveys. By duplicated we mean that individuals participated in more than one training (and completed surveys for more than one training). Although 232 unique individuals participated in more than one training, we received a total of 268 surveys at the time of training and 199 follow-up surveys (approximately 3 months after training).

training location could “drop in” and sign up on the day of training, which occurred at many of the Chicago and Springfield trainings.

Table 2. Descriptions of Strong Foundations’ Big Four Trainings^a

Training	Description
Substance Abuse	Substance misuse and abuse can present multiple problems for any family but is especially stressful for young parents of newborns or toddlers. Substance abuse touches more than the one affected directly by the issue, but has a powerful impact on each member of a household and often leads to a host of related problems such as domestic violence, financial instability, even child neglect or abuse. This training will examine definitions and indicators of substance problems, as well as strategies for intervening or conveying helpful information in a nonjudgmental fashion to those families we work with. The training will focus on how to deal with substance abuse issues in the home setting, and will include time given to discuss specific cases and scenarios from real life examples.
Domestic Violence	Domestic violence has serious implications not only for the disruption of relationships but for the overall stability of the home and the child rearing process. The natural ability for young mothers (and occasionally young fathers) to care for their children is placed at great risk when an environment of violence or abuse is allowed to continue in a home. The optimum time for an infant or young child to feel safe and secure in a stable environment is compromised and children pay the price especially in the area of early social/emotional development. This training will examine the definition, underlying causes and symptoms of domestic violence as well as strategies for responding to victims effectively and in a supportive manner.
Perinatal Depression	Perinatal depression can have serious and lasting consequences on a child’s development. Children of depressed mothers are at risk for developmental and behavioral problems and may be predisposed for developing depressive disorders themselves. Early identification of and response to this issue is critical because a depressed mother is less likely to understand the cues or signals of her young child. This training provides an overview of perinatal depression. It provides discussion for home visitors who are facing challenges with moms experiencing depressive symptoms. The types, symptoms, frequency and strategies for addressing perinatal depression through support and intervention are discussed. Home visitors will learn to administer the Edinburgh Postnatal Depression Scale.
Young Adults with Learning Challenges (YALC)	The transition to adult life is full of complexities for all adolescents, but those with these additional learning challenges, who are also responsible for the care of an infant or toddler, need extra support and assistance to acquire successful parenting skills. Many of us serve the teen parent population, and a certain percentage of that population, as well as young adults, may be impaired by ADD or ADHD, a learning disability, problems with memory or attending to task, dyslexia or a very low literacy level. Some may have emotional challenges associated with these impairments and parenting in the midst of these difficulties creates another layer of stress. When we identify this parenting risk, we need to respond to it with thoughtfulness, but with the care of the baby in mind.

^a Source: Ounce of Prevention Training Institute (the Institute). All of the Institute’s Strong Foundations trainings are scheduled half-day trainings.

Table 3. Training Dates and Attendance per Training Location by Training Topic

Training Topic	Training Site, Date, and Number of Attendees ^a								Attendance Totals by Topic
	Chicago		Dixon		Springfield		Mt. Vernon		
	Date	N	Date	N	Date	N	Date	N	
Substance Abuse	04/10/2012	37	06/06/2012	15	04/11/2012	33	12/07/2011 ^b	10	95
Domestic Violence	02/02/2012	35	04/19/2012	9	12/01/2011 ^b	11	06/14/2012	9	64
Perinatal Depression	01/05/2012 ^b	28	01/26/2012	11	05/31/2012	19	—	—	58
YALC	06/06/2012	28	12/14/2011 ^b	24	02/29/2012	43	03/07/2012 03/21/2012	18 24	137
Site Totals		128		59		106		61	

^a Training Capacity is 40 individuals

^b Attendees were not offered pre-post surveys, but were contacted to complete follow-up surveys

In SFY 2012, there were a total of 447 registrations for the Ounce Training Institute's Big Four trainings, which were offered in four locations in Illinois. The domestic violence and substance abuse trainings were each offered 4 times, while the perinatal depression training was offered 3 times, and the new YALC training was offered 5 times. Of the 447 registrants for the 16 trainings, approximately 354 participated, a rate of approximately 79 percent.¹⁸ Because some individuals attended more than one training, the 447 registrants and 354 attendees actually represent 232 unique attendees.¹⁹ Of those 354 attendees, only 276 could potentially complete day of surveys on or after January 26, 2012, and 268, or 97 percent, completed the pre- and post-surveys as requested. As expected, follow-up surveys were more difficult to obtain and additional phone calls were made to increase response rates of phone-administered surveys. Of the 268 potential respondents (many of whom were duplicated individuals), 151 either completed a follow-up e-mail or phone survey, for a rate of about 56 percent; another 48 individuals who did not complete the day-of surveys did complete a follow-up survey. Combined, follow-up survey data was collected from 199 (58%) training participants who provided correct contact information.

Table 4 takes a closer look at the demographics of those who attended the trainings. In contrast to previous years, all of the evidence-based home visitation models in the Strong Foundations evaluation participated in the Big Four trainings, alongside participants from Baby Talk and Early Head Start programs. Home visitors made up the majority of the training participants, averaging 66 to 70 percent of

¹⁸ Rates are approximate because not all attendees signed in on the attendance sheets, as evidenced by some completed day-of surveys by people not listed on the official sign-in sheet.

¹⁹ Of the 232 unique attendees, 149 participated in 1 training; 92 participated in 2 trainings; 66 participated in 3 trainings; and 60 participated in all 4 trainings.

all attendees. It should be noted that most of the 12 to 18 percent of attendees who selected “other” for their organizational role indicated that they held the position of “family support worker.”²⁰

Table 4. Characteristics of Big Four Training Participants

Characteristic	Percent Attending			YALC <i>n</i> = 109
	Domestic Violence <i>n</i> = 53	Perinatal Depression <i>n</i> = 29	Substance Abuse <i>n</i> = 77	
Role in organization^{a,b}				
Home Visitor	70	67	70	67
Supervisor	6	6	5	7
Doula	6	9	4	6
Director	2	0	2	3
Center Staff	2	6	1	0
Other	13	12	18	17
Length of time in current position				
Less than one year	41	62	32	24
1 to 5 years	31	24	45	38
6 to 10 years	18	7	13	22
More than 10 years	10	7	11	16
Education				
High school/GED	3	0	4	4
Some college	13	10	9	12
2-year college degree	23	24	21	17
4-year college degree	36	45	45	43
Graduate school	26	17	21	23
Other	0	3	0	2
Language regularly used at work				
English	77	94	82	91
Spanish	23	7	17	9
Other	0	0	1	0

^a These numbers are duplicated as participants could attend more than one training and within some items respondents could check more than one item.

^b Percentages are within topic. For example, 70 percent of all those receiving domestic violence training were home visitors.

Participants had been in their current positions for varying amounts of time; however a greater proportion of staff who attended perinatal depression trainings worked in their positions for less than a year as compared to the attendees of the other training topics. Overall, about 70 percent of attendees had been in their position for less than 5 years, although this was slightly skewed by the number of less-tenured staff who attended the perinatal depression trainings. In terms of educational background, most of the

²⁰ Family Support Worker is the title of Healthy Families Illinois home visitors. We did not modify the responses received and are reporting on the home visiting staff responses.

respondents had attended college, and just over half had a bachelor's or graduate degree. Trainees with a 4-year degree were the highest represented group across each training type, comprising 35 to 45 percent of those trained, on average. Also noteworthy is that home visiting staff who primarily use Spanish in their work attended each training topic.

Big Four Training Impact

The pre- and post-surveys were implemented on the day of training to gauge knowledge and confidence in the training topic, as well as to measure overall satisfaction levels.²¹ Survey respondents also provided some demographic information about themselves and general information about their home visiting programs. Further, respondents had the opportunity to share comments about the training and indicate their future training needs. The follow-up surveys, which were completed by e-mail or telephone approximately 3 months after the trainings, allowed us to learn more about the impact of the training on home visitors' practice and provided another opportunity to gather feedback about the training system.²² The first set of follow-up questions was similar to the day-of survey questions in order to measure retention of the training information. Additional questions were posed to learn if home visiting staff had used or shared the knowledge they gained from the training.

With the exception of the newly developed YALC training, the Big Four trainings remained consistent with the prior year's training curricula. Two trainers facilitated all of the Big Four sessions. Typically, one presenter would discuss the topic in detail, presenting the most recent updated knowledge on the topic, followed by a second presenter who would discuss how the topic specifically related to home visiting. Respondents were generally pleased with the updated training method, as indicated by a participant's comment, "I really like the two trainers method. They piggybacked off each other. One would give the information, and then the other would reinforce it and then move on to the next topic. It was seamless."

Objectives and Confidence

How the Big Four trainings met their stated objectives and improved confidence among participants was evaluated based on the training surveys, as well as the in-person focus groups and interviews at the 15 study sites. Overall, supervisors and home visitors alike reported highly positive feedback on the quality and content of the various Strong Foundations trainings. This was similarly reflected across answers to survey questions related to the "newness" of training material and applicability of material to their caseloads of families. As indicated in Table 5 below, the trainings also seemed to meet participants'

²¹ See Appendix C for an example of the Big Four training pre- and post-surveys.

²² See Appendix C for an example of the follow-up training surveys.

perceived objectives in terms of content: they helped staff to identify help-seeking barriers, provided information on practice or skills necessary to work with families, and helped to identify community resources that could be utilized.

Table 5. Participant Views on Whether Training Met Objectives

Training Objective	Mean (SD) Rating of Agreement by Training Topic ^a			
	Domestic Violence <i>n</i> = 40	Perinatal Depression <i>n</i> = 29	Substance Abuse <i>n</i> = 78	YALC <i>n</i> = 105
Identify the types, characteristics, and causes of training topic	3.8 (0.4)	3.6 (0.7)	3.4 (0.6)	3.3 (0.6)
Describe barriers to receiving help for training topic	3.9 (0.4)	3.5(0.7)	3.1(0.5)	3.3 (0.6)
Describe appropriate actions and precautions in working with families affected by training topic	3.7 (0.5)	3.5(0.7)	3.3(0.5)	3.2 (0.6)
Identify appropriate community resources and procedures to inform and link families affected by training topic	3.7 (0.5)	3.4 (0.7)	3.3 (0.5)	2.9 (0.8)

^a Respondents rated the extent to which they agreed or disagreed with each statement on a 4-point scale: 1=strongly disagree, 2=disagree, 3=agree, and 4=strongly agree.

Respondents were mostly positive in their responses when asked to indicate how their general knowledge of the training topic had changed. Respondents were more likely to agree that their knowledge of indicators of the training topic and/or how to take action were positively influenced by the training. They also agreed that their knowledge of how to avoid actions that could exacerbate certain risk situations had changed since attending the training. Responses were mixed as to whether they could identify the appropriate community resource or procedure to make referrals for families. This may have been a more difficult question considering the resource issues currently existing throughout Illinois and described in the previous chapter.

To better gauge knowledge and confidence in each training topic this year, Chapin Hall, in consultation with the trainers, modified the pre- and post-surveys by including four to five newly developed questions for each training topic. (See Appendix C for an example of 2012 surveys.) These modifications allowed for a clearer look at participants' self-report data and allowed for a richer analysis. This year's questions asked respondents to gauge their own confidence and knowledge instead of "quizzing" respondents on specific items learned within a training. For example, attendees of domestic violence trainings were asked to respond on a 5-point scale (1 = not at all confident to 5 = very confident) to statements such as "I feel confident in my knowledge of how to identify and describe the range of types of domestic violence." Average scores, as well as effect sizes using Cohen's *d* calculations, were obtained for comparison of pre-surveys, post-surveys, and follow-up responses.

Table 6 below summarizes average knowledge/confidence scores across the four trainings administered at three points in time. Pre-test scores were lower, averaging 3.1 ($SD = 1.0$) on a 1 to 5 rating scale and indicating an average knowledge or confidence level of “not sure.” The pre-test scores ranged widely, as evidenced by the larger standard deviations (approximately 1.0 each). Both posttest and follow-up average knowledge and confidence scores were higher. The posttest score averaged 4.1 ($SD = 0.6$) and the 3-month follow-up averaged 4.0 ($SD = 0.6$)—“confident” or better.

Table 6. Change in Participants’ Levels of Knowledge and Confidence^{a,b}

Training	N	Pre Mean (SD)	Mean Rating		N	Follow-up Mean (SD)	<i>d</i> -score	
			N	Post Mean (SD)			Pre→ Post	Pre→ Follow-Up
Substance abuse	78	3.1 (1.0)	78	4.1 (0.6)	32	4.0 (0.5)	1.26	1.12
Domestic violence	41	3.2 (1.1)	41	4.2 (0.6)	27	4.1 (0.4)	1.26	1.08
Perinatal depression	29	3.1 (0.9)	29	4.4 (0.5)	14	4.1 (0.5)	1.63	1.28
YALC ^c	109	3.0 (0.9)	109	4.0 (0.6)	51	3.9 (0.7)	1.34	1.16
Overall Mean Rating		3.1 (1.0)		4.1 (0.6)		4.0 (0.6)	1.32	1.19

^a Respondents rated their knowledge and confidence level across 4 or 5 items on a 5-point scale: 1 = Not at all confident, 2 = Not very confident, 3 = Not sure, 4 = Confident, and 5 = Very confident.

^b Only respondents who also completed a pre- or posttest are included in the analysis.

^c YALC trainees only completed 4 questions while all others completed 5 questions.

Effect sizes, indicating the magnitude or the strength of the effect of training, help to compare these scores within each group (training type) across the three time points relative to the pooled standard deviations of within group variation.²³ Results here indicate quite large effect sizes; for example, at posttest, substance abuse trainees indicated more than 1 standard deviation of change ($d = 1.26$) from their pre-test score. Average d -scores for pre- to posttests were 1.32, a very large effect. Impressively, this was relatively similar at the 3-month follow up as scores still averaged 4.0 ($SD = 0.6$) and overall averaged a d -score of over 1 standard deviation ($SD = 1.19$). A straightforward interpretation is simply that training participants indicated more confidence in their knowledge, and maintained that confidence 3 months after training. Results should be taken with some caution, as the study did not utilize an experimental design using a control group for comparison. Additionally, since the test questions were developed for the current study they are not standardized and have not been tested for reliability.

²³ Typically, effect sizes, as proposed by Cohen (1988), range from 0 to 1 and are seen as “large” as they approach 0.8 or 80 percent of a full standard deviation of change. Effect sizes can be larger than 1 and are interpreted in terms of standard deviations to the mean score of whatever scale is being analyzed. More modest approaches in the social sciences note that “large” can be typically indicated over 0.5 of a standard deviation.

Satisfaction with Training

When asked to rate their satisfaction with the Big Four trainings, participants' average ratings on a 4-point scale on the usefulness and relevance of the training content ranged from 3.5 ($SD = 0.5$) for the YALC training to 3.8 ($SD = 0.4$) for the domestic violence training, indicating that the far majority responded that they agreed or strongly agreed with the statements, as indicated in Table 7 below.

Table 7. Participants' Satisfaction with Strong Foundations Trainings

Statement about Training	Mean (<i>SD</i>) Satisfaction by Training Topic ^a			
	Domestic Violence	Perinatal Depression	Substance Abuse	YALC
The content was useful and relevant to my profession	3.8 (0.4)	3.7 (0.7)	3.6 (0.6)	3.5 (0.5)
The training had new material I had not heard before	3.5 (0.6)	3.5 (0.7)	3.2 (0.8)	3.2 (0.7)
The content and materials applies to the families with whom I work	3.6 (0.6)	3.6 (0.5)	3.5 (0.5)	3.6 (0.5)
The training increased my knowledge of the topic	3.8 (0.4)	3.6 (0.7)	3.5 (0.6)	3.5 (0.6)
I plan to integrate what I learned today into my work	3.8 (0.4)	3.6 (0.7)	3.5 (0.5)	3.7 (0.5)
It was easy to make arrangements to attend the training	3.7 (0.5)	3.3 (0.7)	3.6 (0.5)	3.6 (0.6)

^a Respondents rated the extent to which they agreed or disagreed with each statement on a 4-point scale: 1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree.

Again, overall, respondents described highly positive outcomes for the Big Four trainings. As one respondent stated, "They're really informative, and they kind of gave you a case-by-case basis; they give you ideas." Another participant echoed that view, saying, "So far, all the trainings have been extremely beneficial." Supervisors tended to agree that the Strong Foundations trainings were beneficial to their staff. As one supervisor reflected, "I think training ends up being a treat for them. A lot of times they'll bring stuff back like Power Points and they'll bring back their training materials, like, 'Man, I went to the training and it was really good.'" Others described specific ways in which they had been able to apply the trainings in their home visiting work. Staff members at one site shared how their training in substance abuse enabled them to share more materials with their clients and discuss the cycle of abuse with them, while domestic violence training helped another refer a client who was being abused to counseling. Staff who attended the perinatal depression training stated, "Now we're using it. It's helping us...decipher out some of the young ladies who are more or less depressed."

The in-person interviews also provided an opportunity to learn about various perspectives of the training, including satisfaction levels. Respondents from the 15 study sites identified that they had received a significant amount of training, including the Big Four trainings. Of the 15 sites at which focus group interviews occurred, home visiting staff from eleven sites attended the domestic violence training, staff

from ten sites attended the perinatal depression training, and staff from nine sites attended the substance abuse training. At the time of the focus groups, staff from only six sites had participated in the YALC training; however, this was not surprising since this training was developed later than the others.

The majority of the discussions were overwhelmingly positive. Respondents working with families who were experiencing one of the training topics responded overwhelmingly that they used the knowledge or information from the training in their work. In explaining how they used it in their work, they reported that they saw families with issues related to the training and that they or their coworkers used the strategies or knowledge to work with those families and to make referrals when necessary. For example, one respondent referred a client to an appropriate resource following the training on identifying perinatal depression. Another stated, “I have been able to pass information on to my families in need as well as coworkers who are working with families that are influenced by this issue.” A third described a growth in her confidence level and explained, “[The YALC training] made me more confident. It’s important as a home visitor to have a trusting relationship with my participants. I like to talk in a confident manner. I like to have the facts ready to support what you are saying.”

However, some respondents expressed mixed views, with at least one respondent noting the continued need for updated and new topics, stating, “It seems like it’s the same cycle of trainings over and over and over. I mean, I understand—it’s good if you have a staff turnover...but when you have retention, well, we’ve been all trained.” Several home visitors across the different regions in the state and from more than one program model indicated that they found at least some aspects of the Big Four trainings left room for improvement. For example, some said the trainings didn’t go into enough depth or provide enough information. Others felt that the trainings did not connect with their actual experiences as home visitors, and that they were merely informational, rather than experiential. One respondent who felt this way stated, “It was really frustrating because I’m like, ‘Wow, you have all these home visitors in this room who are experts at home visiting, and if you could facilitate them talking to each other, I think we would all learn more rather than just looking at a Power Point.’” Another critique dealt with a related point, the respondents’ ability to network during the training. Several respondents recommended that these trainings should include an on-site lunch to increase their ability to network with their home visiting peers: “We hate that we have to go out for lunch....Having lunch there would give us time to connect with the other participants.”

Findings from training surveys and site visit interviews were more mixed for the new YALC training. For example, one participant commented, “We never addressed those issues [of learning challenges of parents] in the training whatsoever.” In contrast, another participant in the same training remarked that it was quite useful: “The training gave me new insight on how to approach some families with learning

challenges. It also helped me learn what to look for in the event that no one has told me the parent has learning challenges. It helps me gauge how to work with these families.” There were also different perspectives about the objectives of the YALC training. Some felt the objectives were misleading and the training targeted other topics, topics not directly related to the title of the training. However, others appreciated the discussion and praised both trainers for their work.

In summary, as in prior years, respondents were asked to report on their satisfaction related to content of the training, increase in the respondent’s knowledge, logistics of the training, newness of material presented, anticipated future use of training knowledge, and applicability of the training to the respondent’s caseload. Responses were overwhelmingly positive on all of these aspects; on average, respondents reported being more than satisfied on all components. Despite a few variations, for the most part the response to the trainings was overwhelmingly positive. In their comments, home visitors and supervisors expressed appreciation for training specifically focused on the knowledge skills that would benefit home visitors.

Surveys yielded significant findings and implications about the necessity for training and the impact of training on home visitors’ confidence in their knowledge and skill development. Respondents answered a series of questions to gauge levels of knowledge or confidence in the training content area(s) prior to, immediately following, and 3 months after the training to assess change in both content knowledge and practice-related skills. With respect to the question of whether these trainings provided new knowledge and skills, respondents overwhelmingly indicated less confidence and knowledge in each of the four topic areas prior to the training than after training. On average, they indicated that they were “less than confident” before the training. In contrast, immediately following the training, those responses ranged from “confident” to “very confident,” a statistically significant improvement across all four trainings and across the entire year of Strong Foundation trainings offered by the Ounce Training Institute.

We were also interested in knowing whether this increase in confidence or knowledge was maintained after home visitors and supervisors returned to the field with their programs. After 3 months, respondents were again asked the same survey questions and reported sustained training effect. Respondents continued to state that they were “confident” or “very confident,” on average. These results indicate that the addition of these four training areas was necessary, and that the trainings were effective in transmitting knowledge to home visitors that was sustained over the longer term.

Happiest Baby on the Block

Beginning at the end of SFY 2011, Strong Foundations, in partnership with Prevent Child Abuse Illinois, began to offer home visiting programs the opportunity to have staff participate in the Happiest Baby on

the Block (HBOB) certification process. Strong Foundations also provided HBOB materials for participating programs' lending libraries, as well as swaddling blankets for families. HBOB was developed as an approach for calming young children and, in turn, relieving parenting stress and promoting positive child and caregiver relationships. Developed with the intention of helping families avoid conflict with their young children around issues of crying, HBOB techniques facilitate infants' ability to self soothe (Karp, 2002). According to state-level informants interviewed for this evaluation, initial interest in providing home visiting programs with access to the HBOB certification program came from leadership at both program and state levels. The leadership recognized the considerable overlap between their organizational missions and the goals and methods promoted through HBOB. Strong Foundations allocated funding for the HBOB certification, viewing it as another opportunity to grow the state's training infrastructure home visiting programs.

Survey Sample and Method

Twenty-six staff members from different Healthy Family Illinois, Parents as Teachers, Early Head Start and Nurse-Family Partnership programs have received HBOB certification through Strong Foundations. Six home visiting staff members began the certification process in SFY 2011, followed by 20 staff members who began the process in SFY 2012. In semi-structured telephone interviews we asked HBOB participants to provide demographic information and to discuss their experiences with the HBOB certification process and technique. In designing the interview protocol, the evaluation team took into consideration the ways in which training may have impacted the state's infrastructure of supports for home visiting programs. Questions were included to elicit staff opinions on whether the HBOB certification program meets the needs of their communities and families. Interviewers also asked for staff perceptions of where training improvements were needed and inquired about the general level of effectiveness when implementing the techniques with families. This analysis looks at the trends and opinions expressed by 21 of the HBOB participants who received training in either SFY 2011 or SFY 2012. Of the five participants that did not participate in the post-training interview, two were no longer employed by the home visiting program through which they completed the certification. Additional data was also collected during site visits by asking home visiting staff at each of the 15 study sites about their perspectives and satisfaction with the training and training system in Illinois, including the HBOB certification.

Participants represented a fairly even distribution of regions across the state. As noted in Table 8, of the four home visiting program models participating in the SFY 2011 and SFY 2012 HBOB certifications, about half of the participants were staff in Healthy Families Illinois programs, and a third were staff in Parents as Teachers (PAT) programs. Two participants were from the Nurse-Family Partnership program

and one was employed by an Early Head Start program. Happiest Baby on the Block participants represented home visitors, supervisors, doulas, program directors, and other center-based staff and teachers. Eight participants reported that they occupied multiple positions within their organization. HBOB participants' tenure at their agencies was almost evenly split, with about half having worked at their organizations for less than 6 years and about half having worked there for 6 or more years.

Table 8. Characteristics of HBOB Participants, 2011–2012 (*N* = 21)

Characteristic	Number	Percent
Location of Agency		
Northern IL	7	33
Southern IL	6	29
Central IL	5	24
Cook County	3	14
Program Model		
Healthy Families America	12	57
Parents as Teachers	6	29
Nurse-Family Partnerships	2	10
Early Head Start	1	5
Years at Current Agency		
Less than one year	2	10
1 to 5 years	9	43
6 to 10 years	3	14
More than 10 years	7	33

Participants reported that they learned of and were selected for the HBOB training opportunity in a variety of ways. Some supervisors and home visitors had learned about HBOB and its techniques at the Prevent Child Abuse Illinois conference and developed an interest in the training as a result. Although only 66 percent of post-training survey respondents indicated how they were selected to participate, those staff members indicated that they were given the Strong Foundations opportunity largely as a result of independently pursuing the opportunity to receive the HBOB certification. In other cases, supervisors forwarded information regarding the training to the staff members they felt would be interested in the opportunity. In brief, there were no apparent criteria for selecting staff members to become certified in HBOB; instead, it seemed to depend on having prior knowledge of the program and awareness of the training opportunity.

Findings

Home visiting staff reported implementing, or planning to implement, HBOB methods in individual and/or group settings, with most home visitors reporting high levels of success and parent engagement. Certified staff varied in the context in which they apply the HBOB techniques, but they largely reported

that integrating HBOB techniques into practice with families was not difficult. However, there were some reports of difficulties in generating acceptance of HBOB among colleagues who had been trained to handle fussy baby issues differently. Although the majority of participants expressed their willingness or desire to share their HBOB knowledge with other program staff, and many had engaged in informal discussion of HBOB methods with their peers, only a small number had been asked formally to do so.

As seen in Table 9 below, overall, staff reported high levels of satisfaction with the certification process. Participant responses reflected their favorable opinions throughout the follow-up interview. All postcertification respondents reported that the content of the training was useful and relevant to their work. Responses were similarly favorable to questions of whether the staff members have used or would use the information from the training in their work with families.

Table 9. Home Visiting Program Staff Views on Effects of HBOB Training, 2011–2012^a

	Percent of Respondents (N = 21)			
	Strongly Agree	Agree	Disagree	Don't know
The content of the training was useful and relevant to my profession	86	14	0	0
I shared the information I learned with my colleagues	52	29	9	4
I have used the information from the training in my work with families	76	14	4	4
It was easy to integrate what I learned in this training into my work	90	0	4	4
I will use the information from the training in my work with families in the future	95	0	0	4
This training has changed how I handle issues concerning fussy babies	52	24	4	9
This training has changed how my agency handles issues of fussy babies	14	38	9	24

^a Original response scale was 4 points, ranging from “strongly disagree” to “strongly agree” with an option for “I don’t know.”

The participants provided detailed descriptions of the ways in which the technique has influenced their practice. Home visitors and supervisors enthusiastically reported on parents’ reactions to learning the HBOB techniques, as well as their increased confidence in helping parents develop ways to soothe their children. In the words of one home visitor, “I think parents like it when we think about solutions.” Other illustrative comments from our interviews included the following:

I have had [parents] say it saved their life—that every parent should know about it before they leave the hospital. Parents are more relaxed and comfortable with their babies.

I’ve had a few moms who absolutely love it. The white noise CD is great. One mom told me that her husband was always saying that she was spoiling the baby, but then she showed him the video and he is always watching it and uses the technique with their daughter. I feel now that I have more

knowledge and education. I feel more confident in my abilities. I have one mom who calls me her baby whisperer.

It's good because I can give them actual techniques that are written down someplace as opposed to telling them "this might work." It gives a little more validity into what I'm saying. It's good to have a protocol of sort.

Some of them don't believe it and attribute it to other things, but then they do try it and like it. I'm more confident in my techniques in calming a fussy baby so parents are more apt to take my advice. Now I have words to name the techniques.

Perceptions of the certification process were generally positive. There were mixed reactions to the self-study format; however, the majority reported that they enjoyed completing the certification at their own pace. Home visiting staff frequently reported that, even though the content alone was not difficult, the amount of reading that was required by the process was burdensome. The self-study program that is required for HBOB certification took home visitors anywhere from a few days to six months to complete.

All 21 participants who completed a post-certification interview stated that they would recommend the training to others. Almost all of the participants indicated that follow-up training would not be necessary.²⁴ When asked in general whether their agencies would have the appropriate resources moving forward to implement the technique, 80 percent of the staff responded affirmatively. However, several made additional comments that revealed concerns posed by funding limitations, such as that there might not be sufficient materials (i.e., blankets) to continue to implement the program. This concern was also echoed during the focus group and supervisor interviews, as one supervisor explained,

Now, we haven't been able to get the blankets, so what we did was—sometimes we go out and we actually have—one of our case managers actually makes the blankets for us. We buy the material and stuff like that, and she makes the blankets.

When asked explicitly about the way the training has helped the home visitors to build capacity to serve parents, most of the responses focused on acquiring new skills for working with parents. For example, one home visitor shared, "I've gotten questions about crying babies and the parents did not know how to address that. I think being certified allows me to give some relief to parents." Another suggested, "If we had a really fussy baby, maybe instead of referring them out right away, we'd spend more time with them." Other respondents' comments also recognized that although only one home visitor received the training, this individual can serve as a resource for others. One respondent said, "When you have a fussy baby, it's really useful to have someone in the program with these skills." At the same time, at least one

²⁴ Only one participant explicitly requested additional training.

respondent expressed the desire for other staff to learn the HBOB techniques: “I think this is a great tool to have. It would be great if more of the home visitors in our program could get certified.

The HBOB methods received a favorable reception from parents and staff. However, it is important to consider whether their enthusiasm and knowledge is being infused throughout their organizations in assessing whether this training might be influencing the wider infrastructure of support for communities and families. Although the perceived value of HBOB methods appears almost unanimously positive, less than 50 percent of respondents were confident that the training has changed how their agencies handle issues relating to fussy babies.

Moreover, the overall number of participants in the HBOB self-study program to date is quite small. Only 26 individuals throughout the state participated in the program and the selection of these individuals seemed to be somewhat arbitrary and dependent on their knowing about the program and the training opportunity. As a result, HBOB trainees were often the sole certified staff member in their organization. While the HBOB certification was well received, it is not clear that the program has, to date, impacted the state’s infrastructure to support evidence-based home visiting practices. It will be important to consider data on staff retention, ongoing training in the HBOB approach, and the distribution of trained HBOB staff throughout the state in assessing the impact of this opportunity on the state system. Many respondents reported sharing their experiences informally with colleagues, but did not indicate that systems for formally sharing or integrating HBOB’s techniques into the practice of the organization had been established.

Training and Technical Assistance Developments

Along with the Big Four trainings and HBOB certification, it is important to highlight other training and technical assistance developments throughout the state of Illinois, as well as other supports that, while outside of the state’s infrastructure, support home visiting programs. Developing its infrastructure of supports to home visiting programs, Illinois implemented the use of Infant Mental Health consultants, new federally-funded Maternal, Infant, Early Childhood Home Visitation Program (MIECHV) training, and focused supervisor network meetings. Additionally, the national or state offices that support specific home visiting models provide additional training and technical assistance to program staff; in some situations this included major upgrades to models and rolling out extensive new training curricula. One example of this was the Parents as Teachers model (PAT), which rolled out new training to home visiting staff during the past year. This section summarizes these developments and includes feedback from respondents who interacted with one or more of these new training supports.

Under MIECHV, the Illinois Children’s Mental Health Partnership has begun Infant Mental Health consultation in all 6 MIECHV communities. One Prevention Initiative home visiting program in each community has begun receiving the Partnership’s full model, while the other agencies in the communities receive reflective supervisory support and consultation. A systematic evaluation of these consultants was not completed for the current Strong Foundations evaluation; however, perspectives of home visiting staff were obtained through interviews at project sites, which have also been able to utilize the Partnership consultants. One provider noted the benefit for seasoned staff, stating “We’re really excited about this Infant Mental Health consultation because [it’s great] for veteran staff who feel like they’ve done everything at the Ounce and it takes time and energy to find things elsewhere.” Additionally, MIECHV has piloted additional training support to home visitors within designated study areas. As one state-level respondent described:

We’ve also reached out to the Allied Coalition against Domestic Violence. They’re providing our 40-hour certification, and helping guide us through the domestic violence issues, and providing great advice for us. With the private partnerships we are working in tandem with the Ounce of Prevention to help us provide the statewide infrastructure in regards to training and technical assistance. We’re also working with the Allied Children’s Mental Health Partnership; it’s mental health. And we’re working with the Allied Childhood Trauma Coalition.

National program model offices or curriculum developers also made various modifications; however, none impacted home visiting programs in Illinois as much as the new PAT curriculum training. PAT began rolling out the new training throughout the country and all PAT home visiting staff in Illinois have begun to receive this new or updated intensive curriculum training. Through the receipt of additional Illinois State Board of Education (ISBE) funds, the Ounce of Prevention was able to facilitate the training for programs at no cost, with the exception of food and travel. The Ounce offered the trainings at regular intervals to ensure that programs had the opportunity to meet PAT’s requirements of having all staff trained and using the new curriculum by 2014. Programs that implemented other home visiting models, but utilized the PAT curriculum, could also receive the updated training, although they were not required to do so by PAT. PAT set up two training routes for home visiting programs, the curriculum training only (programs which opt for this route are known as “partners”) or the curriculum training plus model implementation training. This more extensive training is required for PAT’s affiliate programs to help maintain the fidelity of the evidence-based PAT model. Illinois programs funded through ISBE were required to take both trainings as part of their new funding requirements. Program supervisors and managers expressed excitement about the new curriculum and its potential impact on practice:

I think [the new curriculum] is great. I think it fits what we do for [the Prevention Initiative], especially the whole case management. Because [the curriculum was] lacking in that area. It was

really good about child development. Really good about parent-child interaction, but it did not have the resources for addressing the parents' goals. I think [home visitors] will like it, because now they'll have the resources right online, handy.

Some respondents from Healthy Families Illinois (HFI) sites that have adopted the PAT curriculum responded that they took the training due to the quality of the PAT curriculum, stating they "went through the training so that we can better help our parents."

One aspect of the new PAT requirements that home visitors described as frustrating and time consuming was the functional hearing screen. As one supervisor stated,

By 2014 all PAT programs must use the new hearing screen. It is very cumbersome and highly sensitive so if a child moves during the screen, it can result in a false positive. We are sharing a hearing machine, which is very expensive, with [two other programs in the area]. I've heard that all of the PAT supervisors are complaining about the sensitivity of the machine. It's very difficult to screen children between the ages of 12 [and] 18 months because they squirm and smile and that throws the machine off. The older children are a bit easier because they can be "bribed" with lollipops.

Home visitors from another PAT program expressed the same type of difficulties and added that often they indicated "unable to test" on their paperwork. This is an area that seems to need additional technical assistance.

As described in previous Strong Foundations reports (Spielberger et al. 2011, 2012), another model-specific support for HFI programs is ongoing cluster meetings facilitated by Prevent Child Abuse Illinois. Some cluster meetings are specifically for supervisors, but some areas have opened their meetings up to all home visiting staff. Attendance requirements and meeting frequency are determined by the specific geographic cluster, with some sites meeting quarterly and some facilitating teleconferences to reduce costs and increase participation. A state-level informant familiar with the cluster meetings described them as follows:

[Cluster meetings] were initially designed to develop some type of mechanism that could help with the additional training that the Ounce doesn't provide. These are trainings that Healthy Family sites have to have their people go through within a certain time frame. So they incorporate a training component [and] a lot of support components.

Another training implemented under Strong Foundations during the past year has been training dedicated to supervisors, now called Strong Foundations Home Visiting Supervisors Learning Communities.²⁵

These meetings were structured to include key linkages between the Big Four training topics, supports to supervisors to bolster supervisors' content knowledge and skills in reflective supervision to support their

²⁵ These were initially called Supervisory Network meetings.

home visiting staff. Meeting facilitators presented on one topic—similar to a Big Four training topic—and then allowed for discussion surrounding the impact on programs and staff and how to support home visitors when working with families affected by the topic. Additionally, these meetings were also viewed as opportunities for networking among supervisors.

A more formal evaluation of these network meetings will occur in the 2013 Strong Foundations evaluation. However, several supervisors in the 15 study site programs attended the meetings and provided some initial feedback on this training. They indicated that while some of them attended due to “requirements,” they also attended “to get ideas from other agencies and see what they’re doing and how to improve our program.” Respondents were pleased with the training opportunity; as noted by one attendee, “I liked it because it was just the supervisors together so we can kind of go through what do we do if our staff has a particular issue.” Others specifically picked up on the main objectives of the meetings, including one who stated,

So it was kind of a refresher about domestic violence, but the perspective that [the facilitator] came from is like this is how you support your staff that may be dealing with this issue. So that’s different because you don’t get that in the 40-hour training. It has the component for supervisors of how do you support your staff that’s dealing with this issue and that kind of stuff.

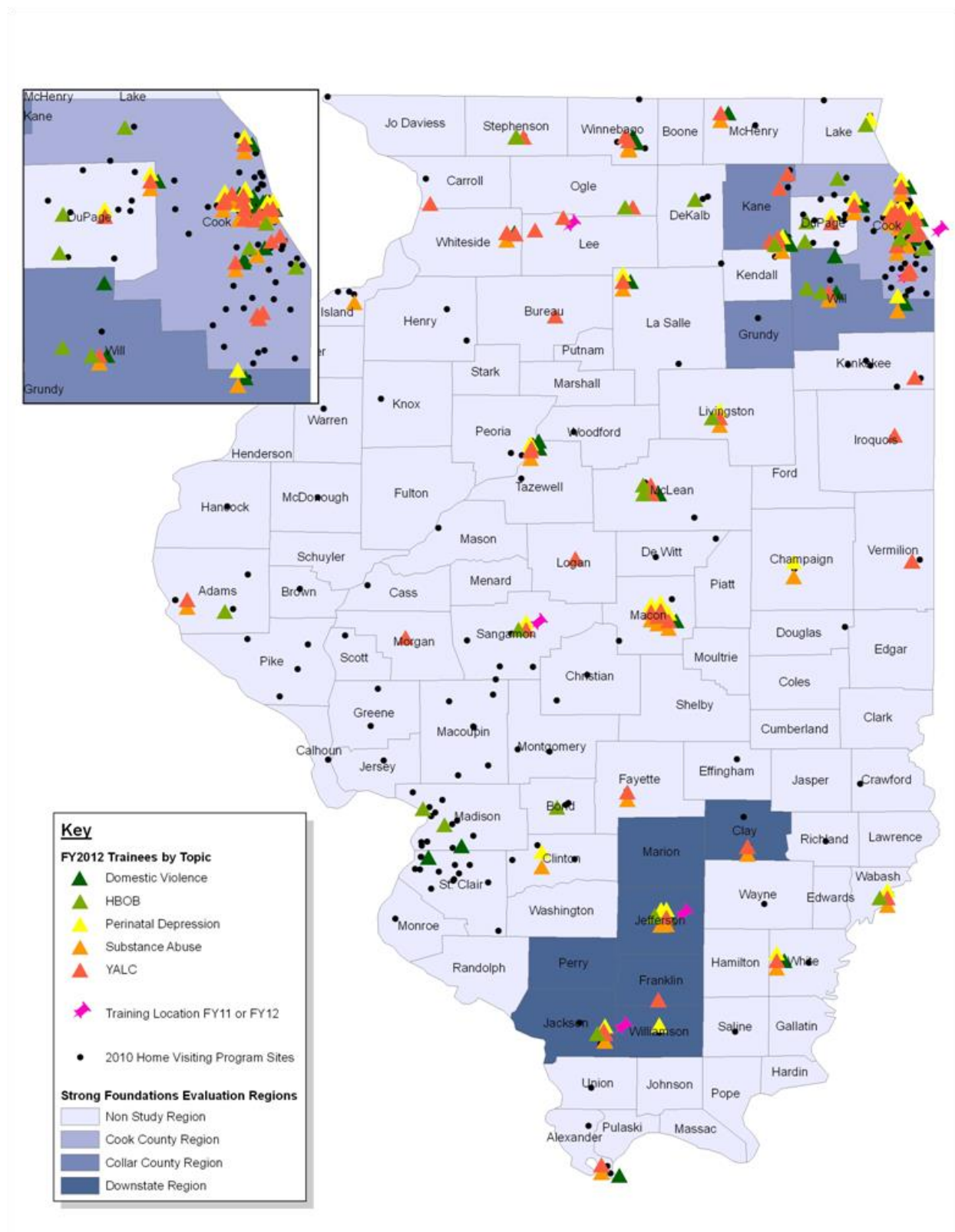
Factors that Facilitate and Hinder Participation in Training

Strong Foundations has increased access to trainings across the state throughout the past 3 years. As detailed in Figure 3 below, expanded access includes a growing venue of training locations and opportunities to lessen the burden on programs located in far reaching locations around Illinois. Evaluators continued to look at the training system for potential barriers to staff attendance, including both systemic and state-level issues as well as agency/program level barriers. Systemic issues addressed included awareness of the appropriate trainings, proximity to the training location, and awareness of the need to attend training. Agency- or program-level barriers mostly surrounded resource issues; however, some program-specific barriers included being unable to travel to training.

The Availability and Reach of Big Four Trainings

The map in Figure 3 plots all Strong Foundations training attendees over a 2-year period over actual home visiting program sites and includes 1) the location of home visiting programs throughout the entire state, 2) the three study areas, 3) training locations for the new Strong Foundations trainings, and 4) program locations where staff participated in trainings. In reviewing the map, it should be noted that regions included in the Strong Foundations evaluation are not separated by program, but instead represent the

Figure 3. Reach of Big Four and HBOB Trainings in Illinois, SFY 2011 and SFY 2012



universe of EBHV programs under the umbrella of the Strong Foundations initiative. These regions include the three program models that are the focus of Strong Foundations—HFI, Nurse-Family Partnership (NFP), and PAT. In addition, five training locations are flagged on the map and represent five locations where new training occurred. Black dots represent an EBHV site where at least one worker received training in one of the new Strong Foundations trainings. Most dots represent duplicate trainings, either for one individual or multiple staff. (If all sites had at least one person trained, all green triangles would be covered by black dots.)

Again, the Big Four trainings were offered in four locations across the state—Chicago, Springfield, Dixon, and Carbondale—as noted by pink pins on the map for both the current year’s report as well as the prior year.²⁶ It is clear that the reach of the Strong Foundations training is wide and has spread throughout the state as more staff in new locations have attended training. (At the same time, several groups of existing programs did not attend training. It was unclear why these programs did not attend.) Although this map does *not* indicate the number of individuals trained, it does show whether at least *one* staff member from a given home visiting location was trained. This coverage of trained home visiting staff helps show that information about trainings was widely disseminated; it also suggests that program staff are still willing to travel great distances for trainings not offered in their region. (In fact, home visitors who had not yet attended the Big Four trainings indicated their desire to do so.) Based on the observation that several areas seem to lack trained individuals, it appears that the coverage was not comprehensive across Illinois. This suggests that these regions should be should be evaluated further when planning future training outreach or training site locations.

Awareness of Training

Lack of awareness of training can be a barrier to attendance and prior report data indicated this could potentially be a barrier in Illinois (Spielberger et al., 2012). In response to the prior report, evaluators developed questions as part of the focus groups and supervisor interviews to gauge if training awareness had improved. Home visiting staff reported receiving e-mail reminders or phone calls, or regularly checking the Ounce Institute Training Center’s website, to learn about available trainings in their area.²⁷ One downstate supervisor noted, “They’ll send us reminders too, which is really great.” Some respondents knew the Big Four trainings by the “Ounce” name instead of the “Strong Foundations” moniker; however, knowledge of these specific trainings was generally present when asked and clarified. There was a general awareness of the availability of training for home visitors in all of our spring 2012

²⁶ There are five pink pins in the four locations because trainings were offered at two different downstate locations during this period of time.

²⁷ The website can be viewed at <http://open.opftrainingcenter.org/ets/welcome.aspx>

interviews; staff often cited the Ounce, Strong Foundations, or their program model national office specifically when discussing training. Notably, an NFP provider (not affiliated with the Ounce) expressed more awareness of Institute trainings than in previous interviews, suggesting perhaps there was greater coordination and communication of training opportunities among programs.

Travel to Big Four Training

Traveling to training can be a significant barrier, as previously reported by respondents, and evaluators continued to look at the issue of proximity. Evaluators asked home visiting staff how the location of training influenced their decision to attend or not. Generally, if trainings were offered within the region, staff noted no barriers to or concerns about their attendance. Obviously, not all locations suited all providers, and some respondents noted the strain of travel prohibited or limited their ability to attend certain trainings. Supervisors across regions shared the perspective that “if it’s something close, we’ll be there” or “if it’s anything on the Ounce website, we allow them to go, we encourage them to go.” One downstate provider noted that expanded locations, specifically to Mount Vernon, had been “very handy.” Travel challenges were also noted in one focus group where participants stated, “We still do [travel to Springfield] for some of them, which is really annoying, but not like we used to. Every time you look around, we’re leaving at five in the morning, going to Springfield.” One staff member also noted travel restrictions from their funder that limited their attendance at what they felt were high quality trainings across the state line, in Missouri: “They don’t want us to go out of the state for any training, but it’s smarter for us to go to Saint Louis than it is for us to go Chicago because that’s two hours versus five.” Scheduling time to attend training was also difficult for some home visitors who felt it conflicted with their typical home visiting schedule.

Limited Resources for Attending Big Four Trainings

Resource limitations were previously documented and the current year’s evaluation continued to monitor how program funding impacted the ability of home visiting staff to attend training. Home visitors and supervisors at study sites reported on the Big Four trainings, which were offered at no cost to home visiting staff in Illinois, as well as on other model-specific trainings. Supervisors interviewed were aware that trainings were offered at no cost through the Institute, however both supervisors and home visitors identified other travel costs, including time, as barriers. One supervisor noted, “We are still charged for your housing needs. All that kind of stuff.” One supervisor wished the program’s national model office would help cover costs by “providing scholarships for events that they feel are important.” Other respondents identified seasonal capacity issues stating, “Last year was a very low training season; this year was a high training season.”

Motivations for Participating in Training

Finally, respondents discussed the “need for training” or what motivations influenced their desire to attend or send staff to training. This was categorized as a potential barrier because programs could be unmotivated to receive a specific training or could somehow misinterpret training topics, with staff incorrectly believing that they did not need the training. Several home visiting staff reported that regardless of the topic, all training was considered useful and necessary, stating that they “take every opportunity there is available.” One supervisor indicated that training and repeat training was important to solidify knowledge, stating, “I just believe the more in depth the training and repeated experiences with it would just be so beneficial for direct service staff.” On the other hand, some staff said they had been through a training or certified in similar areas and did not attend due to their own personal saturation in the subject. For example, one staff member shared, “I have certificates in both of those areas [domestic violence and substance abuse], so I don’t have to go through the training here.” Home visiting staff also identified specific needs of families or within their caseloads as additional motivating factors. One staff member said,

So whenever the Ounce has something new, like the Strong Foundations stuff, I think we all went as a program to—we had to identify substance abuse as an area that none of us felt like really that versed in, you know? And so we all went to that together. And so when we see something like—and I think for the perinatal depression one, I think almost all of us went to that one too. So when we see something new and we feel rusty on or something that we’ve identified, you know, previously, it’s like, “Man, we need to brush up on this or that,” then we’ll do that. And we’ll kind of do it as a team since we’re all—no one’s brand new anymore here.

Also I think the Ounce has been pretty awesome with providing trainings that meet the needs, probably because most folks who are doing this work are having some of the same challenges.

The motivation or “need” for training is also reflected in the results of the pre- and post-training surveys (see Table 6), which indicated an increase in both home visitors’ knowledge and their level of confidence in their knowledge. Their self-reported increased confidence they felt immediately after training was still evident at the 3 month follow-up. Thus, the initial lower rates of both knowledge and confidence also help support the need for trainings in these Big-Four topics. If attendees had indicated that they already had significant knowledge and felt confident in their general skills prior to the training, this would indicate less need for training or possibly, lower levels of participation.

Future Trainings Desired

Respondents were once again asked to provide specific suggestions of other trainings or staff development topics that would be useful for their work. However, suggestions for topics were many and diverse; they included: developing service plans or individual/family goals, advanced topics in mental

health issues, poverty or the culture of poverty, setting boundaries, establishing discipline, working with children or parents with developmental or mental disabilities, and working with teen parents.

Additionally, some home visitors detailed a lack of resources for training in specific areas, whereas home visiting supervisors indicated they proactively respond to their own staff needs:

If we need something, we go out and look for it, and we were also having a lot of clients who had mental issues, or we even had a client who was ready to graduate and a home visitor was focusing on making a list of what do you need, a budget, and that kind of stuff, because she was really low educated and couldn't do it and didn't have anybody to support her and the family. So then we were looking to find somebody, and if we don't find something or we need trainings, we usually sometimes do it ourselves.

Many staff did indicate that they would like more training on certain topics. Based on the first two years of annual staff surveys from 15 programs across the state, and on the responses to the Big Four training surveys, the most commonly requested topic for further training was mental health. Within the broader topic of mental health, home visiting staff identified subtopics of supporting families through grief, depression, teen parent perinatal mental health, and strategies for dealing with stress.

After mental health training topics, staff identified domestic violence, substance abuse, and working with special needs children and parents as other areas they in which they would appreciate further training. For the topic of domestic violence, respondents expressed an interest in learning about legal issues, domestic/child abuse and neglect, and how to approach domestic violence sensitively during a home visit. Possible subtopics for substance abuse included the effect of abuse on families, drug awareness, and potential legal repercussions. For working with special needs families, respondents indicated that trainings on the subtopics of supporting parents with learning challenges, child developmental delays, and autism would be useful.

Several of the sites shared an urgent need for more substance abuse training. They talked about how the drug scene is constantly changing, and it's difficult to keep up: "You could never have enough substance abuse, because the new stuff that these kids do, smoke and ingest into their bodies, comes out almost daily." Home visitors at two sites requested more training in working with children with special needs. One home visitor went into particular detail in discussing working with children with autism:

It's almost impossible to do a home visit with the child who's on the spectrum disorder because they are—number one, unless you're part of their routine, you're throwing them off balance. And it's hard to get their attention and how to work with them and you want to be there, because trust me—those parents need the support more than anybody. So it would be great if we could get more trainings on that.

In addition, respondents also suggested professional development opportunities that would benefit their work with families, such as motivational interviewing, the processes for obtaining citizenship, how to access human services (i.e., WIC (Women, Infants, and Children), medical cards, and Link), counseling strategies, dealing with stress, teen parenting, budgeting and scheduling, doula training, and coping with the loss of a child (e.g., miscarriage or adoption).

Implementation of enhancements to the training infrastructure has already begun. Several components have been rolled out; others are scheduled to be completed in the coming year. Supervisor network meetings have begun and are incorporating Big Four training topics, and evaluation efforts are reaching these new supports. A newly updated domestic violence training curriculum is being implemented within the Strong Foundations training and evaluation efforts, again, have been appropriately adjusted for these modifications.

Summary

Training continues to be a highly valued and noted piece of the state infrastructure across the home visiting system in Illinois. Both qualitative and quantitative results reflect how the state of Illinois is creating a culture of training and ongoing learning that is increasingly being integrated into home visiting programs. Training can take various forms and does not have to solely be provided by the main training entity, the Ounce's Training Institute. It is clear that home visiting staff in Illinois have frequent training opportunities and that they are valued by home visiting staff. Further, evidence from this report helps illustrate that training has also been effective in bringing new knowledge to home visiting staff and increasing their confidence.

In conclusion, during SFY 2012, we looked critically at the physical expansion of trainings offered to support regional training needs and reduce barriers to participating in training. We also examined training quality based on indicators of participants' confidence, knowledge development, and overall satisfaction as reported at the time of training and several months after training. In follow-up interviews conducted several months after training, respondents who were working with families experiencing one or more of the risk factors addressed in the trainings responded overwhelmingly that they used the knowledge or information from the training in their work. They explained that they were able to apply strategies they had learned and make referrals when necessary. Several respondents reported referring clients to appropriate resources and others reported growing confidence as a result of training. Expressing the view of a number of respondents, one home visitor told us, "It's important as a home visitor to have a trusting relationship with my participants. I like to talk in a confident manner. I like to have the facts ready to support what you are saying."

Findings about barriers to participating in training were similar to those identified in previous reports, suggesting that despite the growth of training opportunities in more locations, issues of proximity continue to be a challenge. Illinois is a large state and scarce funding limits extensive growth in training location offerings. Other previously identified barriers, such as resource limitations and logistical issues, were once again reflected in this year's findings; however, Strong Foundations-sponsored trainings helped reduce certain resource limitations by covering the training costs for the participants. Programs noted they were aware of this benefit. Yet they cited travel expenses and time requirements for overnight travel as barriers. In addition, spending significant time away from the program affected work responsibilities or was otherwise simply not feasible. Regardless of these issues, programs noted that if at all possible, the Strong Foundations trainings offered by the Ounce were known to be of high quality and staff would take efforts to attend whenever possible.

These findings suggest that training staff should continue to offer trainings in new and diverse locations as resources permit, and should also consider allocating or obtaining resources to support this future expansion. Based on an examination of the geographic spread of the training across home visiting programs, we also recommend that the state and the Ounce's Training Institute continue to monitor this growth and track the spread of trainings to programs identified as active service providers. Further, training providers should explore regions noted on the map where training does not appear to reach to see how better to reach these locations and staff with resources or whether these regions have other reasons for not attending training. Additionally, training providers should explore whether the map of the spread of Big Four trainings is indicative of other trainings offered through the Institute, for example, if similar programs do not attend other trainings. As a self-study program, the HBOB training offers home visitors another means of strengthening professional skills without having to arrange to attend in-person training in a particular location. On the other hand, learning the skills depends on individual motivation and time to complete the program. Although the length of time it took to complete the program varied, staff were enthusiastic about the new information and skills gained from the program and the increased confidence they felt in using new strategies with families. Several reported sharing their experiences informally with their colleagues. However, it is too soon to know whether their enthusiasm and knowledge is being infused throughout their organizations or whether this training opportunity might spread to other programs over time, thereby influencing the wider infrastructure of supports for communities and families.

Program Implementation, Fidelity, and Quality

In light of Strong Foundations’ goal to build infrastructure to support the implementation of evidence-based home visiting programs with fidelity, it is important to understand the fidelity and quality of programs operating in Illinois during the period of the initiative and how they are being supported. Understanding fidelity is critical to understanding whether implemented programs will have the positive effects that have been demonstrated in research. According to Daro (2010) and other researchers (e.g., O’Donnell, 2008; Paulsell, Boller, Hallgren, & Esposito, 2010), fidelity refers to the extent to which a program is implemented as intended and encompasses both structural and dynamic (or process) characteristics. The relationship between the home visitor and the program participant is an example of the dynamics of program fidelity, whereas structural aspects of fidelity include the engagement of the intended population, appropriate caseload sizes and frequency of home visits, and staff qualifications and retention.

In this chapter we present data on the implementation of a sample of 15 programs—seven Parents as Teachers (PAT) programs, six Healthy Families Illinois (HFI) programs, and two Nurse-Family Partnerships (NFP) programs—selected from across the state to be case studies for the evaluation. These findings were drawn from several sources, both quantitative and qualitative. These include monthly data reported by the programs on caseloads, staff turnover, service delivery, and other program characteristics; surveys of home visitors and program supervisors; individual interviews with supervisors and program managers; and focus groups with home visitors. We also discuss some of the contextual factors that can affect the quality and fidelity of home visiting programs, such as local systems designed to improve the coordination and delivery of home visiting programs, and integration of those programs with other services for families with young children.

In developing a sample of local programs, our goal was to select from various regions of the state programs representative of the three evidence-based models that are the focus of Strong Foundations. As described in previous Chapin Hall reports (Spielberger et al., 2011, 2012), the sample of 15 local programs recruited to participate in the evaluation are located in three distinct regions of Illinois: urban Chicago, suburban and collar counties, and rural and downstate areas. In addition to Cook County, the programs serve families in three suburban and seven rural, downstate counties. Although community demographics are changing, the rural and suburban counties tend to be predominantly white (between 75 and 97%), whereas the Chicago area is approximately 44 percent white, 25 percent black, and 24 percent Hispanic (U.S. Census Bureau, 2011).

As intended by their models, the 15 home visiting programs 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 (food assistance for Women, Infants, and Children) 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 who 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. 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.

Staff Characteristics

In the spring of each year of the study, we surveyed supervisors and home visitors in our 15 sites.²⁸ Almost everyone who received a survey completed and returned the survey to us. In 2011, one person who was employed by their program at the time of the survey distribution did not return their survey; in 2012, three such people did not return their surveys.

In the following discussion of staff characteristics, we do not separate supervisors and home visitors when reporting the results. This is because there were few differences between the two groups and because of shifts in staff positions over time. For example, some staff who worked as home visitors in the first or second year worked as both home visitors and supervisors or became supervisors in the third year. All of the respondents were women and the vast majority indicated that they were parents or guardians. In each

²⁸ The exception to this is the one NFP site which recused itself from the study prior to the 2011 staff surveys being distributed. They were invited to complete the staff surveys in 2010 and again in 2012 but not in 2011.

of the 3 years of the study, more than 80 percent responded “yes” to a question that asked if they had ever been a caregiver for a child.

Table 10 provides a summary of various staff characteristics over the three years. We found quite a bit of consistency in all demographic characteristics. For example, in each of the three years, over three-quarters of survey respondents reported being home visitors and one-quarter reported being supervisors.

Additionally, the age of the staff (home visitors) was also consistent, with at least one-third of all survey respondents each year reporting being between 30 and 39 years of age and at least one-quarter of the staff being between 40 and 49 years of age.

The racial/ethnic breakdown of the staff in all three program models also remained similar over time. Almost half of all staff were white, about one-quarter were black and between one-quarter and less than one-third were Hispanic across the three years. With regard to language fluency, staff reporting being bilingual in English and Spanish mirrored the percent of staff reporting being Hispanic. For example, 30 percent of staff in 2010 being Hispanic and 31 percent of staff being bilingual in English and Spanish.

Additionally, staff reported whether they had previous experience as home visiting staff. Between over one-third and over half of staff reported having such experience each year. At least half of all staff in each of the three years reported having at least a bachelor’s degree. The fields in which staff have earned their degrees varied. However, early childhood education/education, social work, and “other” were the most often mentioned fields in each of the three years.

A small proportion of staff responding to the survey reported being enrolled in an educational program at the time of the survey (between 16% and 18%). At least half of those enrolled each year were working toward their masters degrees.

The surveys also asked about staff members’ prior home visiting experience and the number of years of that experience. In each of the 3 years, PAT staff had the least amount of prior experience (with 5.8 years of experience in 2010 and 7.7 years in 2012). NFP staff had the greatest amount of prior experience (6.7 years in 2010 and 10.7 years in 2012). Within each program model, there was a large (but not significant) increase in years of prior experience between 2010 and 2011. Between 2011 and 2012, only PAT showed a (slight) increase in years of prior experience, while the HFI and NFP programs showed a very small, but not significant, decrease in years of prior experience.

Table 10. Characteristics of Program Staff in 15 Home Visiting Programs, 2010–12^a

Characteristics	2010 (N = 76)	2011 (N = 69)	2012 (N = 76)
Program Model (%)			
PAT	41	45	41
HFI	41	42	40
NFP	18	13	19
Role in Program (%)			
Home Visitor	78	75	80
Supervisor or Supervisor/Home Visitor	22	25	21
Age (%)			
Under 20 years	3	0	1
20–29 years	16	17	20
30–39 years	30	39	34
40–49 years	32	22	24
50+ years	19	21	22
Race (%)			
Black	25	26	26
White	43	46	42
Hispanic	30	23	31
Language Fluency (%)			
Bilingual in English-Spanish	31	25	31
Bilingual Other	3	4	3
Previous Experience as Home Visiting Staff (%)	55	46	43
Education level (%)			
Vocational/technical training program	3	2	1
Some college/No degree	9	8	8
Associates degree	23	13	17
Bachelor's degree	49	56	56
Masters/Doctorate degree	17	21	17
Field of study (%)			
Child development	23	21	17
Early childhood/education	20	26	24
Psychology	18	18	17
Social work	20	27	25
Nursing	18	16	17
Other	20	27	26
Number enrolled in education program at time of survey (n)	n = 13	n = 12	n = 12
Enrolled in education program at time of survey (%) ^b	17	18	16

^a Each year all currently employed home visitors and supervisors, and dual supervisors/home visitors were asked to complete the yearly staff survey. In 2011, we did not ask the staff at the one NFP site which had recently recused itself from the study to participate in the staff survey, but we did ask them to participate the following year and they did.

^b Of those individuals who were, at the time of the survey, currently enrolled in an education program, at least half of those enrolled each year were working toward their Master's degree (54% in 2010, 50% in 2011 and 50% in 2012). In 2010, 23 percent were working enrolled in an education programs, but were not working toward a degree. In 2011, 17 percent were working toward a Bachelor's degree and in 2012, 33 percent were working toward a Bachelor's degree.

All of the staff surveyed in all 3 years either completed high school or earned a GED. One significant difference was noted when looking across the models in 2010 ($p < .10$) and again in 2012 ($p < .10$). Staff in HFI programs had a higher percentage of staff who earned a GED than the other two programs. At least 90 percent of staff across all three program models and across all 3 years had earned more than a high school diploma or GED. In 2011, staff across all three models had a nonsignificant, slightly higher percentage of staff without education beyond a high school diploma or GED, but, again, it was a small percentage (10% of PAT program staff and 7% of HFI program staff or 8% of all staff in 2011).

All survey respondents in all 3 years were asked if they were enrolled in an educational program at the time they completed the survey. Very few staff overall (between 16% and 18%) were enrolled in any educational program at the time of the yearly survey, and among staff who were enrolled most were pursuing a master's degree (see Table 10). Those few staff members who were pursuing a degree at the time of our yearly survey also indicated their area of study. The small group of currently enrolled staff from the PAT and HFI programs were more likely to be pursuing degrees in specific types of counseling, such as family therapy or domestic violence counseling, or public administration.

Staff responding to the yearly surveys also reported whether they held a professional license or certification at the time of the survey. In each of the 3 years, between 79 percent and 100 percent of NFP program staff reported being a licensed registered nurse; none of the PAT and HFI staff in any of the 3 years reported being a licensed registered nurse.²⁹ Very few of the PAT and HFI staff reported having any professional license or certification; only 3 percent of PAT staff in each of the 3 years reported being a Licensed Clinical Social Worker (LCSW) and none of the HFI staff did. HFI staff were more likely to report having some other certification.

Job Characteristics, Supervisor and Staff Training

The annual staff surveys also included questions about various job characteristics and staff training; for example, whether a respondent's position had changed, the number of hours worked in a typical week, and whether the survey respondent had completed program-specific training.

Between 74 percent and 81 percent of staff respondents in each year in each program indicated that their primary role at work was that of home visitor. Conversely, between 13 percent and 26 percent of survey respondents reported that they worked as a supervisor or as a dual supervisor/home visitor. Both PAT and NFP staff reported a similar, nonsignificant trend with a slight increase over time in the percentage of respondents reporting to be home visitors, but there was a decrease in the percentage of respondents who reported being either supervisors or dual supervisors/home visitors. HFI staff, however, showed a slightly

²⁹ Again, staff from only one NFP program responded to the survey in the spring of 2011 (year 2).

opposite trend, with a decrease over time in the percentage of survey respondents who reported being home visitors and an increase in the percentage of respondents who reported being supervisors or dual supervisors/home visitors.

Each year, we asked staff to tell us if they typically worked at least 30 hours per week or not. In 2010, we noted significant differences in the percentage of full-time employees of the NFP program versus the percentage of full-time employees at PAT and HFI programs. NFP staff were significantly less likely to work 30 or more hours per week. In 2011 and 2012, this trend continued, but it was not significant. However, NFP staff are closing the gap on the other programs. In 2010, just 64 percent of NFP staff worked 30 or more hours per week; in 2011, 78 percent of NFP staff worked 30 or more hours per week; and in 2012, 87 percent of NFP staff worked 30 or more hours per week. Over the 3 years, between 90 percent (2012) and 94 percent (2010) of PAT staff worked 30 or more hours per week and between 87 percent (2010) and 93 percent (2011) of HFI staff worked 30 or more hours per week. Although we do not know the specific reasons staff do not work more than 30 hours per week, one could assume that some staff may work full-time for their umbrella agency, but not solely as home visitors or supervisors, whereas others might work less than 30 hours per week by choice or due to funding issues at their agency.

Staff Employment Characteristics

In this section we present data on the characteristics of home visitors and supervisors separately. If a respondent noted that she had a dual role as a supervisor/home visitor, then we included her characteristics in the supervisor selection below. If a staff member was a home visitor in 2010 but a supervisor in 2011, then she is included in the 2010 home visitor data and in the supervisor data in 2011.

Home Visitors

According to the NFP model elements, a full-time nurse home visitor should carry a caseload of no more than 25 active clients at a time.³⁰ Caseload size for PAT and HFI programs is determined by the number of visits required each month. The PAT national office has established a maximum of 60 visits per month for full-time parent educators after their first year of employment (48 visits is the maximum during the first year as a parent educator).³¹ Families who are determined to have two or more risk factors receive at least two visits a month; other families are visited only monthly. HFA core standards allow full-time home visitors to serve no more than 15 families at the most intensive service level and no more than 25 families at any combination of service levels.³² With regard to caseload size of our survey respondents, there were no significant differences between programs over time; all of the programs had an average

³⁰ See <http://www.nursefamilypartnership.org/communities/model-elements> (viewed on 12/15/12).

³¹ See http://www.parentsasteachers.org/images/stories/documents/caseload_version_4.pdf (viewed on 12/15/12).

³² See http://www.healthyfamiliesamerica.org/network_resources/is_quality_assurance.shtml (viewed on 12/15/12).

caseload between 15 and 17 families each year. In all three program models, the caseloads in 2012 were slightly smaller than in the first 2 years of the study. In 2012, the average number of families per caseload was between 15 and 16, as opposed to 2010 when the averages ranged from 16 to 17 and in 2011 when the averages ranged from 17 to 18.

Each year, home visiting staff were also asked about the percentage of foreign-born families on their caseloads. Overall, across all programs and all 3 years, a majority of the staff reported having only a small percentage of foreign-born families on their caseloads. About a quarter of the programs each year reported that at least 50 percent of the families in their caseloads were foreign-born. In addition, each year approximately 20 percent of PAT home visiting staff reported that “between 76 and 100 percent” of families on their caseloads were foreign-born families (22% in 2010 and 19% in 2012). This percentage was higher than the percentage of home visitors at either HFI (14% and 9%) or NFP (9% and 15%) who reported that “between 76 to 100 percent” of their caseloads were foreign born. Interestingly, although PAT programs appeared to serve more foreign-born families than the staff of HFI and NFP programs, HFI staff were more likely to report speaking Spanish during home visits.

When home visitors live in the same community as families on their caseloads, they are likely to be more knowledgeable about the community context in which families are raising their children. Home visitors would also know more about available resources for other services. Thus, the annual staff survey asks home visiting staff if they lived in the same community as the families on their caseloads each year. Although about half (between 46% and 65%) of home visiting staff in all three program models did not live in the same community as their caseload families across the 3 years, in 2012, we found significant differences between the HFI programs and the PAT and NFP programs ($p < .10$). Approximately a third of home visiting staff from the PAT (31%) and NFP (39%) programs reported that they lived in the same community as “all or almost all” of their caseload families, while just 17 percent of HFI home visiting staff reported living in the same community as “all or almost all” of their caseload families.

Supervisors

The number of home visiting staff being supervised by supervisors or dual supervisors/home visitors was fairly consistent among the three program models in 2010 and 2011; supervisors reported supervising between three and four staff each year in each program. However, in 2012 we observed an increase in the number of home visiting staff being supervised in the NFP program. In 2010 and 2011, NFP supervisors supervised four home visiting staff, but in 2012 the number of home visiting staff being supervised increased to between six and seven staff. (Some of this difference could be due to the fact that the one NFP site, which had recused itself from the study after the 2010 staff surveys, completed the 2012 staff surveys.) In 2011, PAT and HFI program model supervisors supervised between three and four home

visiting staff. While the differences between the number of home visiting staff being supervised across the three program models are not significant, they are noteworthy.

Supervising staff were also asked to report the number of hours per month they spent supervising home visiting staff (see Table 11). We found significant differences in 2012 across programs. On average, PAT supervisors provided significantly fewer hours (4.3 hours) of formal supervision to their home visiting staff than supervisors at HFI (17.6 hours) or NFP (20.0 hours). Over 3 years of data collection, the supervising staff at the PAT programs have consistently reported fewer hours of formal supervision with their home visiting staff than the supervising staff in the HFI and PAT programs.

Table 11. Hours Spent in Supervision This Past Month over Time^a

Program	2010 (<i>n</i> = 16) Mean (<i>SD</i>)	2011 (<i>N</i> = 17) Mean (<i>SD</i>)	2012 (<i>N</i> = 16) Mean (<i>SD</i>)
PAT	13.0 (8.25)	7.9 (8.10)	4.3 (4.76)
HFI	12.1 (14.02)	17.3 (11.95)	17.6 (8.25)
NFP	29.7 (18.45)	13.5 (14.85)	20.0 (11.31)
Total	15.8 (13.63)	12.4 (10.81)	12.9 (9.79)

^a Each year all currently employed home visitors, supervisors, and dual supervisors/home visitors were asked to complete the yearly staff survey. In 2011, we did not ask the staff at the one NFP site which had recently recused itself from the study to participate in the staff survey, but we did ask them to participate the following year, and they did. The Bonferroni post hoc test, which uses t-tests to perform pairwise comparisons between group means while controlling for overall error rate, indicates that the mean for PAT supervisors is significantly lower than the mean for HFI supervisors ($p < 0.05$) and the mean for PAT supervisors is significantly lower than the mean for NFP supervisors ($p < 0.10$).

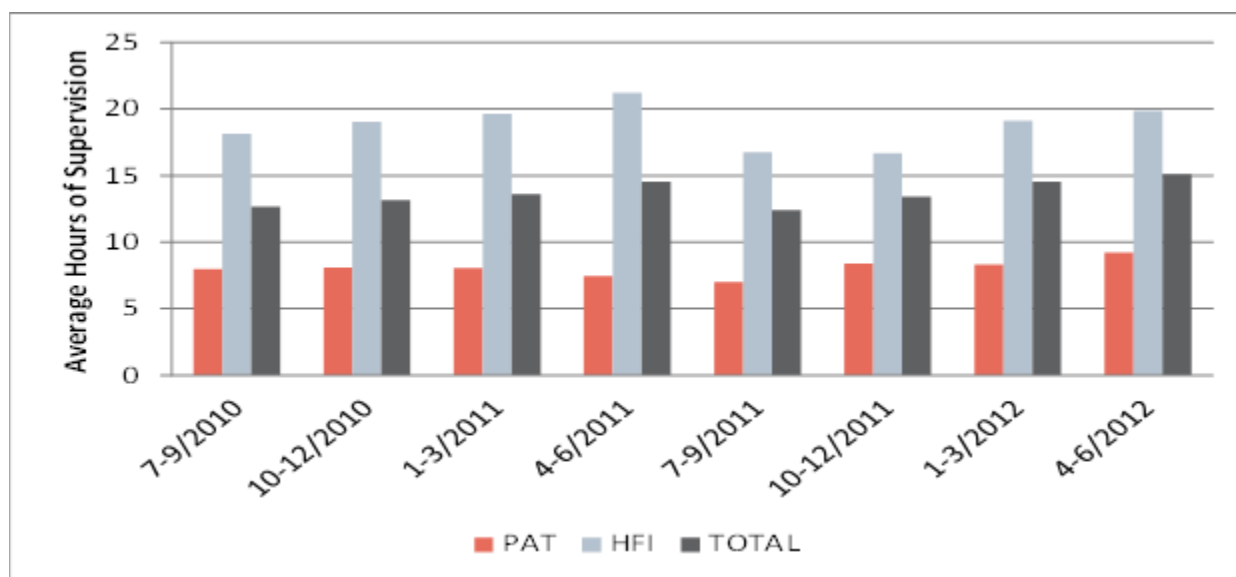
Staff Supervision and Meetings

Staff supervision and all staff meetings are vitally important to the overall success of home visiting programs, as well as to the success of each individual home visitor and her caseload. These meetings provide the home visiting staff with an opportunity to learn from their supervisors and from each other. Supervisors are also provided with the opportunity to help their staff process challenging cases and stay abreast of what is happening in the field and in the community.

Supervision

In their monthly data, the PAT programs reported that their supervisors tended to spend between 5 and 10 hours per month supervising their home visitors, and supervisors in the HFI programs spent about 15 to 20 hours per month supervising their home visitors (see Figure 4). Some of this variation in hours dedicated to supervision each month could be due to program requirements around supervision hours. Another factor potentially impacting the number of hours spent in formal supervision could be whether the home visitors at each program work full time or part time.

Figure 4. Average Number of Hours Supervisors Dedicate to Supervision over Time by Program Model, July 2010–June 2012



PAT: $n = 7$, HFI: $n = 6$, NFP: $n = 1$, Total: $N = 14$

Note: NFP data are included in the TOTAL column only. In 2010, HFI supervisors spent significantly more time in supervision than PAT supervisors (July ($p < .05$), September ($p < .10$), October ($p < .01$), November ($p < .05$) and December ($p < .10$)). In 2011, PAT supervisors spent significantly less time in supervision than HFI supervisors (April ($p < .05$), May ($p < .05$), June ($p < .01$), July ($p < .05$), August ($p < .10$), September ($p < .10$), October ($p < .05$), November ($p < .01$), and December ($p < .05$)). In 2012, PAT supervisors spent significantly less time in supervision than HFI supervisors January ($p < .01$), February ($p < .05$), March ($p < .01$), April ($p < .05$), May ($p < .05$), and June ($p < .05$)).

The amount and quality of supervision was also discussed during the site visits. For the most part, the home visitors did not provide a great amount of detail with regard to what happened in their supervision meetings. However, the overall description of these meetings indicates that at least some time is devoted to going over cases and getting either feedback or suggestions. Many home visitors also spoke about the open door policy they felt their supervisors had with them:

I feel like we have the support through our supervisor, first and foremost, where we usually go to her if we have something.

Any time, she is available by text or phone or she'll constantly be there for us if we need her as far as information or help.

She'll always ask is there anything that we need from her, is there anything she can help us to do, and then her door is open if we have a problem that I can talk to her about. So she gets a lot of walk-ins.

In a few instances the home visitors described some recent changes in the program staff that resulted in them having new supervisors. As can be expected in any organization where there are substantial personnel changes, it takes some time to become accustomed to and familiar with the new arrangement. In certain instances, the home visitors came to rely on each other as an immediate source of support. As

one focus group participant said, “I think we pretty much rely on each other. And if we come back and are like, ‘Hey, this just happened, and I don’t know what to do.’ or ‘What do you think about this?’ And there’s almost always somebody there. You don’t have to go for very long.”

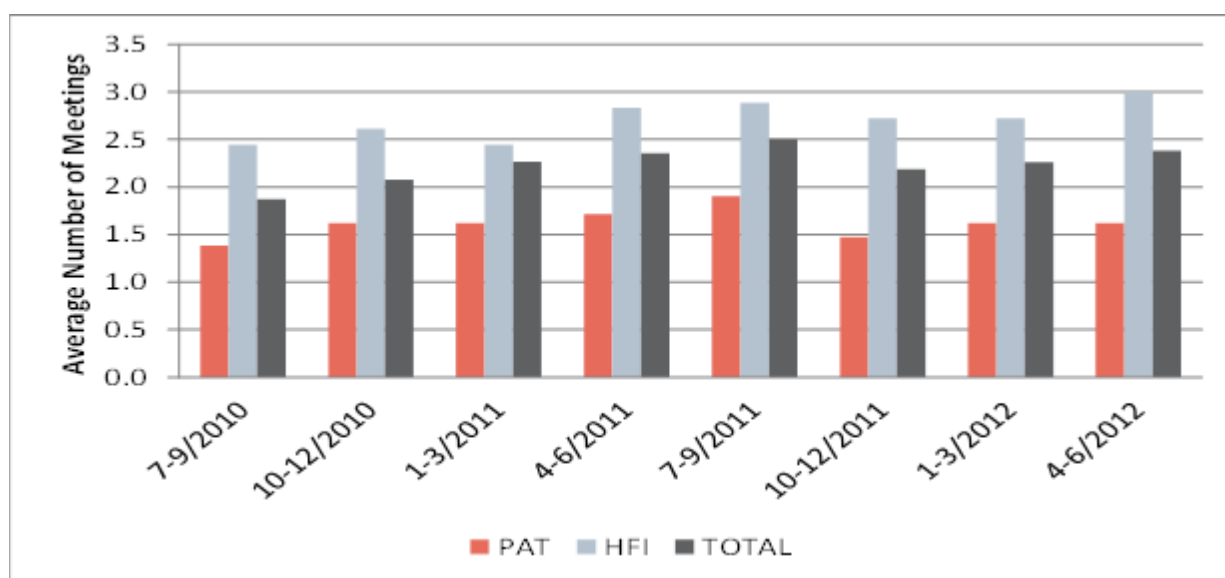
In contrast, supervisors provided a more detailed description of their supervisory meetings. According to their descriptions, most of their time is spent reviewing individual cases, troubleshooting problems, and planning ahead. There was also some emphasis on making sure every case was addressed within a certain amount of time, typically a month. Supervisors also sought to provide emotional support for the home visitor during their supervision times. Reviewing paperwork was also cited, though less frequently, as something done during supervision meetings. Hence, the emphasis of supervision was described with different terminology with regard to its different roles. In terms of personal/professional development, one supervisor said, “The individual supervision is all about the staff member—their professional development.” Supervisors also spoke in bureaucratic terms that emphasize program maintenance: “There are some times that I get more into the documentation, the requirements about the forms, and what I need to see in the file.” They also spoke in emotional terms: “It’s her brag hour or it’s her—you know, not to have burn out time.”

Staff Meetings

The number of staff meetings that occurred each month varied by program model (see Figure 5). PAT programs tended to have the fewest number of monthly staff meetings (typically one staff meeting a month) followed by the HFI programs (typically about two meeting per month). These results are in line with the models’ fidelity requirements.

Even though the PAT programs had fewer staff meeting than the other models, their staff meetings tended to be longer in duration than the other models, their monthly staff meeting tended to last approximately just over two hours (see Figure 6). The HFI staff meetings typically lasted approximately one and a half hours. It appears that PAT and HFI program staff spent a relatively equal amount of time in staff meetings.

Figure 5. Average Number of Staff Meetings by Program Model over Time, July 2010–June 2012

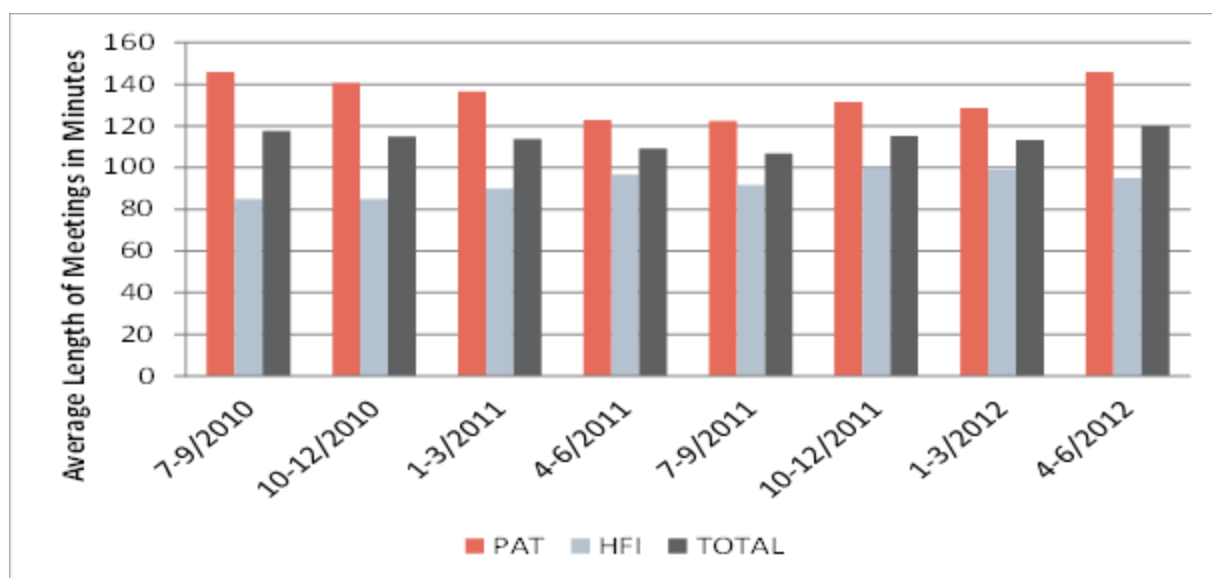


PAT: $n = 7$, HFI: $n = 6$, NFP: $n = 1$, Total: $N = 14$

Note: NFP data are included in the TOTAL column.

Note: In August and November 2010 HFI had significantly more staff meetings than PAT ($p < .05$). In October, November, December 2011 and January and May 2012, PAT had significantly fewer staff meetings than HFI ($p < .10$), and in April 2012, PAT had significantly fewer staff meetings than HFI ($p < .05$).

Figure 6. Average Length of Staff Meetings in Minutes by Program Model over Time, July 2010–June 2012



PAT: $n = 7$, HFI: $n = 6$, NFP: $n = 1$, Total: $N = 14$

Note: NFP data are included in the TOTAL column.

Note: In September, October and November 2010 PAT had significantly longer staff meetings than HFI ($p < .10$).

During their site visit interviews, supervisors elaborated about what is done in staff meetings. The most commonly given purpose for these meetings is to give staff an opportunity to present cases and

brainstorm as a large group on how to solve difficult issues. The multi-purpose content of staff meetings was described as helpful to that end. Staff meetings were also described as a place to connect and talk about logistical issues affecting the whole group. As staff at one program described the meetings:

Every once in a while, everyone will pick a different family, so that's a big reflective. And, that happens once a month. And then we have a developmental pediatrician that's here. So, the social worker, all the therapists, and we brainstorm on what to do with the family.

As with the majority of the programs' "open door" supervisory practice, most program staff also spoke about the camaraderie they shared, which resulted in not having to wait for staff meetings to learn about issues or resources:

The work can be very draining. And we call each other a lot. Like, we'll step out of a visit and we're so overwhelmed by the despair, so we'll call each other and go, "She said this and this and then this happened." We try to help one another. You have to vent; you can't take it home.

Indeed, at one program the staff had to rearrange their desks, and home visitors no longer sat near each other. This took away what the home visitors saw as an important source of support:

It used to be there were four of us in the room and if you needed some emotional support, or you needed to bounce off what would you do with this, all you had to do was like turn and somebody was there. We can still do that, but now I have to walk through somebody else's office to get to the person that I want to talk to.

Although this kind of peer support is important, it is neither formalized nor acknowledged, and hence cannot be leveraged by supervisors to improve the quality of services. It is arguable that peer supervision or instantaneous "open door" supervision could be embedded into programs' procedures, and could result in improving programs' outcomes.

Mental Health Consultants

When available, mental health consultants have provided another source of support for home visiting staff. The consultants offer fresh insight about difficult cases. In that sense, while regular supervision gives room to different demands—some of which are bureaucratic in nature—mental health consultants are able to focus on certain aspects of specific cases. That emphasis was appreciated by supervisors and home visitors alike. Both considered it to be a valuable asset, as one of the supervisors explained:

We've been lucky to have an Infant Mental Health Specialist. When our Workers hit a wall or a challenge we get that additional support and feedback from the Infant Mental Health Specialist. If we have an intense case she helps us to troubleshoot that case.

Staff Training

The overwhelming majority (between 86% and 100%) of staff had completed model-specific training. In 2010, 100 percent of staff in all three program models had completed model-specific training. In 2011, 93 percent of all staff completed model-specific training, with 86 percent of HFI staff, 97 percent of PAT staff, and 100 percent of NFP staff reporting that they had done so. In 2012, 87 percent of NFP staff reported completing model-specific training, whereas 100 percent of HFI staff and 94 percent of PAT staff reported completing the training. None of these differences were statistically significant. The lower rates of completion of model-specific training in 2011 and 2012 were most likely the result of new staff being hired shortly before the time of the annual survey and before they had the opportunity to complete their model-specific training.

In Table 12, we show the comfort level of staff across the three program models with their knowledge of domestic violence, substance abuse, adult developmental disabilities, and adult mental health problems in each year of the survey. No statistical differences were noted between the programs, but each year program staff from each of the three program models reported the greatest level of comfort with their knowledge of domestic violence and the least level of comfort with their knowledge of adult mental health problems and adult developmental disabilities.

Table 12. Comfort Level with Knowledge^a

	PAT Mean (SD)	HFI Mean (SD)	NFP Mean (SD)	Total Mean (SD)
2010				
Domestic violence	3.4 (0.50)	3.1 (0.85)	3.0 (0.00)	3.2 (0.67)
Substance abuse	3.0 (0.69)	3.0 (0.82)	2.8 (0.45)	3.0 (0.72)
Adult developmental disabilities	2.8 (0.66)	3.1 (0.76)	2.8 (0.45)	2.9 (0.69)
Adult mental health issues	2.7 (0.67)	3.0 (0.79)	2.8 (0.84)	2.9 (0.74)
2011				
Domestic violence	3.3 (0.65)	3.5 (0.51)	3.0 (0.71)	3.3 (0.60)
Substance abuse	3.1 (0.54)	3.2 (0.62)	3.0 (0.71)	3.1 (0.59)
Adult developmental disabilities	2.9 (0.68)	3.2 (0.62)	3.0 (0.71)	3.0 (0.66)
Adult mental health issues	2.8 (0.62)	3.1 (0.57)	2.8 (0.84)	3.0 (0.63)
2012				
Domestic violence	3.3 (0.58)	3.5 (0.51)	3.4 (0.55)	3.4 (0.54)
Substance abuse	3.2 (0.71)	3.1 (0.57)	3.2 (0.45)	3.2 (0.61)
Adult developmental disabilities	2.8 (0.92)	3.2 (0.81)	2.4 (0.55)	2.9 (0.86)
Adult mental health issues	2.8 (0.86)	3.2 (0.62)	2.8 (0.84)	3.0 (0.76)

^a Sample includes 45 staff who responded all 3 years to the survey.

For each item, 1 = Very uncomfortable; 2 = Uncomfortable; 3 = Comfortable; and 4 = Very comfortable.

We also asked in which of the four topics staff would like to receive additional training. No statistical differences between program models were noted in any of the 3 years. However, we noticed a trend with regard to the issues of adult mental health problems and adult developmental disabilities. Staff across all three program models indicated that they would like to receive more training in both of these areas (see Table 13). This aligns with staff feeling less comfortable with their knowledge in these areas.

Table 13. Percent of Respondents Wanting More Training^a

	PAT	HFI	NFP	Total
2010				
Domestic violence	47	45	25	44
Substance abuse	42	55	50	49
Adult developmental disabilities	47	60	25	51
Adult mental health problems	63	70	75	67
2011				
Domestic violence	68	67	60	67
Substance abuse	68	76	60	71
Adult developmental disabilities	74	91	60	80
Adult mental health problems	84	91	60	84
2012				
Domestic violence	53	24	20	36
Substance abuse	26	33	20	29
Adult developmental disabilities	58	67	80	64
Adult mental health problems	63	71	60	67

^a Based on the sample of 45 staff who responded to the survey each year.
Chi square differences statistically significant at $^{\wedge}p < .10$, $*p < .05$, $**p < .01$, and $***p < .001$.

As described earlier, the trainings sponsored by Strong Foundations in three of the Big Four topics—domestic violence, perinatal depression, and substance abuse—were implemented during the 2010–11 program year. The fourth training topic, parents with learning challenges, was introduced during the 2011–12 program year. Thus, in the second and third years of the annual survey, we asked program staff if they had attended a Strong Foundations enhanced training. Overall, there was an increase from 2011 to 2012 in the percentage of staff across the programs who had participated in training on the topics of domestic violence, perinatal depression, and substance abuse (see Table 14). Additional differences were found in training attendance by program model. In 2011, staff at the PAT programs (21%) were significantly less likely to have attended the Strong Foundations’ training on perinatal depressions than were staff at HFI (57%) or NFP (40%) programs. Additionally, staff at HFI (71%) programs were significantly more likely to have attended the Strong Foundations’ enhanced training on substance abuse as compared to PAT (16%) or NFP staff (0%). As shown in Table 14, in 2012, HFI staff were more likely to have attended these three topic trainings than were the staff at the PAT or NFP programs.

Table 14. Percent of Respondents Who Reported Participating in a Strong Foundations Training in SFY 2011 and SFY 2012

	PAT	HFI	NFP	Total
2011 (N = 45)				
Domestic violence	26	52	20	38
Perinatal depression [^]	21	57	40	40
Substance abuse***	16	71	0	40
Young adults with learning challenges	—	—	—	—
2012 (N = 45)				
Domestic violence***	32	81	0	51
Perinatal depression [^]	42	71	20	53
Substance abuse**	37	86	20	58
Young adults with learning challenges	21	38	0	27

Chi square differences among programs is statistically significant at [^] $p < .10$, * $p < .05$, ** $p < .01$, and *** $p < .001$.

Staff Satisfaction

A job satisfaction survey was provided to all home visiting and supervising staff responding to the survey in each of the 3 years. The responses presented in Table 15 are from the 45 staff, across all three program models, who responded to each of the 3 years of surveys. This job satisfaction survey was a 12-item survey in 2010 and 2012; in 2011, it was a 14-item survey. In all 3 years, program staff were asked to use a four-point scale ranging from “very dissatisfied” to “very satisfied” to respond to each item. In all 3 years, all program staff were at least “satisfied” with the various aspects of their job that were included on the surveys. The lowest ranked item among all program staff in all 3 years was “salary and benefits.” The top three items all program staff ranked highly in 2010 continued to be highly ranked in 2011 and 2012.

Looking within the 2010 survey, we found ten items that were significantly different across home visiting models. Most of the differences show that NFP program staff were significantly less satisfied than the staff at PAT and HFI programs. Particular items with noteworthy differences included “your interactions with parents,” “being valued for your work,” and “opportunities for professional development.” This trend continued in 2011 and 2012, although there were fewer items that were significantly different across the three program models. In addition, there were two items, “cultural sensitivity of your workplace” and

Table 15. Mean (SD) Satisfaction Levels with Job Aspects over Time^a

	Mean (SD) Satisfaction Level ^b			
	PAT	HFI	NFP	Total
2010				
The support you receive from coworkers	3.5 (0.77)	3.7 (0.48)	3.2 (1.30)	3.5 (0.73)
Your interactions with parents*	3.6 (0.51)	3.7 (0.73)	2.6 (0.89)	3.5 (0.73)
The quality of training you receive*	3.5 (0.62)	3.5 (0.60)	2.6 (1.14)	3.4 (0.73)
Cultural sensitivity in your workplace [^]	3.2 (0.43)	3.7 (0.48)	2.8 (1.10)	3.4 (0.62)
The supervision you receive	3.3 (0.58)	3.5 (0.60)	2.8 (1.10)	3.3 (0.67)
Being valued for your work**	3.3 (0.56)	3.6 (0.50)	2.2 (1.30)	3.3 (0.76)
Physical working conditions**	3.3 (0.46)	3.5 (0.51)	2.4 (0.89)	3.3 (0.62)
Your influence on the program*	3.2 (0.60)	3.6 (0.51)	2.4 (0.89)	3.3 (0.69)
Your influence on parent-child interactions [^]	3.4 (0.52)	3.6 (0.54)	2.3 (1.16)	3.3 (0.73)
Your workload*	3.2 (0.50)	3.4 (0.50)	2.4 (0.89)	3.2 (0.62)
Opportunities for professional development***	3.3 (0.65)	3.4 (0.67)	1.8 (0.84)	3.2 (0.82)
Salary and benefits*	2.4 (0.78)	3.1 (0.66)	2.5 (1.00)	2.8 (0.80)
2011				
Your interactions with parents	3.6 (0.50)	3.6 (0.51)	3.3 (0.50)	3.6 (0.50)
Your influence on parent-child interactions	3.5 (0.51)	3.7 (0.48)	3.3 (0.50)	3.6 (0.50)
The support you receive from coworkers	3.3 (0.48)	3.3 (0.48)	3.6 (0.55)	3.4 (0.48)
The quality of training you receive*	3.2 (0.54)	3.5 (0.60)	2.6 (0.55)	3.3 (0.62)
The supervision you receive	3.4 (0.50)	3.3 (0.55)	3.4 (0.55)	3.3 (0.52)
Cultural sensitivity in your workplace	3.2 (0.42)	3.3 (0.58)	3.2 (0.45)	3.3 (0.50)
Your influence on the program	3.2 (0.54)	3.3 (0.48)	3.0 (0.00)	3.2 (0.48)
Physical working conditions	3.0 (0.49)	3.2 (0.60)	3.0 (0.00)	3.1 (0.52)
Your workload*	3.1 (0.40)	3.2 (0.54)	2.6 (0.55)	3.1 (0.51)
Opportunities for professional development	3.1 (0.66)	3.0 (0.74)	2.4 (0.89)	3.0 (0.74)
Being valued for your work	3.0 (0.75)	3.1 (0.57)	2.8 (0.45)	3.0 (0.64)
Salary and benefits	2.4 (0.61)	2.8 (0.70)	2.8 (0.84)	2.6 (0.68)
2012				
Your interactions with parents	3.6 (0.51)	3.8 (0.44)	3.3 (0.50)	3.6 (0.49)
Your influence on parent-child interactions	3.4 (0.77)	3.7 (0.46)	3.3 (0.50)	3.5 (0.63)
The support you receive from coworkers	3.3 (0.73)	3.2 (0.77)	3.8 (0.45)	3.3 (0.73)
Cultural sensitivity in your workplace	3.2 (0.75)	3.4 (0.74)	3.0 (0.00)	3.3 (0.70)
The quality of training you receive	3.2 (0.76)	3.3 (0.57)	3.0 (0.71)	3.2 (0.67)
Physical working conditions	3.1 (0.97)	3.1 (0.65)	3.0 (0.00)	3.1 (0.75)
Being valued for your work	2.9 (0.73)	3.3 (0.66)	2.6 (0.55)	3.1 (0.71)
The supervision you receive	2.9 (0.62)	3.3 (0.58)	3.0 (0.71)	3.1 (0.63)
Your influence on the program*	3.0 (0.58)	3.3 (0.72)	2.4 (0.89)	3.0 (0.71)
Your workload	2.9 (0.68)	3.1 (0.48)	2.6 (0.55)	3.0 (0.59)
Opportunities for professional development	2.8 (1.07)	2.9 (0.72)	2.6 (0.55)	2.8 (0.86)
Salary and benefits	2.4 (0.68)	2.8 (0.89)	2.6 (0.55)	2.6 (0.78)

Chi square differences among programs is statistically significant at [^] $p < .10$, * $p < .05$, ** $p < .01$, and *** $p < .001$.

^a The sample is 45 staff who responded to all 3 years of the survey.

^b For each item: 1 = Very dissatisfied; 2 = Dissatisfied; 3 = Satisfied; and 4 = Very satisfied.

“salary and benefits,” that were significantly different between PAT program staff and HFI program staff. HFI program staff were more satisfied than the PAT program staff on both items.³³

Looking within the 2010 survey, we found ten items that were significantly different across home visiting models. Most of the differences show that NFP program staff were significantly less satisfied than the staff were at either the PAT and HFI programs. Particular items where these differences were noted included “your interactions with parents,” “being valued for your work,” and “opportunities for professional development.” This trend continued in 2011 and 2012, although there were fewer items that were significantly different across the three program models. In addition, there were two items, “cultural sensitivity of your workplace” and “salary and benefits,” that were significantly different between PAT program staff and HFI program staff. HFI program staff were more satisfied than the PAT program staff on both items.³⁴

Program Implementation, Quality, and Fidelity

Below, we present findings related to the operation, quality, and model fidelity of our sample of 15 home visiting programs from administrative data on program operations and surveys of supervisors and home

³³ These comparisons were conducted using the Bonferroni post hoc test, which uses t-tests to perform pairwise comparisons between group means while controlling for overall error rate. For 2010, results indicate that the mean for “your workload” is significantly different between NFP and PAT ($*p < .05$) and between NFP and HFI ($**p < .01$); “the quality of training you receive from coworkers” is significantly different between NFP and PAT ($*p < .05$) and between NFP and HFI ($*p < .05$); “opportunities for professional development” is significantly different between NFP and PAT ($***p < .001$) and between NFP and HFI ($***p < .001$); “being valued for your work” is significantly different between NFP and PAT ($**p < .01$) and between NFP and HFI ($***p < .001$); “cultural sensitivity in your workplace” is significantly different between HFI and PAT ($\wedge p < .10$) and between HFI and NFP ($**p < .01$); “physical working conditions” is significantly different between NFP and PAT ($**p < .01$) and between NFP and HFI ($**p < .01$); “salary and benefits” is significantly different between PAT and HFI ($*p < .05$); “your influence on the program” is significantly different between NFP and PAT ($*p < .05$) and between NFP and HFI ($**p < .01$); “your interactions with parents” is significantly different between NFP and PAT ($*p < .05$); and between NFP and HFI ($**p < .01$); “your influence on parent-child interactions” is significantly different between NFP and PAT ($\wedge p < .10$) and between NFP and HFI ($*p < .05$). In 2011, the Bonferroni post hoc test indicates that the mean for “your workload is significantly different” between NFP and HFI ($*p < .05$) and “the quality of training you receive” is significantly different between NFP and HFI ($*p < .05$). In 2012, the Bonferroni post hoc test indicates that the mean for “your influence on the program” is significantly different between NFP and HFI ($*p < .05$).

³⁴ These comparisons were conducted using the Bonferroni post hoc test, which uses t-tests to perform pairwise comparisons between group means while controlling for overall error rate. For 2010, results indicate that the mean for “your workload” is significantly different between NFP and PAT ($*p < .05$) and between NFP and HFI ($**p < .01$); “the quality of training you receive from coworkers” is significantly different between NFP and PAT ($*p < .05$) and between NFP and HFI ($*p < .05$); “opportunities for professional development” is significantly different between NFP and PAT ($***p < .001$) and between NFP and HFI ($***p < .001$); “being valued for your work” is significantly different between NFP and PAT ($**p < .01$) and between NFP and HFI ($***p < .001$); “cultural sensitivity in your workplace” is significantly different between HFI and PAT ($\wedge p < .10$) and between HFI and NFP ($**p < .01$); “physical working conditions” is significantly different between NFP and PAT ($**p < .01$) and between NFP and HFI ($**p < .01$); “salary and benefits” is significantly different between PAT and HFI ($*p < .05$); “your influence on the program” is significantly different between NFP and PAT ($*p < .05$) and between NFP and HFI ($**p < .01$); “your interactions with parents” is significantly different between NFP and PAT ($*p < .05$); and between NFP and HFI ($**p < .01$); “your influence on parent-child interactions” is significantly different between NFP and PAT ($\wedge p < .10$) and between NFP and HFI ($*p < .05$). In 2011, the Bonferroni post hoc test indicates that the mean for “your workload is significantly different” between NFP and HFI ($*p < .05$) and “the quality of training you receive” is significantly different between NFP and HFI ($*p < .05$). In 2012, the Bonferroni post hoc test indicates that the mean for “your influence on the program” is significantly different between NFP and HFI ($*p < .05$).

visitors. Data on program operations, staff, and families served were collected on a monthly basis from each of the participating Illinois sites using a form created by the MPR-Chapin Hall cross-site evaluation team and adapted by Chapin Hall over a 2-year period, July 2010 through June 2012. Additional data on fidelity and program quality come from interviews and focus groups with program staff. It should be noted that, for the Healthy Families Illinois (HFI) and Parents as Teachers (PAT) sites, we have monthly data dating back to October 2009. However, data for the two Nurse-Family Partnership (NFP) programs only date back to January 2011, and one of the NFP sites was only able to provide data in January, February, and March 2011.³⁵ Thus, we include data from the one NFP site in our aggregated findings, but, for reasons of confidentiality, do not present individual data for this program model.

Model Certification

Each month the sites were asked to report whether “your program [has] been certified by your national model.” Responses were received from all seven PAT programs and all six HFI programs.³⁶ Although HFI uses the term “accreditation” and PAT uses the term “commendation,” all of the HFI and PAT programs indicated an official connection to their national model by responding “yes” to this question each month and then providing the date on which they were certified. During site visit interviews some HFI supervisors and program managers reflected on the time-consuming, but beneficial, HFA credentialing process. For example, one program manager explained, “accreditation really helped us take a look [at how long families stay on Level One] more closely because before, we were looking at [families staying on Level One for up to] for the first nine months to a year... but there’s no reason to do that.” At another point in the interview, she noted that through the accreditation process she and her staff realized that they had not been adhering to all aspects of fidelity. She explained, “We hadn’t been doing everything. But now that we are doing it and it’s in place, it’s not as dramatic and it’s fine.”

PAT has begun looking at fidelity more stringently, beginning with its new curriculum requirements. As discussed in the previous section on training and technical assistance, PAT has instituted a new curriculum and requires all “affiliates”—that is, programs that implement the curriculum with model fidelity—to be trained in and utilize the curriculum by 2014. A state-level informant familiar with the new requirements explained, “This new curriculum requires much more reflection in putting together the plans on a regular basis for working with families. So it requires a higher level of reflection and maybe a

³⁵ We began collecting these data in December of 2010, asking sites to report data back to October 2009. Although we treat these data as reliable and accurate for the purpose of this report, we could not verify them. More recent data were and continue to be reported on a monthly basis. We cannot verify the data as they are being collected, but we are able to follow up on data that seem inconsistent or inaccurate; thus, we have more confidence in the accuracy of data from October 2010 forward.

³⁶ All NFP programs, by definition, are certified by their national model.

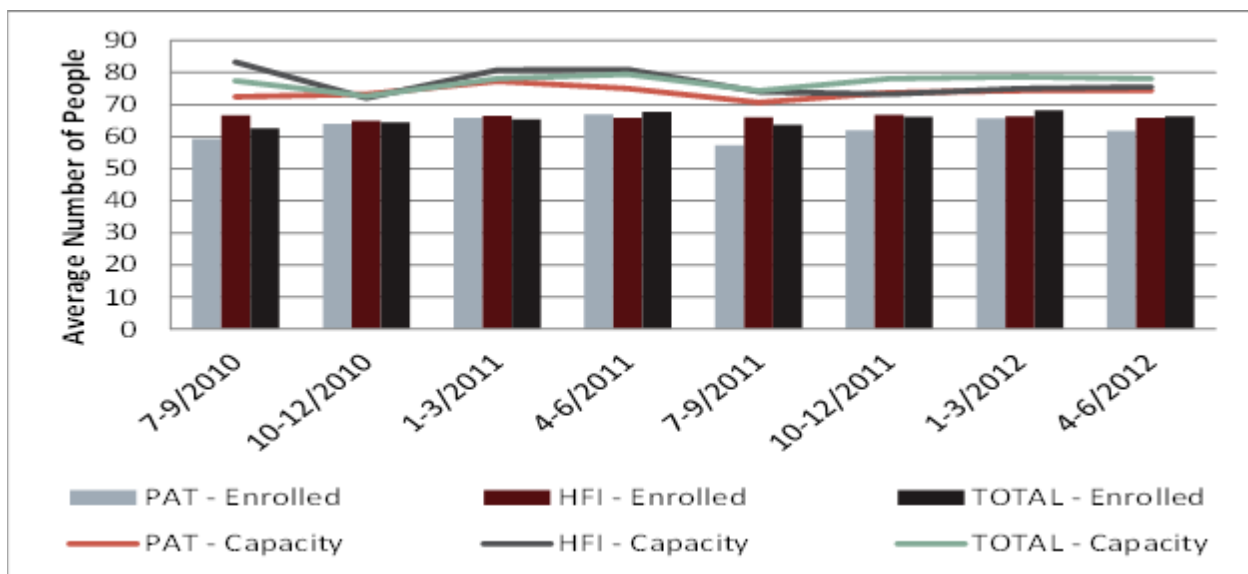
higher level of skill. There's a lot of opportunity to help the family reflect on [their situation]. It's a really collaborative process."

Program Capacity

Figure 7 displays both the maximum capacity of each program model as well as the "currently enrolled" families by quarter. The PAT and HFI programs' current enrollment remains just under their programs' maximum capacity steadily over time.

Sites also reported whether or not they had experienced a change in capacity each month. Although there were few changes to overall capacity during the 2 years of data reporting, there was some fluctuation across the 2 years (see Figure 8). Most of the changes in capacity were the result of program modifications, staff changes, or family changes. As indicated in the monthly program data collected, programs' modifications included: closing of a site in a multi-site program; changes in case weights, levels, or "points" because of changes in participants or participant characteristics; and, changes at the agency level that, in turn, affected program staffing. For example, some respondents reported that their program was down-sizing or that changes in how caseloads were weighted and counted resulted in capacity changes. One of the HFI providers highlighted the complexity of calculating enrollment capacity while using the HFI point system: "Full time staff can carry 25 clients with 1 part-time staff carrying 20 clients, however [this has] to convert to points." Another provider reported, "We reduced caseloads from 24 to a range of 20 to 22 to improve quality. Also one [home visitor] went from 40 hours to 30 hours."

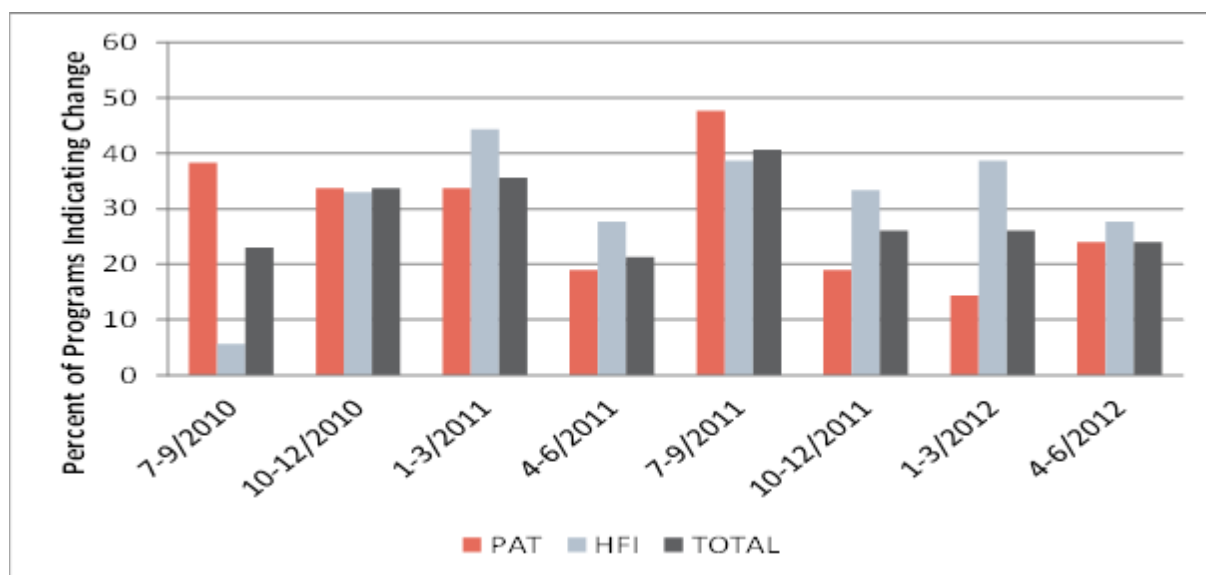
Figure 7. Average Capacity and Enrollment of Families by Program Model over Time, July 2010–June 2012



PAT: $n = 7$, HFI: $n = 6$, NFP: $n = 1$, Total: $N = 14$

Note: NFP data are included in the TOTAL line and column only

Figure 8. Percent of Programs Indicating a Change in Capacity by Program Model over Time, July 2010–June 2012



PAT: $n = 7$, HFI: $n = 6$, NFP: $n = 1$, Total: $N = 14$

Note: NFP data are included in the TOTAL column only

Note: In March 2012 the one NFP program and two HFI programs noted a change in capacity while none of the PAT programs noted such a change ($p < .05$).

At the staff level, capacity changes came about because of families terminating services, staff resigning or leaving the program for other reasons, or the hiring of new staff who needed training before assuming a full caseload. In a few instances, changes in staffing (e.g., the return of staff who had been on maternity leave) also affected program capacity. During focus groups and supervisor interviews, a number of home visiting staff across programs reflected on how a lack of stable and sufficient funding has impacted their programs' capacity and caseload sizes.

We've done that whole roller coaster thing: lay off, come back, lay off, come back. It's devastating because you've got to close [families] out. And then when you come back you've got to start all over. It takes *forever* to build a caseload—forever.

Our program was very big when I started. I think we had maybe 11 or 12 people, 2 supervisors, and 10 full-time workers. Everybody had a full caseload. Now, she and I are the only full-time staff here.

[Coworker] and I were not called back to the program until three weeks into the school year. So we couldn't start the birth-to-three program until well into September.

Additional capacity issues resulted from changes at the family level, such as the completion of services, a decrease in the level and frequency of visits, or departure from the program for other reasons. As one informant reported, "We have open enrollment and gain/lose families all the time." One program

described how changes in the demographics of families referred to the program resulted in participants with shorter tenures:

For the most part, they were all very similar—low educated and young. Now we’re all over the board and it’s very difficult to maintain the clients. It’s different working with a 15-year-old who has no support versus a 28-year-old who has a bachelor’s degree and a full-time job. When you have the older people, they’re like, “I’m way too busy. I have too much to do.” That wasn’t an issue before. We didn’t have an attrition problem for the most part until we neared the end of services. We didn’t get this right at the beginning like now.

Home visiting staff most often pointed to their families’ transient situations as the major factor that influenced changes in enrollment. Home visitors across all three of the study’s geographic regions noted the difficulty of keeping up with some families who moved frequently or “couch surfed” from one home to the next. Home visitors also noted that some families move out of a program’s eligible service area.

We tend to have families that move around a lot, so we lose some because of that. And they can’t pay for their phones, or their numbers change, and just all sorts of things that make it hard [to follow families].

You wouldn’t believe what we go through to find these people. It’s like looking for a needle in a haystack. And even after you’ve gotten them, I can’t tell you how many times I have to go on my phone and change to this new number and that new number.

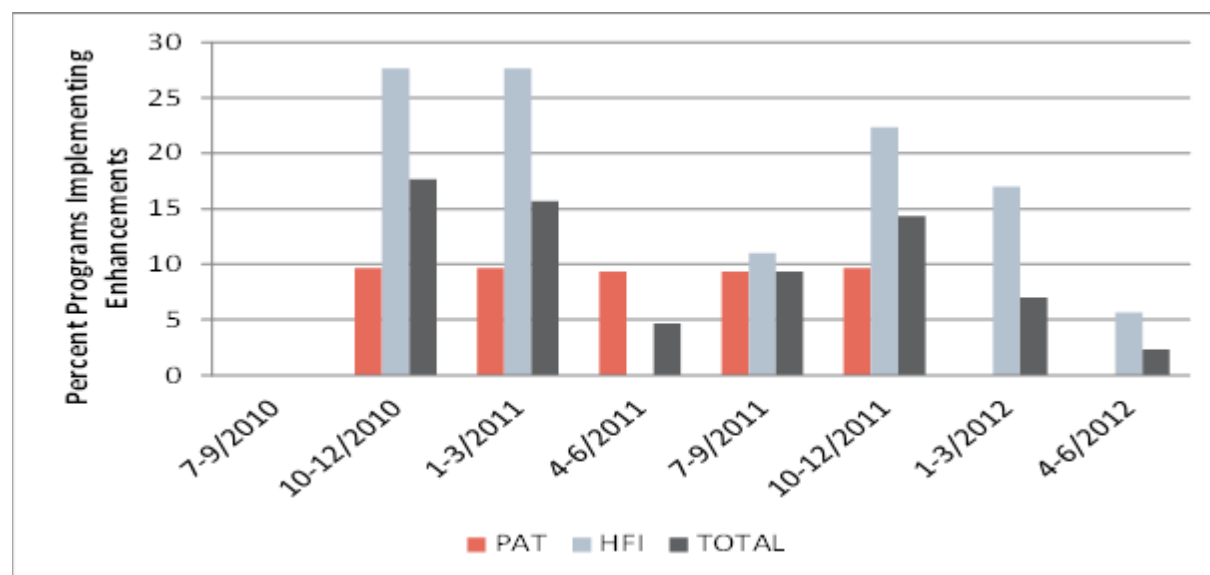
Those who are higher risk sometimes tend to move a lot and it’s understandable. They’re just trying to move where they have more support or where they can find the resources that they need.

It [how long a family stays with the program] doesn’t have anything to do with the age of the baby or when they came in or anything. It’s more about their purpose and what else is going on in their life. And how “at-risk” they are. The more “at-risk” they are, then the shorter the timespan they stay with me. The less “at-risk” they are, the more they stay.

Program Enhancements

Each month, programs also reported on enhancements they made. As shown in Figure 9, the percentage of programs that made any enhancements over the past 2 years was fairly small—on average, about 10 percent of the programs reported enhancements each quarter. The planned program changes that occurred tended to fall into one of five basic categories: administrative enhancements, staffing changes, training opportunities for staff, additional program components or curriculum, or other enhancements.

Figure 9. Percent of Programs Implementing Program Enhancements by Program Model over Time, July 2010–June 2012



PAT: $n = 7$, HFI: $n = 6$, NFP: $n = 1$, Total: $N = 14$

Note: NFP data are included in the TOTAL column only

Some of the reported administrative enhancements referenced changes in caseload weights and staff assignments; others reflected new referral sources and linkage agreements. For example, one program reported “a collaboration with new obstetrician that will be sending referrals to program.” Another reported “our program has established linkage agreements within our service area and re-established prior linkage agreements.”

Staffing changes were noted as enhancements by a number of programs and included the addition of staff to improve services, such as the appointment of a “public health director [who] will begin having supervision one time per month with the [program model] coordinator,” or the addition of “services of [an] infant early childhood mental health consultant.” Other sites noted the addition of staff to provide specific programs services such as “[a] group services specialist with the intention of increasing frequency and improving intensity of our group services” and “our program [added] 2 new home visitors at our [location] site; 1 part time and 1 full time.”

Sites also noted various training opportunities as program enhancements. For example, some sites noted when new staff completed program-specific training, which allowed these new staff to work with families. Other sites noted when staff earned their certification on screening tools such as the Ages and Stages Questionnaire (ASQ) or the Otoacoustic Emissions (OAE) instrument for hearing screening, or when staff completed training in other vital services that benefit their families such as CPR, automated external defibrillator (AED), choking, and basic first aid training.

Another commonly noted type of enhancement included the addition of components or curriculum to the programs. These types of enhancements included lending libraries, the receipt of a state funded car seat grant or the addition of services from an infant mental health consultant. Curriculum enhancements included such things as an 8-week HIV/AIDS curriculum, breast feeding peer counseling; a GED program, including childcare and transportation; and various other curricula available from each program's national model.

Participant Referrals

Each month sites reported the number of families who were referred to the program, and, of those referred, how many met their program's criteria for enrollment. Of those who met their program's criteria for enrollment, sites reported how many families actually enrolled in their services. Over the 2 years of data being reported here for PAT and HFI sites, the referrals remained fairly consistent with at least one and no more than about 20 families typically referred to the programs per month. Usually, HFI programs had more families referred to them than PAT programs did; this could be due to the fact that PAT program staff are typically expected to do more of their own recruiting than HFI program staff are. Recruitment issues and strategies were a much-discussed topic during the focus groups and supervisor interviews. A number of home visitors, from all three program model types, discussed these activities with a "whatever it takes" attitude, and listed a number of conventional and unconventional ways in which they work to find new clients:

We have gone to more than two dozen providers of schools with information about [our services].

I'm the crazy person that sees pregnant people in Walmart and says, "Have you been in the WIC office?" That's what you need to do. Just go to Walmart and walk around the pregnant people.

We are on the street flagging them down, basically. We have gone through the neighborhoods passing out flyers before. Sometimes the flyers end up on the ground, and sometimes they don't.

We went to a food pantry and we passed out flyers there and everything to promote the agency.

Some of the home visiting programs are colocated in agencies that offer other services to families. The proximity to another service offers additional recruitment opportunities, including adult education (GED and ESL classes) and child care services. As one home visitor shared, "A lot of families come in because they're interested in child care. And so that becomes part of our recruiting tool."

The most commonly cited source of referrals was word of mouth or self-referrals, such as clients who heard about home visiting services from family members or friends. As one home visitor noted, "Our girls spread the word more probably than anyone else." Home visitors also indicated WIC offices and health care providers as being two other common sources of their referrals, across all geographic regions.

When talking about referrals to their programs, different agencies emphasized different strategies. Some providers discussed referrals more in terms of outreach and recruiting; others talked about referrals more in terms of existing structures, relationships, and collaborations with other organizations. As highlighted in last year's Strong Foundations report (Spielberger et al., 2012), one of the counties with Strong Foundations study programs has a strong local collaborative history. The members of the collaborative saw their home visiting referrals shift in response to a change in the county's federal qualified health centers (FQHC) and family case management (FCM) providers. The home visiting provider that had been co-located with the FCM program saw its referrals drop, while the home visiting provider that was co-located in an agency that took on FCM and FQHC responsibilities saw its referrals rise. During interviews and focus groups with the four study sites in that county, we asked about the current status of the collaborative and the programs' referrals. An individual familiar with the collaborative's history and administration shared her perspective of the ongoing work:

We maintained the collaborative and we are working on some things that go beyond just doing the referrals together. For example, we just did a joint ASQ training. We have redesigned our flowchart for the referrals, because the family case management programs are now [in different agencies] and there is a whole different dynamic to getting those home visit referrals. [Because] home visit referrals from the case management agencies have decreased over the last 6 months, we're setting up dialogue sessions between home visit staff and the five family case management [FCM] sites. Home visitors from any program in that particular FCM community are welcome to attend the dialogue sessions. The goal is to talk about what intensive home visiting is and how it differs from family case management. We're taking the approach that dialogue will help the case managers understand what they are referring to and help them make it attractive to the client. On the flip side, the home visitors said they want to know more about what the case managers do so they can know about referrals. We are also keeping the home visiting collaborative abreast of all MIECHV work happening [nearby] with the idea that if there's something that works well, the rest of the Collaborative might want to adopt it down the line.

Two other members of the collaborative indicated that their home visiting programs still received fewer referrals from the collaborative and FCM since the change in the countywide system; however, their outreach efforts had improved and they received referrals from other sources. One supervisor explained, "Families are finding ways to get to our services, with the outreach that we do. We have new collaborations with doctors, clinics, and people who care about the families, because the main concern is the families." Other program supervisor shared similar comments, "Once family case management transferred to the FQHC, the referral stream lessened. But, we're better with referrals than we were last year. We've been doing a lot of marketing around and we've been doing a lot of calculation and focused

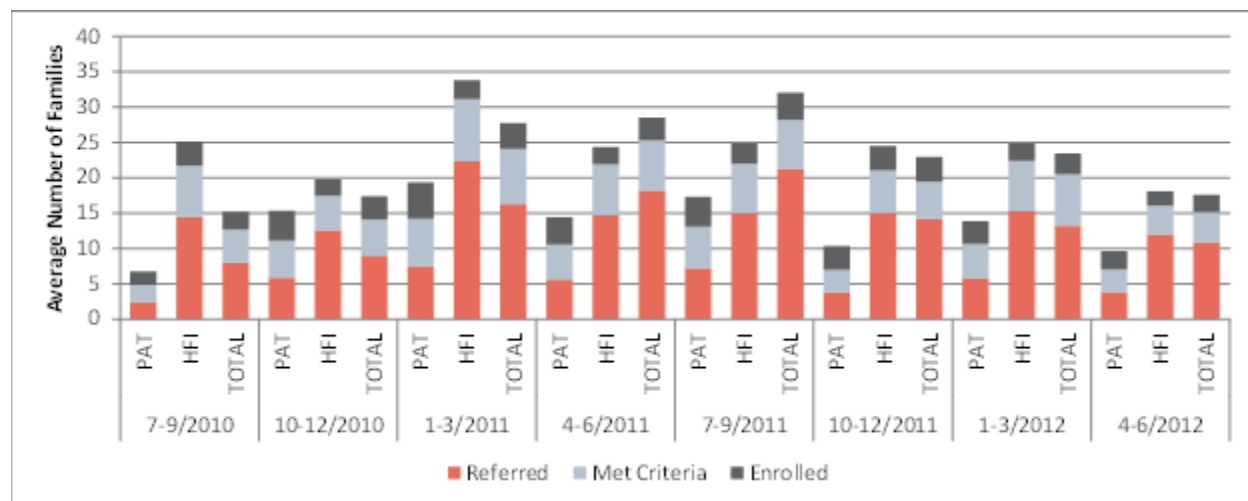
activities.” As was the case last year, the agency that took on the family case management continues to see an uptick in their referrals:

Because the family case management program is now located in our same building, we literally get first dibs on referrals and we never have an issue of filling caseloads. If there’s someone that’s at higher risk one of the case managers will literally walk over and say, “Here’s your referral. I really think you would benefit from the program.” And it’s been really beneficial having them in-house, to say the least.

Participant Enrollment

As seen in Figure 10, even though many families can be referred to programs, not all families meet the specific criteria required for program enrollment. For example, some programs only serve teen mothers, or prenatal women, or first-born children, or families living in specific geographical areas, or some other criteria. Typically the PAT and HFI programs had between 2 and 9 referred families who met their program’s criteria for enrollment each quarter. The number of families who actually enrolled in the programs was typically about half of the number of families who were eligible to enroll in services.

Figure 10. Average Number of Families Newly Referred, Met Criteria, and Enrolled in Program by Program Model over Time, July 2010–June 2012



PAT: $n = 7$, HFI: $n = 6$, NFP: $n = 1$, Total: $N = 14$

Notes: NFP data are included in the TOTAL column only. In August ($p < .05$) and September ($p < .10$) 2010, HFI had significantly more families referred to them than the PAT programs. In August 2010 HFI had significantly more families who met their eligibility requirements than PAT ($p < .05$). In August and November 2010, HFI had significantly more families enroll in their programs than did PAT ($p < .10$). In June and July 2011, NFP had significantly more families enroll in their program than did PAT or HFI ($p < .05$).

Engagement

Once a family is found to have met a program’s eligibility requirements, the focus shifts to engaging the family with the program’s services. Home visiting staff shared the numerous innovative and traditional

strategies that they employ to engage families and connect them with other needed services. During focus groups and interviews, the most commonly discussed method of engagement and retention was the use of incentives. These incentives take a variety of forms, including gifts cards, field trips, and supplies:

The goodies are an incentive to allow us in. They're an incentive to continue, because if I attend so many meetings, I'm going to get a \$10.00 gift card from Walmart. If you have the [home visitor] come out a dozen times, we praise, we support, we may be able to give you something or we may not. We make no promises.

They have a punch card and every time they come to an event, we punch it. When they have ten angels, we give them a \$10.00 Walmart gift card.

We go on outings in the summer so they never know when we're going to go. We went to [the] aquarium one year. Those are the perks that come up. I think everyone does a good job as far as engaging the families.

Our incentive program with the teen moms is where the young ladies are able to earn points to buy different products such as Pampers, wipes, lotion, different things that they need for themselves and their child. They're able to earn points doing different things, like coming to group, or volunteering to do different services.

The home visiting staff expressed a wide range of opinions about the value of these incentives. Some home visitors saw them as beneficial, both in terms of increasing program participation and in giving participants something they would like or could use. Other home visitors expressed discontent that their programs did not have funding to provide incentives and saw this as a detriment to their programs. Still other home visitors viewed incentives as a negative influence, or at best a necessary evil. These home visitors shared their belief that incentives draw participants into the program who do not really want to be there and mask what they see as the actual benefits of home visiting. As one home visitor explained, "I don't like the expectation of, 'Oh, I met you the whole month so I can get diapers now, right?' It's like, 'No.'" Another home visitor told us, "We did an incentive-type program, but we really found that the clients that were going to participate were going to be there regardless of if we gave them something. And the clients who wanted that \$10.00 gift card would be there long enough to get their \$10.00 gift card, and then they would go."

Outside of incentives, the home visiting staff members shared the challenges and joys of staying connected with the families they serve. As detailed in the section on enrollment, the transient nature of many of the families served by home visiting programs often makes it difficult for home visitors to keep track of their clients' whereabouts and contact information. Many home visitors remarked upon the seemingly constant change in their clients' cell phone numbers and access. Ironically, home visitors also reported having the opposite problem with cell phones—that cell phones make them overly available to

their clients. As one home visitor noted, “They have your personal cell phone number which means they are calling you at inopportune times. There is a real struggle with boundaries.” Another home visitor from a different program echoed that, saying, “If you want a day off, if you seriously honest to goodness want a day off, you have to shut your phone off. You have to tell these girls, ‘I’m on vacation.’ I get phone calls and text messages at 3:00 and 4:00 in the morning.”

Logistical challenges are another issue with which home visitors contend as they work to engage their families. Many of the programs have specific hours within which the home visitors were allowed to make home visits. In some cases, this leads to problems if parents are working or in school during those set times. Two home visitors from different programs and geographic regions described these problems. One said, “A lot of my moms work. They work in full-time jobs, working the same hours that I do and it’s like when do we have time to do a home visit?” The other home visitor said, “I have a family that wants to be in the program, but the mom’s work hours are 8:00 to 5:00, and while I’m willing to stay the two days a month, the office that I’m in, the building, closes down early.” In other programs, home visitors talked about working less traditional hours, either starting early or working late in order to accommodate their families.

Another frequently-cited challenge of home visiting was the amount of travel necessary for the work. This was most frequently discussed by downstate home visitors, but was also mentioned by home visitors in the other regions. Home visitors lamented the amount of time it takes to travel for home visits. A sample of comments include: “I might spend four hours of my day just traveling to and from visits,” and, “We’re pretty much spread out, and sometimes we find the struggle is driving from visit to visit.” Travel is a difficulty not just for the time it requires, but because of its financial impact. One home visitor expressed the difficulty she and her coworkers share, “I think we struggle with having vehicles to use for travel and the price of gas. They haven’t raised our mileage rate. A working minivan is the technical support that we need right now.”

As part of learning about how the home visiting staff engages their families and provides curricula-based information and services, focus group questions included asking about adherence to their planned curriculum. In response to the question of how often they needed to change their home visit plans because the family was going through some sort of crisis, respondents agreed fairly consistently that they were able to facilitate their planned curriculum about half of the time. For the most part, these disruptions were treated as par for the course and accepted as part of the job. As described by some home visitors:

If you go in today and the girl’s having a meltdown over something, whatever you brought in with you goes out the window and you deal with the crisis you need to deal with.

There are times you have to deal with other economic problems. Like sometimes the lights are off or you go into a home and they have no gas in the winter. It's like, "Maybe we shouldn't do a parent/child activity. Let's figure out how to get your gas back on."

Connecting families to other community resources is an important aspect of home visiting. Connections with and awareness of other community agencies is critical for home visiting programs to be able to help families meet their needs. As described earlier, the home visiting programs in one of the geographic regions of the study participate in a home visiting collaborative, through which they share resource information. Two of the programs in that same region added that they also learn about resources through their area's All Our Kids (AOK) Early Childhood Network, a collaborative effort among IDHS, the Maternal & Infant Health Bureau, ISBE, local health departments and agencies; and community members serving very young children and their families. In other regions, programs described relationships (either existing or being built) with other agencies or organizations that kept them abreast of service resources to which they can refer their clients. One program talked about periodic meetings by their area's health department: "They came in and did a talk with us to let us know about their resources that are available and how the process would go to nominate somebody for their resources. I think it was a very good program." Another program described the relationships they have with four WIC offices through which they exchange information about resources. Yet another program described an effort to get home visitors to meet in person across agencies to better support their work: "We had, what was it called, 'Worker to Worker' or 'Visitor to Visitor' meetings. We had at least three of them." Home visiting staff also described learning about resources as part of their own outreach efforts and by checking for online information.

In some instances, providing resources and referrals presented challenges for the home visiting staff. As one worker shared, "They always want things that we can't provide. We can get them the resources, but they think that we can get them jobs. Every time I try to recruit somebody, they ask, 'Can you give me a job?' That's a hindrance right there." Another difficulty for the home visitors and their clients is the extensive delays encountered in obtaining services. This problem seems especially prevalent for mental health referrals:

It's already hard to convince parents to go for mental health services, but once you refer them they pour themselves out to the intake worker and then nothing happens. There's a huge lapse of time in between.

Some [parents] don't think they need it. But the ones that you encourage to get it, then you don't really have anywhere to send them to. If I say okay, get it and they call somewhere, there's a three-month wait. It's like what's the point.

In addition to the long waits, some service providers have requirements that put an undue burden on their clients, making receiving services all but impossible:

Well, let's not even talk about Link. For me, it's really confusing because some moms live with their moms and they're able to receive food stamps, whereas other moms live with their moms and they are denied food stamps. You appeal and you fight, but the answer is no and nobody seems to be able to tell you what the exact policy is.

The biggest thing is they will help the families with their utilities, but they need to turn in everyone's Social Security number. In some households not everybody has [a Social Security number]. Or the person that is actually working and earning money doesn't have one.

Despite these challenges, as mentioned in the staff satisfaction section earlier, home visitors and their supervisors enjoy most aspects of the jobs and are committed to the families and communities they serve. Indeed, the home visitors wanted to make it clear that they love and care about their work despite the difficulties and limitations of the job. As one home visitor shared, "I don't think any of us here want to give you the idea that we don't like home visiting because everybody here thinks it's wonderful." Another home visitor in another region simply stated, "We love our programs." Because of the dedication to their work, these home visitors often go to incredible lengths to help families, despite limited resources. One explained, "We're so creative, because we have such little resources and we make the best out of those little resources that we have." Another home visitor added, "We will do whatever we have to for our clients. We will just keep on going until it just can't be done anymore."

One of the most frequently cited strengths of the home visiting services was the positive impact on the mothers in the programs. By being connected with resources and supported through home visits, these moms are able to accomplish a number of things, including gaining increased independence and confidence, finishing school, finding work, and staying off drugs. Home visitors across regions and programs shared examples of these successes. One indicated, "We work with them for three years and some of them are able to find jobs. Some of them are able to go back to school. Some of them are able to find or reconnect with friends." Another home visitor said, "I've noticed that a lot of my clients are actually graduating from high school. They are actually considering going to college and they actually doing it." A third home visitor related, "A lot of them, it's been ten years that they've had a drug problem. I have a few like that, but they're wonderful moms now. They're amazed."

Home visitors at one site told a story of a client who had particularly strong outcomes:

I have to tell you about my superstar. When I first started working with her and her child, who has some developmental issues, our conversations went like this, "So how are you doing today?" "Okay." "Anything new at school?" "No." Then I told her about a subsequent pregnancy prevention program

and asked her if she would be interested in learning more about it. In one-word answers she indicated that she would and we called together right then. Now it's like, oh my goodness. She's speaking in front of groups at high schools about birth control, about her experience with her pregnancy as a teen mom, and making choices for yourself.

In addition, some home visitors talked about their programs' positive impacts on their clients' parenting abilities as a strength of the programs. One said, "I like that we get a chance to help the parents and give them resources and advocate for them. Teach them social development to learn how to interact with each other as well as with their children." Another said, "The biggest strength is how holistic it is. We look at research-based child development information and bring it to the parent according to the child's development and we look at the family's short term and long term goals." A third home visitor added, "She said, 'I'm a good mom.' I don't know if a year ago she would have said, 'I'm good at that.'"

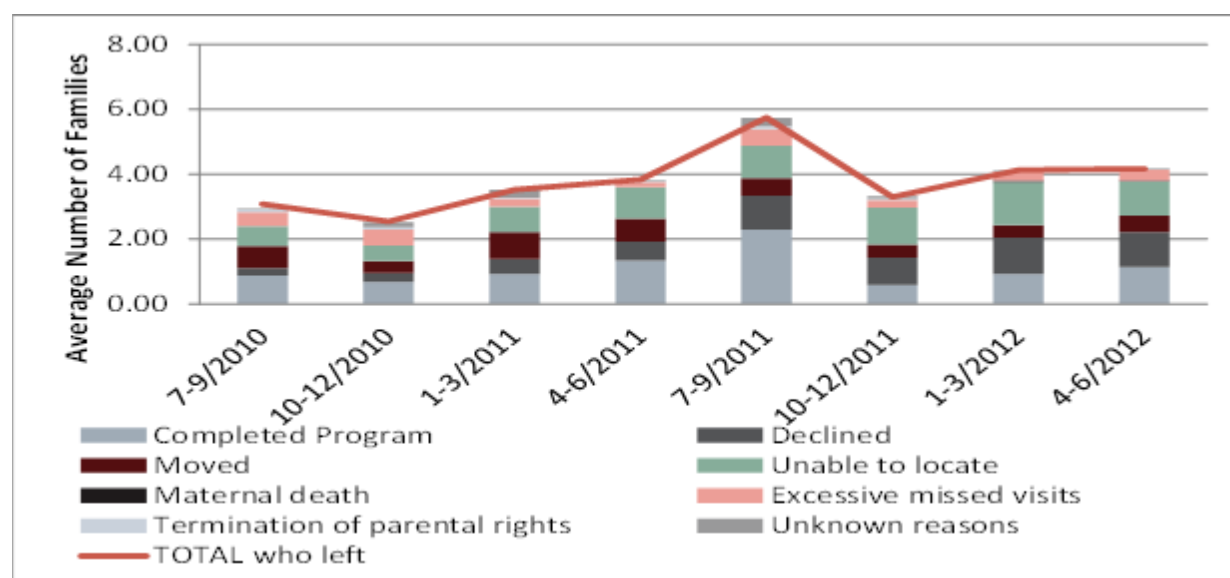
These positive outcomes are partially the result of another program strength—the fact that home visitors are an unconditional source of support for their clients:

And they know that they can call us. No matter what the problem is, they can call us. Even if they screw up and we have to tell them, 'We want you to choose the right thing, but we don't ruin your life. You get to make your own decisions. And we're going to help you from there, whichever decision you make.'" So just having someone that's there unconditionally [is important].

Termination Reasons

In their monthly data, programs also reported on the families who left their respective programs between July 2010 and June 2012 (see Figure 11). On average, between two and six families left their programs each quarter. The most often cited reason for families leaving their programs was "program completion," followed by "families who moved" or families who the program "could not locate." The spike in families leaving their programs between July and September 2011 could be related to the spike in new families being referred for services during the same time period.

Figure 11. Average Number of Families Who Left Their Programs over Time, July 2010–June 2012



During the site visits we asked about if families are referred after their children age out of the program and if so to where are they referred. The most common responses were to Early Head Start and Head Start programs. Also mentioned were pre-K and the local school districts. In at least one instance the program manager highlighted her concern that her geographic region was devoid of age-appropriate services for the families who graduate from her program. She noted,

As NFP we do not have the option of maintaining a family until the child is three or five. We have to graduate when the baby turns two. Now in our area where there are no other home visiting services, very minimal affordable pre-school or independent day care options, that doesn't meet the need.

Summary

Monthly reports from 14 of the 15 programs in our study sample indicated that during a 2-year period, SFY 2010 and SFY 2011, enrollment was almost always just below capacity. Although there were small fluctuations from month to month (e.g., there was an increase in new enrollments and terminations during the summer of 2011), capacity and enrollment tended to stay fairly stable over time. Reasons for changes in capacity included the enrollment of new participants and closing of cases, changes in client levels, the addition of clients, and seasonal variations (e.g., for programs that do not operate during the summer, staff stop home visits at the end of the school year and resume them at the beginning of the next school year).

Engagement and enrollment of new families varied from program to program for various reasons, including differences in family needs and the eligibility guidelines and capacity of the three model programs. Like with changes in capacity, there also were seasonal and regional variations. Overall, about

half of those referred were found to be eligible for services. Likewise, families leave programs for a variety of reasons. The reasons for closing a case varied from month to month during this time period; the more commonly noted reasons were completion of the program and inability to locate a family or a family moving. We also observed some variations in termination reasons by program model. For the HFI and PAT programs, the most commonly cited reasons for families to leave the programs were program completion, families moving out of the program catchment area, and programs not being able to locate the families. The NFP programs, however, most often cited not being able to locate the families, followed by families completing the program and families declining further participation.

Additional, qualitative data drawn from focus groups with home visitors indicate ongoing challenges to keeping high-risk families engaged in services (although they also provided many examples of “success.”) Home visiting staff most often pointed to their families’ transient situations as the major factor that influenced changes in enrollment. Home visitors across all three of the study’s geographic regions noted the difficulty of keeping up with some families who moved frequently or “couch surfed” from one home to the next. Home visitors also noted that some families move out of a program’s eligible service area.

Administrative Data Study: Trends in PAT and HFI Program and Family Characteristics

The Strong Foundations initiative was designed to enhance the state infrastructure of supports to home visiting programs and local system development. This enhancement, in turn, is intended to improve the implementation and quality of home visiting services for families as well as their access to other community-based services. Improved program quality and service access, in the long term, is expected to result in better outcomes for families. Thus, one component of the Strong Foundations evaluation is an examination of available administrative data on home visiting program characteristics (e.g., caseloads and family demographics), use of other early childhood services, and child outcomes over time before and during the initiative.

Using administrative data records to track home visiting program practices and the implementation of evidence-based models in Illinois is not an easy task. The three program models are being implemented in different scales, and the data collection procedures across these models vary widely. The Nurse-Family Partnership (NFP) program maintains high-quality data covering a broad array of background information and program activity, but with only two sites in Illinois during the period of observation, detailed reporting cannot be included here because of concern over appropriate levels of privacy. The Parents as Teachers (PAT) program is the largest of the three models, touching almost five times as many children at any given time as Healthy Families Illinois (HFI), the next largest. PAT has been working to encourage use of a centralized data collection resource, but participation by local programs is voluntary. Thus, the only comprehensive data we use are from the internal annual aggregate reports generated within the PAT system. The HFI program presents our best data resource, as the Illinois Department of Human Services (IDHS) tracks much program activity in its Cornerstone database. The availability of much individual,

event-level information in Cornerstone affords us the opportunity to aggregate smaller bits of data into the pictures that we choose to present. Thus, for practical reasons, HFI is the focus of our administrative data study.

Below, we begin with a discussion of trends, using available data from the PAT national office for a 3-year period starting in state fiscal year (SFY) 2009. We then present an analysis of data describing the HFI program drawn from the IDHS Cornerstone data system and links to child maltreatment based on data from the Illinois Department of Children and Family Services (DCFS) system.

Parents as Teachers Annual Program Reports 2008–11

Characteristics of Families and Children Served

The national PAT office provided annual program report (APR) data for Illinois programs for three program years (SFY 2009, 2010, and 2011).³⁷ Some of the data categories remained consistent over the 3 years, while other data elements were modified from year to year. The tables in this section include all Illinois programs for which we have data in any year. When applicable, table notes below each table outline changes to how data elements were collected. We note similarities and differences between the state-level data provided by the national office and the data we collected for the seven PAT sites participating in the local evaluation below.

During the 3-year period, programs across Illinois served between 11,540 and 13,184 families and between 13,900 and 16,310 children. On average, programs served a mean (*SD*) number of families ranging between 62 (65.3) and 68 (74.0) families and between 76 (81.7) and 85 (95.5) children per program. This corresponds with the monthly fidelity data reported by the seven programs in the local evaluation, which indicates that those programs served between 55 and 65 families and had a maximum capacity between 70 and 80 families during each of quarters for which we have data.

Table 16 also displays selected characteristics of the children and families served. In each of the three years, the largest proportion of children served was white (35–49%), with black children the second-largest (28–36%). Less than a quarter of the children in any of the three years were Hispanic (20–23%). With regard to the families served, just 10 percent or less participated in the program prenatally. With regard to the percent of 2-year-old children who were fully immunized. The majority of 2-year-old children are fully immunized with programs reporting, on average, between 86 and 89 percent of their 2-year-olds being fully immunized. (Just 7 programs in 2008–09 and one program each in 2009–10 and in 2010–11 reported that none of their 2-year-old children were fully immunized.)

³⁷ As part of recent changes to the PAT curriculum, PAT programs now complete Affiliate Performance Reports (APR).

Table 16. Race/Ethnicity of Children Served by Illinois PAT Programs over Time

	SFY 2009	SFY 2010	SFY 2011
Programs responding (N)	193	193	176
Families served (N)	13,184	11,947	11,540
Mean (SD)	68.3 (74.0)	61.9 (65.3)	65.6 (66.8)
Range	5–460	5–403	0–357
Children served (N)	16,310	14,633	13,900
Mean (SD)	84.5 (95.5)	75.8 (81.7)	79.4 (78.5)
Range	5–569	5–467	4–478
Race/Ethnicity of children served (%)^a			
Black	28	36	32
White	42	49	35
Hispanic	20	21	23
Other	6	16	8
Unknown	7	4	1
Families starting services prenatally (%)	10	8	7
2-year-old children fully immunized (%)	89	88	86

^a Percentages for racial/ethnic groups total more than 100 percent, but it is not clear if these are the result of data entry errors, the fact that more than one response could be entered for a given child, or another reason. Additionally, in 2009–10 race/ethnicity data was collected differently than in the other 2 years. In 2009–10, programs reported the number of children who were Hispanic and non-Hispanic. For each group, the program then reported the number of children who were black, white, Asian, Hawaiian or Pacific Islander, American Indian or Alaskan Native, multi-racial and other. For 2009–10, we used PAT’s Hispanic count and then combined Hispanic and non-Hispanic Black, Hispanic and non-Hispanic White, etc. In 2010–11, PAT asked programs to provide the number of Hispanic children, and then the number of non-Hispanic black children, non-Hispanic white children, etc.

For the 3 years of APR data, programs across Illinois reported the number of families in which there was at least one foreign-born parent. As shown in Table 17, the percent of families included in this count is rather small ranging from 14 to 15 percent across the years. The percentage of families in PAT programs across Illinois where Spanish is the primary language spoken in the home was around 20 percent. This could be due to having other family members living in the home who only speak Spanish or due to having native-born parents who still prefer to use Spanish in the home. The seven PAT programs participating in the local evaluation reported having just 10 percent or fewer families with at least one foreign-born parent. On the other hand, the seven programs reported having a greater percentage (between 17% and 27%) of parent educators who use Spanish in their home visits, suggesting the percentage of families where Spanish is the primary language spoken in the home might be slightly higher.

Programs were also asked to provide the number of families who had one or more of a variety of characteristics (see Table 18). Families could be included in multiple categories. The list of data categories changed slightly from year to year, but data were consistently collected on 15 characteristics each of the 3 years. At least three-quarters of the families were identified as being “low income” and between one-third and half were identified as being “single-parent households.” About a quarter of the families were identified as “low educational attainment,” “teen parents,” “speakers of other languages,” or

as having “involvement with mental health or social service agencies.” The other 9 characteristics programs were asked about in each of the 3 years were attributed to fairly small percentages of families.

Table 17. Nativity of Families Participating in Illinois PAT Programs over Time

	SFY 2009	SFY 2010	SFY 2011
Programs responding (<i>N</i>)	193	193	176
Families served (<i>N</i>)	13,184	11,947	11,540
Mean (<i>SD</i>)	68.3 (74.0)	61.9 (65.3)	65.6 (66.8)
Range	5-460	5-403	0-357
Families with at least one foreign-born parent (%)	14	15	15
Spanish is the primary language spoken at home (%)	20	19	19

Table 18. Characteristics of Illinois PAT Families over Time

	SFY 2009	SFY 2010	SFY 2011
Programs responding (<i>N</i>)^a	193	193	176
Families served (<i>N</i>)	13,184	11,947	11,540
Low income (%)	74	75	84
Single-parent household (%)	36	42	50
Low educational attainment (%)	31	33	35
Teen parents (%)	22	23	27
Speakers of other languages (%)	21	21	21
Involvement with mental health or social service agencies (%)	21	23	20
Transient (%)	8	11	11
Child with disabilities (%)	7	7	7
Parent with disabilities (%)	5	5	6
Ongoing health problem of child, parent or sibling (%)	6	5	6
Involvement with the corrections system (%)	5	5	5
Low birth weight (%)	5	5	5
Chemical dependencies (%)	3	2	3
Referred to PAT because of suspected child abuse and/or neglect (%)	2	2	3
Death in the immediate family (%)	1	1	2
Court appointed legal guardians (%)	--	1	3
Very low birth weight (%)	--	--	1
Military family (%)	--	1	1
Foster parents (%)	2	2	--
Relative who is the primary person in the parent support system (%)	6	5	--
Children with serious behavioral concerns (%)	4	4	--
Multiple children under age 5 (%)	11	10	--
Uninsured (%)	4	--	--
Homeless or resided in shelter for at least part of year (%)	6	--	--

^a The number of programs responding to individual items varied. In 2008–09 responses for individual items ranged from 138 (Chemical Dependencies) to 185 (Teen Parents). The number of programs responding in 2009–10 for individual items ranged from 120 (Chemical Dependencies) to 185 (Single Parents); The number of programs responding in 2010–11 for individual items ranged from 154 (Chemical Dependencies and Referred to PAT because of suspected CA/N) to 172 (Low income).

Characteristics of Parent Educators

PAT programs across Illinois provided some descriptive data about their parent educators in their APRs. We have at least some information on between 599 and 690 Illinois parent educators. As shown in Table 19, over three-quarters of all parent educators are employed full time and over three-quarters have earned at least a Bachelor's degree. The yearly staff surveys collected for the local evaluation indicate that 90 to 94 percent of parent educators in PAT programs worked 30 hours or more. This suggests that more of the parent educators in the local evaluation are employed full time, although there could be discrepancies in how "full time" is defined in the two data sets. Like their statewide counterparts, at least three-quarters of the parent educators in the local evaluation have also earned at least a Bachelor's degree.

Full-time parent educators provided, on average, 23.6 (17.2) visits per month; the number of visits provided by full-time parent educators ranged from none to 100 visits.³⁸ Those parent educators who provided no visits were presumably new parent educators who were not assigned to participating families at the time of the APR. Part-time parent educators typically delivered one-third of the visits that full-time parent educators delivered.

Finally, programs across the state were asked to provide the number of parent educators who were bilingual, Spanish-speaking, and male (see Table 19). Less than one-quarter of parent educators were bilingual and slightly fewer than that were Spanish-speaking. A somewhat greater percentage of parent educators in the seven programs in the local evaluation are bilingual and Spanish-speaking compared to parent educators across Illinois (25% vs. 31%). Very few of the parent educators were male, with the largest percent of male parent educators being on staff in Illinois in 2008–09 (7%).

Additional Services Provided

In addition to personal visits with each family on a parent educator's caseload, parent educators also link their caseload families to various community resources, coordinate group meetings with all families enrolled in their PAT program, and undertake other activities. The APR collected information on the total number of group meetings provided to families each year. There were between 11,212 and 12,782 group meetings provided during each of the 3 years of data, which means that on average there were approximately 1,000 (between 934 and 1,065) group meetings held each month across the state of Illinois. Programs conducted approximately 5 group meetings per month in each of the 3 years of data.

³⁸ Comparable data for our sample of PAT programs are not available, because we do not know which staff are full or part-time.

Table 19. Characteristics of Illinois PAT Parent Educators over Time

Staff Characteristic	SFY 2009	SFY 2010	SFY 2011
Parent Educators (N)	599	690	685
Employed full time (%)	77	79	77
Employed part-time (%)	23	21	23
Parent Educators' Education Level (N)^a	599	672	682
Less than Associate's Degree (%)	14	13	12
Associate's Degree (%)	19	13	14
Bachelor's Degree (%)	60	57	57
Master's Degree (%)	17	15	15
Beyond a Master's Degree (%)	4	2	3
Monthly visits provided			
<i>Full-time Parent Educators</i>			
Mean (SD)	23.6 (17.2)	27.4 (15.8)	30.9 (16.7)
Range	0–100	0–60	0–72
<i>Part-time Parent Educators</i>			
Mean (SD)	8.5 (9.4)	25.7 (16.5)	10.6 (11.5)
Range	0–36	0–60	0–48
Parent Educator Cultural Sensitivity			
Bilingual parent educators (%)	20	15	18
Spanish-speaking parent educators (%)	19	13	16
Male parent educators (%)	7	1	2

^a The percentages for education level add up to more than 100 percent. This might reflect the fact that more than one response was provided for some staff, or the way data were reported for part-time and full-time staff (including staff who were full time for part of the year and part-time the other part of the year). As noted below, the number of responses varied for each item reported in the table:

The number of programs responding for 2008–09 ranged from 47 (Beyond a Master's degree) to 191 (How many parent educators are bilingual and how many are male?)

The number of total parent educators for 2008–09 comes from adding the total number of full time parent educators' education and part-time parent educators' education as the variable Total parent educator's education was 58 less than the total when added. Full time and part-time status for 2008–09 was not collected outside of education and ethnicity. We used the part-time and full time status associated with education level as the sample was larger.

Education levels for 2008–09 were created by adding the totals provided for full time and part-time. However, doing so must include 79 parent educators twice, therefore the percentage totals to 114 percent. Our discussion is based on 2009–10 and 2010–11 data only.

191 programs responded to the questions about bilingual and Spanish-speaking parent educators in 2008–09, while 189 programs responded to the male parent educators question. These sample numbers were used to calculate the percents.

One program noted 4,044 visits provided by part-time parent educators in 2009–10; this program was not included in the analysis. The part-time number for 2009–10 do not appear to be accurate, this discussion is based on 2008–09 and 2010–11 data. The number of programs responding to questions in 2009–10 ranged from 56 (Beyond a Master's degree) to 193 (Total parent educators in your program)

The number of bilingual parent educators for 2009–10 had 188 programs responding, but Spanish-speaking and Male parent educators had 187 programs responding. These sample sizes were used to calculate the percents.

The number of programs responding for 2010–11 ranged from 71 (Beyond a Master's degree) to 176 (Total parent educators in your program)

All of the cultural sensitivity items in 2010–11 had an sample of $n = 173$

About two-thirds of families enrolled in Illinois PAT programs were linked to community resources each year (see Table 20). Of the families that the Illinois PAT programs worked with each year, about half

were newly enrolled that year, while a little more than one-quarter of the families exited during the reporting year. The monthly fidelity data collected in the local evaluation indicate that those 7 PAT programs had a slightly higher number of families (between 40 and 45 families) enrolling per year and also more families (between 42 and 49 families) leaving each year as compared to the rest of the state. The reasons for the difference between enrollment and termination figures in the two samples are not clear. It is understandable that the number of families enrolling in the 7 programs might be larger than the number leaving due to the start of new programs and a desire for programs to be close to, but not over, capacity. However, we would have expected that the two numbers would be closer together—as they are in our sample of 7 programs—than the data for the Illinois programs indicate. These data might reflect more programs across the state that were farther below capacity or more programs that have been unable to terminate families from the programs at a rate that aligns with the rate of new enrollment.

Table 20. Services Provided by Illinois PAT Programs over Time

Service Provided	SFY 2009	SFY 2010	SFY 2011
Total group meetings per year (N)^a	12,782	11,294	11,212
Mean (SD)	70.6 (99.0)	58.5 (79.4)	63.7 (96.0)
Range	0–632	1–530	0–686
Estimated total group meetings per month (N)	1,065	941	934
Mean (SD)	5.9 (8.3)	4.9 (6.6)	5.3 (8.0)
Range	0–53	0–44	0–57
Families linked to community resources (%)	63	65	66
Mean (SD)	43.5 (59.5)	40.8 (50.8)	44.4 (53.5)
Range	0–383	0–330	0–357
Families newly enrolled this program year (%)	58	49	52
Mean (SD)	40.6 (59.8)	30.8 (38.3)	33.9 (39.6)
Range	0–518	0–250	0–257
Families who exited this program year (%)	27	29	31
Mean (SD)	18.6 (26.9)	18.1 (26.5)	20.4 (26.7)
Range	0–210	0–212	0–169

^a In 2008–09, 181 programs provided data on group meetings per year, 190 provided data on linked families, 189 provided data on newly enrolled, and 188 provided data on exited families. In 2009–10, 193 programs provided data on group meetings per year, 190 provided data on linked families, 191 provided data on newly enrolled, and 193 provided data on exited families. In 2010–11, 176 programs provided data on group meetings per year, 172 provided data on linked families, 176 provided data on newly enrolled and 175 provided data on exited families.

Cost of Providing Services

Most of the programs reported the estimated cost of operating the PAT portion of their programs each year. The amounts budgeted for this cost ranged from as low as \$200 (in 2008–09) to as high as \$5,229,081 (in 2010–11). During the three years we studied, mean budgets ranged between \$164,109 and \$209,231. The budget size could be related to the number of parent educators on staff and the number of

families served each program year. When they are available, it will be interesting to compare these results to the results of a national cross-site cost study now being conducted by MPR and Chapin Hall.

Table 21. Estimated Cost of Providing PAT Services in Illinois over Time

	SFY 2009	SFY 2010	SFY 2011
Programs responding (N)	178	169	150
Mean estimated cost of operating PAT portion of program	\$164,109	\$175,393	\$209,231
<i>SD</i>	\$208,192	\$287,878	\$451,204
<i>Range</i>	\$200–\$1,428,460	\$294–\$3,158,276	\$600–\$5,229,081
Cost Brackets (%)			
\$35,750.50 or less	30	25	17
Between \$35,751 and \$100,000	23	26	27
Between \$100,001 and \$223,949	24	24	27
\$223,950 or more	24	25	29

Across all three years, any programs who noted the estimated total cost of running their program as being \$0 were excluded from the analysis of data.

Cost brackets were the quartiles from 2009–10, which were very similar to 2008–09 and 2010–11.

HFI Caseloads and Clients, State Fiscal Years 2006–12

This section presents an analysis of data describing the HFI program. The data have been drawn from the IDHS Cornerstone data system, which also provides basic enrollment information for other social service programs, including Women, Infants, and Children (WIC), Family Case Management (FCM), and Early Intervention (EI). The primary virtue of the Cornerstone data is that it tracks the participation of individual persons (infants and children, parents, and home visiting program staff) in the program context. This offers a potentially rich collection of information for studying many types of questions about the operations and service delivery of HFI programs and about the recipients of HFI services. Being able to identify individuals also allows data to potentially be linked to other information systems. In this case, we include a brief look at the contacts that participants in IDHS programs have had with investigations of alleged child abuse and neglect as documented by the Illinois Department of Children and Family Services (DCFS) during the 4-year period prior to the implementation of Strong Foundations, and the immediate years since.

The presentation of information drawn from administrative data sources in this report is exploratory in several ways. It is not clear how to best apply these data to clarify trends and relationships in home visiting in Illinois, and it will not be clear until we define the trends and patterns we expect to explain with this information. Thus, here we will describe certain trends and patterns and lay out a series of baseline results as a basis for future comparisons. As we continue to accrue information, and as our understanding of the impact of state-level reforms supporting home visitation increases, we anticipate

being able to evaluate stronger substantive questions of how measures have shifted from the baseline patterns that are described here.

A basic picture of the Healthy Families Illinois program across the state is given in Table 22. This is a 7-year summary starting with the 2006 state fiscal year (July 2005–June 2006), which shows that the combined HFI programs maintained an ongoing caseload of about 2,000 family units during this period. There was modest growth in caseload size from 2006 through 2009, but this was followed by a small drop to just under 1,800 units in 2010 through 2012. The average caseload per home visitor varied between 9 and 11 each year. Table 22 also shows that the activities we associate with HFI programs occurred regularly over the period studied. The typical client family received almost two completed home visits per month. Each child averaged over 4 doctor visits per year, although there was a slight decrease in the mean number of doctor visits between SFY 2006 and SFY 2012.³⁹ Each child is screened, on average, for developmental issues just over 3 times per year, a rate that was remarkably steady during this time period. All of these measures trend similarly to the total caseload; they increased by a small margin during the first three or four years, and then tapered off in 2010.

HFI programs were run at a total of 52 different local sites, and home visits were delivered by almost 350 separate workers. In any given year, there were between 40 and 48 sites and between 168 and 208 workers. There were small year to year changes in program sites (four new sites started home visiting while seven sites terminated the visiting programs), but substantially more circulation among workers. There has been a slight drop-off in the number of active sites and in the number of workers for the most recent years observed.

³⁹ We assume that the doctor visits include both well-child visits and visits for illness or injury, so it is not clear how to interpret the decrease.

Table 22. Healthy Families Illinois Program Components, SFY 2006–12

	State Fiscal Year						
	2006	2007	2008	2009	2010	2011	2012
Monthly average caseload size	1,856	1,984	2,067	2,148	1,851	1,805	1,746
Mean number of home visits per month	3,612	3,817	4,055	4,168	3,383	3,557	3,668
Mean number of visits per month per child	1.95	1.92	1.96	1.94	1.83	1.97	2.10
Number of doctor visits during year	7,978	8,659	9,038	9,083	7,265	6,910	5,479
Mean number of doctor visits/year/child	4.30	4.36	4.37	4.23	3.92	3.83	3.14
Number of developmental screenings per year	6,144	6,489	7,114	7,466	6,307	5,995	5,637
Mean number of developmental screens/year/child	3.31	3.27	3.44	3.48	3.41	3.32	3.23
Number of HFI programs operating during year	48	46	46	45	45	40	40
Mean caseload size per program site	38.7	43.1	44.9	47.7	41.1	45.1	43.7
Number of HFI workers employed during year	201	199	211	199	208	168	184
Mean number of workers per program site	4.2	4.3	4.6	4.4	4.6	4.2	4.6
Mean client caseload per worker	9.2	10.0	9.8	10.8	8.9	10.7	9.5

The characteristics of clients entering these HFI programs are described in Table 23. The level of care measure is taken at the time of the first home visit, and the termination reason is determined only when the home visiting episode is finally completed. If there is substantial change in the population of families referred to (or recruited by) HFI, or if there is a major shift in how the clients are classified by the programs, these characteristics will show it. For example, these data show a sizable increase in the percentage of cases with care levels of “HFII” and “prenatal” in 2012. Other data suggest that some of the patterns that appear in these data may be the result of changes in data coding rather than in actual behavior, reflecting program staff learning to conform to appropriate coding protocols. Although this limits our ability to interpret trends in this information over the time period of interest, it also signals that the SFY 2010 baseline data are accurate.

Table 23. Characteristics of Clients Entering Healthy Families Illinois Programs

	State Fiscal Year Client Started Receiving Visits							7- Year
	2006	2007	2008	2009	2010	2011	2012	Total
Number of new HFI clients (N)	718	947	955	895	935	752	761	5,958
	%	%	%	%	%	%	%	%
Race								
Black	30	30	31	27	30	29	31	30
Hispanic	34	36	34	41	34	38	38	36
White	34	31	32	30	31	29	26	31
Other	2	3	3	3	5	3	4	3
Birthweight								
Low	10	8	10	8	9	8	9	9
Normal	90	92	90	92	91	92	91	91
Region								
Chicago city	29	25	28	27	31	34	38	30
Suburban ring	27	33	29	28	30	27	28	29
Downstate	44	42	43	45	39	39	35	41
Mother age at enrollment								
Under 18 years old	29	29	26	27	24	22	21	25
18-19 years old	28	28	27	29	29	28	26	28
20-22 years old	22	22	23	24	28	25	27	24
Over 22 years old	21	22	25	20	19	26	26	23
Mother education								
< HS graduate	47	48	44	47	47	42	42	46
HS graduate	37	38	39	36	38	37	37	37
Post HS education	15	13	16	14	14	19	20	16
Unknown	1	1	1	3	1	2	1	2
HFI level at first home visit								
Outreach	39	37	31	28	25	24	10	28
HFI1	29	27	28	33	34	36	59	35
HFI2	6	9	16	14	20	26	7	14
HFI3	12	13	13	12	11	4	0	10
HFI4	7	6	4	2	2	0	0	3
Prenatal	6	6	5	6	6	8	24	8
Other	1	2	4	5	3	3	1	3
Termination reason (if episode closes)								
Voluntary	14	13	10	8	10	10	4	10
Normal	20	16	11	9	6	3	1	9
Move	21	20	20	15	16	14	4	16
Lost	10	8	9	7	7	7	2	7
Refuse HFI	15	14	13	15	14	10	5	13
Other	11	15	15	19	11	7	5	12
Prob closed (no reason)	6	8	11	10	5	0	0	6
Not yet closed	3	6	11	16	32	49	79	27
Enrollment time^a								
After birth of child	34	38	37	38	43	38	36	38
Before birth of child	51	49	50	51	47	48	33	47
Child never enrolled	15	14	13	12	10	14	30	15

^a These two characteristics are influenced by time constraints, especially in more recent years.

The information in Figure 12 through Figure 14 illustrates patterns of recent change in several indicators of caseload size and composition. Figure 12 presents time trends over fiscal year quarters for three separate geographic units: Chicago city, the suburban ring around Chicago, and the remainder of downstate Illinois. These caseload graphs show small growth and relative stability from the first quarter of SFY 2006 through the fourth quarter of SFY 2009 in all three regions. Then an abrupt decrease in HFI caseload occurs during the first quarter of SFY 2010, which represents July through September 2009. This drop is more pronounced for the Chicago and downstate regions than for the suburban ring areas. After this drop, the Chicago numbers appear to return to a level near their value in the fourth quarter of SFY 2009, while the downstate number stays low and even decrease slightly through the end of the observation period.

Figure 12. Average HFI Caseload, by Region and SFY Quarter

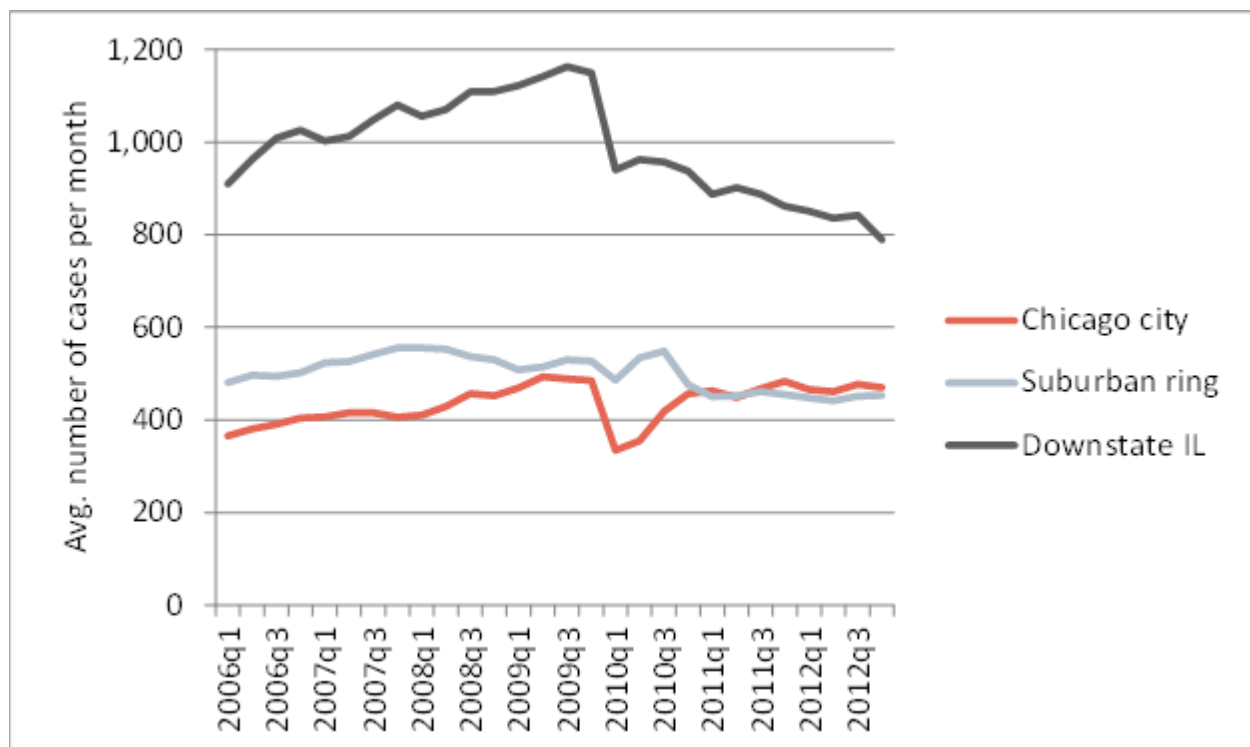
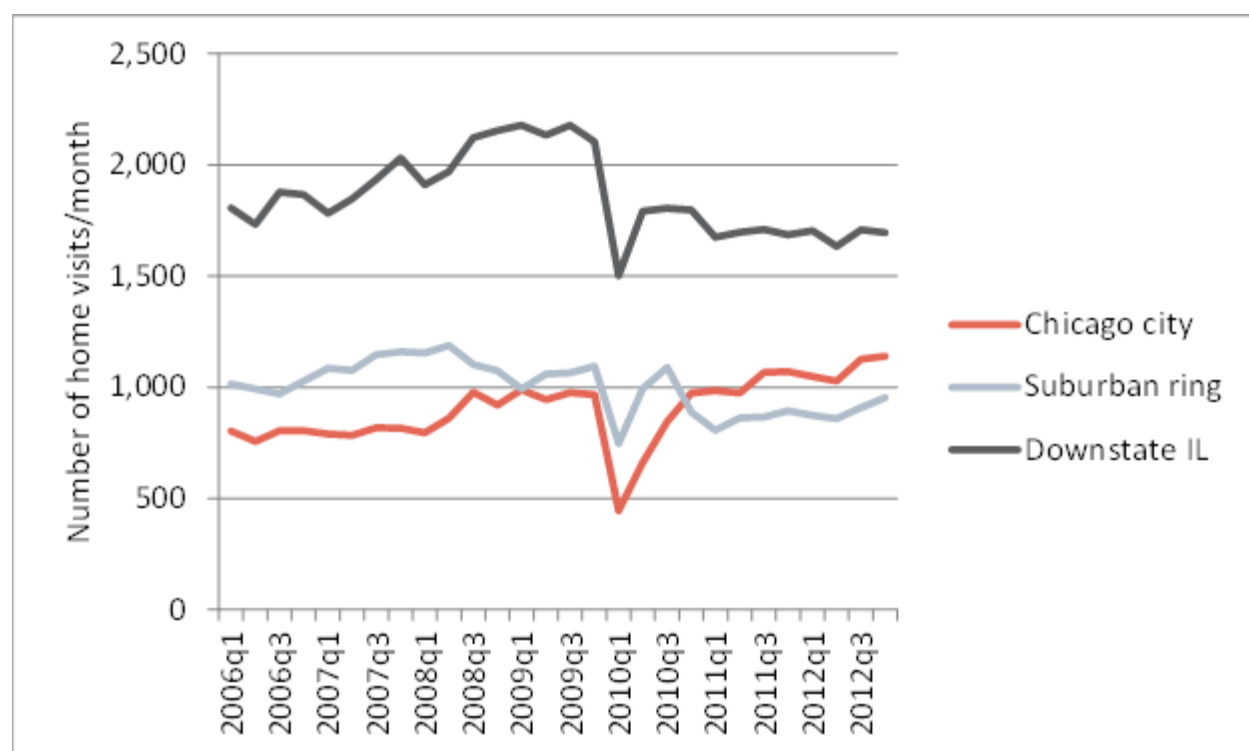
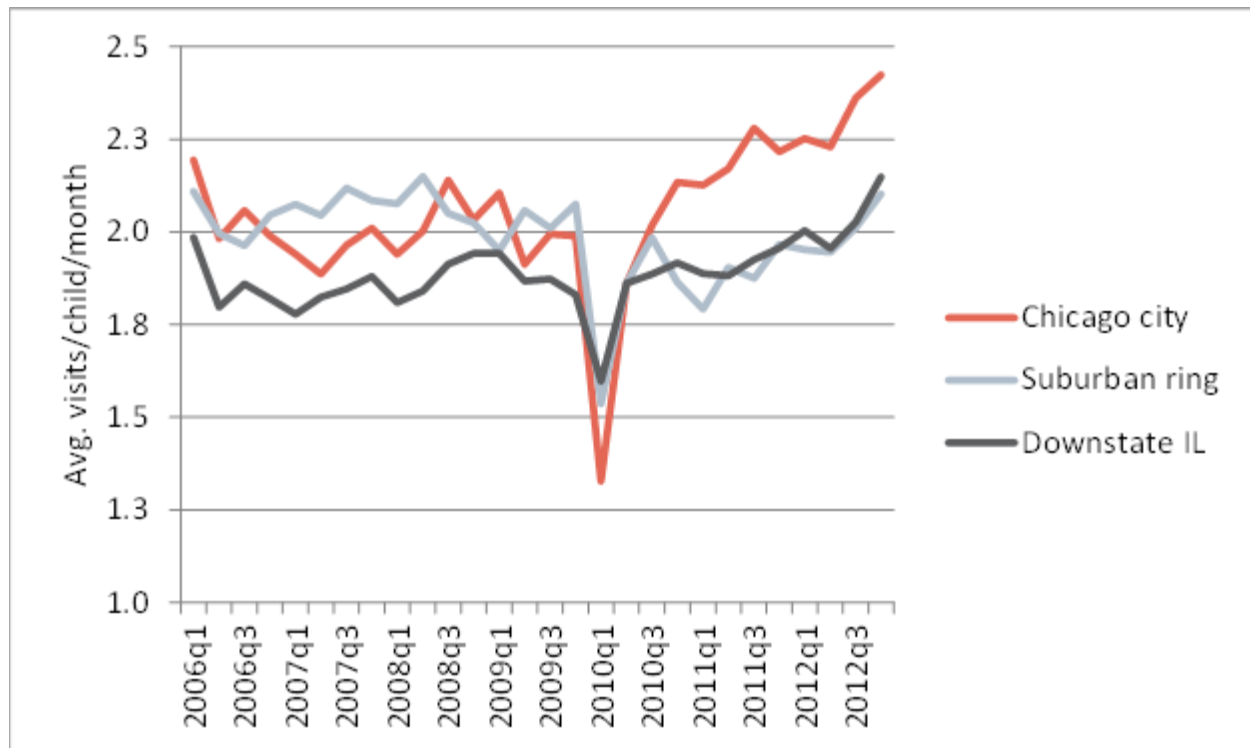


Figure 13. Number of Completed Home Visits per Month, by Region and SFY Quarter



This observed sharp decrease might have been predicted, because it occurs during the time of pronounced fiscal crisis in Illinois government. During the summer of 2009, funding for HFI programs was uncertain. And, even when program allocations were finally made, payments to the agencies continued to be very slow. It is well documented that the provider agencies were operating under pressure and uncertainty, and that numerous staff reductions or cutbacks were made during this time. Figure 14 shows the average number of home visits that were actually completed each month, again by region. This is an important measure of fidelity to the HFI program model because the prescribed number of visits (usually two) is supposed to be made in order to properly implement the protocols of the evidence-based model program. For most of the seven years, it appears that between 1.75 and 2.25 home visits actually do take place each month for each client. At the time of the fiscal crisis, the average number of monthly home visits per case drops to its lowest level of under 1.5 percent, only to rebound during the final three quarters observed to about 2.0 in Suburban and downstate areas, and over 2.25 in the city of Chicago.

Figure 14. Monthly Visits per Child, by Region and FY Quarter



The graphs in Figure 15 through Figure 17 below show elements of caseload dynamics on a quarterly basis. Again, the pattern of activity in the summer and fall of 2009 stand out. Increases in the number of case closings are quite apparent for Chicago and downstate regions during the fourth quarter of SFY 2009. In addition, all three regions show increased recruitment of new cases during the following months, in early 2010. At the end of the observation period, however, there was virtually no overall change in the number of clients served in Chicago and the suburban ring, and a small cumulative decrease in the number of clients served by HFI programs downstate. But the “ripples” caused by a short period of unusually high terminations followed by a period of active enrollment show instability in the caseload that could potentially be a problem. Rapid system change is not typically a hallmark of the stable provision of supports to client families.

Figure 15. Entries to HFI Programs, by SFY Quarter and Region

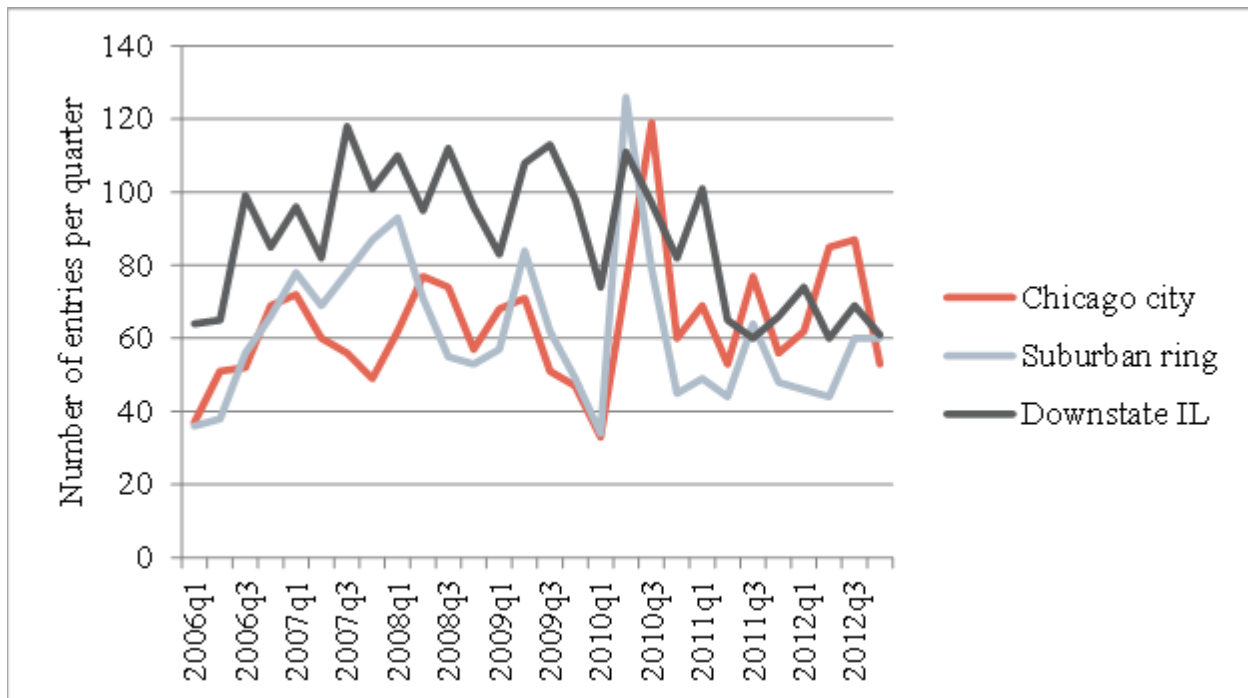


Figure 16. Terminations from HFI, by Quarter and Region

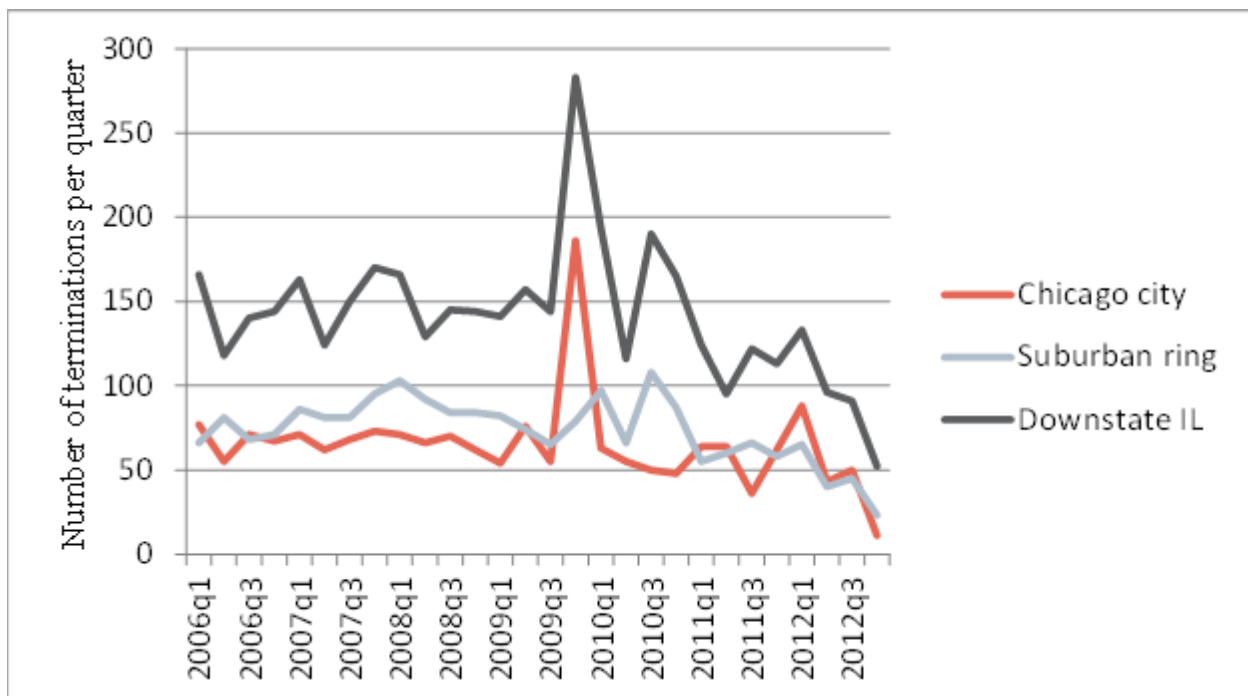
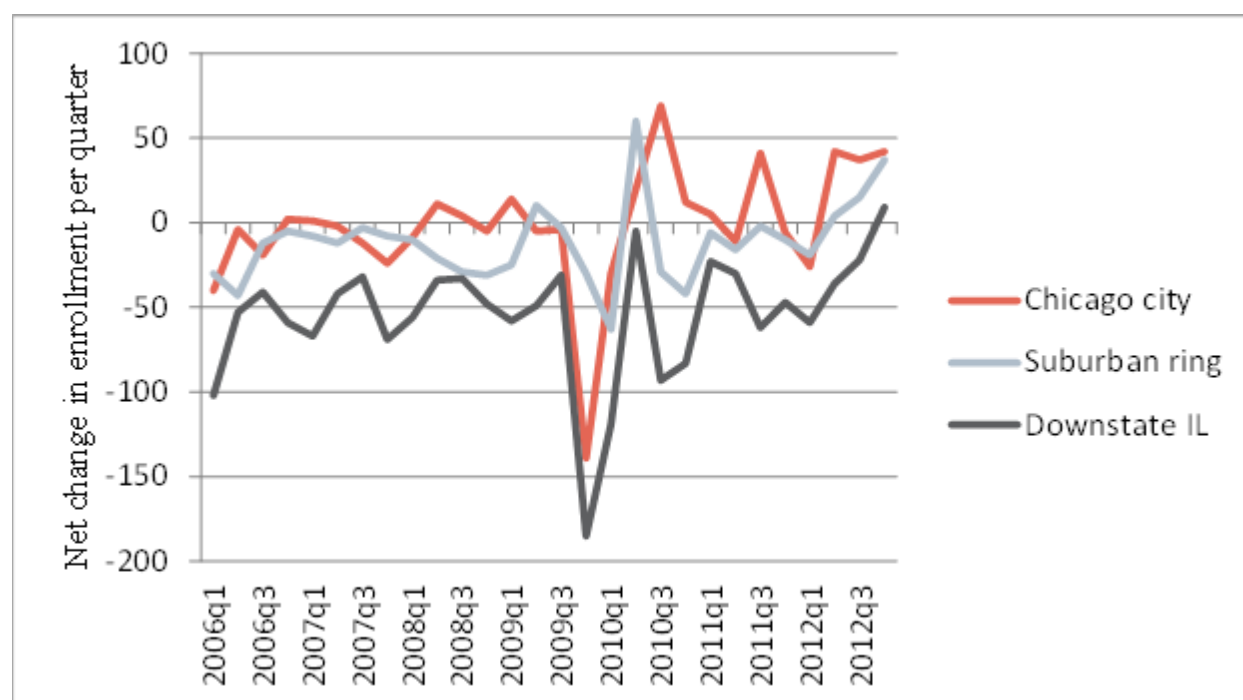


Figure 17. Net Change in HFI Caseload, by SFY Quarter and Region



Home visiting planners believe that interventions become more effective when they are initiated earlier in the parenting process; there is a growing trend towards considering engagement of pregnant mothers as preferred practice. Table 24 shows the types of maternal enrollment over time and by region. The mother is engaged prenatally in about one-half of all HFI cases, and in about 10 percent of the cases, a child is never enrolled. The remaining 40 percent are initiated after the birth of the child. Although these patterns have been fairly stable, there is a clear upward trend in prenatal engagement in Chicago during SFY 2010 and SFY 2011, and a decrease in prenatal enrollments in the Suburban programs during the same time period. The SFY 2012 data are not fully interpretable because insufficient time had elapsed after enrollment to clearly differentiate prenatal enrollments from cases with no child recorded.

There is a difficulty with defining whether an enrollment is prenatal or not from these data. We prefer to compare the child's birth date and the date of the first home visit to determine whether an enrollment is prenatal. However, in some cases, there is no child record. Mostly, these are cases that never really get started after the initial enrollment. Yet any case without a child record "looks" prenatal, because the child being born is never defined as an event after enrollment. This creates a methodological problem in the final year of observation, where the data provide no criteria to clearly distinguish "true" prenatal cases from those cases that will never show a child's engagement. To address this, we list the "child never enrolled" category separately from the prenatal category, while realizing that in the most recent year, this category may include many cases that will soon be identifiable as prenatal.

Table 24. Type of enrollment in HFI, by Region of Illinois and State Fiscal Year, 2006–12

	2006	2007	SFY of enrollment in HFI			2011	2012
			2008	2009	2010		
All HFI cases							
Entries (<i>N</i>)	691	1275	1273	1209	1186	1024	1031
Prenatal enrollment (%)	51	49	52	52	48	50	37
Postnatal enrollment (%)	36	39	37	36	42	37	35
Child never enrolled* (%)	13	12	11	12	10	13	28
Chicago city sites							
Entries (<i>N</i>)	190	272	305	282	318	285	313
Prenatal enrollment (%)	51	49	47	45	57	54	35
Postnatal enrollment (%)	29	31	38	38	31	30	22
Child never enrolled* (%)	20	19	15	17	12	16	42
Suburban ring sites							
Entries (<i>N</i>)	192	375	319	308	323	252	250
Prenatal enrollment (%)	51	46	57	56	39	42	33
Postnatal enrollment (%)	38	43	29	34	53	46	44
Child never enrolled* (%)	11	11	14	10	8	12	23
Downstate sites							
Entries (<i>N</i>)	309	628	649	619	545	487	468
Prenatal enrollment (%)	51	50	52	53	49	51	40
Postnatal enrollment (%)	39	40	41	37	41	37	38
Child never enrolled* (%)	10	10	7	10	10	12	22

* “Child never enrolled” cases are usually incomplete cases, where mother is enrolled but parent-child visits never become routine. They look like prenatal cases, but are separated here to clearly delineate the prenatal cases that follow through with services. Some of the “child never enrolled” cases in SFY 2012 will eventually appear as true prenatal enrollments. Some of the “child never enrolled” cases in SFY 2012 will eventually appear as true prenatal enrollments.

Note: Shaded cells are censored due to incomplete observation.

One important indicator of program fidelity is the extent to which cases are retained after the initial engagement and enrollment. The HFI model necessitates that services be provided at a level that has been shown to affect family outcomes in previous research. In order to do this, clients need to be retained for continuing service provision. Table 25 shows the distribution of the duration of enrollment spells in HFI programs. The length of enrollment spells do not change markedly over time. There is not a fixed standard for how long a client should engage with home visitors; the standards are based on progress. Overall, most home visiting planners prefer that periods of engagement be at least six months and usually one year or more. The distribution in Table 25 shows no marked change over time in enrollment times. In brief, somewhere around one in six HFI cases end before one month, while two or three out of ten last over two years.

Table 25. Duration of HFI Home Visiting Spells, Percent Distribution of time periods from enrollment to termination, SFY 2006–12

	2006	2007	SFY of Enrollment in HFI				2011	2012
			2008	2009	2010			
New HFI Enrollments (<i>N</i>)	691	1,275	1,273	1,209	1,186	1,024		1,031
Enrollments with duration of:								
Less than one month (%)	17	16	14	17	17	17		31
One to 3 months (%)	19	22	19	23	21	19		39
3 to 6 months (%)	10	9	8	12	8	9		18
6 to 12 months (%)	11	12	14	13	11	23		12
12 to 18 months (%)	9	7	12	7	9	23		0
18 to 24 months (%)	5	6	8	6	11	8		0
Over 2 years (%)	30	27	25	21	22	0		0

Note: Shaded cells are partly censored (light gray) or fully censored (dark gray) due to incomplete observation.

Table 26 presents a comparison of the duration of home visiting spells for all HFI cases and across three groups of families: a group that had their first home visit prenatally, a group that had their first visit after the birth of the child, and a final group that never saw a child enrolled. It should be noted that with active program data, duration is difficult to represent because many of the cases are still open, and thus the duration is “censored” because the terminating event has not occurred during the period of observation. Yet, the time already accrued by these still-open cases can contribute to the comparisons; ignoring these cases would create bias by removing the longer episodes.

In these tables, all numbers that are not shaded should be considered as “fair” bases of comparison. All cells that are shaded lighter grey are partially censored (meaning that the final values will probably increase), and the darkened cells are fully censored. Thus, a case that started in SFY 2011 and that is still open at the close of observation (here in June 2012) could not possibly show a duration of two years. In the same vein, all cases that started in SFY 2011 and had durations of less than one year would be fully observed and interpretable in these data.

Table 26. Duration of HFI Home Visiting Spells, by Year of Engagement and Type of Enrollment, SFY 2006–12

	SFY of Enrollment in HFI						
	2006	2007	2008	2009	2010	2011	2012
All HFI Enrollments							
Number of new cases	691	1,275	1,273	1,209	1,186	1,024	1,031
Cumulative % terminated:							
By 1 month	17	16	14	17	17	17	31
By 3 months	35	38	33	40	38	37	70
By 6 months	45	47	41	52	46	45	88
By 12 months	56	60	55	65	58	69	100
By 18 months	65	67	67	73	67	92	100
By 24 months	70	73	75	79	78	100	100
Postnatal Enrollments							
Number of new cases	248	496	472	440	494	379	361
Cumulative % terminated:							
By 1 month	17	17	16	22	19	21	32
By 3 months	32	39	34	46	39	41	73
By 6 months	43	48	43	57	48	49	88
By 12 months	52	61	58	69	58	70	100
By 18 months	63	68	72	76	67	93	100
By 24 months	66	74	79	82	76	100	100
Prenatal Enrollment							
Number of new cases	353	622	664	628	571	510	378
Cumulative % terminated:							
By 1 month	5	5	4	6	6	5	8
By 3 months	23	25	21	26	25	20	51
By 6 months	35	36	28	40	34	31	79
By 12 months	48	50	43	56	49	60	100
By 18 months	59	59	57	64	60	89	100
By 24 months	66	66	67	72	75	100	100
No Child Enrolled							
Number of new cases	90	157	137	141	121	135	292
Cumulative % terminated:							
By 1 month	62	54	59	55	62	5	8
By 3 months	91	85	88	84	95	20	51
By 6 months	93	90	93	92	97	31	79
By 12 months	96	96	96	96	98	60	100
By 18 months	97	97	97	99	98	89	100
By 24 months	98	99	99	100	98	100	100

Note: Shaded cells are partly censored (light gray) or fully censored (dark gray) due to incomplete observation.

A comparison of case durations between the prenatal and postnatal groups is instructive. The comparison reveals that program retention, at least as measured by elapsed duration of services, is noticeably greater for prenatal cases, where visiting is initiated before the birth of the infant. This is consistent with anecdotal information from the field suggesting that mothers engaged in HFI prenatally tend to have a more positive program experience. (It does not suggest whether this is a program effect or a selection effect). At all levels, the prenatal group shows stronger program retention than the postnatal group. Almost none terminate in the first month, only about one-quarter terminate by 3 months, and one-half

make it to one year or more. In contrast, almost one-sixth of the cases in the postnatal group do not last past one month, and almost one-half have terminated by 6 months. The SFY 2012 results for both groups appear unsettling, because if they hold up it will be the first time in five years that a noticeable increase in earlier exits occurred. However, it is likely that this increase is an artifact of how the termination of visiting spells is defined here. It bears watching through next year's data. If these increases are real, they will persevere. If they are due to an "end of observation" artifact, they will disappear for SFY 2012, and probably appear anew for SFY 2013. The "no child enrolled" cases clearly are mostly short episodes, as 85 to 90 percent are terminated before three months elapse.

HFI and other IDHS Social Service Programs: WIC, FCM, and EI

All data description thus far has involved only information from Cornerstone describing Healthy Families Illinois. In order to place some of this HFI data in context, or to demonstrate its relative scale, it is useful to consider it in combination with data from other sources or programs. One such source is Illinois birth data, published by the Illinois Department of Public Health. We also use information from Cornerstone for related programs, namely Women, Infants, and Children (WIC); Family Case Management (FCM); and Early Intervention (EI). WIC is a means-tested nutrition support program, and serves well as an enumeration of poor families with children. Family Case Management should be provided to most families at risk of poor health outcomes. It is closely related to, but not identical to, WIC. Theoretically, most HFI referrals should result from FCM caseworkers. EI is designed to provide direct service to young children with diagnosed disabilities or delays. While WIC, FCM, and HFI all can begin early (often prenatally), children will not be referred to EI until they are diagnosed with a condition or as being at risk.

Table 27 enumerates all live births in Illinois in 2009, categorized by race/ethnicity, region, and by teen mother and low birth weight flags. The primary contextual information this presents is about relative scale⁴⁰. While both WIC and FCM reach over one-half of all children born in the state, HFI programs enroll less than one percent of all infants (0.7%). HFI programs do enroll a disproportionate number of cases with teen mothers. Over one-half of all HFI cases involve teen mothers, and while HFI has less than 1 percent of all births, it enrolls almost 4 percent of the births to teens. While HFI is somewhat over-representative of African American and Hispanic babies, WIC is more targeted to persons of color. EI includes a very high share of children born at a low birth weight.

⁴⁰ This is the same table that appeared in the 2011 report, as the birth data available from the Illinois Department of Public Health has not been updated since the last report. As this data is used to provide a general picture, the fact that more recent data is not available should not be problematic.

Table 27. Comparison of All Live Births in Illinois during 2009 with Infants Enrolled in IDHS Programs. Program enrollees from infants born during SFY 2009

		Race/Ethnicity			Teenage Mother	Low Birth weight
		<i>Total</i>	<i>Black</i>	<i>Hispanic</i>		
				<i>White/Oth</i>		
Counts						
Illinois births		171,077	30,186	40,369	100,522	16,376
IL WIC	<i>n</i>	98,645	27,742	37,208	33,695	16,217
IL FCM	<i>n</i>	85,868	21,685	30,657	33,526	14,156
IL EI	<i>n</i>	8,682	1,766	2,196	4,720	762
IL HFI	<i>n</i>	1,200	336	402	462	624
% of statewide total						
Illinois total		100	100	100	100	100
IL WIC	%	58	92	92	34	99
IL FCM	%	50	72	76	33	86
IL EI	%	5	6	5	5	5
IL HFI	%	1	1	1	0	4
% of within program total						
Illinois total		100	18	24	59	100
IL WIC	%	100	28	38	34	16
IL FCM	%	100	25	36	39	16
IL EI	%	100	20	25	54	9
IL HFI	%	100	28	34	39	52
		Total	Chicago	Sub Ring	Downstate	Unknown
Counts						
Illinois total		171,077	44,449	71,586	55,042	—
IL WIC	<i>n</i>	98,645	28,478	25,683	28,797	15,687
IL FCM	<i>n</i>	85,868	22,948	21,684	29,215	12,021
IL EI	<i>n</i>	8,682	1,603	1,417	1,882	3,780
IL HFI	<i>n</i>	1,200	248	229	447	276
% of statewide total						
Illinois total		100	100	100	100	100
IL WIC	%	58	64	36	52	34
IL FCM	%	50	52	30	53	33
IL EI	%	5	4	2	3	5
IL HFI	%	1	1	0	1	0
% of within program total						
Illinois total		100	26	42	32	—
IL WIC	%	100	29	26	29	16
IL FCM	%	100	27	25	34	14
IL EI	%	100	18	16	22	44
IL HFI	%	100	21	19	37	23
% of within program total (known geo only)						
IL WIC	%	100	34	31	35	—
IL FCM	%	100	31	29	40	—
IL EI	%	100	33	29	38	—
IL HFI	%	100	27	25	48	—

Links to DCFS Abuse/Neglect Investigations

The Healthy Families model is an evidence-based program that has been demonstrated to reduce child abuse and neglect. The target population receiving HFI services is mothers and infants at risk for child abuse and neglect. So, basic monitoring activity for HFI programs should include tracking the involvement of program clients in investigations of reported child abuse and neglect. To this end, Cornerstone data were linked to Child Abuse and Neglect Tracking System (CANTS) data from the Illinois Department of Children and Family Services (DCFS). CANTS includes detailed reporting of every investigation of abuse and neglect, including codes for specific allegations, the findings of the investigation, the type of person who reported the maltreatment, and identification of the alleged victims, caregivers, and perpetrators.

We wanted to demonstrate that a link between DHS service recipients and DCFS abuse/neglect investigations can be established and to produce a rudimentary baseline of data to guide future study. Table 28 looks at abuse/neglect investigations (both indicated and unfounded findings) during SFY 2006–10 for clients from WIC, FCM, EI, and HFI. It presents the percentage of children 3 years and younger in DHS programs who have ever been involved in an abuse/neglect investigation and the percentage of those investigated who were indicated to be in an abuse/neglect situation. We also report the percentage of those who were exposed to substances at birth. The primary link of interest is the share of infant clients alleged to be victims of child maltreatment. This table describes percent of infants investigated by DCFS (at any time through 2010, and of those, the percent of cases that were indicated as being child abuse/neglect upon investigation. Also reported is the percentage of investigations that were for reasons of infant drug exposure at birth. We can also see the related link, whereby in most of these investigations, the client mother is also included as an alleged perpetrator of the abuse/neglect. There is a third link of interest here, which is the extent to which the clients who are mothers in the current program relationship were onetime victims of child abuse or neglect themselves. Thus, the intergenerational aspects of child maltreatment can also be considered with these data.

Table 28 presents the percentage of children 3 years and younger in DHS programs who have ever been involved in an abuse/neglect investigation. For newly enrolled infants, the time period during which they can be considered “at risk” of abuse/neglect is very short. Older child clients have been at risk of maltreatment for a longer period of time. We are still analyzing details about the specific investigation outcomes and the timing of child protective interventions relative to program participation, but these results are descriptive of the period prior to Strong Foundations. WIC and FCM are seen as serving as “control” groups of other poor or at-risk populations.

**Table 28. DCFS Investigation of alleged Child Abuse and Neglect for DHS program enrollees
Children born SFY 2006–10 and enrolled in programs any time during SFY 2006–10**

DHS Program	Enrolled infants born SFY 2006-10	Infants with Abuse/Neglect Investigations		Of those involved in an Abuse/Neglect investigation	
	<i>N</i>	<i>N</i>	%	% indicated	% SEI
WIC	445,113	37,306	8	60	6
FCM	392,774	34,682	9	61	6
EI	62,805	10,302	16	71	11
HFI	7,018	917	13	59	2

SEI refers to substance exposed infants (drug exposure at birth).

Over these four years, 13 percent of children enrolled in HFI programs were involved in an abuse/neglect investigation. Of these investigations, 59 percent were found indicated, meaning that the investigation found credible evidence that abuse or neglect had occurred. Even unfounded investigations often point to substantial protective issues—sometimes maltreatment may have occurred but not been proven, and in others, while abuse or neglect was not found, difficult situations existed. The number of investigations based on capricious reports is extremely small. The investigation rate was higher for HFI (13%) than for WIC (8%) and FCM (9%), but lower than for EI (16%). This is expected because HFI clients are explicitly selected based on various risk factors, including their risk for maltreatment. During the time period we examined, HFI entry was contingent on having a high risk score during an assessment screen at the time of enrollment. However, it should be noted that this is a very basic description of the link between HFI program participants and DCFS investigations. Further analysis is needed to understand the timing of an investigation—that is, whether it occurred before, during, or after program participation. In addition, there likely will be variations in investigations for different ages of children, demographic characteristics, regions of the state, and so forth.

One particularly interesting finding is that, of mothers from all of the four programs, the HFI mothers were the most likely to be involved in maltreatment investigations during their childhood (see Table 29). Almost 30 percent of HFI mothers were identified as having been an alleged victim within the DCFS child protective framework. No more than 20 percent of the mothers from the other three programs had been an alleged victim in their childhood.

It is apparent that experience with child maltreatment and DCFS abuse/neglect investigation is still relatively common within the HFI client community. This fact is consistent with the HFI strategy of targeting the program to families at risk. For this reason, we had expected to observe some recent maltreatment cases involving HFI infants. It is interesting to notice that a pronounced pattern of maltreatment can also be observed for the current HFI mothers (as child victims themselves), who historically show unexpectedly high rates of abuse and/or neglect.

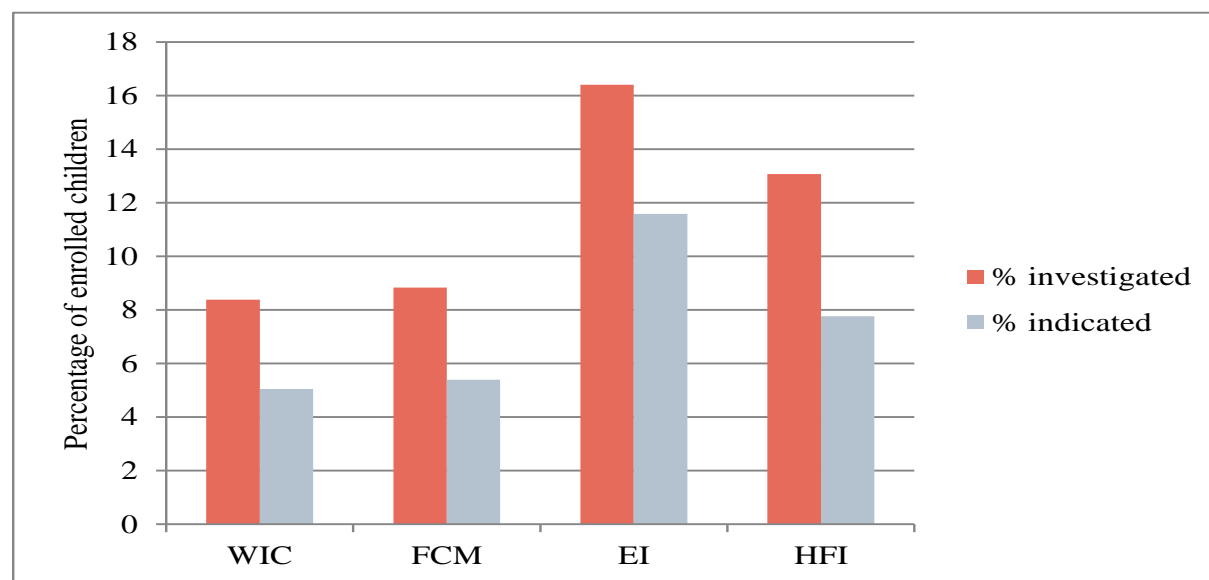
Table 29. Alleged Child Abuse and Neglect as Perpetrators of Victims for DHS mothers in DHS programs during SFY 2006–10

DHS Program	Mothers w/ child born SFY 2006-2010	Mothers involved in A/N (Alleged as perpetrators)		Mothers involved in A/N (Alleged as victims)	
	<i>N</i>	<i>N</i>	%	<i>N</i>	%
WIC	285,195	35,262	12	46,790	16
FCM	239,399	33,183	14	43,092	18
EI	36,278	7,912	22	7,384	20
HFI	5,662	978	17	1,671	30

Note: Mothers as alleged perpetrators are identified as being investigated in current cases involving their own children, while mothers as alleged victims are identified based on their own prior childhood history.

Figure 18 shows graphically the percentage of children, 3 years and under, who were enrolled in WIC, FCM, EI, and HFI and who have been the subjects of DCFS investigations. While the number of children who are the subject of a DCFS investigation is rather small, a greater percentage of investigated children are also enrolled in EI. HFI, while targeting families at greatest risk for children being maltreated (e.g., families with teen mothers), also has a sizeable percentage of children in its program who are the subject of a DCFS investigation. Children enrolled in FCM and WIC are less likely to also be the subjects of DCFS investigations.

Figure 18. Enrolled Children in Investigations of Child Abuse and Neglect, SFY 2006–10



Summary of HFI Administrative Data Findings

The analysis of a 6-year period beginning with the 2006 state fiscal year (July 2005) shows that HFI programs collectively had an ongoing caseload of about 2,000 family units, with modest growth from SFY 2006 through 2008, followed by a decrease to just under 1,800 units in SFY 2010. The drop in caseloads in SFY 2010 was marked during the first quarter of that fiscal year (i.e., July through September 2009), which coincided with the state budget crisis. It was especially apparent in programs in the Chicago and downstate regions, whereas programs in the suburban ring appeared to be little affected.

During the 6-year period, HFI programs operated in 52 different local sites, and visits were made by almost 350 separate workers. In any given year there were between 40 and 48 sites and between 190 and 208 workers. There were small year to year changes in program sites, but substantially more changes occurred in staff during this time. The typical client family received almost two completed home visits per month. Each child averaged over 4 doctor visits per year and received developmental screenings a little more than 3 times per year. The demographic characteristics of families varied somewhat year to year, but overall were fairly stable over the period of study, with 36 percent of the families being recorded as Hispanic, 30 percent as black, 3 percent white, and 31 percent “other.” Over half of the mothers served were teen mothers (54%). Just over half were high school graduates (52%).

The proportion of expected home visits that were actually completed is an important measure of fidelity to the HFI program model. For most of the 6 years from SFY 2006 through SFY 2011, it appears that between 75 and 90 percent of the planned home visits took place, with the lower completion levels occurring in programs in the city of Chicago. At the time of the SFY 2009 fiscal crisis, the completion level in Chicago dropped to its lowest level, 70 percent, although it rebounded to about 85 percent during the final three quarters. In contrast, programs in the other regions of the state showed only a minor shift in completion levels during the same time. In addition, the number of case closings increased considerably in the Chicago and downstate regions during the fourth quarter of SFY 2009. All three regions showed increased recruitment of new cases in early 2010. Although the final result of these changes is small in terms of the number of clients served, the fluctuations caused by a short period of unusually high terminations followed by a period of active enrollment reflect instability in the caseload that potentially poses a problem for the system’s ability to provide stable services to families.

Another important indicator of program fidelity is the extent to which cases are retained after initial engagement and enrollment. A comparison of program duration across two groups of families—those who entered the HFI program prenatally and those who had their first visit shortly after the birth of the child—suggests program retention as measured by elapsed duration of services is noticeably greater for prenatal cases.

Thirteen percent of HFI children from a 4-year baseline period (SFY 2006–10) were involved in an abuse/neglect investigation at some time before SFY 2012. These investigations found indications—credible evidence that abuse or neglect had occurred—in 59 percent of cases. The investigation rate was higher for HFI (13%) than for WIC (8%) and FCM (9%), but HFI’s rate was lower than for EI (16%). This would be expected because the HFI clients are explicitly selected based on various risk factors, including their risk for maltreatment. For example, whereas both WIC and FCM reach over one-half of all children born in the state, HFI programs enroll less than one percent of all infants. HFI programs also enroll a disproportionate number of cases with teen mothers.

We must emphasize that this is a very basic description of the link between families who participate in HFI (or one of the other IDHS programs analyzed here) and DCFS investigations. Further analysis is needed to understand the timing of an investigation—that is, whether it occurred before, during, or after program participation. In addition, there likely will be variations in investigations for different ages of children, demographic characteristics, regions of the state, and so forth.

Finally, analyzing official reports of child abuse and neglect that involved clients of home visiting programs in Illinois is grounded in the premise that reduction of abuse and neglect is the primary long-term outcome of these programs. Thus, it is reasonable to look for decreased levels of child maltreatment as part of the evidence that efforts to improve the infrastructure of supports for home visiting programs have been successful. This evidence also suggests the programs positively influence their quality and model fidelity—at least in the long term. Trends in abuse/neglect levels should also be examined to describe the distribution of child maltreatment and what groups across Illinois are at risk of child maltreatment. This information could inform the ongoing planning of services and resources.

However, because the changes being implemented under Strong Foundations are structural and much more likely to influence system- and program-level outcomes—rather than individual family or child outcomes—during the period of the initiative, any observable changes in child abuse and neglect statistics were likely not the result of any of the initiative’s activities. Moreover, the fact that Strong Foundations is not implementing activities at the service delivery level produces a second serious challenge to analysis of individual-level outcomes—the absence of a viable control group. Even if we were to measure abuse/neglect outcomes for home visiting clients and their families, we are not in a position to provide any controls for the composition of this group. This group of clients is a nonrandom group of parents and children. They are, by definition, vulnerable and at high risk of abuse/neglect; they also have been referred to or recruited by a home visiting agency and they have voluntarily agreed to participate in the program offered. Without an experimental or quasi-experimental design, we cannot produce another control or comparison population against which to measure these outcomes.

Summary and Recommendations

Evaluation findings from the third year of the evaluation of Strong Foundations indicate continued growth in the system of supports for home visiting during 2012, most notably in the areas of state-level collaboration and partnerships, leadership, and professional development and training. In this chapter we highlight the progress and challenges in aspects of the state system and program implementation detailed in the report and offer recommendations to continue to improve Illinois’s home visiting infrastructure.

State System

Leadership and Administration

Key informants at the state level emphasized the integration of the Strong Foundations Evidence-Based Home Visitation (EBHV) initiative with the new Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program—both of which are administered by the new Strong Foundations Partnership project director in the governor’s Office of Early Childhood Development (OECD)—as a sign of progress in system building. In their view, the partnership director’s role as the liaison to the Home Visiting Task Force (HVTF), working alongside the HVTF cochairs, has helped to advance the work of the Early Learning Council (ELC). Considering the MIECHV work as a pilot for efforts state leaders would like to see implemented statewide keeps the goal of infrastructure building as a priority during the MIECHV expansion work. It also helps mitigate the perception that MIECHV implementation and expansion has created “haves” and “have-nots” among home visiting programs.

State informants also were generally optimistic about the growing collaboration among the three main state agencies involved in the development of the home visiting system—the Illinois Department of Human Services (IDHS), the Illinois State Board of Education (ISBE), and the Illinois Department of Children and Family Services (DCFS). Their optimism reflects progress towards the vision of the original Strong Foundations plan for shared leadership and accountability among organizations in the home

visiting system. However, there is still work to be done to have all of the evidence-based models and funding agencies fully engaged in the state's system-building effort.

Communication and Transparency

A key challenge in any complex system is communication. Although there was less discussion in our spring 2012 interviews about lack of communication than in the previous two years, some informants continued to express concern about the way decisions were made in the system and by whom. A structured assessment of collaboration factors also suggested that either state-level stakeholders face lack of time to confer with their organizations about major decisions or lack authority to speak for their organizations. Concerns expressed in the collaboration assessment about a lack of funding and people resources, and a lack of trust among some participants, suggest that the complexity of the system continues to pose barriers to clear communication and transparency in decision making. We believe that the ongoing progress made in the areas of governance, leadership, and administration of the home visiting system and state-level partnerships will allow them to continue to respond to these concerns. However, because the system is made up of multiple domains and operating at multiple levels, we wish to emphasize the importance of clear communication within the system, particularly between state and local levels, and the need to continually monitor the effectiveness of communication.

Monitoring Program Fidelity and Quality

The ability to collect common data across home visiting programs and funding stream is another important component of an effective infrastructure. In the first year of Strong Foundations, a working group of the HVTF produced recommendations for the development of a statewide monitoring and quality assurance infrastructure, but few resources were allocated for continued work in this area. MIECHV and other federal initiatives have provided new incentives and resources to build a data system for the collection of common indicators or benchmarks of child, family, and community well-being. The data system is in its final stages of development and early stage of implementation at the time of this report.

Although there is greater interest among agencies in sharing data across systems and technological progress in integrating data from different systems in a form that can be used by multiple agencies, individual providers supported by multiple funding streams are still subject to multiple data reporting requirements. It is not clear to what extent the current system can address this burden. However, we would urge stakeholders in the home visiting system to continue to explore ways to develop a more integrated system of common data elements for all home visiting programs, which might also link with other existing or developing systems (e.g., the DHS Early Intervention system, the DCFS Statewide

Provider Database, and the ISBE data system) that eventually will facilitate the tracking of families' service use and outcomes throughout the early childhood system.

Funding and Sustainability

Each year of the Strong Foundations evaluation, state-level informants and representatives of local programs have highlighted funding as an ongoing threat to the stability of the state infrastructure. It has been 2 years since the first evaluation report discussed the impact of the summer 2010 budget cuts on home visiting programs (impacts that included reductions and reallocations of staff and caseloads). Even with the restoration of some of the funding, it took time for programs to rehire staff and rebuild their caseloads. The infusion of MIECHV funding and strong advocacy during the past year helped to stem proposed cuts to funding for home visiting services. Nonetheless, state and local stakeholders do not feel secure about funding. In addition, despite improvements in the new procurement process, it has slowed efforts in a number of areas and will be an ongoing challenge. It is reassuring that the HVTF now includes a dedicated Sustainability Work Group that will be able to focus on long-term funding strategies, particularly in light of ongoing budget problems in the state and the fact that MIECHV funding will only be available for a few more years.

Staff Training and Development

The state system continues to demonstrate an increasing capacity to provide training for a range of home visiting staff and foster a “culture for training and learning” among local programs. As a result of Strong Foundations, more participants than in the previous year engaged in professional development to enhance their work with high-risk families in the areas of domestic violence, perinatal depression, substance abuse, and adult learning challenges. Pre- and post-training surveys, as well as a sample of participant interviews, indicate a very positive response to the quality and content of these trainings and indicate that home visitors had more confidence in applying their knowledge to their work with families. It is also important to note that the trainings offered during SFY 2012 were modified so that they were cofacilitated by an educator with home visiting experience who could help participants integrate the content knowledge into their work with families. Strong Foundations has also helped to develop and implement additional professional development trainings to provide information and support to supervisors of home visiting programs, recognizing that their training needs are likely to differ from those of frontline staff. Both of these changes address the requests for more comprehensive and deeper training targeted to the diverse needs of different staff that were articulated by home visitors in focus groups during the first year of the Strong Foundations evaluation. We are encouraged that the professional development component of the home visiting system has responded to these requests.

At the same time, some home visiting staff continued to identify the location of the trainings as a barrier. The training infrastructure still does not reach all regions of the state equitably. Barriers to attendance remain for staff working in rural areas of the state, particularly in southern and southwestern regions. We recommend that, as resources permit, the Training Institute continue to explore other training locations and modalities for training. We also recommend that both the Training Institute and the HVTF monitor training participation trends and follow up to learn why attendance might be low in certain regions of the state or in particular topic areas.

In addition to the Big Four and supervisory network trainings, Strong Foundations also made the Happiest Baby on the Block (HBOB) certification program available to a small sample of home visitors across models. Only 26 individuals throughout the state participated in the program and the selection of these individuals seemed to be somewhat arbitrary and dependent on knowing about the program and the training opportunity. As a result, HBOB trainees were often the sole certified staff member in their organization. Thus, while the HBOB certification was well received, it is not clear that the program has, to date, impacted the state's infrastructure to support evidence-based home visiting practices. It will be important to consider data on staff retention, ongoing training in the HBOB approach, and the distribution of trained HBOB staff throughout the state in assessing the impact of this opportunity on the state system.

It is too soon to know whether the capacity of Illinois home visiting programs to serve high-risk families has increased as a result of the trainings provided in 2011 and 2012. As more home visitors receive training in these topic areas and as more formal systems for sharing and integrating this knowledge into practice are developed, we believe that capacity will increase accordingly. Long term, it will be important to examine whether these additions to the training infrastructure continue to be offered and whether they are able to strengthen other aspects of the system. These aspects could include staff retention, staff interest in obtaining additional training in these and other topic areas, and staff's ability to engage and retain families with higher risk characteristics in services. Home visitors who participated in focus groups in the spring 2012 emphasized that it is more difficult to keep families with higher risk characteristics engaged in services. In the words of one home visitor, "The more at risk they are, then the shorter the time space they stay with me. The less at risk they are, the more they stay." Although the current menu of trainings are designed to develop knowledge skills in particular areas of risk, staff might need additional support and training, at multiple levels, for engaging and working with the most at-risk and transient families. In surveys, home visitors suggested a wide number of training topics, although the most frequent suggestions were in the area of mental health. This is not surprising as many communities identified mental health services as their most needed resource in a recent statewide needs assessment (Daro, et al., 2010). The Big Four training topics were selected at the beginning of the Strong Foundations initiative

based on research and feedback from the field; additionally, training was one of the initial HVTF committees. There does not currently seem to be a formal mechanism in place to raise the question of how new training topics will be determined and implemented in order to meet the needs of the home visiting workforce. Perhaps training issues can be included under the Sustainability or Research and Evaluation Work Groups' purview.

Finally, it should be noted that our examination of the overall training infrastructure cannot be considered comprehensive; it has been focused on only some of the training opportunities funded through Strong Foundations or other sources. Thus, we recommend a more comprehensive review of the professional development infrastructure in terms of access to and participation in training across the state, as well as an examination of the relationships between participation in training and outcomes such as family engagement and retention and staff qualifications and retention.

Program Capacity and Local Collaboration

This report has noted both perceived and real capacity issues that affect the home visiting infrastructure. The 15 programs studied as part of the evaluation appear to be just under capacity during the 3-year study period. However, as we will discuss below, evidence from administrative data and key informant interviews indicate that some programs are under enrolled and that home visiting staff have to be creative and diligent in recruiting families to their programs. Some respondents expressed concern about the need for increased funding to build capacity when current programs are not full. We agree with one of our informants who suggested that the state needs to explore which programs are under capacity, the extent to which the programs are under capacity, and the reasons that they struggle. This might entail conducting another needs assessment like the one done 2 years ago in preparation for the MIECHV program, as well as a more comprehensive analysis of take-up and retention rates in home visiting programs. Another capacity issue is the lack of available and affordable mental health and other resources for home visiting clients. There are two sides to this issue: awareness of resources and access to resources. Community collaborations can help to bridge programs and increase awareness of resources that exist; towards this end, some of our informants highlighted the community systems work that is being piloted through MIECHV as another step towards increasing awareness and collaboration. In addition, the HVTF might explore, with the ELC's System Integration and Alignment Committee, ways to address the current shortage of needed resources and long waiting lists for some types of services, and work to develop new strategies that communities might adopt to improve access to resources.

Program Implementation

Administrative Data Study

An analysis of trends in administrative data on program and family characteristics for the PAT and HFI programs showed modest changes over time. For example, data for PAT programs over a 3-year period starting in SFY 2009 showed a decrease in the total number of programs providing data and the number of families served between SFY 2009 and SFY 2011. At the same time, there were small increases in the percentage of families designated as “low income” over this period (from 74% to 84%), the percentage of single-parent households (from 35% to 50%), and parents who were teens (from 22% to 27%). These trends suggest that as a group, the PAT programs are increasingly serving a higher risk population. Other findings included a small increase in the number of Hispanic families served during this time period (from 20% to 23%) and small declines in the percentage of families starting services prenatally (from 10% to 7%) and in the number of 2-year-old children who were fully immunized (from 89% to 86%).

Data on HFI programs over a 7-year period beginning in SFY 2006 showed there were programs in 52 different local sites; in any given year, there were between 40 and 48 programs. The demographic characteristics of families were fairly stable over the period of study, with 36 percent of the families being recorded as Hispanic, 30 percent as black, 3 percent white, and 31 percent “other.” A little more than half of the mothers served were teen mothers; just over half were high school graduates. HFI administrative data indicated that programs, on average, engaged mothers prenatally in about one-half of all HFI cases, while 40 percent of cases were initiated after the birth of the child. Although these patterns have been fairly stable, there was a clear upward trend in prenatal engagement in Chicago and a decrease in prenatal enrollments in the suburban programs during SFY 2010 and SFY 2011. The increase in prenatal cases in Chicago is a positive trend: A comparison of program duration for two groups of families—those who entered the HFI program prenatally and those who had their first visit shortly after the child’s birth—suggests program retention as measured by elapsed duration of services is noticeably greater for prenatal cases.

The proportion of expected home visits that were actually completed is an important measure of fidelity. For most of the 7 years between 75 and 90 percent of planned home visits took place, with the lower completion levels occurring in programs in Chicago. At the time of the SFY 2009 fiscal crisis, the completion level in Chicago dropped to its lowest level, 70 percent, although it rebounded to about 85 percent during the final three quarters of the year. In contrast, programs in the other regions of the state showed only a minor shift in completion levels during the same time. In addition, the number of case closings increased considerably in Chicago and downstate regions during the fourth quarter of FY 2009. All three regions showed increased recruitment of new cases during the following months in early 2010.

Although the final result of these changes is small in terms of the number of clients served, the fluctuations caused by a short period of unusually high terminations followed by a period of active enrollment reflect instability in the caseload that raises concerns about the system's ability to provide stable services to families.

In general, monthly reports from 14 of the 15 programs in our study sample indicated trends similar to those found in the statewide data. During SFY 2010 and SFY 2011, enrollment was almost always just below capacity. Although there were small fluctuations from month to month, capacity and enrollment tended to stay fairly stable over time. Engagement and enrollment of new families varied from program to program for various reasons, including differences in family needs and the eligibility guidelines and capacity of the three model programs. There also were seasonal and regional variations. Overall, about half of those referred were found to be eligible for services. Likewise, families left programs for a variety of reasons, but the more commonly noted reasons were completion of the program, inability to locate a family, or a family moving out of a program's eligible service area. Additionally, qualitative data drawn from focus groups with home visitors indicated ongoing challenges to keeping high-risk families engaged in services (although they also provided examples of "success"). Home visiting staff most often pointed to their families' transient situations as the major factor that influenced changes in enrollment. Home visitors across all three of the study's geographic regions noted the difficulty of keeping up with some families who moved frequently or "couch surfed" from one home to the next.

Final Thoughts

In conclusion, in evaluating year 3 of Strong Foundations, we observed a number of accomplishments that strengthened the training infrastructure, leadership and administration of the system, and partnerships at the state level. The remaining challenges to the state's efforts to strengthen the system of supports for home visiting programs and improve program quality and model fidelity—notably stable funding, building common data collection and monitoring systems, local system building, and communication across the system—are ones that have been discussed before. There are many considerations when 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 attention on the most underserved families and regions. It is a large strategic, organizational, and logistical task. Despite the challenges, the infrastructure in Illinois continues to reflect resiliency and strength in a number of areas that affect program quality and effectiveness. These include having strong advocacy organizations; growing state-level collaborative leadership that includes public entities such as the OECD, the new Strong Foundations Partnership, the Early Childhood Comprehensive Systems Initiative (ECCS) and state agencies as well as public-private collaborative groups like the ELC

and the HVTF Although the new MIECHV program is focused on several communities, it is providing needed, if short-term, resources to expand home visiting services, which also contributes to the development of infrastructure. We agree with our key informants that the integration of the two initiatives, Strong Foundations and MIECHV, has been a positive development. It recognizes the importance of system building in any effort to expand services, improve service quality, and positively affect family and child outcomes.

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Appendix A: Home Visiting State Systems Development Assessment Tool (HVTF 2009)

Home Visiting State Systems Development Assessment Tool Framework Components

Revised by the Home Visiting Task Force, December 2009

Governance: Administration & Strategic Planning

Vision: An infrastructure serves as a central administration to provide leadership and administrative support for the comprehensive state system. The statewide system has a strategy to sustain and/or expand multiple home visiting models in the state.

KEY ELEMENTS

- Does a **key individual** (primary contact) exist to serve as a resource within the state and with the national office?
- Have **personnel** been identified to oversee the management of the state system?
- Does a **policies and procedures manual** exist for sites in the state?
- Is there a **succession plan** in place to ensure the future leadership of the state system?
- Has a **mechanism for evaluating** the leadership/governance structure been developed?
- Has a statewide collaboration/entity been identified to serve as a **planning group, advisory committee or task force** with a charge of leading a strategic planning process for the state system?
- Does the strategic plan address all the **components** of the state system?
- Has the strategic plan been **disseminated** and explained to all program sites?
- Is there a process for **reviewing and updating** the strategic plan?

Workforce Development, Training & Technical Assistance

Vision: The statewide system provides home visiting training and technical assistance for staff from all sites.

KEY ELEMENTS

- Has a system been developed to **identify and meet** a variety of training and technical assistance needs for all sites in the state?
- Is there enough **trained staff** to coordinate and provide training and technical assistance for the state?
- Does a **training institute** or other structure exist through which training is provided?
- Is there a process to **ensure the quality** of the training provided?
- Has **funding** been secured to enable the provision of both required (core) and wrap-around training needs?

Collaboration, Community Planning & Site Development

Vision: There are strong and inclusive collaborations at the state level and in local communities. The statewide system provides technical assistance for developing, sustaining and expanding home visiting.

KEY ELEMENTS

- Does the statewide collaboration include **key stakeholders** and **existing statewide coalitions** or work groups?
- Has **consensus** been built around what is needed to promote and support quality community-based programs?

- Has **leadership** been provided around the development of local collaborations and partnerships?
- Have **key players** in the community been convened to discuss home visitation in the state?
- Has a method been developed to **educate communities** about home visiting?
- Has there been a concentrated effort to **build onto existing collaborations** and programs?
- When new home visiting sites come on board, is there a method of **providing support** to those new programs?

Research, Evaluation & Continuous Quality Improvement/Credentialing

Vision: The statewide system has established criteria for quality assurance and has a system to ensure adherence to these criteria. The statewide system also collects data for program planning and evaluation purposes.

KEY ELEMENTS

- Has a **quality assurance plan** been developed?
- Have **requisite resources** (staff and/or technology) been procured to meet data management needs?
- Does the **monitoring system** allow for coordinated, confidential and consistent data collection across program funders and models?
- Do programs conduct a **self-assessment** to inform continuous quality improvement and result in the credentialing/certification/commendation of their chosen program model?
- Have **key stakeholders** been included in developing and defining outcome measures?
- Has an **evaluator** been contracted to conduct a statewide evaluation?
- Has a system been developed to **enhance communication between researchers and practitioners** to enable best practices to be incorporated into service delivery?
- Has the impact of **state systems** been evaluated regarding child and family outcomes?

Communication, Public Awareness & Outreach

Vision: All state and local program stakeholders will have current and relevant information to maximize their effectiveness. This information is disseminated so that Home Visiting is well known and recognized as essential support service for families in communities all over the state.

KEY ELEMENTS

- Do **communication processes** exist that connect program sites with one another, the state system, the national offices and other network members (i.e. listservs, websites)?
- Are opportunities being created to **bring people together** to share information and successes?
- Are **regular outreach and public education** efforts conducted?
- Have a diverse variety of **spokespersons** been cultivated and trained?
- Have **user-friendly materials** been developed?
- Are **conference workshops** and other venues being utilized to educate the public about the benefits and importance of home visitation services?

Financing

Vision: The statewide system secures sufficient funding to assure comprehensive quality services based on standards.

KEY ELEMENTS

- Are **diverse funding streams** leveraged to assure adequate funding of Home Visiting services, program improvement, system infrastructure development, research and evaluation?
- Does the strategic plan developed by the advisory body have a corresponding **financial plan** to ensure the success of its implementation?

Evidence-Based Standards

Vision: Standards are aligned across the statewide system and reflect effective practices, programs and practitioners.

KEY ELEMENTS

- Do programs reflect the **Big Tent** and represent a diverse delivery of models to meet the varying needs of communities?
- Do program models reflect **evidence-based practice** with clear standards and criterion for implementation?
- Is there a **comprehensive monitoring system** that is coordinated across funders and models of birth to three home visiting programs that improves program quality by ensuring model fidelity?

Innovation

Vision: Illinois will invest in the development of innovative, evidence-based approaches to home visiting to support the diverse needs of at-risk families.

KEY ELEMENTS

- Does the statewide system support a **balance of model fidelity and innovation** in order to adapt to meet the diverse and changing needs of families across the state?
- Is there a systematic method for enabling and encouraging **promising models** that may not yet have a strong research base?
- Is **ongoing monitoring and evaluation** capturing the findings of these promising models in order to add to the research base of the field?

Appendix B: Ratings of Individual Items on Wilder Collaborative Factors Inventory by State Informants⁴¹

⁴¹ Copies of the Wilder data collection protocols are available from Chapin Hall upon request.
Chapin Hall at the University of Chicago

Table B-1. Ratings of Individual Items on Wilder Collaborative Factors Inventory by State Informants (Spring 2012)^a

Factor	Statement	N	Mean Level of Agreement		Strongly Disagree/ Disagree %	Neutral %	Strongly Agree/ Agree %
			Mean	SD			
<i>History of collaboration or cooperation in the community</i>	Agencies in our community have a history of working together.	17	4.1	0.70	0	18	82
	Trying to solve problems through collaboration has been common in this community. It's been done a lot before.	17	3.6	1.06	12	29	59
<i>Collaborative group seen as a legitimate leader in the community</i>	Leaders in this community who are not part of our collaborative group seem hopeful about what we can accomplish.	17	3.8	0.53	0	24	77
	Others (in this community) who are not a part of this collaboration would generally agree that the organizations involved in this collaborative project are the "right" organizations to make this work.	17	3.6	0.62	0	47	53
<i>Favorable political and social climate</i>	The political and social climate seems to be "right" for starting a collaborative project like this one.	17	3.8	0.95	12	0	88
	The time is right for this collaborative project.	16	4.2	0.75	6	0	94
<i>Mutual respect, understanding, and trust</i>	People involved in our collaboration always trust one another.	17	2.8	1.03	41	29	29
	I have a lot of respect for the other people involved in this collaboration.	17	4.1	0.83	6	12	82
<i>Appropriate cross section of members</i>	The people involved in our collaboration represent a cross section of those who have a stake in what we are trying to accomplish.	17	4.1	0.43	0	6	94
	All the organizations that we need to be members of this collaborative group have become members of the group.	17	3.3	0.85	18	41	41
<i>Members see collaboration as in their self interest</i>	My organization will benefit from being involved in this collaboration.	17	4.4	0.51	0	0	100
<i>Ability to compromise</i>	People involved in our collaboration are willing to compromise on important aspects of our project.	17	3.4	0.87	18	29	53

Factor	Statement	N	Mean Level of Agreement		Strongly Disagree/ Disagree %	Neutral %	Strongly Agree/ Agree %
			Mean	SD			
<i>Members share a stake in both process and outcome</i>	The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts.	17	3.8	0.75	6	24	71
	Everyone who is a member of our collaborative group wants this project to succeed.	17	4.3	0.85	6	6	88
	The level of commitment among the collaboration participants is high.	17	4.1	0.75	6	6	88
<i>Multiple layers of participation</i>	When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations to confer with colleagues about what the decision should be.	17	2.9	0.78	35	41	24
	Each of the people who participate in decisions in this collaborative group can speak for the entire organization they represent, not just a part.	16	2.6	0.81	50	38	13
<i>Flexibility</i>	There is a lot of flexibility when decisions are made; people are open to discussing different options.	17	3.5	1.00	18	18	65
	People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working.	16	3.7	0.89	6	25	69
<i>Development of clear roles and policy guidelines</i>	People in this collaborative group have a clear sense of their roles and responsibilities.	17	3.8	0.75	6	24	71
	There is a clear process for making decisions among the partners in this collaboration.	16	3.3	0.79	13	50	38
<i>Adaptability</i>	This collaboration is able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or change in leadership.	15	4.0	0.38	0	7	93
	This group has the ability to survive even if it had to make major changes in its plans or add some new members in order to reach its goals.	16	4.0	0.52	0	13	88

Factor	Statement	N	Mean Level of Agreement		Strongly Disagree/ Disagree %	Neutral %	Strongly Agree/ Agree %
			Mean	SD			
<i>Appropriate pace of development</i>	This collaborative group has tried to take on the right amount of work at the right pace.	16	3.8	0.75	6	19	75
	We are currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	16	3.5	0.97	25	6	69
<i>Open and frequent communication</i>	People in this collaboration communicate openly with one another.	16	3.3	1.06	25	25	50
	I am informed as often as I should be about what goes on in the collaboration.	16	3.6	0.72	6	31	63
	The people who lead this collaborative group communicate well with the members.	16	3.6	0.81	13	25	63
<i>Established informal relationships and communication links</i>	Communication among the people in this collaborative group happens both at formal meetings and in informal ways.	16	4.2	0.54	0	6	94
	I personally have informal conversations about the project with others who are involved in this collaborative group.	16	4.1	0.77	6	6	88
<i>Concrete, attainable goals and objectives</i>	I have a clear understanding of what our collaboration is trying to accomplish.	14	4.2	0.80	7	0	93
	People in our collaborative group know and understand our goals.	14	3.9	0.73	0	29	71
	People in our collaborative group have established reasonable goals.	14	3.8	0.89	7	29	64
<i>Shared vision</i>	The people in this collaborative group are dedicated to the idea that we can make this project work.	14	4.3	0.47	0	0	100
	My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others.	14	3.9	0.66	0	29	71

Factor	Statement	N	Mean Level of Agreement		Strongly Disagree/ Disagree %	Neutral %	Strongly Agree/ Agree %
			Mean	SD			
<i>Unique purpose</i>	What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself.	14	4.8	0.43	0	0	100
	No other organization in the community is trying to do exactly what we are trying to do.	13	4.2	0.99	8	15	77
<i>Sufficient funds, staff, materials, and time</i>	Our collaborative group had adequate funds to do what it wants to accomplish.	14	2.9	1.07	29	36	36
	Our collaborative group has adequate "people power" to do what it wants to accomplish.	14	2.9	1.00	36	29	36
<i>Skilled leadership</i>	The people in leadership positions for this collaboration have good skills for working with other people and organizations.	14	4.0	0.39	0	7	93

Appendix C: Enhanced Trainings on Domestic Violence, Perinatal Depression, Substance Abuse, and Young Adults with Learning Challenges⁴¹

⁴¹ Included in this report is the Pre-/Post-Survey and the 3-month Follow-up Survey for Young Adults with Learning Challenges. Copies of the Domestic Violence, Perinatal Depression, and Substance Abuse Pre-/Post-Surveys and 3-month Follow-up Surveys are available from Chapin Hall upon request.

Strong Foundations Training Survey Participation Information/Informed Consent

Dear Training Participant,

Today's training is part of Strong Foundations, an initiative to strengthen the infrastructure for home visiting programs in Illinois. Researchers at Chapin Hall at the University of Chicago, a children's policy research center, are evaluating Strong Foundations for the Illinois Department of Human Services. Because you are a participant in today's training, we are interested in your perspective about the training and its content. Before participating in any research study, you must go through a process called "informed consent." This ensures that you understand the purpose of the research, what you will be asked to do, and what researchers will do with the information you provide. The following information is the informed consent process for this study.

What is this study?

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 (IDHS). Part of that study is to learn from you and other staff about your experience with trainings sponsored by Strong Foundations, including today's training about topic.

Who is doing this study?

Chapin Hall is a research center at the University of Chicago that conducts policy research on children, families, and their communities. If you have any questions about this study, please contact the study director, Julie Spielberger: Chapin Hall at the University of Chicago, 1313 East 60th Street, Chicago, IL 60637; 773-256-5187 or 1(800) 508-6023, julies@uchicago.edu. If you have any questions about your rights or are upset in any way about the study, you can contact Mike Schoeny, IRB Coordinator, School of Social Service Administration, University of Chicago (773) 834-0402, mschoeny@uchicago.edu

What will we ask you to do?

If you agree to participate, you will be asked to complete a survey before and immediately after today's training that includes questions about your knowledge of today's topic, and some basic demographic information. In addition, we will email you a follow up survey with similar questions in the Spring. You do not have to answer any questions that you don't want to. Each survey should take about 5 to 15 minutes to complete. This survey is being given to about 80 training participants. Your participation is completely voluntary and there are no consequences to your employment or participation in future trainings if you choose not to participate.

Will we get information about you from other sources?

No.

Will the information about you be kept confidential?

Yes. We will not share the individual information you provide with anyone other than members of Chapin Hall's research team. . Survey responses will be presented in a way that no participant can be identified to anyone outside of the Chapin Hall research team. Nobody at the Ounce of Prevention, your agency, DHS, or the Illinois Board of State Education will ever be able to tell who you are, whether you participated in the survey, or what your responses were.

How will we use the information you provide?

Analysis of survey responses will be presented in a way that no individual can be identified. The information we collect from you 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. Any future research using this data will be presented in the aggregate (grouped together) so that there is no chance of anyone being able to identify your individual responses.

What are the risks associated with participating in this study?

We believe there is very little risk for you to be in this study. One possible risk is someone could find out your survey responses. To avoid this risk, we will keep all your information private and confidential. Your name will not be on any of the surveys, and all responses will be kept in locked file cabinets or on a password protected computer file in a locked room. Only our researchers will be able to see this information. They have promised to keep all of this information private.

Another risk is sometimes you might feel uncomfortable answering some of the survey questions. However, you do not have to answer any question you do not want to.

What are the benefits of participating in this study?

Participating in this survey is an opportunity for you to inform DHS and other Strong Foundations' collaborators about your needs and experiences. While you may not experience this benefit directly, the information you provide about your needs and experiences will help shape the future trainings that Illinois offers to staff of home visiting programs.

What do you do now if you want to participate?

If you choose to participate, please check off the boxes below and fill in your contact information. Then please fill out the attached pre-training survey (the WHITE copy). After today's training, please complete the attached post-training survey (the PURPLE copy) and place the entire stapled packet (including this consent form) in the envelope provided and seal it. There are no wrong answers to any of these questions. Please answer as honestly as you can.

You can skip any questions that you don't want to answer without any penalty or consequence. Your participation is completely voluntary and will have no impact on your employment. Although we hope that you will participate, you can choose not to participate in this survey at all without any penalty or consequence to you.

If you choose not to participate, please check the box below declining to participate and return both of your blank surveys in the envelope provided.

Please return your **SEALED** envelope to the trainer at the end of today's training. Thank you for your consideration!

Please check the appropriate box.

☐ I will participate in both of today's surveys as well as the follow-up survey which should be mailed to the following email address:

Name (PLEASE PRINT)

Email address

☐ I decline to participate.

Young Adults with Learning Challenges Pre-Course

1.

Please check one response to each of the following statements.

	Not at all Confident	Not Very Confident	Not Sure	Confident	Very Confident
a. I feel confident in my knowledge of the common types of learning challenges young adults may be facing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I feel confident in my knowledge of how to identify the common characteristics of most young adults with learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I feel confident in my knowledge of how to intervene in situations where young adults have learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I feel confident in my knowledge of how to develop initial action plans to better serve young adults with learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. What would you like or hope to get out of today's training?

Demographic Questions: *Please help us develop a summary description of training participants.*

1. What is your role at your organization? *(Check all that apply)*

- ☐ Home Visitor
- ☐ Supervisor
- ☐ Doula
- ☐ Program Director
- ☐ Center-based Staff/Teacher
- ☐ Other *(please specify)* _____

2. What home visiting program model do you utilize?

- ☐ Parents as Teachers (PAT)
- ☐ Healthy Families America (HFA)
- ☐ Nurse-Family Partnership (NFP)
- ☐ Early Head Start
- ☐ BabyTalk
- ☐ Other *(please specify)* _____

3. Which home visiting curriculum (if any) does your organization utilize?

3a. What is your program's funding source? _____

4. How long have you been at your current position?

- ☐ Less than 1 year
- ☐ 1 to 5 years
- ☐ 6 to 10 years
- ☐ More than 10 years

5. Approximately how old are you?

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Under 20 years | <input type="checkbox"/> 40-49 years |
| <input type="checkbox"/> 20-29 years | <input type="checkbox"/> 50-59 years |
| <input type="checkbox"/> 30-39 years | <input type="checkbox"/> 60 or older |

6. With which race/ethnicity do you most closely identify? *(Check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> American Indian/Native American |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Hispanic/Latina |
| <input type="checkbox"/> White | <input type="checkbox"/> Other <i>(please specify)</i> _____ |

7. What is your highest level of education?

- | | |
|--|--|
| <input type="checkbox"/> High school/GED | <input type="checkbox"/> 4-year college degree |
| <input type="checkbox"/> Some college | <input type="checkbox"/> Graduate school |
| <input type="checkbox"/> 2-year college degree | <input type="checkbox"/> Other <i>(please specify)</i> _____ |

8. Which language(s) do you use regularly in your work? *(Check all that apply)*

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

Young Adults with Learning Challenges Post-Course

1. Please **check one** response to each of the following statements.

	Not at all Confident	Not Very Confident	Not Sure	Confident	Very Confident
a. I feel confident in my knowledge of the common types of learning challenges young adults may be facing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I feel confident in my knowledge of how to identify the common characteristics of most young adults with learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I feel confident in my knowledge of how to intervene in situations where young adults have learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I feel confident in my knowledge of how to develop initial action plans to better serve young adults with learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please **check one** response to each of the following statements

2. Satisfaction Survey

	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
a. The content of the training was useful and relevant to my profession.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The training increased my knowledge of the subject.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. It was easy to make arrangements to attend today's training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. The training included new material that I had not heard before.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I plan to integrate what I learned today into my work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. The content and material presented at the training today applies to the families with whom I work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. The presenters involved the group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

through discussion and/or other learning activities.					
h. The presenters clearly communicated the subject matter.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. The presenters made good use of examples and materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. The presenters possessed the appropriate qualifications and expertise on the topic.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. The presenters were well organized.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. The presenters kept the session alive and interesting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. The training was well timed and coordinated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. The training allowed time for participation, questions, and discussion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please indicate whether today's training met its specific objectives for you in your home visiting role.

	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
a. The training adequately covered the types, characteristics and causes of learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The training adequately covered the barriers to receiving help for learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The training adequately prepared me to take the appropriate actions and precautions necessary when working with families who are affected by learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. The training adequately prepared me to identify the appropriate community resources and procedures to make sure families who are affected by learning challenges are informed of or linked to these resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Too Easy	Easy	On Target	Difficult	Too Difficult
4. The content and material presented at the training today was...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I would recommend this course to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please explain	

6. I feel I need follow-up training on this subject

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

7. Today's training has increased my desire to stay in this field

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Poor	Fair	Good	Very Good	Excellent
------	------	------	-----------	-----------

8. Overall, how would you rate opportunities for training and professional development for your home visiting role?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

9. Please add your suggestions for improving this training below. Including how it could better be focused for someone in your role associated with home visiting.

10. Please describe any cultural issues related to today's training topic that need further discussion or training.

11. Where would you prefer to receive future training?

Please number from 1 to 4 the following training locations in order of your preference (with '1' indicating your first choice):

_____ The Ounce Training Institute (Chicago or Springfield)

_____ Regional location

_____ Online training available at any time

_____ Webinar at specific times

_____ If you have another suggestion for a training location, please write it here:

12. What other training topics would you be interested in or find useful?

13. What other types of training have you attended in the past 2 years? (*Check all that apply*)

- ☐ Domestic Violence
- ☐ Substance Abuse
- ☐ Depression
- ☐ Parents with Learning Challenges
- ☐ Other Assessment (e.g. ASQ) (*please specify*) _____
- ☐ Program Model specific (*please specify*) _____
- ☐ Other (*please specify*) _____
- ☐ Other (*please specify*) _____
- ☐ Other (*please specify*) _____

Please explain:

THANK YOU!

**Strong Foundations' Trainings
3 Month Follow-up Survey E-mail**

Dear Strong Foundations' Training Participant,

Three months ago you participated in a training by the Ounce Training Institute that was supported through the Strong Foundations Initiative. At the time you signed in, you provided your email address and were informed that you would be contacted by Chapin Hall to participate in a 3 month follow up survey. Below you will find a link to that 3-month follow up survey and a cover letter that explains the survey process and invites you to participate.

Chapin Hall, a children policy research center, has created this survey as part of a study being conducting for the Illinois Department of Human Services. The survey is voluntary, but we hope to have full participation so that Chapin Hall has comprehensive data for the evaluation of all trainings supported by Strong Foundations. All individual responses will remain confidential. Only members of the Chapin Hall research team will have access to the individual survey responses. Your survey will have a unique ID number to help us keep track of the surveys and match your response to the survey you completed 3 months ago.. If you choose not to participate, there will be a place to indicate that you are declining this invitation.

If you have any questions about the survey or the Strong Foundations evaluation, please contact the study director, Julie Spielberger: 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.

Thank you,

ChapinHall

at the University of Chicago
Celebrating 25 years 1985–2010

Dear Strong Foundations Training Participant:

Thank you for participating in the evaluation surveys of the Strong Foundations' training that was offered by the Ounce of Prevention three months ago. At that time you were asked to provide your email address on the sign-in sheet and were informed that Chapin Hall might contact you in the future. These surveys are part of an independent study of Strong Foundations, a state-wide plan to strengthen the infrastructure of supports for home visiting programs. The study examines how the infrastructure is working, whether the current array of evidence-based programs in Illinois is meeting the needs of communities and families, and whether any needed improvements in the operation and effectiveness of local programs. This study is being conducted by Chapin Hall, a policy research center, 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 with the previous surveys you completed this follow-up survey is voluntary, but we hope to have full participation so that Chapin Hall has comprehensive data for the evaluation. All individual responses will remain confidential. Only members of the Chapin Hall research team will have access to the individual survey responses. Your survey will have a unique ID number that will only be used by the Chapin Hall research team. If you choose not to participate, please indicate so below by checking the box to the left of "I decline to participate in the Strong Foundations Training 3 month Follow-Up survey."

As part of our effort to learn more about the recently offered Strong Foundations trainings, we are sending surveys to those training participants who provided their email addresses for follow-up. Basic information about the survey appears below:

1. The survey asks questions about the content of the training and if it has impacted your current home visiting work.
2. Completion of the survey is voluntary and should take no more than 10-15 minutes to complete.
3. Whether or not you choose to participate will have no impact on your employment.
4. You are not required to answer any questions that you do not wish to answer.
5. All of your answers are confidential. They will become part of summary reports in which no individual home visiting program or person is identified.
6. We have assigned you an ID number to help us keep track of the surveys and match your response to the survey you completed 3 months ago. 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.

While participation is voluntary, it is very important to have responses from all of the participants who provided their contact information so we have a more comprehensive picture of the training and its impact. If you have any questions about this study, please contact the study director, Julie Spielberger: 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 any way about the study, you can contact Anita Goodnight, IRB Coordinator, School of Social Service Administration, University of Chicago (773) 834-0402, abg@uchicago.edu. Please check the appropriate box below indicating if you wish to participate or not.

☐ I will participate in the Strong Foundations Training 3 month Follow-Up survey.

☐ I decline to participate in the Strong Foundations Training 3 month Follow-Up survey.

Thank you for helping with this important study.

Sincerely,
Julie Spielberger, Study Director

**Strong Foundations
Young Adults with Learning Challenges Training
3-Month Follow Up Survey**

1. Please check one response to each of the following statements.					
	Not at all Confident	Not Very Confident	Not Sure	Confident	Very Confident
a. I feel confident in my knowledge of the common types of learning challenges young adults may be facing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I feel confident in my knowledge of how to identify the common characteristics of most young adults with learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I feel confident in my knowledge of how to intervene in situations where young adults have learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I feel confident in my knowledge of how to develop initial action plans to better serve young adults with learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. I feel confident in my knowledge of the common types of learning challenges young adults may be facing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Please check one response to each of the following statements.					
	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
a. The content of the training was useful and relevant to my profession.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I shared the information I learned with my colleagues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I have used information from the training in my work with families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. It was easy to integrate what I learned in this training into my work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I will use the information from the training in my work with families in the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. This training has changed how I handle issues of young adults with learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. This training has changed how my agency handles issues of young adults with learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please comment on any item(s) above that you checked “disagree” or “strongly disagree.”		
4. Please respond to the following questions and then provide a brief example of how you have used the information from this training in your work.		
	YES	NO
a. Do you have more confidence in your ability to handle young adult clients with learning challenges as a result of this training?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you used any strategies or knowledge from the young adults with learning challenges training since the training?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you shared what you learned with co-workers (other home visitors or other staff of the home visiting program)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you referred clients to other services for young adults with learning challenges as a result of this training?	<input type="checkbox"/>	<input type="checkbox"/>
e. Have you used the training in other ways? (If yes, please specify): _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
f. Please describe an instance in which the training helped you with your work: _____ _____		
5. Please indicate whether or not your knowledge of the following changed as a result of this training:		
As a result of this training, I am now better able to...	Disagree (My knowledge DID NOT change as a result of the training.)	Agree (My knowledge DID change because of the training.)
a. Identify the signs and indicators that a parent is a young adult with learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>
b. Describe appropriate actions and precautions to take in working with families where the parent is a young adult with learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>
c. Describe actions to avoid in working with families where the parent is a young adult with learning challenges.	<input type="checkbox"/>	<input type="checkbox"/>
d. Identify appropriate community resources and procedures to make sure families where the parent is a young adult with learning challenges know about or linked to them.	<input type="checkbox"/>	<input type="checkbox"/>

6. What part of this training has been most useful to you in your work?			
7. Please indicate whether or not you think this training has had or will have a positive impact on the following:			
	Has not had an impact and I do not expect it will	Has had an impact on this	Has not yet had an impact, but I expect it will
a. My self-confidence in working with families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. My interest in pursuing other professional development in this topic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My level of commitment to this field of work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My interest in pursuing professional development in other topics related to the needs of families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. At this point in time, how satisfied do you feel in your work with infants and families in your home visiting program?				
Not at all satisfied <input type="checkbox"/>	Not very satisfied <input type="checkbox"/>	Not sure <input type="checkbox"/>	Satisfied <input type="checkbox"/>	Very satisfied <input type="checkbox"/>

9. What other information, training, or staff development opportunities would you find useful?				
a.				
b.				
c.				
d.				
e.				

10. Please add any other comments or suggestions for improving this training below:

THANK YOU!!

Appendix D: Monthly Data Collection Form

Program Name:				
Home Visiting Model:				
Has your program been certified by your national model <i>(Please answer yes or no)</i> :				
<i>If yes, date of program certification:</i>				
Q.	PART 1: PROGRAM-LEVEL INFORMATION			
	<i>For each question below, please respond based on each month's information</i>	Apr-12	May-12	Jun-12
Q.				
1a	What is your program's maximum capacity IN FAMILIES this month?			
1b	What is your program's maximum capacity IN POINTS this month? <i>[If applicable]</i>			
2a	How many families were served this month? <i>(Note: this number should match the total caseload number on the staff sheet.)</i>			
2b	IF your program uses points for capacity , please provide the total number of points being served this month. <i>(If not, please leave blank.)</i>			
*3	Has there been a change in capacity (since last month)? *(Please answer yes or no - if yes, please see Q. 13)			
4	What is the total number of families newly referred for services?			
5	Of those newly referred families, how many met the criteria for participation in your program?			
6	Of those who met the criteria, how many new families were enrolled in your program?			
**7	Were there any enhancements - planned changes to the program model? **(Please answer yes or no - if yes, please see Q. 14)			
8	How many staff meetings with both home visitors and supervisors were held?			
9	Typically, how long did each meeting last? <i>(Please answer in minutes)</i>			
10	What is the total number of <i>hours</i> of one-on-one supervision that you had with all home visitors this month? <i>(Please break down hours by supervisor, if applicable.)</i>			
a.	Supervisor #1 [INITIALS:_____]			
b.	Supervisor #2 [INITIALS:_____]			

11	How many families left the program?			
12	Of the families who left the program this month (line 11), how many left or each reason listed below:	Apr-12	May-12	Jun-12
a.	program completed			
b.	declined participation			
c.	moved from area			
d.	unable to locate			
e.	maternal death			
f.	excessive missed visits			
g.	terminate parent rights			
h.	unknown reason			
	Total: (please note this number should match the number in Q.11)	0	0	0
*13	*If yes in line 3, please indicate why there was a change in home visiting capacity	Reason for change in capacity		
	Apr-12			
	May-12			
	Jun-12			
**14	**If yes in line 7, please describe the planned program enhancements	Planned program changes		
	Apr-12			
	May-12			
	Jun-12			

PART 2A: STAFF CASELOAD INFORMATION					
Please detail the monthly caseload for each home visitor and home visitor supervisor. Please include all home visitors and supervisors in your program			Apr-12	May-12	Jun-12
STAFF Caseloads (Number of <i>families</i> being served)	Initials				
Home Visitor #1					
Home Visitor #2					
Home Visitor #3					
Home Visitor #4					
Home Visitor #5					
Home Visitor #6					
Home Visitor #7					
Home Visitor #8					
Home Visitor #9					
Home Visitor #10					
Supervisor #1 (if carrying a caseload)					
Supervisor #2 (if carrying a caseload)					
Totals Note: this should match the number provided in Question 2A on the program info sheet.		0	0	0	
SUPERVISION of STAFF (Number of <i>home visiting staff being supervised</i>)	Initials	Apr-12	May-12	Jun-12	
By supervisor #1					
By supervisor #2					
Totals: (This number should match the total number of staff carrying caseloads)		0	0	0	

PART 2B: STAFF DEPARTURE INFORMATION				
<i>If a home visitor or supervisor departed, please indicate which code below best describes the reason for their departure.</i> Departure Codes: A. Left the field B. Relocated/moved C. Took position with greater salary and/or responsibility D. Position eliminated E. Involuntarily separated F. Other, please specify.		Apr-12	May-12	Jun-12
	Initials			
Reason Home Visitor #1 departed				
Date Home Visitor #1 departed				
Reason Home Visitor #2 departed				
Date Home Visitor #2 departed				
Reason Home Visitor #3 departed				
Date Home Visitor #3 departed				
Reason Home Visitor #4 departed				
Date Home Visitor #4 departed				
Reason Home Visitor #5 departed				
Date Home Visitor #5 departed				
Reason Supervisor #1 departed				
Date Supervisor #1 departed				

Appendix E: Program Supervisor and Home Visitor Survey

Dear Home Visiting Program Staff Member:

As a staff member at one of the local sites that is participating in the evaluation of Strong Foundations, we are asking 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 80 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 10-15 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.

While participation is voluntary, it is very important to have responses from all staff so we understand everyone's point of view. If you have any questions about this study, please contact the study director, Julie Spielberger: 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 any way about the study, you can contact Anita Goodnight, IRB Coordinator, School of Social Service Administration, University of Chicago (773) 834-0402, abg@uchicago.edu. Please check the appropriate box below indicating if you wish to participate or not.

- ☐ I will participate in the home visiting program survey.
- ☐ I decline to participate in the home visiting program survey.

Thank you for helping with this important study.

Sincerely,

Julie Spielberger, Study Director

**HOME VISITOR/HOME VISITOR SUPERVISOR
DEMOGRAPHIC 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 ☐ 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 level of education completed (please select only one)?

- ☐ 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:* (select only one)

- ☐ 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:* (select all that apply)

- ☐ 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

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

- ☐ Yes
- ☐ No

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

SECTION II: Employment Characteristics

14. Date on which you began working in this home visiting model:

___ / ___ / ___ (mm/dd/yyyy)

15. Have you completed model specific training or certification?

- ☐ Yes Date training/certification completed ____ / ____ / ____ (mm/dd/yyyy)
☐ No

16. Your role in the home visiting model:

- ☐ Home visitor
☐ Supervisor
☐ Both

17. **For Home Visitors:** What is your current caseload?

_____ families

_____ number of points (if applicable)

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

- ☐ 10% or less
☐ 11-25%
☐ 26-50%
☐ 51-75%
☐ 76-100%

19. In which languages do you conduct home visits? (*Check all that apply*)

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

20. 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 (26-50%)
☐ Most (51-75%)
☐ All or almost all (76-100%)

21. **For Supervisors:** What is the number of home visitors in the _____ home
program that you supervised this month? visitors
22. What is the average number of hours you spend in direct one-on-one _____ hours
supervision activities each month?
23. **(For All Respondents):** Please indicate the number of hours that you work in a typical
week.
Number of hours worked in a typical week: ____
24. 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:
- _____
- _____
- _____
- _____

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

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

26. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Adult developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Adult mental health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. 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

28. Please indicate if you have participated in any of the following Strong Foundations trainings through the Ounce of Prevention:

- ☐ Domestic Violence
- ☐ Perinatal Depression
- ☐ Substance Abuse
- ☐ Young Adults with Learning Challenges

Thank you for your time. 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 F: State Level Informant Consent, Program Supervisor Consent and Interview Guide and Home Visitor Consent and Focus Group Guide

State Level Respondent, including Coordinating Agencies Consent to Participate in Interview

ChapinHall at the University of Chicago
Policy research that benefits children, families, and their communities

Strong Foundations Evaluation Informed Verbal Consent and Interview Guide for State Level Respondents, including Coordinating Agencies

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, 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 select staff of state and local agencies as well as management staff from select home visiting programs to learn about their activities and experiences with and perceptions of home visiting programs as well as the supports for such programs in Illinois. 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 the state has done to address these challenges. We might contact you again in the next year about completing additional interviews.

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 study is being done to find out how Strong Foundations supports three home visiting programs in their work with families: Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP). The study examines how Strong Foundations is working, how home visiting programs can improve, and how these programs affect parent-child interactions. We are interviewing approximately 20 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 precautions. 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 that in these reports and data presentations 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, program type, or location). However, you may request that we not use quotes from your interview.

Audio-taping our interview provides a more accurate record of our conversation. 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 and transcript of the interview.

This interview will take about one hour to an hour and a half to complete. 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 approximately 20 state level 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 to complete.
 - ☐ 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, 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 any way 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?

Consent for Management of Home Visiting Programs (PAT, HFI, NFP)

ChapinHall at the University of Chicago

Policy research that benefits children, families, and their communities

Strong Foundations Evaluation Informed Verbal Consent and Interview Guide for Management of Home Visiting Programs (HFI, PAT, NFP)

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, 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 select staff of state and local agencies as well as management staff from select home visiting programs to learn about their activities and experiences with and perceptions of home visiting programs as well as the supports for such programs in Illinois. 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 the state has done to address these challenges. We might contact you again in the next year about completing additional interviews.

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 study is being done to find out how Strong Foundations supports three home visiting programs in their work with families: Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP). The study examines how Strong Foundations is working, how home visiting programs can improve, and how these programs affect parent-child interactions. We are interviewing approximately 20-30 agency and program representatives 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 precautions. 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 that in these reports and data presentations 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 interview provides a more accurate record of our conversation. 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 and transcript of the interview.

This interview will take about one hour to an hour and a half to complete. 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 20-30 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 to complete.
- ☐ 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, 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 any way 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 Management of Home Visiting Programs (PAT, HFI, NFP)

Thank you for continuing to participate 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 is examining how the infrastructure is working, whether the current array of evidenced-based programs in Illinois is meeting the needs of communities and families, and helping us 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

1. What is your position and title? Has this changed since our interview last year?
 - a. How long have you held this position?
 - b. What services does your agency provide? Has this changed since our interview last year?

Your Home Visiting Program [HFI PAT NFP]

2. Please describe your home visiting program? ***[Note to Interviewer: Interviewers should review last year's interview prior to this interview. Do NOT assume that the home visiting program is the same as it was at the time of the last interview.]***
3. How many staff do you have? Have there been changes in your staff since last year? Have staff left the program, returned to the program or been newly hired by the program? What are some reasons for staff turnover?
4. 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 the target population for your program? Has this changed?
5. Is your program at or near capacity? What is your program's capacity? NOTE: you can check capacity of program prior to interview from 1/4ly data sheets). Is your program meeting its caseload targets? If there has been staff turnover, how has that impacted the provision of service to families? How does your current capacity state affect home visitors (too many families/too few families, etc.) Are you trying to increase/decrease the number of families to be at capacity or is that not an issue?

6. How is your program funded? Has this changed during the past year?
 - a. If any 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)?
 - b. 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?).
 - c. During the past few years, Illinois has faced some rather significant budget crises, were there any state or national level supports that you turned to during these times? If so, how did you learn about these supports and how did you use them?
7. 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 year, 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. During the past year, 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?
8. What factors affect the implementation of home visiting programs in local communities?
 - a. 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?
9. Overall, what are some of your programs strengths? Weaknesses?

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

10. 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?
11. What type of data does your program keep/collect? How do you use the data (program improvement, evaluation, credentialing/certification something else? Do you use any type of electronic databases? Cornerstone, Visit Tracker, OunceNet? Does your staff prefer to keep paper records? Why? What reports do you provide to your funder and to your program model? If reports are provided to multiple entities, are these reports similar? Are there shared reports?
12. What support do you receive from your agency, program developer, or the state system to help you maintain the quality of your program?

Training/Supervision

13. 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 your staff for working with issues related to culture or at-risk populations?
 - b. During the past year, have there been changes in staffs' perceptions of their professional skills and training needs?
 - c. Have you or your staff attended any of the Strong Foundations training - those trainings offered by the Ounce of Prevention Foundation (perinatal depression, DV, substance abuse)? What are your thoughts about these trainings, if you/your staff have attended them? What is your view of the quality of training provided to programs at the state level?
 - d. Are there other training areas you feel would benefit your staff or agency? Have you shared these ideas with others? If so, who?
 - e. Who gets the on-going training? All staff or just one staff member who then shares what s/he has learned?
 - f. Do you find the trainings are convenient for the staff? Please explain how they are or are not convenient.
14. What support do you receive from your agency or the state system to ensure that your staff are well trained and supervised?
15. Please describe supervision at your agency.
 - a. How frequently do home visitors meet with supervisors? How is supervision conducted?
 - b. If a supervisor carries a caseload, does she have regular supervision as a home visitor? If so, with whom? If not, what alternatives does the supervisor have for processing her case issues?
 - c. Are there 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."

16. Please describe the current state of home visiting in Illinois? Do you feel this has changed in the past year? If so, how?
 - 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?
17. Do you think home visiting programs are supported in IL or your region? How could they be better supported? Have you seen any changes in how home visiting programs are supported during the past year?
 - 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 technical assistance offered to all home visiting programs at the state level? What is your experience with this kind technical assistance? What is your view of the quality technical assistance provided to programs at the state level?
 - c. Have you seen any changes in how home visiting programs are supported during the past year?

18. How would you describe the level of collaboration among home visiting programs in Illinois?
 - a. What about sharing of resources, information, or data? 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?
19. How aware are families and other community members of home visiting programs? Do you think they understand their purpose and support them? Why or why not?

Strong Foundations

20. What do you view as the primary mission and goals of Strong Foundations? Do you think Strong Foundations has made progress towards these goals in the past year? If yes, please describe. How would you define success for the initiative?
21. Are you familiar with other collaborative efforts in Illinois similar to Strong Foundations?
22. 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 Visitor Focus Groups

ChapinHall

at the University of Chicago

Policy research that benefits children, families, and their communities

Strong Foundations Evaluation Informed Verbal Consent for Home Visitors of 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, 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 15 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 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 about 15 voluntary focus groups with 2-10 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 statement 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 type, 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 \$20 in cash.

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

- ☐ The researchers will be conducting 15 focus groups with home visiting staff from PAT, NFP, and HFI. You will be one of two to ten participants in one of these focus groups.
- ☐ 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 \$20 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 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

STRONG FOUNDATIONS GROUP INTERVIEW GUIDE for Home Visitors

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

Year 1 Focus Group Interview Guide for HFI, PAT, NFP Home Visitors

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.

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:

Your Home Visiting Program

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

Referral, Assessment, Engagement Process for your program

4. How available and accessible is your home visiting program to families who could benefit from it?
 - a. Are there populations that are not using the program due to one of those availability or accessibility issues? (if any) Are there other reasons your program may not be serving or is utilized by some population? (e.g. language differences)
5. Are there waiting lists and if so, how long?

How are families referred to your program?

6. 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?
7. 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?
8. Do parents provide feedback about your program? If so, how is that feedback used?

Typical home visits and families

9. How do you typically spend your time during a home visit?
10. How do you work with at-risk families who are hard to engage or hesitant about receiving home visiting services?
11. How do you connect the families with whom you work to other community services including medical services?
12. Tell us a little about the families with whom you work. What are the biggest challenges? What are the biggest strengths?

Supervision and Training

- a. When have you received training? (How often?)
13. What type of training have you received?
14. Do you feel that this training has prepared you for working with issues related to culture or at-risk families?
 - a. Are there any state-level trainings or technical assistance services that have been offered to you? If so, have you participated?
 - b. Are there other training areas you feel would be of benefit to your or your agency?
15. What type of supervision do you receive? How often? Is the amount and quality of supervision enough help to you in your work with families?
16. Do you have any concerns about the program or your training that we haven't talked about?

Community

17. Are you familiar with referral services in your community?
18. How do you learn of new or changing services that may benefit your families?
19. 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?
 - b. Do other agencies refer families to your program?
20. How does your home visiting program meet the cultural needs of the population?

21. 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?

Strong Foundations

22. Prior to learning about this focus group had you heard of the new state initiative called, “Strong Foundations?”

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

23. 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.

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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