

**Building a System of  
Support for Evidence-Based  
Home Visiting Programs  
in Illinois:**  
Findings from Year 2  
of the Strong Foundations  
Evaluation

Julie Spielberger  
Elissa Gitlow  
Carolyn Winje  
Allen Harden  
Aaron Banman  
Kimberly Dadisman

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**January 2012**

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# Executive Summary

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## Introduction

In the fall of 2009, the Illinois Department of Human Services (IDHS), in collaboration with the Illinois State Board of Education (ISBE), the Illinois Department of Children and Family Services (DCFS), and the Home Visiting Task Force (HVTF) of the Early Learning Council began the implementation of Strong Foundations. Funded by the Children's Bureau of Administration for Children, Youth, and Families at the U.S. Department of Health and Human Services, Illinois was one of 17 grantees in 15 states to receive funding for 5 years to support the implementation, scale up, and sustainability of evidence-based home visiting programs for the prevention of child maltreatment. Each grantee 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.

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

- *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 a process evaluation to assess the implementation of the state system, local infrastructure, and the operation of local programs; a pilot study of the newly implemented Strong Foundations trainings on domestic violence, perinatal depression, and substance abuse, and an administrative data study of program performance, capacity, and fidelity.

This second year report is based primarily on interviews in the spring of 2011 with state-level informants and program directors and supervisors at 15 local programs; surveys of supervisors and frontline staff; and records and other secondary information from local programs and state agencies. The report also includes an analysis of administrative data from the IDHS Cornerstone system for Healthy Families Illinois (HFI) programs for a 5-year baseline period prior to full implementation of Strong Foundations. Based on findings from the first two years, we conclude with preliminary recommendations to improve state level structures and supports for evidence based home visitation services, as well as program implementation and quality.

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

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## Key Findings and Recommendations

Findings from the second year of Strong Foundations implementation indicate growing strength in several elements of the state system for home visiting programs. These include an increased emphasis on the use of evidence-based practices and the use of data systems for program monitoring and quality improvement, a range of forums for staff training and development, new trainings to help home visitors work with families with certain risk factors, structures to facilitate communication, increased willingness to blend funding for services, and growing opportunities for collaboration. Most of our key informants in the second year of data collection could envision a more comprehensive training and monitoring system taking place. This is bolstered by the creation of the new Strong Foundations Partnership in the Governor's Office of Early Childhood Development, which now has oversight of both Strong Foundations and initiatives funded under the federal Affordable Care Act's Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). Along with the existing structures for cross-agency collaboration—the Early Learning Council (ELC), the HVTF, and Strong Foundations itself—partners in the home visitation system produced and submitted several proposals for new funding through the MIECHV program.

Growth in the training infrastructure continued to be where Strong Foundations had the most obvious impact. Trainings to enhance the capacity of home visitors to work with families affected by three risk areas—perinatal depression, substance abuse, and domestic violence—were implemented across the state. There were a total of 12 trainings, four in each topic, which engaged more than 200 staff from a range of home visiting programs. The Strong Foundations leadership is also sponsoring “train the trainer” sessions for the Happiest Baby on the Block approach in selected HFI programs. Plans are in place to launch another training to work with families affected by a fourth risk area—adult learning challenges—in the coming year.

In addition to these strengths, state and local stakeholders identified several challenges to system-building efforts in our spring 2011 interviews. Despite the expected influx of new money to expand home visiting services and improve service quality in high need communities, current programs continue to operate in a climate of limited resources at both the program and community levels. Analysis of administrative data on the operations of HFI programs shows a sharp decrease in program services in mid-2009 coinciding with state budget uncertainties and cuts. Although service levels since that time have recovered, suggesting some resiliency in the system, the drop in services during this period of time suggests that the system is still vulnerable when faced with economic shifts. Communication within the system is another challenge that some informants identified in their interviews, particularly in the midst of the intensive, fast-paced work effort required to complete the MIECHV grant applications within tight federal timelines.

Findings detailed in the full report suggest a number of conclusions and recommendations for building the supports for evidence-based home visiting programs in Illinois, as follows:

- *Staff development and training.* Again, the state system continues to demonstrate considerable capacity to provide basic training for a range of home visiting staff. It is encouraging that the importance of continuing to allocate resources to staff development and training across the state is also highlighted in the MIECHV implementation plan. As a result of Strong Foundations, professional development to assist home visitors working with high-risk families in the areas of domestic violence, perinatal depression, substance abuse, and adult learning challenges is more available than in the past. In addition, trainings have been modified for the coming year to incorporate more attention to the application of knowledge in home visiting settings. Other new professional development is being planned 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 from participants in the Strong Foundations evaluation for more comprehensive and deeper training targeted to the diverse needs of different staff.
- *Monitoring, program performance, and quality assurance.* Another important part of the infrastructure is the ability to collect common data across home visiting programs. Although few Strong Foundations resources have been directed at the development of a statewide monitoring and quality assurance infrastructure, a working group of the HVTF produced a set of recommendations towards such a system in the first year of Strong Foundations that provide a foundation for continued work in this area. MIECHV and other federal initiatives provide new incentives and resources to build a data system for the collection of common indicators or benchmarks of child, family, and community well-being. Along with technological advances in integrating data from different systems in a form that can be used by multiple agencies, there is increasing interest among partners in the home visitation system and other agencies to share data across systems. We trust that Strong Foundations stakeholders will continue to explore ways to develop a system of common data elements for all home visiting programs in the state but also to integrate its efforts with existing systems (e.g., the EI system and the DCFS Statewide Provider Database) as well as those being pursued in other state initiatives (e.g., Illinois Project LAUNCH and the Healthy Beginnings II initiative of the Illinois Chapter of the American Academy of Pediatrics). Some of these initiatives include efforts to develop a common screen to be used to enter the system and to track families throughout the system, in order to know when and where referrals are made and the outcomes of those referrals.
- *Communication and public awareness.* A key challenge in any complex system is communication. Our Year 1 interviews suggested that communication between the state and local communities and

programs is not as strong as the communication between state agencies and advocates. Although structures and processes exist to facilitate communication across agencies and across levels of the system, it cannot be assumed that they work equally well at all levels. Participants at the higher levels of the system, in particular, need to be mindful of, and perhaps more intentional about, the way they reach out to and share information with those at the practice level, including frontline staff and families. In addition, findings from Year 2 suggest that in the context of responding to multiple MIECHV funding opportunities some stakeholders in the system did not feel included in the decision-making process or understand the process. We do not have enough information to fully evaluate the extent of these concerns, but they suggest a need for better forms of communication vehicles at different levels of the system to report and explain the planning and decision-making processes to the broader group of stakeholders in the home visitation system.

- *Local system-building.* There is continuing momentum to strengthen local collaborations and partnerships. Thus, the importance of the Strong Foundations-supported community systems development work cannot be overstated. The effectiveness of home visitation as a strategy to improve family functioning and child development depends in part on communities' capacity to offer high-quality programs that meet the diverse needs of their families. It also depends on connections to other services and systems, including health and mental health care and early care and education programs. Staff of local programs in Years 1 and 2 expressed concern about the lack of resources, especially in the current economic climate, and a desire for more knowledge of and connections with other service providers to increase their capacity.
- *Funding strategies.* It goes without saying funding remains an ongoing challenge to the state system, yet any system needs to be flexible and resilient when faced with budget changes and delays in state payments to local providers through resource sharing, collaboration, and innovation. Although data collected for this evaluation provide a somewhat limited view of the impact of the state budget problems on individual home visiting programs, they indicate that staff and caseloads were reduced or reallocated in response to budget cuts but also highlight some of the strategies that individual programs took to maintain the quality of services to families who remained on their caseloads. Given that the original Strong Foundations plan included a funding strategies subcommittee, and the concern expressed by some of our informants about the lack of a solid, long-term plan for generating revenue for services in the future, along with advocacy to sustain current funding, there is a need to renew efforts to look at long-term funding strategies.

In conclusion, there are several challenges that remain to the state's efforts to strengthen the system of supports for home visiting programs and improve program quality and model fidelity. Somewhat paradoxically, as the reach of home visiting programs and other early childhood services have expanded,

the difficulties of coordinating them and maintaining communication networks have multiplied. Bringing quality services to all communities in a large state—making efficient use of all the available resources and sources of talent, ensuring consistent quality of service, reaching the full range of racial and ethnic groups, and focusing particular attention on the most underserved families and regions—is a large strategic, organizational, and logistical task.

Despite these complexities, the infrastructure in Illinois has several strengths that increase program quality and effectiveness. These include strong advocacy organizations; growing state-level collaborative leadership that includes state agencies but also the ELC, HVTF, Early Childhood Comprehensive Systems Initiative (ECCS) and other collaborative initiatives; emerging collaborations at the local community level; and sustained participation by a wide range of stakeholders. In addition to Strong Foundations, the new MIECHV grants are not only bringing more financing for home visiting but are also providing support to ongoing infrastructure development. System-building takes time and challenges, particularly in the still precarious economic climate, are likely to exist for the long term. Yet, our findings indicate that the state's home visitation system has made notable progress in several areas, and that the system is increasing its resiliency and capacity to meet and respond to its challenges in an effective and sustainable way.

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# Introduction

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

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 to implement activities to strengthen the infrastructure of supports for home visiting programs in Illinois and to ensure that these programs operate with fidelity to their model and are supported with necessary training and resources.



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Corresponding to the logic model, the purpose of the local evaluation is to assess the home visiting infrastructure in Illinois and the changes in state infrastructure and program quality that result from the implementation of Strong Foundations. For the purposes of the evaluation, we were asked to concentrate on three models of evidence-based home visiting programs in Illinois—Parents as Teachers (PAT), Healthy Families 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 disability; technical assistance to communities in selecting evidence-based programs to meet the needs of their families and coordinating services; monitoring and assuring the quality of services; use of data for evaluation and program improvement; and public awareness. During the planning year of the grant, which ran from October 2008 through September 2009, the HVTF established six work groups to develop implementation plans for each of these areas.

As described in our first year report (Spielberger, Gitlow, Winje, Dadisman, Harden, Banman, & O'Reilly Schlect, 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.<sup>2</sup> 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?

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<sup>2</sup> Despite the later restoration of funding, it was not sufficient to restore data collection with families.

- *Program quality and fidelity.* Are home visiting programs being implemented and delivered in a way that is faithful to their program models, for example, with respect to staff selection, training, and supervision; engagement, participation, and retention of families; intensity, length, and frequency of services; and links to other community services? What factors affect the fidelity of program implementation?

To address these questions, the evaluation in Year 2 included a process evaluation to assess the implementation of the state system, local infrastructure, and the operation of local programs; a pilot evaluation of the newly implemented Strong Foundations trainings on domestic violence, perinatal depression, and substance abuse; and an administrative data study of 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 1. Copies of the Year 2 interview and survey protocols can be found in the Appendix.

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## **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.<sup>3</sup> 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 (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 tool’s system components, which included perspectives on how well the state was doing in the area, if changes were seen during the previous year or since the beginning of the initiative, strengths and weaknesses, and suggestions for improvement.

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<sup>3</sup>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.

**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, Institutional Review Board (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"><li>• IRB submissions</li><li>• Key informant interviews</li><li>• Review of program documents and data systems</li><li>• IDHS Funding survey</li></ul>	<ul style="list-style-type: none"><li>• IRB submissions</li><li>• Interviews with program administrators</li><li>• Focus groups with frontline staff</li><li>• Survey of program supervisors and frontline staff</li><li>• Collection of administrative and secondary data</li></ul>	<ul style="list-style-type: none"><li>• Analysis of administrative data on evidence-based home visiting (EBHV) program participants at selected time points prior to and during Strong Foundations</li></ul>	<ul style="list-style-type: none"><li>• Collect data for online program and participant variables for assessment of fidelity and child maltreatment outcomes</li><li>• Assist with 2010 site visit</li><li>• Grantee meeting</li></ul>
10/2010-9/2011 (Year 3)	Year 2 Data Collection/ Analysis and Year 2 progress report	<ul style="list-style-type: none"><li>• IRB submissions</li><li>• Key informant interviews</li><li>• Review of program documents and data systems</li><li>• Provider change surveys to assess “special needs” trainings<sup>a</sup></li></ul>	<ul style="list-style-type: none"><li>• IRB submissions</li><li>• Interviews with program administrators</li><li>• Survey of program supervisors and frontline staff</li><li>• Administrative and secondary data collection</li></ul>	<ul style="list-style-type: none"><li>• Analysis of administrative data on HFI, PAT, and NFP participants after implementation of Strong Foundations</li><li>• Collection of DCFS data</li></ul>	<ul style="list-style-type: none"><li>• Collect data for online program and participant variables for assessment of fidelity and child maltreatment outcomes</li><li>• Grantee meeting</li></ul>
10/2011-9/2012 (Year 4)	Year 3 Data Collection/ Analysis and Year 3 progress report	<ul style="list-style-type: none"><li>• IRB submissions</li><li>• Key informant interviews</li><li>• Review of program documents and data systems</li><li>• Provider change surveys to assess “special needs” trainings<sup>a</sup></li></ul>	<ul style="list-style-type: none"><li>• IRB submissions</li><li>• Interviews with program administrators</li><li>• Focus groups with frontline staff</li><li>• Survey of program supervisors and frontline staff</li><li>• Administrative and secondary data collection</li></ul>	<ul style="list-style-type: none"><li>• Analysis of administrative data on HFI, PAT, and NFP participants after implementation of Strong Foundations</li><li>• Collection of DCFS data</li></ul>	<ul style="list-style-type: none"><li>• Collect data for online program and participant variables</li><li>• Assist with 2012 site visit</li><li>• Grantee meeting</li></ul>
10/2012-9/2013 (Year 5)	Data analysis and final report	Note: Administrative and other secondary data collection might continue into the fifth year, but no primary data collection is planned.			

<sup>a</sup> “Special needs” trainings in working with families experiencing domestic violence, perinatal depression, and substance abuse were first implemented in the 2010-2011 program year; training in working with young adults with learning challenges and the Happiest Baby on the Block program were added in 2011-2012.

In addition, we continued to work with 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 visiting 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.<sup>4</sup>

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, with the exception of the focus groups with home visitors so as to minimize their burden. Thus, in the spring of 2011, we again conducted individual interviews with 25 program directors and supervisors and sent surveys to 75 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. Additional information on primary data collection and analysis is available in our first year report (Spielberger, et al., 2010).

New to the evaluation this year was the opportunity to survey a small number of participants in the new Strong Foundations special needs trainings. In the winter of 2011, educators from the Ounce of Prevention Training Institute began the implementation of "Phase I" of the Strong Foundations trainings. Four sessions of home visitor trainings were offered on three topics—domestic violence, substance abuse, and perinatal depression. The evaluation team collected surveys from participants from one session of each of the three training topics—30 participants from the substance abuse training, 18 participants from the domestic violence training, and 10 participants from the perinatal depression training. In addition, the evaluation team made efforts to conduct 3 month follow-up surveys with those training participants who consented to participate in additional surveys.<sup>5</sup>

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<sup>4</sup> It is difficult to get precise counts of programs of different models. The 2010 needs assessment conducted for Illinois indicated that there were 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, and according to the MIECHV Program Implementation Plan there are 47 HFI programs in Illinois. Since the 2010 needs assessment, three new NFP programs have or are set to open in Illinois.

<sup>5</sup> As described later, the response rate for the follow-up surveys was only 43 percent of those who agreed to be contacted for a follow-up survey. We will revise our procedures for 2011-2012 in an effort to increase our response rate.

In Year 3, the evaluation team will again conduct surveys of participants in an expanded array of training opportunities. These will include the trainings mentioned above, as well as the new training, Working with Young Parents with Learning Challenges, which completes the Big Four agenda under Strong Foundations. Several additional trainings and technical assistance efforts are planned as part of “Phase II” of the Strong Foundations trainings. First, Strong Foundations, through the Ounce Training Institute, is in the process of developing new Regional Supervisors Networks, which will emphasize supervision and support for home visiting staff who have attended the Big Four trainings and/or encountered the Big Four risk factors on their caseloads. Two Strengthening Families trainings, Protective Factors and Understanding Trauma and Children Exposed to Violence, will be offered under the Strong Foundations umbrella as part of “Phase II.” In addition, IDHS has contracted with Prevent Child Abuse Illinois (PCA-IL) to implement the Happiest Baby on the Block program based on a soothing technique developed by Dr. Harvey Karp. The Strong Foundations Happiest Baby on the Block project will provide certification and/or training to parents and direct service staff of the three program models in the initiative, as well as to Early Head Start programs. The project is designed to form a certified network of Happiest Baby on the Block trainers from home visiting program staff and to enable new parents who participate in the trainings free access to Happiest Baby on the Block techniques and materials (Prevent Child Abuse Illinois, 2011).

### **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 have established data sharing agreements with the appropriate state or national agencies to obtain state-level data electronically. We are continuing to collect and analyze data over an extended period of time beginning 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. For this second year report, only HFI data are analyzed. (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 16 other grantees. The goal of the cross-site evaluation is to identify successful strategies for adopting, implementing, and sustaining high-quality home visiting programs for the prevention of child maltreatment. MPR-CH conducted a partnership survey and telephone interviews in the spring of 2010

with selected agency directors, other state-level participants, and home visiting program staff. In Year 3, MPR-CH will conduct site visits to each of the 17 grantees. The Chapin Hall local evaluation also contributes selected home visiting services data collected from local sites and data on staff characteristics collected through a quarterly data reporting form (see Appendix D).

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## **Overview of this Report**

This report draws primarily from interviews with state-level informants, interviews with program directors and supervisors at 15 local programs, staff surveys, and surveys from the special needs trainings. It begins with perspectives on the state system from key informants at the state and local program levels and then turns 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.

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# State Context and System for Evidence-Based Home Visiting Programs

In this chapter, we discuss the state infrastructure that supports evidence-based home visiting programs, respondents' perspectives on the strengths and weaknesses of the current system, and enhancements to the state system supported by Strong Foundations. As noted in our first report, Illinois has a strong record of working collaboratively at the state and local levels to build a comprehensive system of early childhood services. This is reflected in initiatives such as the AOK Networks and the Children's Mental Health Partnership. The three lead state agencies in the Strong Foundations initiative—the Illinois Department of Human Services (IDHS), the Illinois State Board of Education (ISBE), and the Illinois Department of Children and Family Services (DCFS)—and other public and private stakeholders—the Ounce of Prevention Fund, Voices for Illinois Children, and Prevent Child Abuse Illinois, among other providers and advocacy groups—built on this history in developing the proposal for Strong Foundations and strategies for implementation. In the proposal, as well as in the implementation strategies of the Home Visiting Task Force (HVTF), it was noted that despite the legislative successes and growing collaboration across different state agencies serving young children and their families during the past decade, a number of gaps and challenges remain to meet the goal of a unified infrastructure.

For much of the period from 2000 to 2010, Illinois has enjoyed a political climate supportive of the development of the early childhood system. For example, in 2003 a state statute created the Early Learning Council (ELC) to guide the development of a statewide early childhood education and care system. Subsequently, legislation creating the Preschool for All program was passed in 2006. In 2008, the HVTF was created under the auspices of the ELC. The task force includes IDHS, ISBE, DCFS, Voices for Illinois Children, the Ounce of Prevention Fund and many others—including parents, researchers,



home visiting service providers and other interested persons and organizations. In the fall of 2009, at the recommendation of the ELC, the governor created the Office of Early Childhood Development (OECD) within the governor's office to solidify Illinois's efforts to establish a comprehensive, statewide early childhood system. This office became fully operational in the fall of 2010 when the Director of the OECD was hired. In the spring of 2011, a Strong Foundations Partnerships Director was hired. The Strong Foundations Partnerships Director has responsibility for both Strong Foundations and efforts funded through the new federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program established as part of the Patient Protection and Affordable Care Act (2010).

During the second year of Strong Foundations implementation, participants in the initiative continued to focus their efforts on two broad strategies likely to strengthen the system and benefit local programs and communities during the remaining grant period. One strategy, and perhaps the more central one in the second year, develops and implements specialized training for home visitors on how to approach issues of domestic violence, developmental disabilities, substance abuse, and parents with learning challenges. The second strategy provides technical assistance to develop local systems that support communities as they choose and implement the evidence-based home visiting model(s) that best fits their needs.

These efforts were bolstered during 2011 by additional funding available through the federal MIECHV to expand home visiting and build upon the state-level infrastructure and the enhancements supported by the Strong Foundations grant. The public-private partnership that implemented Strong Foundations worked together to determine how Illinois could use the MIECHV funding to benefit the long-term development of home visiting. Indeed, much of the state's focus on strengthening the infrastructure for home visiting depends on the MIECHV program, which provides an unprecedented opportunity for collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs. When asked about the relationship between Strong Foundations and MIECHV funding opportunities, several informants noted that although they are distinct efforts, Strong Foundations has helped to strengthen the system for home visiting in Illinois as well as the public-private partnership represented by the HVTF, both of which have been essential in the state's response to the MIECHV opportunities. As one respondent noted,

I think everybody is at the bigger table that is connected to the Maternal, Infant, and Early Childhood program. Strong Foundations is really the framework to support the Maternal, Infant, and Early Childhood Visiting program. And, so, with that in mind, we have an opportunity to hear the direction that home visiting and Illinois will be going in and adjust or make plans for Strong Foundations in relation to those things.

Another informant explained the distinction between MIECHV and Strong Foundations, but acknowledged that because many of the same individuals and organizations are involved in both efforts, it is challenging for some participants to keep them separate:

MIECHV is a much bigger project, and it is going to be funding direct services. Strong Foundations is [about] building the capacity so program people are going to try to leverage as best they can what is going [on] in Strong Foundations to affect the delivery of services in MIECHV, but there are two sets of outcomes. The outcome for Strong Foundations is whether or not the capacity is being built through measures of fidelity to the existing models. The focus of MIECHV is on individual client outcomes. I mean, through providing the services it is anticipated that we will see improvements in general outcomes. That type of emphasis is not part of Strong Foundations but everybody that is involved with Strong Foundations is also involved in MIECHV so that is a challenge.

During 2010, the HVTF Executive Committee and its partners worked diligently to respond to the federal requirements for MIECHV funding. In September 2010 the state submitted the required comprehensive needs assessment for the purpose of identifying those areas in Illinois at highest risk for negative maternal and child health outcomes. Using data on 11 need indicators, 18 communities were identified as possible candidates for MIECHV funding.<sup>6</sup> The Executive Committee of the HVTF then developed criteria to select semifinalist target areas. Once the criteria were presented to and approved by the full HVTF, the Executive Committee utilized a quantitative and qualitative assessment to narrow the field to nine semifinalists (Illinois Department of Human Services, 2011). The Community Systems Development Work Group (CSDWG), a work group comprised of members from the ELC's Infant Toddler Committee, its Oversight and Coordination Committee, and the Government Interagency Team of the state's Birth to Five Project, provided technical assistance to the nine semifinalist communities. These communities submitted written narratives and made presentations to a multidisciplinary review panel. The panel awarded the first MIECHV implementation grant (MIECHV-1) to the top scoring city (Elgin), township (Englewood/West Englewood/Greater Grand Crossing), and county (Macon County).

Subsequently, in June 2011, the applications for the MIECHV state fiscal year 2011 *Competitive* Grant (MIECHV-2) and the *Formula* Grant (MIECHV-3) were released and both were due back in short order. Given the requirements and deadlines of these new grants, a written request for proposals that included a research component was sent out to the members of the HVTF for MIECHV-2. The Executive Committee of the HVTF selected two innovations as the basis of their applications. One was the expansion and

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<sup>6</sup> According to the Maternal, Infant, and Early Childhood Home Visiting Program Overview, a document distributed at the 8/31/11 HVTF meeting, the indicators of need were the following: premature births, low birth weight infants, infant mortality (particularly early death due to child maltreatment), poverty, crime, domestic violence, high rates of school drop-outs, substance abuse, unemployment, child maltreatment, and existing gaps in current home visiting capacity.

randomized control trial of doula-enhanced, evidence-based home visiting models and the other was the implementation and enhancement of the Fussy Baby Network in selected Healthy Families Illinois programs. MIECHV-3 allows for maintenance of state fiscal year 2010 (SFY2010) funding for the three initial MIECHV (MIECHV-1) communities and the opportunity to expand to three additional communities. The Executive Committee of the HVTF selected the next highest-scoring city (Rockford), township (Cicero), and county (Vermillion County) from the nine semifinalists (Illinois Department of Human Services, 2011).

Below we discuss the perspectives of our key informants on the current infrastructure of supports for evidence-based home visiting programs in Illinois and changes that have occurred as a result of the Strong Foundations program. These views were collected in interviews conducted in the spring of 2011 with state-level participants and local program directors and supervisors. We then present findings on the implementation of strategies to enhance the system, with a focus on training of home visitors and technical assistance to communities, during the second year of the Strong Foundations implementation.

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## **Perspectives on the State System**

As described above, 2011 brought a number of significant changes and opportunities to Illinois's early childhood system and specifically to Illinois's evidence-based home visiting system. The restructuring of the ELC under the auspices of the OECD and the new federal funding opportunities under MIECHV created some new priorities and strategies during the past year, but most of our informants saw the Strong Foundations initiative as a necessary foundation for the state's MIECHV applications to expand and strengthen the state's home visitation efforts.

## **Governance and Strategic Planning**

According to the Healthy Families America State Systems Development Guide (2003), a centralized administrative structure to provide leadership and management and a plan for sustaining and expanding home visiting models throughout the state are critical components of the system. The recently established Governor's Office of Early Childhood Development (OECD) provides overall coordination and policy leadership for the developing system of early childhood services, including home visitation, in the state. The fact that the Project Director for Strong Foundations is also the Director of the MIECHV-funded Strong Foundations Partnership ensures that the implementation of both projects has the highest level of support within the Executive Branch. This structure also helps to maintain Illinois's "big tent" approach in supporting evidence-based and promising approaches to home visiting, as well as coordinating policy development and program management across agencies responsible for home visiting programs in Illinois.

The OECD works closely with the public-private partnership that is the HVTF, which also (either through the Executive Committee of the HVTF or the full Task Force) recommends policy to the OECD, IDHS, and ISBE regarding the development, support, expansion, monitoring, and evaluation of home visiting in Illinois, including the services that will be supported through the MIECHV grant. According to the implementation plan for the first MIECHV grant, “in support of this effort, the Executive Committee plans and executes the activities of the Evidence-Based Home Visiting (EBHV) and MIECHV grants synergistically” (IDHS, 2009). For the past year (July 2010 to July 2011) the primary charge of the HVTF Executive Committee has been to guide the development of the three different MIECHV funding opportunities, an implementation plan for the first application, and the completion of a statewide needs assessment. 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.<sup>7</sup>

Although it is beyond the scope of this report to provide more detail on the development of the MIECHV application processes, it is important to note the multiple application processes required significant and intense activity during the past year. The start-up of the OECD, the hiring of its director, and the subsequent hiring of the director for Strong Foundations Partnership more or less occurred during this period, so considerable change took place in a fairly short time. Therefore, there were times when decisions had to be made without full discussion or review by the full Task Force; perhaps it was unclear to some state and local stakeholders how decisions were being executed. This context is important background for understanding our findings related to the topic of governance and leadership of the state home visitation system.

Centralizing strategic planning and decision making for the home visitation grants in Illinois in the OECD was seen as a necessary move given the “big tent” approach stakeholders intended for the home visitation system in Illinois. As one informant explained,

Our goal was to go across systems and [create] a true public-private collaboration and thereby there would not be a single owner, if you will, particularly that it would not be just another IDHS-owned

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<sup>7</sup> As described in the MIECHV implementation plan submitted June 8, 2011, the Strong Foundations Partnership supports and is supported by the Home Visiting Task Force. The HVTF, led by its Executive Committee, serves as the convening, policy-setting, and decision-making body for the Strong Foundations Partnership. The Task Force is currently co-chaired by the President of the Ounce of Prevention Fund and the Vice President of Voices for Illinois Children and has more than 100 active members. The members of the Strong Foundations Partnership, along with a researcher with expertise in home visitation research and policy from Chapin Hall at the University of Chicago, comprise the Home Visiting Task Force’s Executive Committee. Hereinafter, the term “Executive Committee” refers to the joint actions or decisions of its members working in collaboration.

initiative. And I'm not using that in the negative sense, but in a descriptive sense. So the Task Force is out of the governor's office by virtue of it being a committee of the ELC. So we worked with leadership at IDHS and the ISBE particularly to forge an agreement that the Task Force itself would have perhaps an unusual level of ownership. It would be more than advisory.

Recognizing that different agencies and funding sources for home visiting programs in Illinois mean heterogeneity of models, expectations, and target populations, most of our informants viewed locating the infrastructure for home visiting in the governor's office as a positive move. In the words of one state-level informant, it is "100 percent positive in terms of process." Another informant told us that this move represents "some really significant progress," explaining that Strong Foundations and the Strong Foundations Partnership, although unusual, "is truly a cross-agency initiative [that has taken] a lot of time to build the capacity of the governor's office to be its home." Another informant echoed this view: "The Director has the broader vision of early childhood as a system as a whole, and she's able to, from her perspective, see across all of the programs and the silos and all that we're doing and see where there's possibilities for us to integrate and collaborate and work better together."

At the same time, one informant noted that the shift in governance and administration to the OECD "has been a really big change." Implementing and communicating the new structure has been complicated by the fact that IDHS continues to serve as the lead agency for the MIECHV grants and their implementation. As another informant explained,

IDHS is the grantee for Strong Foundation and is going to be the grantee for MIECHV, and they're fully accountable. But all of the sudden, another government Executive Branch is heading the leadership for programmatic [efforts]. And the governor's office doesn't really have programmatic [experience]. So I think a lot of people in the state departments are saying 'how did this happen, and how is it going to work?'

Another test for the new governance structure was the "human capital challenge" posed by the delay in hiring the Strong Foundations Partnership Director. As one administrator explained,

IDHS has a very complicated and labor intensive procurement process that slows down. It's like we can make a decision but in order for it to get paid, the approval process is long. We work together really very well. I think in terms of planning for activities, in terms of making sure that we're lining up our strategies and activities to meet the goals of those projects, we're doing well in those areas. I think it's just the red tape.

Until that position could be filled, an "ad hoc Management Team," in the words of one informant, had to be created to "keep things moving forward." Thus, the HVTF Executive Committee was designated as an interim decision-making body of the HVTF.

Its job is to shape and plan how things need to be carried out at a strategic level along with the [HVTF]. And we don't want to get out in front of the whole task force for any length of time. The Management Team was set up primarily because the day-to-day, nitty-gritty needed to keep moving and it was a shared sort of responsibility. It was an interim "keep it moving" dynamic that we intend to phase out now that there's a Project Director coming onboard.

In forming the Executive Committee Management Team, members chose not to include representatives of specific evidence-based home visiting models—although they were represented on the HVTF—because they did not know at the time which models would be involved in MIECHV and did not want to include anyone that might have had a conflict of interest at the point of community selection.<sup>8</sup>

In our spring interviews, although they were positive about the establishment of the OECD, state-level informants differed in their perspectives on how decision-making was managed during the transition in leadership and governance during the past year, particularly around the new MIECHV funding. As one informant explained, it can be challenging to maintain a participatory decision-making process when stakes are high and decisions have to be made quickly.

What was requested through MIECHV is strong committed partnerships. But when you need to get things done, it's always been my experience that you have a singular force. The governor's office was trying to be that singular force, but certain things conspired against it. One is who has the responsibility for the purse strings, and in this case, the purse strings reside in [at least] two other offices. If you had a singular force that came in and made all of these directions, it could result in alienating the partnerships and then you're kind of like at square one. It's difficult.

Indeed, a few respondents expressed a concern about a lack of transparency in the decision-making process around the MIECHV funding and the fact that some stakeholders were or felt left out of the process.

The process [for decision making] has not been transparent. That's been a huge challenge. Last summer the MIECHV was released and the stakes became higher. And the way it's been set up is an Executive Committee and of that Executive Committee there is a small group of leadership making [most of the] decisions. A lot of people have said they feel like they don't necessarily have a voice in what's going on, or that their voice doesn't matter.

More communication about the process and the reasons for the decision-making structure might have made the process both more transparent and more acceptable to stakeholders who were not directly

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<sup>8</sup> According to the MIECHV Implementation Plan (IDHS, 2011), the following evidenced-based home visiting models—all of which were currently operating to some degree in the state at the time of the application—were designated as approved models, with the understanding that the list of models might change over the course of the initiative: Healthy Families America, Parents as Teachers, Early Head Start, Nurse Family Partnership, and Healthy Steps for Children.

involved in the MIECHV applications. The primary communication vehicles were the quarterly meetings and occasional e-mail updates. Given the pace of the work, it might have been difficult to create other communication vehicles—for example, an online portal that provided an overview of the process and opportunities for feedback from viewers—but they might have helped to explain the planning and decision-making processes and how they were built on prior system-building work to the broader stakeholder group.

At the same time, even among respondents who expressed concerns about some of the decision-making processes of the past year, there was a general sense of optimism about the growing collaboration among the three main state agencies involved in the development of the home visiting system—IDHS, ISBE, and DCFS.

[The] state partners have become a lot more involved than they were a year ago. The role of IDHS has become a lot stronger. They've really unified their administration around home visitation and their leadership. Also they've made some progress with the State Board [of Education] and with understanding how DCFS is involved as a player. There's been a lot more strengthening of relationships because [they] spent more time together working on projects and just working together in general.

This increased collaboration, it should be noted, reflects the original Strong Foundations plan, which envisioned shared leadership and accountability for the home visiting system among these three organizations.

### **Collaboration and Community Planning**

Another important part of the home visitation infrastructure is the existence of “strong and inclusive collaborations at the state level and in local communities” (Home Visiting State Systems Development Assessment Tool, HVTF, 2009). As discussed above, some of our informants pointed to the stronger relationships among IDHS, ISBE, and DCFS as evidence of growth in the home visitation system. In addition, some informants pointed to the emergence of new relationships at the state level with, for example, the Maternal and Child Health Division of IDHS and the state's Substance Abuse and Domestic Violence Divisions, as another indicator of progress made possible by Strong Foundations.

We have brought new partners to the table in home visitation, which has been a really great thing for families. One idea is that Maternal/Child Health really is the one who takes the lead in home visitation, and that they need to be strong partners [in other divisions of IDHS]. And what that has been meant is IDHS is the grantee for all of Maternal/Child Health. We've also brought substance abuse to the table, and that's something that has long been missing from home visitation. We know it's there, but those are kind of two different human service worlds. [These] new partners have been



really, really a benefit to home visitation. Now, how it's working, I think anything new has definitely had its growing pains.

According to another informant, “[Substance abuse, domestic violence, etc.] programs are working with very, very complex families. They enrich the core program and offer dimensions that help with these very vulnerable families. And without Strong Foundations we wouldn't have been able to get as far as we have.”

When asked about progress in building collaboration at the local level, most informants agreed that this component of the system was receiving attention through the work of the Community Systems Development Work Group (CSDWG). A few noted that because of the technical assistance provided by Strong Foundations in the first year of implementation, potential communities selected for funding under the MIECHV program were rather quickly provided with assistance from Positive Parenting DuPage, the agency that provides technical assistance to communities. On the other hand, the general view at the time of our interviews in the spring of 2011 was that there was still a lot of work to be done. The following excerpt reflects the view that more support at the state level is necessary for progress in local system-building:

On a state level I think there is collaboration; we work with our partners to try to make sure everybody's at the table who needs to be there. At the local level, they are collaborating as best they can too, and it's up to the funders to help them collaborate because a lot of times we verbalize that we want them to collaborate, but when you look at the work that's required for them to receive their funding, it doesn't support that.

### **Technical Assistance to Communities**

Consistent with the goal in the Home Visiting State Systems Development Assessment Tool (HVTF, 2009) to provide technical assistance to develop, sustain, and expand home visiting, a specific goal of Strong Foundations was to develop a technical assistance strategy for communities to implement the home visiting model that best fit their local needs or to help communities work with their multiple home visiting models so that they were available to families in a coordinated and efficient manner. Much of this charge has been led by the CSDWG, a cross-committee, cross-system work group of the ELC. The CSDWG created and distributed two community toolkits to assist interested communities with the process of assembling a collaborative local planning team, assessing community needs and resources, identifying potential funding sources, developing a strategic plan, and selecting the home visiting model or



combination of models that best met the communities' needs.<sup>9</sup> The work group also recommended two levels of outreach to local communities to disseminate the toolkits. As described in more detail in our previous report (Spielberger et al., 2010), the first phase, Awareness Level Outreach, began in the spring of 2010 with Positive Parenting DuPage leading seven regional Collaboration and Systems Building Technical Assistance sessions to disseminate information on building community partnerships and home visiting to new or existing community partnerships, home visiting providers, and state agencies (e.g., IDHS, ISBE, Head Start).

During this past year, technical assistance to communities was largely focused on the MIECHV program. As indicated in the MIECHV implementation plan,

The creation or enhancement of an early childhood collaboration in each of the target communities is intended to ensure that each home visiting program is firmly embedded in the community's service delivery system. The early childhood collaboration will also strengthen the relationships among Title V and other agencies which serve families with young children (IDHS, 2010).

With the goal of raising awareness about the importance of community collaborations and building strong local community partnerships in Illinois's communities, the CSDWG provided technical assistance to the MIECHV semifinalist communities on matching home visiting models to their community's needs. In the spring of 2011, the chair of the work group conducted a webinar for the semifinalists, as well as provided technical assistance to interested communities utilizing the CSDWG's Resource Toolkit (Community Systems Development Workgroup, 2010). Each semifinalist team made a community presentation and prepared a written description of their community needs and resources and presented a justification for selecting one or more of the primary models.

## **Funding**

Financing is another key component of a state system, particularly diverse funding streams that are leveraged to assure adequate support for quality home visiting services, program improvements, development of the system infrastructure, and research and evaluation. As mentioned above, for example, one respondent pointed out that funding could be more effectively leveraged to help foster collaboration at the local level.

Again, three organizations are primarily responsible for funding home visiting programs in Illinois, two state level agencies—ISBE and IDHS—and the Administration for Children and Families of the US

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<sup>9</sup> Two toolkits developed by the CSDWG, the Community Systems Development Resource Toolkit: Supporting Local Communities in Collaboration and Partnership Building and Resource Toolkit for Communities Considering and Implementing a Home Visiting Strategy: Identifying Program Models to Meet Community Needs, are available at <http://www2.illinois.gov/earlychildhood>.

Department of Health and Human Services (HHS). The ISBE Division of Early Childhood Education funds the largest number of programs through the Early Childhood Block Grant, which includes an infant/toddler set-aside that ensures that a percentage of funding will be spent on programs and services for infants and toddlers. The majority of the ISBE-funded programs are home visiting programs, and most of them are PAT programs, although not exclusively; ISBE also supports a Healthy Families Illinois (HFI) program and a Nurse-Family Partnership (NFP) program. In addition, ISBE provides financial support to the Ounce of Prevention Fund to operate the Parents as Teachers state office. IDHS, which serves as the lead agency for Strong Foundations and MIECHV, funds 37 HFI programs. The Ounce of Prevention Fund, which operates as a public-private partnership, combines private resources with state funds from IDHS to operate the Parents Too Soon (PTS) program.<sup>10</sup> IDHS and ISBE also provide financial support to the Ounce of Prevention Fund to operate the Ounce Training Institute, which trains local staff from all state-funded home visiting programs. In addition, the Administration for Children and Families of the US Department of Health and Human Services (HHS) provides federal funding for a total of 30 Early Head Start programs in Illinois, of which 28 provide home visitation services (IDHS, 2011). Other than the federally funded Early Head Start and Head Start home-based programs, most of the other funding streams are relatively small and, according to our informants, cannot help support a comprehensive, intensive evidence-based model of home visiting.

In our 2011 interviews, state and local informants continued to express the same concerns they had the previous year about funding, delayed payments to providers, and the lack of financing strategies. As indicated in recent national news reports, as of September 2011 Illinois owed a staggering 5 billion dollars on 166,000 unpaid bills.<sup>11</sup> News coverage cited a 2009 Urban Institute survey which found that even then, when the backlog was less severe than it is today, Illinois nonprofits faced the most state and local payment delays in the nation—83 percent compared with the national average of 53 percent (Wills, 2011). Given this context, it is a significant achievement that the governor announced that he would not reduce home visitation funding and restored funding to SFY2010 levels in order to comply with the “Maintenance of Effort” requirement for federal funding. As one state-level informant explained,

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<sup>10</sup> A third NFP/PTS program in Illinois began in the spring of 2011. Two additional NFP programs, one in Lake County and one in DuPage County, are being launched by local health departments with county funds. Nine PTS sites use the Healthy Families America model, nine use the Parents as Teachers model, and one uses the Nurse-Family Partnership model.

<sup>11</sup> See, for example, Susan Frick Carlman, "Behind on its bills, state shares \$5 billion shortfall with businesses, nonprofits ." Chicago Sun Times, October 23, 2011. Naperville Sun. 25 Oct. 2011. Available at <<http://napervillesun.suntimes.com/news/8238951-418/behind-on-its-bills-state-shares-5-billion-shortfall-with-businesses-nonprofits.html>>.

If you ask programs the best thing that happened to them this year, it would have to be that the governor said he was not going to reduce home visitation, and then the funding levels were increased back to their original levels, and that really is huge. That happened because of advocacy efforts and the pressure on the governor to have a memorandum of agreement that Illinois would not reduce current home visitation funding levels, so that we could receive federal funding. That definitely was a huge positive for Illinois.

Another respondent remarked upon the increased level of security that having the Maintenance of Effort provision included in the federal funds provides.

The best thing that has happened to help secure funding for home visiting was the Maintenance of Effort requirement that was written into the federal statute. So, at the very least, unless the state wants to jeopardize its federal funds for home visiting, the amount of general revenue that has to be appropriated to IDHS to support these programs is locked in, at least at the level of SFY2010, for the next four or five years.

Despite the Maintenance of Effort requirement, almost all respondents spoke about the severe repercussions to local service providers and communities from a lack of timely payments. According to one informant, “The inability of the state to pay out in a timely manner has caused some programs to have to make a really sad decision to suspend services because the burden of the ongoing funding has fallen on the shoulders of the local providers.” Another informant, a state-level administrator, told us:

Right now our fiscal crisis is our biggest issue. We have not received any cuts as a result of the Maintenance of Effort related to the MIECHV grant, but because the state is in such a financial crisis and the programs are funded through general revenue, the money is just not there to pay the providers in a timely manner. That has been a critical blow to the provider’s ability to provide services. The State is doing what it can to respond to this fiscal challenge. They’re adjusting. It’s just really hard. I don’t think we’ve ever been in this position before, and everyone is doing everything they can.

For some providers and communities, the discussions about expanding home visiting with the anticipated influx of MIECHV funding might have seemed incongruous with the delays in state payments to local providers. As one informant explained:

The funding on paper is outstanding, with the MIECHV Maintenance [of] Effort and the increase in the block grant. I read how the legislature is supporting home visiting and I say, “Great, now pay them.” When I’m out in the field, I literally hear stories of people who say, “I won’t apply next year,” [or] “We’re dropping it,” or they’ve already dropped off. There’s attrition. Somebody just said to me, “We’re not allowed to apply again because big cash flow is so bad.”

In addition, a few informants expressed concern about the lack of financing strategies and a solid, long-term plan for generating revenue for services in the future. As one informant noted, in addition to

advocacy to sustain current funding, there was a need to convene a subcommittee of the HVTF to look at funding and to continue advocacy efforts that never got off the ground.

There's a Finance Committee that has never really fully taken place. Making sure the Finance Committee is convened is a very important thing to move forward on. And the other thing would be making sure that at the state and federal levels there's advocacy to ensure that we maintain our level of funding and hopefully have even more funding coming in.

### **Communication and Public Awareness**

According to the Healthy Families America State System Development Guide (2003), another component of an effective infrastructure includes a way to communicate and disseminate current and relevant information about home visiting to different stakeholders in the system. These include communication processes that “connect program sites with one another, the state system, the national offices and other networks,” as well as “regular outreach and public education efforts.” In our previous report, we found that communication processes and efforts among both advocates and state leaders and state and local programs were rather good. However, there was also the perception that local programs are not necessarily part of local networks, nor are they fully aware of being part of a statewide network. The work of the Community Systems Development Work Group in the first year of Strong Foundations implementation and the subsequent effort to solicit proposals from and provide technical assistance to local communities as part of the state's response to the MIECHV funding opportunities have helped to increase awareness at the local level about the state system.

The Public Awareness Work Group was one of the six initial work groups established by the HVTF to develop implementation plans for the core areas of Strong Foundations.<sup>12</sup> However, like the Funding Strategies Work Group, after the federal budget cuts to the EBHV grants, the Public Awareness Work Group was put on hiatus. Consequently, public awareness issues were largely left to the individual programs and communities. As described in greater detail in a later section of this report, during 2011 several individual programs increased their own direct marketing and public awareness efforts. A state respondent noted,

[Public awareness] is a very local issue. Each community is different. It's not really a state issue. I guess you could see on the various state agency web sites what is Healthy Families, what is Parents as Teachers, [and] where they are located. But there's not coordinated public awareness going on right now. I would like to see a web designer involved in the Strong Foundations project. That person

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<sup>12</sup> The initial, six work groups are: Funding Strategies; Special Needs Training; Technical Assistance to Communities; Monitoring and Assuring the Quality of Services; Data; and Public Awareness.

could maintain a web site and a universal home visitation listserve. Right now you can be on the PAT listserve or the NFP list, the Infant Mental Health list, the HVTF list, but there is no universal list.

With the introduction of MIECHV into Illinois home visiting, the HVTF Executive Committee determined that it made sense to reconvene the Public Awareness Work Group to develop an outreach strategy targeting the MIECHV communities.<sup>13</sup> As one member of the HVTF indicated,

We decided months ago that it [a public awareness campaign] didn't make sense. We didn't have a ton of dollars for that and we decided it didn't make sense to do it statewide, particularly in this climate. So we decided to wait until the [MIECHV] communities were named and then we would do some targeted work in those communities.

### **Data, Monitoring, Evaluation, and Continuous Quality Improvement**

As in 2010, our 2011 informants viewed the capacity for program monitoring, research, and evaluation as an important component of the system for ensuring the quality of service delivery and fidelity to evidence-based models. Strong Foundations is considered an important opportunity to create a common, integrated infrastructure to coordinate resource allocation, community capacity building, training, data collection, monitoring, and technical assistance, as well as support innovations in programming, across the three state agency partners and an existing network of more than 200 home visitation programs. In the course of our interviews, informants discussed two particular requirements for this domain of the system: a common data reporting form and a centralized intake system.

Currently, each of the models that are the focus of Strong Foundations has its own standards and methods for ensuring quality, which are established by the model developer (termed, alternatively, as “model elements,” “essential requirements,” or “critical elements”). During the past decade, online data systems have increased the availability and use of data for monitoring program performance and adherence to the components of quality. All of the programs implementing the evidenced-based models that are the focus of Strong Foundations annually report data on client characteristics, home visits, and other services to their national program offices and state administrators. In most cases, data are entered into a central electronic reporting system and then returned to program managers on a regular basis to help them monitor the extent to which a program is operating with fidelity to its model.<sup>14</sup>

However, even though reporting requirements are similar, there is no common data system that satisfies the needs of multiple agencies. A Monitoring Work Group was created during the planning year for

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<sup>13</sup> [DRauner@ounceofprevention.org](mailto:DRauner@ounceofprevention.org) to Public Awareness Work Group mailing list, July 7, 2011.

<sup>14</sup> PAT programs have been somewhat of an exception to this process. Some use the national reporting system, while others do not; however, the national PAT office is strongly encouraging use of the Visit Tracker.

Strong Foundations and proposed a set of common indicators that might be collected and shared across program models. However, resources have not been available to implement the plan. Since that time, other components of the system—for example, the training, and the MIECHV application processes—have taken priority.

Thus, in our interviews, state-level administrators and local program directors remained concerned about the fact that the monitoring and reporting requirements for different funders usually differ in required information and reporting timelines. This makes data collection for programs—especially those in larger agencies or those with multiple funding streams—potentially burdensome.

We can say there's a centralized administration, but the outcomes expected by ISBE and the ISBE contracts look very different from DHS outcomes. And the federal [outcomes] will look different from those, too. So, when you have different funding sources and different models and different expectations and different populations, there's not going to be a homogeneous system. It's like the opposite.

They also emphasized that aligning evidenced-based program standards, developing a common data system, and using data to monitor program performance remain urgent needs in the state infrastructure. As one informant explained:

We've got three separate programs and they all have their different models. And it's been my experience that their standards are [different]. They're not aligned. And I think that [some models have] an information system that is used to monitor the performance of providers [but others], if they do have a system, it's not used for that as far as what I've been told.

The importance of and commitment to using data for program improvement was underscored in the state's MIECHV implementation plan, which indicates:

The state funding agencies (IDHS, ISBE and the Ounce of Prevention Fund) must increase their commitment to collecting, analyzing and applying program data for continuous quality improvement, quality assurance and outcome evaluation. This includes a sustained commitment to the information systems used for this purposes, as well as the staff required to analyze and interpret the data and assist local organizations in applying the information to improve program performance.

However, it is not clear if this commitment includes the development of one integrated data system that might serve all home visiting programs and funders, or whether such a system can be easily created in the near future. As one state-level administrator summarized the current state of affairs,

The state overall has not come up with a Continuous Quality Improvement (CQI) plan, but there's been a lot of work looking at data collection and monitoring, [and] we are planning to fund a monitor in ISBE. We are looking at the development of data systems to help in making decisions at all levels—the client, the family, the agency, and the state. They're interviewing potential contractors to

develop or enhance an existing data collection system in home visitation. It's such a complex issue because there's just so many things involved. We've had multiple meetings around this; the governor's office convened a meeting about data in Illinois with all of early childhood and pulled in people from healthcare and public health. But right now there is not a universal data collection, and that makes continuous quality improvement or evaluation very challenging. There are definitely some systems in place that you have to engage in CQI and different models, or you have to do credentialing. There's a committee now looking at whether Healthy Families Illinois should become credentialed as a state or each program being credentialed. So there's work going on, and it's something in the forefront of work in home visitation. This is definitely something we want, but it's really challenging.

In addition to a common data system, a couple of our informants also discussed the need for a common or universal screening process in the state system. One of them explained,

The centralized intake process is really the direction I'd like to see Strong Foundations move in the future. In order to be really successful, you have to have an entity that's accountable and responsible for it; just simply putting a form out there and asking people to use it is not going to get it done. Although hospitals would be a really good place to do it because most babies are born in hospitals and you're going to have universal touch, if you wait until the baby's born, you are too late. So you have to have almost an independent third party that's responsible, somebody whose job is to contact obstetricians, health departments, and all those places where moms enter the system prenatally to make sure that we have the opportunity to screen as many moms as possible. And then from there make the appropriate referral to early childhood services or prenatal services or whatever they need.

The MIECHV application and implementation plan has re-energized the conversation and brought the concept of a universal screening system to the forefront of the discussion. The plan suggests that under MIECHV "one of the system enhancements will be the development and piloting of a universal screening and coordinated intake system" in at least one of the targeted communities to be funded under the initiative. At the same time, the plan states that developing and testing such a system will take time. The system being envisioned will not be limited to families of newborns but will include multiple entry points for families with young children and who are expecting a child. The system will also have to interface with other existing childhood systems, such as Part C Early Intervention and Child Care programs, as well as regional intake or information and referral coordination systems.

### **State Level Training and Technical Assistance**

Training continues to represent a key component of the state infrastructure of support for home visiting programs in Illinois and a significant piece of the Strong Foundations implementation plan. Consistent with our first year's findings, informants at all levels continued to highlight the system of training for home visiting staff as a particular strength of Illinois's infrastructure. As the following excerpts illustrate,



our informants praised both the range and the quality of training available through the Ounce Training Institute.

I think we have an outstanding network for training. Compared to many other states we have a lot of really great centralized training for home visiting, regardless of model. I think it provides not only the basic training, but also the wraparound training that home visitors [need to] do their job and achieve their goals.

I'm very confident in the quality of the training that the Ounce of Prevention Fund provides for Healthy Families, Parents Too Soon, and Parents as Teachers programs. I've always been very comfortable with their ability to train at a high level [of expertise]. We see good things when we go out and do program reviews. By and large, the staff from local programs are very satisfied with the quality of the training that they receive from the Ounce; that's been one of our real strengths for a long time.

While statements regarding the trainings were overwhelmingly positive, it is worth noting that some state level respondents, though positive about the trainings, questioned the practice of having one organization be responsible for so many different types of support. There can be challenges, actual or in appearance, to having multiple roles stem from one organization—in this instance the trainings are housed in an organization that also funds home visiting programs and provides technical assistance/monitoring for some home visiting programs. As noted by one respondent, if the same organization providing training is also the funder, staff might feel a conflict when asked to provide feedback on the training:

We have a strong training, statewide system, but it's by one provider, and maybe in the future we could benefit from getting some other providers in the state involved in the training. The other part is that conflict of interest to some degree, that you are getting your training and your funding [for your job from the same agency]. Plus the people evaluating the trainer and the training are funded by the agency providing the training. Or another example is the TA [technical assistance] providers could also be the trainer, and you're not going to negatively evaluate the TA providers. They're the ones who come and do the annual evaluation of your program.

Another concern raised by state and local respondents pertains to how and when Strong Foundations training information is shared with home visiting stakeholders. For example, some HVTF member respondents indicated their surprise at learning (through informal channels) that Happiest Baby on the Block was being offered as part of Strong Foundations through a contract with Prevent Child Abuse Illinois. One respondent stated:

I just learned through no formal communications but just by talking to somebody else that Strong Foundations has dedicated funding towards the Happiest Baby [on the Block program] and that's part of our training stock. It was just out of the blue and it's not really clear why they chose to do that or how that came about or what kind of a need...it fills.



Similarly, while many programs and stakeholders were made aware of the Big Four trainings in a timely manner, others were not. A member of the HVTF, for example, stated, “I didn’t even know that those had gotten up and implemented.” She then offered the suggestion that a “red-flagged” e-mail be sent to members of the Task Force indicating when trainings are developed and when and where they will be launched. According to a respondent familiar with the publicity for the Big Four trainings, an e-newsletter that contains information about upcoming trainings, as well as a “print and carry” calendar is sent to everyone who has attended a training at the Ounce Training Institute. Training staff also maintain a list of home visiting programs and attempt to contact programs about the trainings.

Despite these issues, it is important to reiterate that the responses we received in regard to questions asked about Strong Foundations trainings were overwhelmingly positive. State and local respondents consistently pointed to the trainings as a success of the Strong Foundations initiative, as reflected in the following comment from one of our informants: “The feedback that I had [from staff who attended the Strong Foundations trainings] was there was something different and very informative, and that it was very helpful to work with families.”

## **Year 2 Strong Foundations Training**

This past year, IDHS contracted with the Ounce of Prevention’s Training Institute to conduct three of the planned Strong Foundations Big Four trainings—Substance Abuse: A Home-Based Approach; Domestic Violence: Identification and Getting Help; and Perinatal Depression: Screening and Strategies—to support evidence-based home visiting programs in line with the initiative’s goals and objectives. Additionally, a fourth training, Working with Young Parents with Learning Challenges, is in the process of being developed for implementation in Year 3 to complete the Big Four training needs identified in the original Strong Foundations implementation plan (see Table 2). The addition of these new topic-focused trainings for home visitors has helped to address a gap in training that was identified through the Strong Foundations planning process and reiterated during key informant interviews about the needs of families. As indicated above, during the latter part of the year IDHS also contracted with Prevent Child Abuse Illinois to partner with interested home visiting sites to form a network of Happiest Baby on the Block trainers and expand the availability of the Happiest Baby on the Block program for families involved with home visiting programs.

Trainings in the three topics were offered in four locations across the state—Chicago, Springfield, Dixon, and Carbondale (see Table 2 and Figure 1). Although we cannot show how many unique individuals were trained at any one site, it is evident that the new Strong Foundations trainings reached many areas throughout Illinois. While some are more concentrated—for instance, in heavily populated Cook County—the spread shows that information was widely disseminated. It is also clear that certain regions

did not attend these trainings; however, without interviews or feedback from those regions the reasons they did not attend are unknown. There are two regions of note that do not appear have had staff attend any of these trainings; these are Sangamon County, just west of Springfield, and the region just outside of the Chicago collar counties.

Each training was offered four different times during the program year. There were a total of 361 initial registrations for the 12 trainings, but only 262 of the registrants attended a training, resulting in a total participation rate of 73 percent. Because some people attended more than one training, the 361 registrants and 262 attendees represent 202 unique registrants and 168 unique attendees. Of the 168, 98 (59%) attended training in one topic, 46 (27%) attended two, and 24 (14%) all trainings in all three topics. On average there were about 22 attendees per training. There was some variability in registrations and attendance across the three trainings, with substance abuse attracting the greatest number of registrants and attendees and perinatal depression attracting the least.

To understand the experiences of the training participants and obtain feedback on the content of training, the Ounce Training Institute administered post-training surveys at each Strong Foundations training. In addition, as part of the Strong Foundations evaluation, the Chapin Hall research team conducted pre- and initial post- surveys during the last three sessions of the new Strong Foundations trainings. (Due to a variety of factors, we could not start the survey process until after a majority of trainings were held.) Training surveys were received from 58 of the 68 training participants. We also attempted to conduct a 3 month follow-up survey to understand the potential longer term impact of these trainings.

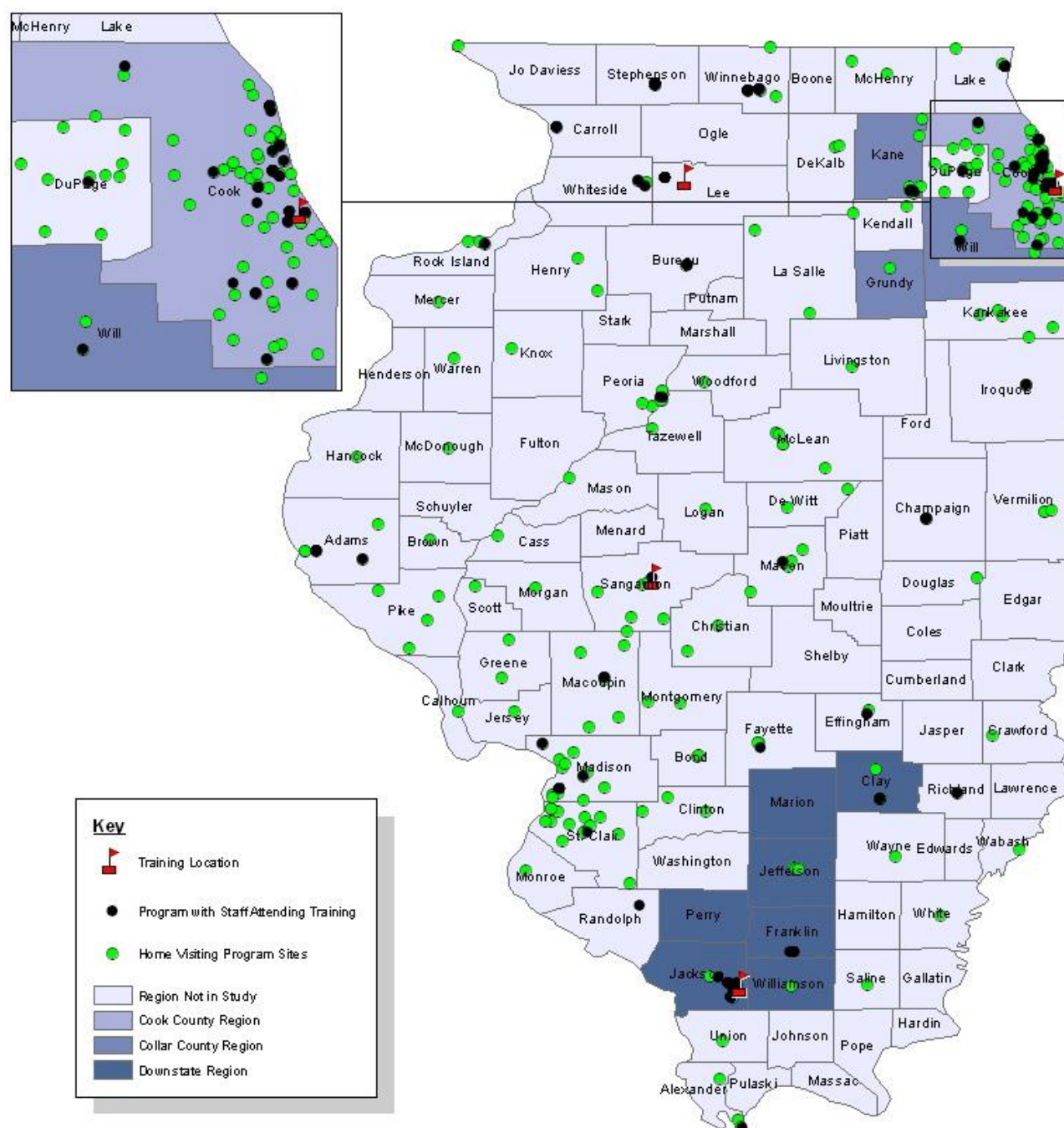
**Table 2. Strong Foundations' Training Descriptions<sup>15</sup>**

<b>Training</b>	<b>Description</b>	<b>Trainings Provided</b> *Capacity of 40
<b>Substance Abuse</b>	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 non-judgmental 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.	<b>Chicago</b> – 2/15/11: 32 Attendees <b>Carbondale</b> - 3/22/11: 24 Attendees <b>Springfield</b> - 4/6/11: 14 Attendees <b>Dixon</b> – 4/21/11: 35 Attendee
<b>Domestic Violence</b>	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	<b>Chicago</b> – 2/22/11: 11 Attendees <b>Dixon</b> – 3/17/11:

<sup>15</sup>These descriptions were provided by the Ounce of Prevention Training Institute. All Training Institute Strong Foundations trainings are scheduled half-day trainings. The Prevent Child Abuse Illinois trainer trainings are self-studies that are expected to take approximately 40 hours to complete.

	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.	36 Attendees <b>Springfield</b> – 3/24/11: 12 Attendees <b>Chicago</b> – 4/26/11: 24 Attendees
<b>Perinatal Depression</b>	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.	<b>Chicago</b> – 2/27/11: 29 Attendees <b>Dixon</b> – 3/2/11: 26 Attendees <b>Carbondale</b> – 4/12/11: 9 Attendees <b>Springfield</b> – 6/8/11: 9 Attendees
<b>Parents with Learning Challenges</b>	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.	<i>Information not yet available for this training.</i>
<b>Happiest Baby on the Block</b>	<i>Happiest Baby on the Block</i> is a technique developed by Dr. Harvey Karp for soothing a crying infant. It is based on natural responses to the infant which mimic conditions in the womb and is consistent with recent studies showing that there is a normal period of excessive infant crying during the first six months after birth. Dr. Karp's technique has been around for the past 25 years and is being used successfully by thousands of parents. It triggers what Dr. Karp calls the "calming reflex" and has five components which he refers to as the 5 S's; they are <u>S</u> waddling; <u>S</u> ide or Stomach position; <u>S</u> hushing; <u>S</u> winging; and <u>S</u> ucking.	<i>Information not yet available for this training.</i>

**Figure 1. Reach of Strong Foundations Training in Illinois – SFY2011**



Notes: Figure 2 also shows the three study areas and training locations for the new Strong Foundations trainings. Study locations are not separated by program, but instead represent the universe of Evidence-Based Home Visiting (EBHV) programs under the umbrella of the Strong Foundations initiative. Locations include the three program types: Healthy Families Illinois (HFI), Nurse Family Partnership (NFP), and Parents as Teachers (PAT). 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 members.

Forty-nine of the 58 respondents to the surveys conducted at the time of training agreed to provide contact information for a follow-up survey; however, only 21 actually completed the 3 month follow-up surveys. Below we summarize the results for both the Ounce Training Institute's evaluations and the additional surveys developed by Chapin Hall.

### **Findings from the Ounce Training Institute Evaluations**

Participants in trainings conducted by the Ounce Training Institute are typically asked to complete a brief survey immediately after training that asks for an overall assessment of the training, the presenters, and the attendee's participation, and provides an opportunity to make other comments or recommendations for future training. For this report, we were able to collect surveys from 233 (93%) of the 251 participants in eleven of twelve new Strong Foundations trainings.

Evaluations from all sessions reported above average marks for the trainings. Overall, comments and scores were overwhelmingly positive about the training curriculum, experience, and the presenters. By far, most felt that they would recommend it to others and that they would apply the knowledge to their work. These responses indicating high satisfaction among training participants were typical of post training evaluations for the Strong Foundations trainings the previous year. Although there was modest variability across the ratings of the three trainings, with Domestic Violence garnering the highest overall ratings and Substance Abuse the lowest, the differences were modest and overall ratings across the trainings were at least 4.2 on a 5-point scale on all items. More in-depth and specific feedback can be gleaned from variations in the training response data included in the individual participation and open response sections of the survey. For example, respondents were mixed on whether follow-up was necessary for the topic presented at the training. This did not necessarily represent a negative response—in fact it could represent a sentiment that the training filled in the knowledge for the training topic adequately enough to not warrant further training. Another example is in the response variations to the survey question: "The information presented to me was new." Most felt the information presented to them was new; however, a significant number did not feel the information was new, especially the Substance Abuse training material.

Additionally, each training topic presented a wide range of positive comments that show the distinct strength of the Ounce Training Institute trainings. Their comments reflected an appreciation for the information, which they felt was valuable for all home visitors. In the word of one respondent, "Those in social services need to have as many tools available as can be." Comments from those who attended the domestic violence training, in particular, highlighted both the quality of the training (for example, "There wasn't enough time to talk about everything—so much great information and deep knowledge that the

trainer has”) and the applicability to their families (“This will heighten my awareness of domestic violence when working with my families”).

Respondents also provided feedback about the length of the training and the topics presented. Several respondents requested more time for the trainings, either by spreading the time over separate days or having longer days. Training participants also indicated that additional training and information on teens and teenage issues, poverty or low-income resource issues, and trainings tailored to specific cultural groups or populations were needed.

### **Findings from Chapin Hall Pre- and Post- Surveys**

Prior to the start of the trainings, the trainers distributed Chapin Hall survey packets to participants. The packets included consent forms, a pretest to be completed before the training session to gauge initial knowledge of the topic, and a posttest for completion after the training to gauge what participants learned from the training. Participants were also asked to provide an e-mail address for a follow-up survey to be sent 3 months after the training was completed. Survey data were collected from 30 participants in the Substance Abuse training in Dixon, 18 participants in the Domestic Violence training in Chicago and 10 participants in the Perinatal Depression training in Springfield. Participants’ background in each training varied somewhat. Most (90%) of the respondents had attended college, and just over half (53%) had a bachelor’s or graduate degree. About half of the respondents indicated that they were white, a quarter self-identified as black/African-American, and another quarter indicated they were Hispanic. Eighty percent of participants at each of the three trainings described themselves as home visitors. Most of the other participants identified themselves as either supervisors or doulas, and a few served in other roles.<sup>16</sup> Two of the three evidence-based home visiting models in the Strong Foundations evaluation were represented at the trainings, PAT and HFI. Other models represented at the trainings included Baby Talk and Early Head Start. Forty percent of participants at the Substance Abuse training were from a PAT program and 57 percent were from an HFI program. PAT programs were overwhelmingly represented at the Domestic Violence (72%) and Perinatal Depression (70%) trainings.

When asked to rate their satisfaction with different aspects of training, participants were quite positive (see Table 3). Mean ratings on a 4-point scale on the usefulness and relevance of the training content ranged from 3.4 for the Substance Abuse training to 4.0 for the Perinatal Depression training. Training participants reported that for the most part, the material presented was new to them. Participants also

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<sup>16</sup> In some instances, respondents served more than one role in their organizations. Other roles included childcare worker, family support specialist, parent child specialist, therapist, case manager, grant supervisor, and support staff. The domestic violence training was more likely to include participants other than home visitors.

reported on how much they agreed with the statement, “The content and materials presented at the training today apply to the families with whom I work.” Across the three training topics, means on this item ranged from 3.3 to 3.6, suggesting that the material presented was relevant to the participant’s work.

We also asked participants about increases in knowledge leading to a potential change in practice (see Table 3). Responses were again positive, with an overall mean of 3.6 for the item, “The training increased my knowledge of the subject,” across the three trainings. Mean ratings for, “I plan to integrate what I learned today into my work,” were also highly positive, ranging from 3.5 (for the Substance Abuse training) to 3.9 (for the Perinatal Depression training). In general, means for the Substance Abuse training were somewhat lower than the other trainings, and mean scores rating the Perinatal Depression training were slightly higher than the other two.

Participants also reported that, in general, the trainings met their objectives in terms of content, identifying barriers to receiving help, describing appropriate practice when working with families, and identifying appropriate community resources related to the topic (see Table 4). Again, there was some variability in ratings across the three training topics. These differences might reflect differences in how respondents experienced the training, differences in the interests and backgrounds of participants, prior training in these special topics, and/or differences in the relevance of each topic for the families they serve.

**Table 3. Participants’ Satisfaction with Strong Foundations Trainings**

Statement about Training	Mean ( <i>sd</i> ) Rating by Training Topic <sup>a</sup>		
	Domestic Violence <i>N</i> =16	Perinatal Depression <i>N</i> =9	Substance Abuse <i>N</i> =29
The content was useful and relevant to my profession	3.9 (.25)	4.0 (.00)	3.4 (.82)*
The training had new material I had not heard before	3.3 (.77)	3.6 (.52)	2.9 (.98)
The content and materials applies to the families with whom I work	3.6 (.51)	3.6 (.52)	3.3 (.82)
The training increased my knowledge of the topic	3.8 (.39)	3.9 (.32)	3.6 (.82)
I plan to integrate what I learned today into my work	3.8 (.40)	3.9 (.32)	3.5 (.83)
It was easy to make arrangements to attend the training	3.7 (.48)	3.8 (.42)	3.4 (.82)

<sup>a</sup> 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.

\*The mean rating of the usefulness of the substance abuse content was significantly lower than the ratings of the other two training topics ( $F = 5.103, p < .01$ )

**Table 4. Participants’ Views on Whether Trainings Met Objectives**

Mean ( <i>sd</i> ) Rating by Training Topic <sup>a</sup>
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Training Objective	Domestic Violence N=16	Perinatal Depression N=9	Substance Abuse N=29
Identify the types, characteristics, and causes of training topic	3.8 (0.45)	3.0 (1.31)	3.1 (0.77)
Describe barriers to receiving help for training topic	3.8 (0.45)	3.0 (1.31)	3.1 (0.74)
Describe appropriate actions and precautions in working with families affected by training topic	3.6 (0.50)	3.1 (1.27)	3.1 (0.74)
Identify appropriate community resources and procedures to inform and link families affected by training topic	3.6 (0.50)	3.1 (1.36)	3.1 (0.79)

<sup>a</sup> 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.

Most of the respondents had participated in other trainings provided by the Ounce Training Institute, including the other trainings developed for Strong Foundations. However, across the group of respondents, they were more likely to have received prior trainings in domestic violence and perinatal depression than in substance abuse. In addition, a third of the participants in the Substance Abuse training and 56 percent of participants in the Domestic Violence training had attended other trainings in the same topic, whereas only ten percent of participants in the Perinatal Depression training had received prior training on the topic. Compared to participants in the Substance Abuse and domestic Violence trainings, those in the Perinatal Depression training also had less previous training experience with the Ounce Training Institute's trainings in general. These differences might account for some of the differences (though small) we observed in ratings of the trainings. In terms of other respondents' experiences with other types of trainings, almost 40 percent of our respondents had attended training in the Ages and Stages Questionnaire or another child assessment tool, and small percentages had attended other trainings (identified as parent, child, or family).

**Three-Month Follow-Up Surveys.** As mentioned above, the evaluation team administered 3-month follow-up surveys to gauge the longer-term impact of the Strong Foundations trainings on the home visitors' work. As with any follow-up survey—particularly one about a single training event—the study had issues with return rates. Of the 49 training participants who consented to be contacted for a 3-month follow-up survey, the evaluation team received only 21 completed follow-up surveys across the three trainings. Given the small number of respondents, we combined the survey responses for all three topics for the analysis reported here.

Respondents were first asked to respond to questions surrounding the training content, similar to those asked in the pre- and initial post-surveys. Generally, the follow-up surveys illustrated that information was retained at the 3-month mark, with most respondents marking the correct statements. It should be



noted, however, that many responded correctly for both the pre-and initial post-surveys, making a statement about knowledge retention difficult to defend. The 3-month follow-up survey will be further developed for consistency and reliability, as well as to reflect information given and test knowledge gained during the training.

In the next section of the 3-month follow-up survey, respondents were asked to respond to questions regarding the relevance and usefulness of the training, the newness of information provided, whether they shared information with others post-training, whether they used the information, the ease of integrating the information into work, the relevance of the information, and how it changed their individual or agency response to those clients affected by the specific issue. Respondents overwhelmingly stated that the training was useful and they obtained new information. Additionally, they responded that they shared the information with colleagues or put the information to use when they returned from the training. While most agreed that the training had changed how they personally handled issues, the responses were mixed surrounding whether their agency had also changed its response. This is expected as the training was aimed at increasing individual knowledge of frontline staff and not at organizational decision makers.

Respondents with clients who were affected by the training topic 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 from the training 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.”

Respondents were also positive in their responses when asked to indicate how their knowledge had changed. More respondents agreed that their knowledge of indicators of the issue or how to take action were positively influenced by the training. They also agreed that they had learned how to avoid actions to exacerbate certain risk situations. Respondents were mixed as to whether they could identify the appropriate community resource or procedure to make the appropriate referrals for families. However, this may have been a more difficult question given the current resource issues in specific regions of the state.

Overall, respondents felt that trainings had made an impact or expected it would make an impact on their self-confidence working with families, their interest in pursuing other training in the topic, their level of commitment to the field of work, and their interest in pursuing other professional development topics

related to the topic. They also agreed that the content and material were on target. Responses varied as to what part of the training was most useful, but many noted that hard copies of materials (e.g., notes, handouts, etc.) were most useful to refer back to after the training. Additionally, recognizing and identifying various signs and symptoms of the topic were identified as being particularly useful.

Respondents were also asked to provide specific suggestions of other trainings or staff development topics useful to their work. Respondents were mixed about the best format, requesting a variety of types of materials, in-person training, or training online or via webinars. Topics requested included: working with children or parents with developmental or mental disabilities, discipline, diversity and cultural capacity, parent stress, prenatal clients, assessment for infants and toddlers, discipline and techniques for infants and toddlers, resources for housing, sexual abuse (child or parent), child trauma, and professional development topics such as creating boundaries and avoiding burnout.

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## Summary of Findings

When we compared what our informants told us in interviews in the spring of 2011 with what they told us a year before, we saw considerable change. In 2010, for example, our informants recognized that state agencies and other stakeholders working across the state have common goals with regard to home visiting programs and the infrastructure of support for these programs. They also understood that through Strong Foundations the state was working towards a more systemic approach to home visiting. However, some perceived that the state did not have a plan for home visiting or that it was not a strong priority for the public or the state. Others believed that the state had made a committed effort to home visiting and creating common standards for home visiting programs, but did not have enough staff and other resources to support efforts such as monitoring or training.

In contrast, in 2011 most of our key informants could envision a much more comprehensive training and monitoring system that was starting to take shape and was bolstered by the work of the Strong Foundations Partnership, which now includes both the MIECHV and EBHV grants. Indeed, along with progress in informing and engaging new partners, a few respondents noted the importance of Strong Foundations in building awareness of home visitation within the early childhood system as well as its purpose as a “building block” for MIECHV. As one respondent noted, Strong Foundations has transformed home visiting in the state from a program to a system initiative.

Home visiting has become a key element of the whole Early Learning Council infrastructure and it's the Early Learning Council and the [early childhood system] vision that's going to bring us along over time. Home visiting was a program initiative, if you will, up until Strong Foundations, and now it is an early childhood system's major building block. We are moving along.

Training, especially in the areas of risk that are likely to be experienced by families served by home visiting programs, continued to be a significant focus of the Strong Foundations effort during the past year. This was evident in the increased number of training opportunities around the state to assist home visitors in working more effectively with families experiencing domestic violence, substance abuse, and perinatal depression. Evaluations conducted by the Ounce Training Institute of training participants were very positive overall. It is encouraging that the MIECHV implementation plan also highlights the quality and availability of training as key components of the state infrastructure, stating,

Illinois will continue to allocate resources to training and ensure that training is regularly available and accessible to programs across the state. Trainers must also continue to meet national standards.... [And] state level leadership must maintain its commitment to operating local programs with fidelity to their national models.

Some concerns surfaced during the MIECHV application process about the extent to which the governance, leadership, and administration of the home visiting system was being shared among state-level administrators and other key participants in the system and communicated to a broader audience of stakeholders. Not all of our informants would consider the process of developing the application and implementation plan to be indicative of how the system is governed. However, these concerns do suggest a need for better communication about the process and decisions that were made than the quarterly HVTF meetings and occasional HVTF email updates. (This relates to the need for better communication among vertical levels of the system, which was highlighted in our Year 1 report.) The fast pace of the work made more frequent communication difficult but also emphasized the need for some other vehicle for public communication to report and explain the planning and decision-making processes to the broader stakeholder group. Creating space and time for participants in the process to debrief on the way the process was managed might be one method of strengthening the system. This debriefing should include members of the communities that submitted applications for funding. Additionally, developing processes for future applications might strengthen information sharing as well as relationships among the various levels of the system.

At the same time, even among respondents who expressed concerns about some of the decision-making processes of the past year, there was a general sense of optimism about the growing collaboration among IDHS, ISBE, and DCFS—the three main state agencies involved in the development of the home visiting system. This increased collaboration, it should be noted, reflects the original Strong Foundations plan, which envisioned shared leadership and accountability for the home visiting system among these three organizations. However, with regard to support for local system-building, the general sense from our informants in the spring of 2011 was that there is still work to be done. As some informants pointed out,

local system building continued to receive attention in 2011 through the work of the CSDWG and technical assistance from Positive Parenting DuPage to the communities applying for MIECHV funding during the past year. However, local collaboration is still complicated by the different funding streams that govern individual home visiting programs. Until there is better coordination among state agencies with respect to funding and monitoring, local communities are likely going to need additional support from the state to strengthen their local collaborations and systems. As DelGrosso and Daro (2009) point out, integrating home visitation programs into local service networks can be complicated and takes time. It requires attention to multiple components of the system, including collaborative planning, workforce development, funding, communication, capacities for monitoring and quality assurance, and public awareness.

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# Local Systems and Program Implementation

In this chapter, we present findings related to the operation, quality, and model fidelity of a sample of home visiting programs in the state. These findings have been drawn from individual and group interviews with supervisors and program managers, and surveys of home visitors and program supervisors. We begin with a brief recap of the sample of programs on which these findings are based and report findings about their staff characteristics and service delivery. Next, we discuss some of the contextual factors that can affect the quality and fidelity of home visiting programs, such as staff turnover. We then describe an example of a local system designed to improve the coordination and delivery of home visiting programs in one community and the integration of those programs with other services for families with young children.

In developing a sample of local programs, our goal was to select programs representative of the three evidence-based models that are the focus of Strong Foundations from various regions of the state. A previous Chapin Hall report (Spielberger et al., 2011) describes the sample of 15 local communities from which we recruited program staff to participate in the evaluation. These programs 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 (75 to 97%)<sup>17</sup>, while the Chicago area is approximately 44 percent white, 25 percent black/African-American, and 24 percent Hispanic (U.S. Census Bureau, 2011).<sup>18</sup>

As expected, 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 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.

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## **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, based on individual interviews with program managers and supervisors, an online survey of supervisors and home visitors, and administrative data on program operations. Year 2 staff interviews and surveys were conducted during the spring of 2011. Data on program operations, staff, and families served were collected on a monthly basis from each of the 15 participating Illinois sites using a form created by the MPR-Chapin Hall cross-site evaluation team and adapted by Chapin Hall. 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 dates back to January 2011, and one of the NFP sites was unable to provide data in April, May, or June 2011.<sup>19</sup>

## **Model Certification, Curriculum, and Program Enhancements**

Although not currently a requirement, the Illinois Department of Human Services (IDHS) and the Illinois State Board of Education (ISBE) encourage local HFI and PAT programs to formally affiliate with their national organizations and to complete the model developer's independent quality assurance process

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<sup>17</sup> Not including Cook County, 89 of the 101 counties in Illinois have populations that are at least 75% white.

<sup>18</sup> US Census Bureau (2011). Current Estimates Data . Retrieved December 12, 2011, from <http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?ref=geo&refresh=t>

<sup>19</sup> 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 or quarterly 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.

(“accreditation” for Healthy Families America (HFA) and “commendation” for PAT). IDHS provides financial support for a limited number of Healthy Families Illinois programs to complete the accreditation process each year. According to the IDHS 2011 MIECHV implementation plan, 33 HFI programs are accredited by Healthy Families America, and 110 PAT programs are affiliated with the Parents as Teachers national organization, but none has yet achieved commendation. When asked in the quarterly data collection process if their programs had been certified by their national model, all of the respondents representing PAT programs reported to us that they were; however, it is likely that these responses reflect their affiliation with the national office. All but one of the HFI programs were certified by their national model. The one HFI program that was not certified was in the process of becoming certified when the study began and completed the HFA accreditation process by April 2011.<sup>20</sup>

Of the three models in our sample, the PAT and NFP programs each follow a curriculum model that has been established by their national offices. For PAT, the Born to Learn curriculum and for NFP the Nurse-Family Partnership Model. HFI operates under a set of core principles but the specific curriculum used by individual programs can vary. Among the five HFI programs in our sample, the most frequently mentioned curricula are the Minnesota Early Learning Design (MELD) and the San Angelo programs. All of these curricula are supplemented with other information, depending on the needs and ages of the parents in the program and whether or not the program has a doula or other specialized component. The following excerpts from interviews with HFI program supervisors in the spring of 2011 reflect how curricula are supplemented.

We use the San Angelo primarily and we supplement with some other resources. I’m always looking for something new. Curriculum is really, really expensive and a lot of curricula requires training and so the advantage of the San Angelo is that it didn’t require any training and it’s a pretty straight forward, easy to use curricula. I don’t always think it meets all of our needs but some of the other curricula and how they’re set up, if they don’t require a week-long training that you have to pay for, then they require that you can’t photocopy and so you have to purchase everything constantly. There’s some really nice curricula that are not realistic for us so I think I’m happy with our San Angelo curricula but I always do think, hmm, wonder if we could do something different.

We use a lot of curriculums. The main is the Partners for a Healthy Baby, MELD, and there is another one, Nurturing Parents, which is a very old curriculum, but it’s very, very good. [And] we tailor

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<sup>20</sup> The Nurse-Family Partnerships programs do not have a certification or accreditation process sponsored by their national model. According to the MIECHV implementation plan (June 2011), none of the PAT sites in Illinois have what is called a national “commendation.” We do not know if there is a difference between being certified and commendation or, if not, whether PAT programs in our sample had a different interpretation of “certification.”

things [for our teen parents]. We use books, magazines, the Internet—different resources, like videos that are specific for teen parents.

We don't have prenatal curriculum so much, so it's a little looser during the prenatal time for Healthy Families but we definitely start and if the doula is not in the picture then they could do their birth planning with them [first] and then do all those things [with the mother and use videos to supplement]. We do a lot of videos and that kind of a thing but a lot of times the doula and the home visitor will go together because, again, Healthy Families, prenatally, is a little bit more open.

With regard to specific program enhancements or planned changes, just a few home visiting programs reported such changes during the year-long collection of monthly program data. However, it did not appear that planned changes occurred regularly in any of the PAT and HFI programs in our sample. (In any one month from July 2010 through June 2011, only a third or fewer of the thirteen programs reported any of these enhancements or planned changes.)

Changes or enhancements that were reported fell into three main categories: changes in capacity, additional staff training to complement other skills and knowledge to enhance service delivery (without changing the model), and changes in outreach strategies. There was a wide range of changes or planned changes reported by our sample of programs over the one-year period. These include the following: staff completed certification on Ages & Stages Questionnaire (ASQ), CPR, choking, and Basic First Aid; client cases were closed; staff completed PAT 3-K training to serve babies ages 3 years and over; a lending library was added to the program; a grant was received from the Illinois Department of Transportation for a car seat program; a Breast Feeding Peer Counseling program was initiated; staff were moved into different positions; a new curriculum was added; there was a change in case weights that decreased capacity; services from an Infant Early Childhood Mental Health Consultant were added; a new brochure and presentations in the community about available services was development; and a new collaboration with an obstetrician to provide referrals was formed.

### **Supervisor and Home Visitor Characteristics**

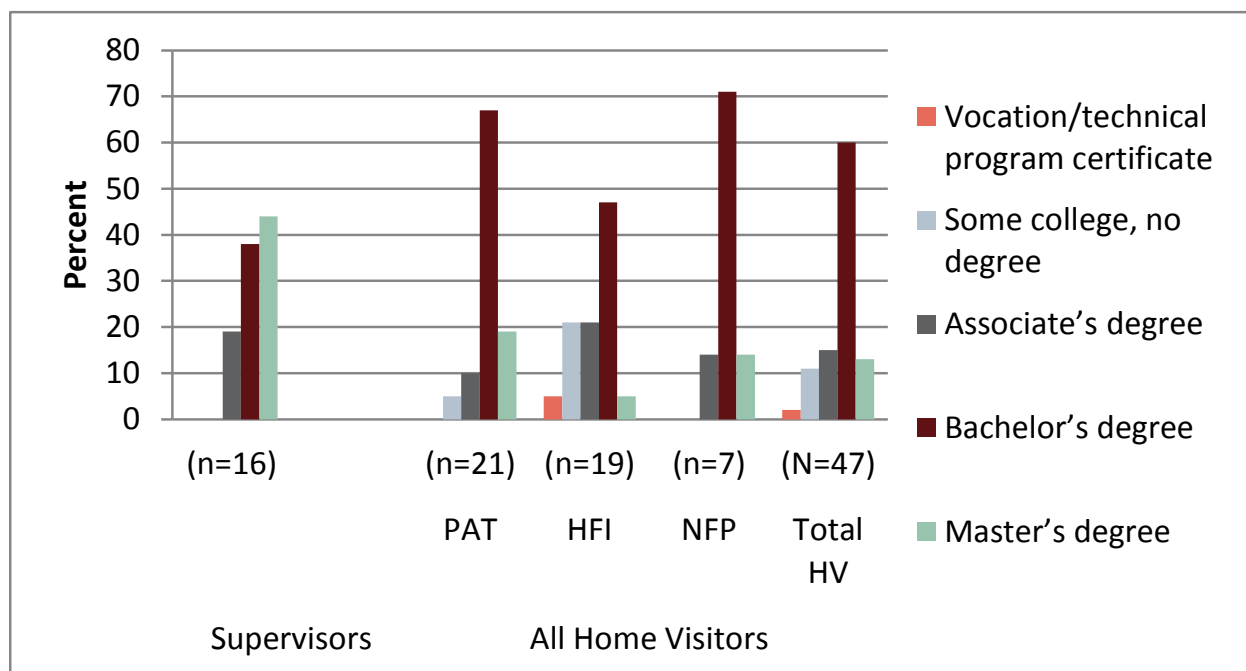
Turnover in staff occurred in a number of the local programs in our sample between July 2010 and July 2011, an issue that we discuss later in this chapter. However, there were only modest differences in the aggregate characteristics of the staff. In the second year of the study, we again asked all home visitors and supervisors at the HFI, PAT, and NFP programs participating in the study to complete a web-based survey about their education and experience (see Appendix C). We received responses from 69 of the 75 home visitors and supervisors (90%) to whom we sent an e-mail request to complete the online survey.

In this sample, the PAT and HFI programs continued to report more racially and ethnically diverse staff than the NFP programs. About 40 percent of the PAT home visitors are black/African-American and



about half of the HFI home visitors are Hispanic. The majority of supervisors across all three models are white (59%). The majority of home visitors and supervisors are between 30 and 49 years old; the NFP programs have an overall older staff than the other two program models. In terms of education, a majority of supervisors and home visitors across all three models have a bachelor's degree or higher; 44 percent of supervisors hold a master's degree (see Figure 2). The home visitors with the NFP program all hold nursing degrees, while almost two-thirds of HFI home visitors (63%) hold a child development, early childhood education, or education degree and 60 percent of PAT home visitors have an early childhood education or social work degree. The pattern was similar for supervisors across the three models; however, one-third of supervisors (35%) held a degree outside the fields of education, social work, or nursing. In addition, 17 percent of home visitors and 18 percent of supervisors reported that they were currently enrolled in school, either in a bachelor's degree program or a master's degree program. For supervisors, this represents a slight increase from 13 percent the previous year.

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



Overall, almost half of all supervisors (47%) and home visitors (46%) reported prior experience in home visiting. Half of home visitors in the HFI programs and close to half of home visitors in the PAT program (48%) reported prior home visiting experience, but just 29 percent of NFP home visitors reported prior experience. Supervisors reported a mean of 8 years of prior experience, the least experienced having supervised only 1 year and the most experienced having supervised 15 years. Home visitors reported a mean of almost 9 years of prior experience, with a range from only 1 year at the low end to 25 years at the Chapin Hall at the University of Chicago

high end. PAT home visitors had the least amount of prior experience (almost 7 years) and the HFI home visitors had the most prior experience (a little over 10 years). In addition, a large majority of both supervisors (82%) and home visitors (89%) reported that they either are currently parenting or have parented a child.

Finally, based on the assumption that strengthening the infrastructure for home visiting programs might positively affect staff satisfaction with their work, we also asked supervisors and home visitors to rate their satisfaction with several aspects of their jobs. Overall job satisfaction was high across all groups, with some variations by program model. As shown in Table 5, most of the job satisfaction items received average ratings of 3 or higher on a 4-point scale, with 3 indicating “satisfied” and 4 “very satisfied.” One noteworthy item that received a lower rating was “being valued for your work”; supervisors gave this item an average rating of only 2.8 in 2011 whereas in 2010 they rated it 3.5, on average. Other items of note were “opportunities for professional development” and “administrative responsibilities,” which home visitors rated 2.8 and 2.9 respectively. Both ratings were lower, on average, in 2011 than in 2010. Overall, Table 5 shows a general decline in job satisfaction when we compared ratings from program staff in 2011 with those from 2010. The reasons for the decrease in satisfaction are not clear, although one reason might be the ongoing uncertainty about program funding and another might be some of the agency changes that occurred during the past year. We discuss these changes in a later section of this chapter.

There were some variations in responses by program model. For example, all (100%) of the nurses in the NFP programs reported being “very satisfied” with the support they receive from their coworkers, compared to 44 percent of PAT home visitors and about a third (32%) of the HFI home visitors. Staff of NFP and HFI programs also reported higher satisfaction with their interactions with parents and their influence on parent-child interactions than staff of PAT programs, although these differences are not statistically significant.

**Table 5. Mean Ratings of Job Satisfaction by Supervisors and Home Visitors in 15 Local Programs in 2010 and 2011<sup>a</sup>**

Job Characteristics	Supervisors		Home Visitors	
	2011 (N=17)	2010 (N=15)	2011 <sup>b</sup> (N=40)	2010 <sup>c</sup> (N=42)
The support you receive from coworkers	3.2 (0.44)	3.5 (0.52)	3.4 (0.54)	3.6 (0.73)
Your interactions with parents	3.4 (0.51)	3.7 (0.49)	3.5 (0.51)	3.5 (0.75)
Your influence on parent-child interactions	3.4 (0.51)	3.6 (0.52)	3.6 (0.50)	3.5 (0.75)
The supervision you receive	2.9 (0.43)	3.1 (0.59)	3.4 (0.54)	3.4 (0.63)
Cultural sensitivity in your workplace	3.2 (0.56)	3.5 (0.52)	3.2 (0.53)	3.3 (0.60)
Overall job satisfaction	3.2 (0.44)	3.4 (0.63)	3.0 (0.51)	3.3 (0.74)
The quality of the training you receive	3.3 (0.47)	3.5 (0.52)	3.2 (0.69)	3.3 (0.76)
Your influence on the program	3.2 (0.44)	3.5 (0.52)	3.2 (0.46)	3.2 (0.68)
Being valued for your work	2.8 (0.64)	3.5 (0.64)	3.0 (0.66)	3.2 (0.73)
Administrative responsibilities	3.1 (0.49)	3.3 (0.46)	2.9 (0.52)	3.2 (0.76)
Opportunities for professional development	3.2 (0.56)	3.4 (0.63)	2.8 (0.78)	3.1 (0.85)
Physical working conditions	3.1 (0.43)	3.3 (0.59)	3.0 (0.54)	3.1 (0.64)
Your workload	3.0 (0.61)	3.3 (0.46)	3.0 (0.62)	3.1 (0.64)
Salary and benefits	2.8 (0.64)	2.9 (0.73)	2.5 (0.72)	2.6 (0.75)

<sup>a</sup> Based on a 4-point scale, with 1 = very dissatisfied, 2 = dissatisfied, 3 = satisfied, and 4 = very satisfied. Data are from 57 staff who responded to both the 2010 and 2011 surveys. Two respondents who were home visitors in 2010 became supervisors in 2011. Standard deviation is indicated in parenthesis.

**Participation in Strong Foundations Training.** Given the Strong Foundations focus on improving the training infrastructure for program staff, we asked staff in our program sample about their participation in the three trainings sponsored by Strong Foundations in the special topic areas during 2010-2011.<sup>21</sup> Over a third of supervisors reported attending the Strong Foundations Perinatal Depression training (35%) and the Strong Foundations Substance Abuse training (41%); just 24 percent reported attending the Strong Foundations Domestic Violence training. A third (33%) of all home visitors in our sample reported attending the Strong Foundations Substance Abuse training; a little more than a third (39%) attended the Domestic Violence training; and 40 percent attended the Perinatal Depression training. There was wide variation in participation in training among the home visitors in our sample; for example, 64 percent of HFI home visitors reported attending the Substance Abuse training compared to 13 percent of those in PAT programs, and no NFP home visitors attended these trainings ( $p < .001$ ). While 59 percent of HFI

<sup>21</sup> It is possible that not all respondents may have been aware of that the trainings were offered as part of Strong Foundations. The survey question asked respondents to indicate if they had “participated in any of the following Strong Foundations trainings through the Ounce of Prevention” and then listed the three offered in 2010-2011.

home visitors reported attending the Strong Foundations Domestic Violence training, 26 percent of PAT home visitors and just 14 percent of NFP home visitors reported attending these trainings ( $p < .05$ ). It is important to keep in mind, however, that our sample is limited and cannot be presumed to represent all potential participants from HFI, PAT, and NFP programs in the state.

Program staff in our sample were also asked to rate their level of comfort, on a 4-point scale (with 1 indicating “very uncomfortable” and 4 “very comfortable”), with their knowledge of family risk factors, including domestic violence, substance abuse, adult developmental disabilities, and adult mental health problems. For supervisors and home visitors from all three models, means were highest for the topic of domestic violence, suggesting that both supervisors and home visitors are more confident in their knowledge of domestic violence and how it impacts families than in their knowledge of other risk factors (see Table 6). As might be expected, supervisors reported higher comfort levels in knowledge of all of the content areas—especially domestic violence and adult mental health problems—than did home visitors.

We also found variations among home visitors from the three program models in our sample. Those home visitors working in the HFI model reported being more comfortable with their knowledge level than did home visitors in either the PAT or NFP models. Home visitors with the NFP programs had the lowest means in the areas of domestic violence, substance abuse and adult developmental disabilities. While these differences are not statistically significant, they suggest that nurses in the NFP program might welcome more training in these areas.

Indeed, Table 7 indicates that all of the NFP staff who responded to the survey desired additional training in the area of domestic violence. On average between 77 and 92 percent of home visitors expressed interest in additional training. All of the NFP home visitors reported a desire to attend training about working with families experiencing domestic violence, and all of the HFI home visitors reported a desire for training on adult mental health problems. These numbers are consistent with respondents’ levels of comfort with knowledge presented in the previous table.

**Table 6. Home Visitors' Level of Comfort with Knowledge about Family Risk Factors<sup>a</sup>**

Risk Factor	Supervisors ( <i>N</i> = 17)	Home Visitors			All Home Visitors ( <i>N</i> = 52)
		PAT ( <i>n</i> = 23)	HFI ( <i>n</i> = 22)	NFP ( <i>n</i> = 7)	
Domestic violence	3.5 (0.51)	3.1 (0.63)	3.3 (0.72)	3.0 (0.58)	3.2 (0.66)
Adult mental health problems	3.2 (0.66)	2.7 (0.62)	3.0 (0.49)	2.9 (0.69)	2.9 (0.58)
Substance abuse	3.2 (0.64)	3.0 (0.58)	3.3 (0.55)	2.7 (0.76)	3.1 (0.61)
Adult develop mental disabilities	3.1 (0.57)	2.9 (0.73)	3.2 (0.50)	2.9 (0.38)	3.0 (0.61)

<sup>a</sup>Mean ratings of comfort levels are based on a 4-point scale (1 = Very uncomfortable; 2 = Uncomfortable; 3 = Comfortable; 4 = Very comfortable).

**Table 7. Additional Training about Family Risk Factors Desired by Home Visitors**

Training Area	% Supervisors ( <i>N</i> = 17)	% Home Visitors			All Home Visitors ( <i>N</i> = 52)
		PAT ( <i>n</i> = 23)	HFI ( <i>n</i> = 22)	NFP ( <i>n</i> = 7)	
Domestic violence	59	52	68	100 <sup>^</sup>	65
Substance abuse	77	52	82	86 <sup>^</sup>	69
Adult developmental disabilities	82	65	96	57 <sup>*</sup>	77
Adult mental health problems	88	78	96	86	87

<sup>^</sup> Chi square tests indicate differences among home visitors in different program models are statistically significant at  $p < .10$ .

<sup>\*</sup> Chi square tests indicate differences among home visitors in different program models are statistically significant at  $p < .05$ .

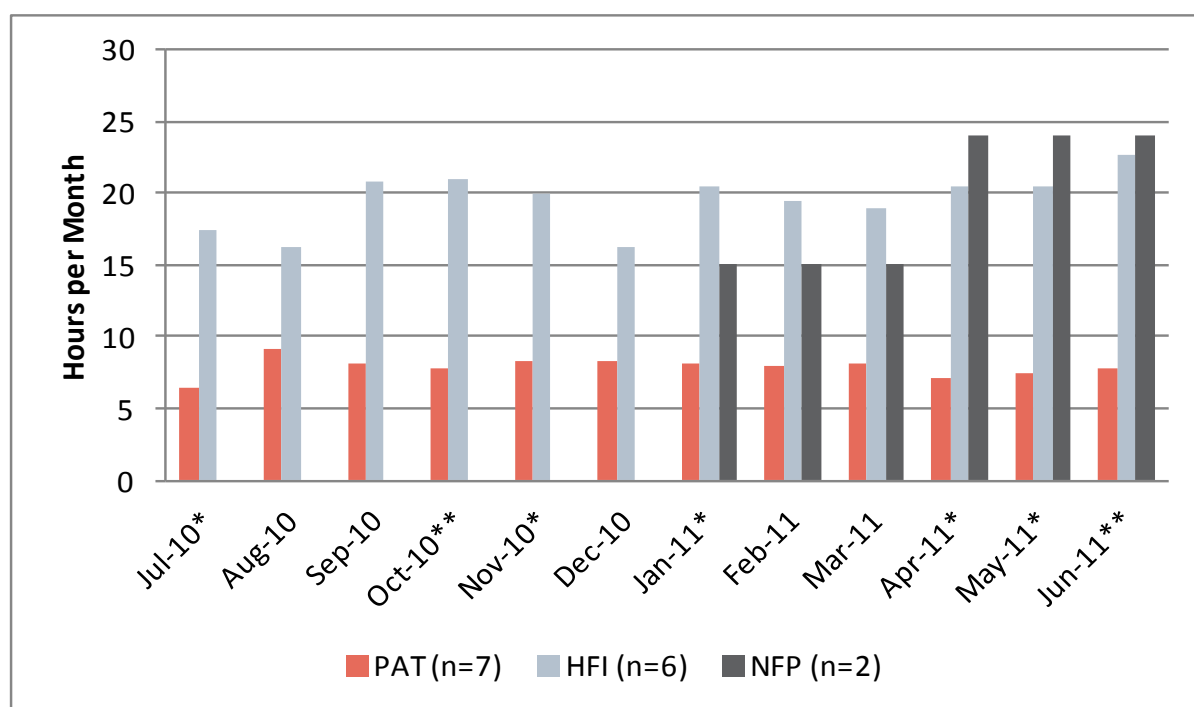
### Staff Supervision and Meetings

Since supervision is vital to maintaining fidelity to the program model, we asked supervisors about the typical amount of time they spend in supervision each month. On average, supervisors spent 13.5 hours in supervision each month, with a range of 6.5 hours to 24 hours (see Figure 3). Some of this variability can be attributed to staff size at each individual program.<sup>22</sup> The PAT supervisors spent significantly less time in clinical supervision than the HFI supervisors in July, October, and November 2010. Additionally, the PAT supervisors spent significantly fewer hours in supervision than did HFI and NFP supervisors in January, April, May, and June 2011. However, caution should be taken in reviewing these numbers because only one NFP site provided data in April, May, and June 2011. The fact that HFI supervisors

<sup>22</sup> The number of staff at individual programs remained stable over the course of the year. The number of staff at the PAT programs ranged from two to nine staff members who carry a caseload, whereas at HFI programs, the staff size ranged from 3 to 7 and at NFP sites, the staff size fell between 6 and 8.

were in supervision more often than their PAT counterparts is consistent with the standards of each model. HFI supervisors are required to spend 90 minutes each week in supervision with each home visitor and PAT supervisors are required to meet with their home visitors just once a month.<sup>23</sup> Based on the average number of staff at the HFI and PAT programs in our sample, staff appear to be receiving appropriate levels of supervision.

**Figure 3. Mean Number of Hours Supervisors Spent in Supervision per Month by Program Model**



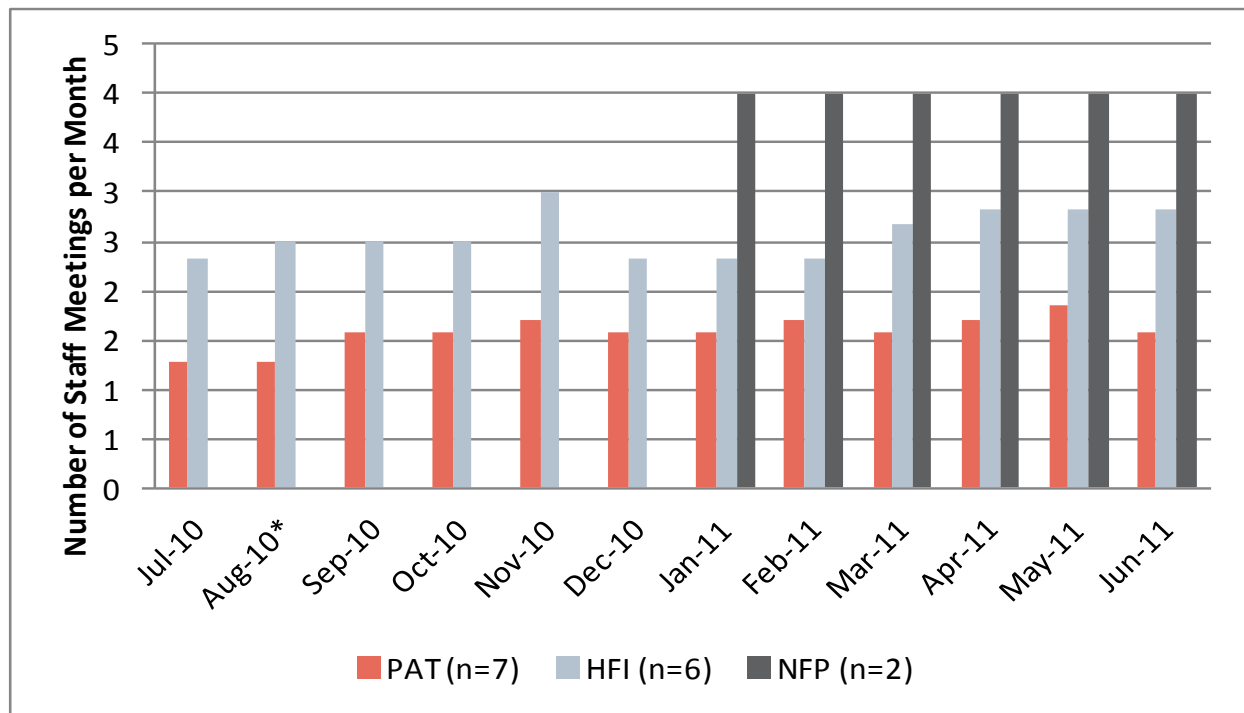
One-way ANOVA tests indicate differences are statistically significant at \* $p < .05$ , \*\* $p < .01$ , or \*\*\* $p < .001$

In addition to visiting families, preparing for visits, assisting the families on their caseloads, and engaging in clinical supervision with their supervisors, all staff attend regular staff meetings. The mean number of staff meetings occurring each month at any program ranges from one meeting to four meetings with an overall mean of about two meetings per month. The number of staff meetings held by each program remained fairly stable month to month as depicted in Figure 4. In August 2010 the HFI programs reported having significantly more staff meetings than the PAT programs. The PAT programs are surpassing what

<sup>23</sup> Before 2011, the Born to Learn Performance Indicators read, “Each parent educator participates in reflective supervision that occurs on a regular basis, at least once a month.” IDHS, HFI, HFA Critical Elements/Standards Fiscal Year 2010 Compliance Expectations read, “The program ensures that all direct service staff receive 1.5 hours of individual reflective supervision per week.”

their national model requires as they typically offer more than the required monthly staff meeting.<sup>24</sup>

**Figure 4. Mean Number of Staff Meetings Held per Month by Model**



Oneway ANOVA tests indicate differences are statistically significant at  $*p < .05$

On average, staff meetings tended to last just under 2 hours; meeting duration ranged from 85 to 180 minutes. For the most part, the length of time spent in meetings was similar each month, although PAT programs showed slightly more variability in meeting length than did the HFI or NFP programs during the year. (PAT met more often during August, perhaps coinciding with the beginning of the school year.)

### Job Responsibilities and Caseloads

In the annual survey, supervisors reported working about 36.5 hours per week with a range of 6 to 50 hours per week. Home visitors reported working a mean of 38 hours per week with a range of 10 to 50 hours per week. NFP home visitors worked significantly ( $p < .05$ ) fewer hours per week (34) as compared to PAT home visitors (38) and HFI home visitors (40) although the range of hours reported by PAT home visitors was greater (10 to 50 hours) than it was for NFP (20 to 40 hours) or HFI home visitors (36 to 46 hours).

<sup>24</sup> According to the PAT performance indicators, the program should offer at least monthly group meetings in which child development or parenting information is provided and a parent educator or program supervisor is present. The HFI compliance chart makes no mention of group staff meetings.

Supervisors reported having a staff of a little over 3 home visitors, on average, with a range of 1 to 9 home visitors per program. On average, supervisors in our sample provide a little over 12 hours of supervision to their supervisees per month, which suggests that each home visitor received approximately 1 hour of clinical supervision each week. Supervisors reported spending approximately 51 percent of their time engaged in supervisory activities with the least amount of time spent being 10 percent and the most being 100 percent.

Supervisors were asked to report the percent of time they spend doing work other than supervision and, for those who also carry a caseload, home visiting. Supervisors reported spending approximately 36 percent of their time on “other duties.” Home visitors reported spending 27 percent of their time on duties beyond home visiting, on average. NFP home visitors reported spending 24 percent, HFI home visitors reported spending 26 percent and PAT home visitors reported spending 29 percent of their time on duties beyond home visiting.

All supervisors carrying a caseload and all home visitors were asked to report the number of families they were visiting at the time they completed their yearly survey. Supervisors carrying a caseload reported working with between 1 and 15 families, with a mean of 9 families. Home visitors reported visiting an average of 17 families with a range of between 6 and 26 families. Although there were only slight differences in caseload sizes of home visitors among the three program models, there were some variations within individual programs that could be attributed to the employment status (full-time vs. part-time) of each home visitor at each program.

Both supervisors carrying a caseload and home visitors were asked to report the percentage of time they dedicated to home visiting. Not surprisingly, supervisors reported allocating less of their time to home visiting than home visitors (33% vs. 75%). Among the three program models, PAT home visitors reported allocating the highest percentage of time, on average, to home visiting (77%) while HFI home visitors reported the lowest (71%). The difference between the percent of time supervisors dedicate to home visiting and the percent of time dedicated by home visitors can be explained by the fact that the supervisors are visiting families in addition to their supervisor duties.

We asked staff who carry a caseload about the percent of families on their caseload who are foreign-born. Over half of supervisors (57%) reported that a very small percent (0-10%) of their families are foreign-born. However, the other 43 percent of supervisors reported that most (75-100%) of the families on their caseloads are foreign-born. The majority of home visitors in the PAT and HFI programs reported that few (10% or less) of the families on their caseloads are foreign-born (74% and 59% respectively). Thirty-three percent of NFP home visitors reported that between a quarter and half of their families are foreign-born.



Since few families on the home visitors' caseloads are foreign-born, it is not surprising that only a quarter (25%) of the home visitors reported conducting home visits in any language other than English. Ninety-four percent of all home visitors and 71 percent of supervisors who carry a caseload reported speaking English when conducting home visits. A quarter of all home visitors and 36 percent of HFI home visitors in particular reported speaking Spanish when conducting home visits. Forty-three percent of supervisors who carry a caseload reported speaking Spanish when conducting home visits.

When asked how many of the families on their caseloads live in the same community as them, the majority of the home visitors across geographic locations (downstate Illinois, Chicago, and the collar counties) reported "none or almost none" of the families on their caseloads live in their communities. The home visitors in downstate Illinois, however, were less likely (36%) than their counterparts in Chicago (68%) and the collar counties (68%) to report this. For the downstate home visitors, just over a quarter (27%) reported living in the same community as "all or almost all" of the families on their caseloads. Of the seven supervisors who also carry a caseload, 29 percent reported that they live in the same community as "some" of their caseload and another 29 percent live in the same community as "all or almost all" of the families on their caseloads.

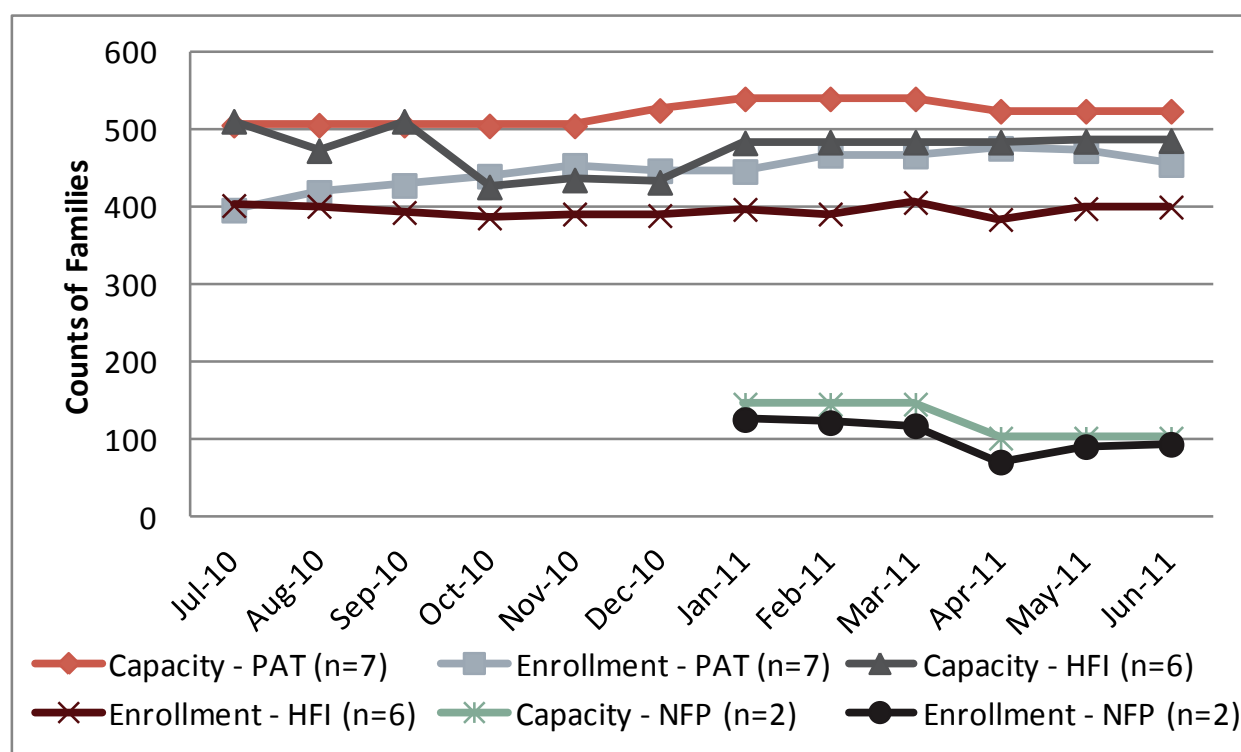
### **Program Capacity and Enrollment**

On a monthly basis, programs report their maximum capacity and their program's current enrollment. However, for several reasons, it is not easy to use the same metric in calculating program capacity and enrollment for all of our program sites. Although a majority of programs consider capacity and enrollment information in terms of number of families or participants, some programs define capacity and current enrollment in terms of "points" based on the level of need and intensity of services provided to families in the program. In addition, there are other factors which potentially complicate the sites' ability to provide capacity and enrollment information. For example, staff time may fluctuate between full-time and part-time either by the choice of the staff member or by necessity of program funding. Another issue may be that while some staff are full-time employees and we would expect them to provide home visits to a set number of families each month, they may not be providing home visiting services full-time. Their agency may also require them to spend a specific percent of their time on other functions within the program or within the agency.

However, we were able to work with the sites which reported capacity and enrollment information in terms of points and convert that data into families for our analysis. We tallied the total number of families to determine each program model's maximum capacity as well as current enrollment over the course of a year. As shown in Figure 5, enrollment was almost always just below capacity for our sample of

programs and capacity and enrollment tended to stay fairly stable over time even though some individual programs did fluctuate slightly more dramatically than what is depicted below. For example, one program was a nine-month program where just a handful of families were visited during the summer months. Thus both capacity and enrollment dropped dramatically for this program during the summer, but in September they resumed normal operations at full capacity.

**Figure 5. Monthly Capacity and Enrollment by Program Model, July 2010–June 2011<sup>a</sup>**



<sup>a</sup> NFP data were not available prior to January 2011. Only one NFP site reported data for April, May and June 2011.

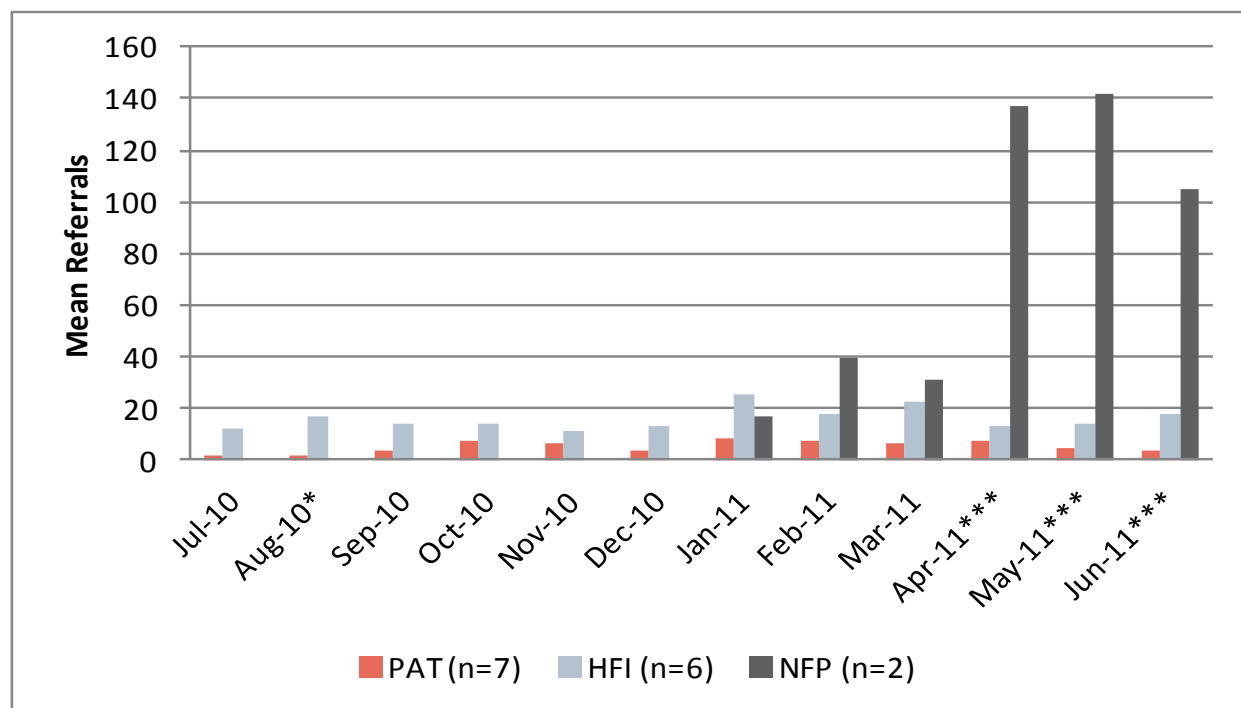
We also observed that the counts of both capacity and enrollment varied from month to month. Reasons for changes in capacity included the enrollment of new participants and closing of cases, changes in client levels and the addition of clients, and seasonal variations (e.g., for programs that do not 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). Although programs in our sample reported more changes in capacity during January and February and fewer in April, May, and July, the reasons for the differences are not apparent.

### Engagement and Enrollment of Families

Each month, programs report the number of families who were referred to their program, of those families who were referred, how many were eligible for participation, and of those eligible the number of families who actually enrolled in their program. The mean number of families referred to each type of program in

our sample each month ranged from a low of two families to a high of 142 (see Figure 6). Overall, an average of 13 families was referred each month. In August 2010, the HFI programs reported significantly more referrals than the PAT programs while in April, May, and June 2011, one NFP site reported significantly more families referred to their program each month than did the PAT and HFI programs. The reasons for these differences are not clear but likely are affected by the level of needs of families, eligibility guidelines, and regional variations and capacity for each type of program.

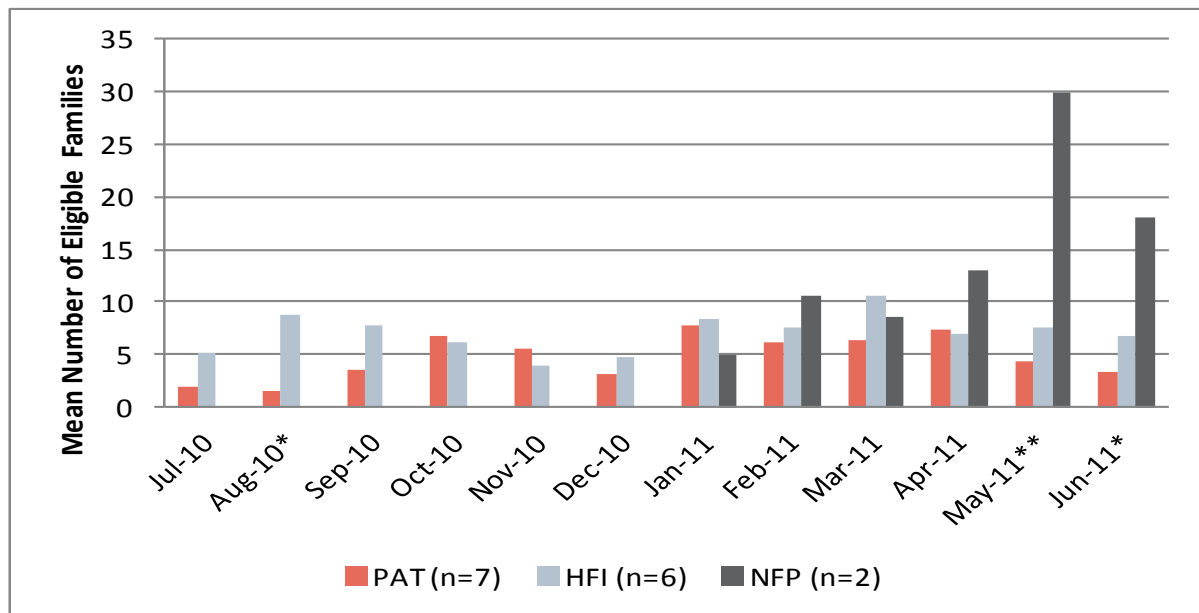
**Figure 6. Mean Number of Families Referred each Month, by Program Model<sup>a</sup>**



<sup>a</sup> Data for NFP sites prior to January 2011 were not available. Both sites reported the number of referrals for January through March 2011, but only one site reported data for April through June 2011. One-way ANOVA tests indicate differences are statistically significant at \* $p < .05$  or \*\*\* $p < .001$

Since families can be referred to programs but not meet the programs' criteria for enrollment, we asked the programs to record the number of referred families who were eligible for services. The number of referred families eligible for services ranged from 2 to 30, a range that corresponds to the range for the families referred to the programs (see Figure 7). An overall mean of 6 referred families were eligible for services; in other words, a little less than half of those referred were found to be eligible. In August 2010, the HFI programs were reported to have significantly more eligible families referred than the PAT programs, while in May and June 2011, one NFP site had significantly more eligible families referred to their program each month than did the PAT and HFI programs in our sample.

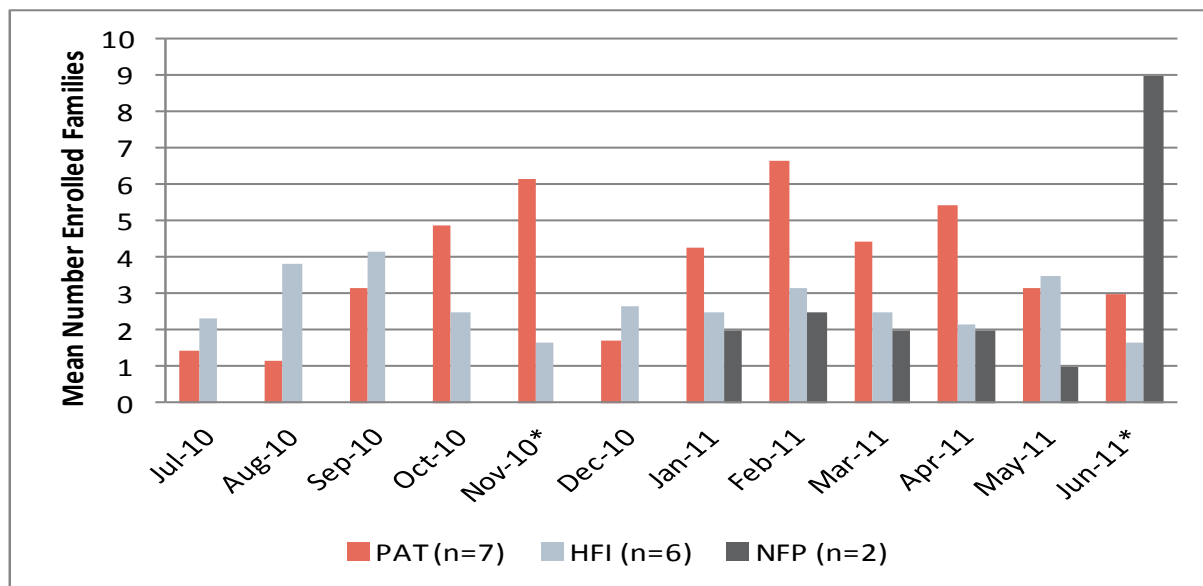
**Figure 7. Mean Number of Referred Families Eligible for Services Each Month, by Program Model**



One-way ANOVA tests indicate differences are statistically significant at \* $p < .05$  or \*\* $p < .01$

Finally, we asked each program about the number of eligible families who actually enrolled in services. The mean number of eligible families who enrolled in services ranged from 1 to 9 families per month with an overall average of just over 3 families per month (see Figure 8). In November 2010, the PAT programs had significantly more eligible families enroll in services than the HFI programs and in June 2011, the one NFP site had significantly more eligible families enroll than the PAT and HFI programs.

**Figure 8. Mean Number of New Eligible Families Enrolled in Services Each Month, by Program Model**



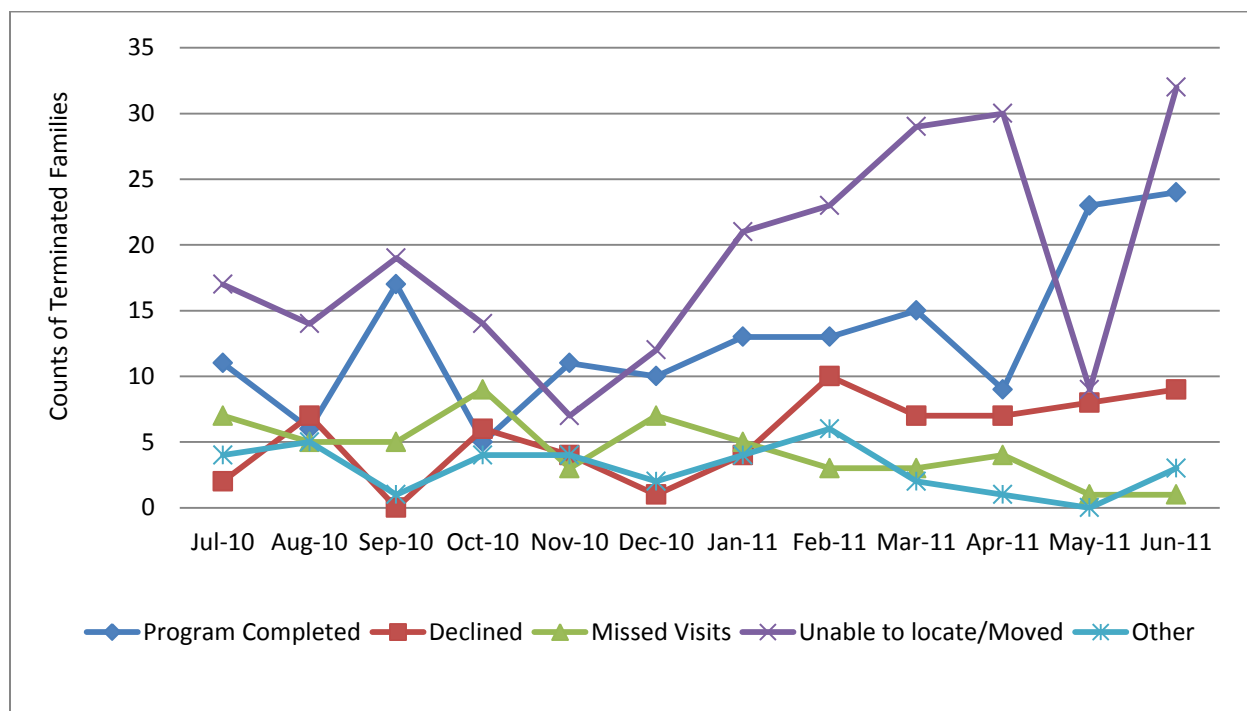
One-way ANOVA tests indicate differences are statistically significant at \* $p < .05$

## Reasons Families Terminated Services

Families enroll in the three home visiting models for a variety of reasons and they also leave the programs for a variety of reasons. We provided, on the monthly data collection forms, seven specific reasons as to why families typically leave home visiting programs: the family completed the program, the family declined to continue to participate in the program, the family missed an excessive number of visits, the family moved out of the service area, the program was unable to locate the family, the parent's parental rights were terminated, the child died, and the family left for unknown reasons. Figure 9 below displays the varying reasons families have left the programs over the past 12 months. The reasons for closing a case fluctuated month to month during this time period; the more commonly noted reasons are completion of the program and inability to locate a family or a family moving.

In addition, there were some variations in termination reasons by program model. For the HFI and PAT programs, the most commonly cited reasons for families to leave the program was program completion, as well as families moving out of the program catchment area and programs not being able to locate the families. The NFP programs, however, most often reported not being able to locate the families, followed by reasons of program completion and declining further participation. Without additional data, the reasons for these differences are not obvious, although it might reflect differences in families targeted by the programs or the success of their recruitment and engagement efforts.

**Figure 9. Reasons Families Terminated Services in 15 Home Visiting Programs July 2010-June 2011**



## **Training and Technical Assistance to Programs**

As discussed above, training and technical assistance is a significant component of the state infrastructure of support for home visiting programs in the state. Home visiting programs receive training and technical assistance to improve the quality and fidelity of their programs from several sources. In addition to the statewide training provided through the Ounce Training Institute, programs in our sample receive more targeted, model-specific support and technical assistance from the state agency or agencies that fund them and from their national program model. Because this training and support is model specific we discuss findings on this topic in this section of the report rather than in the section about the state infrastructure.

When asked about technical assistance available for programs, state and local respondents from all three program models referred to the assistance offered by their funder and/or national model. The Nurse Family Partnership (NFP) programs obtain training, technical assistance, and monitoring from their National Service Office (NSO). NSO staff have been active participants in the Home Visiting Task Force (HVTF) and are available to the NFP programs for clinical nursing support, ongoing education for supervisors and staff, data review, and an annual visit by a nurse consultant. Sites also participate in an on-site, full quality assurance review every three years. For Healthy Families Illinois programs, IDHS funded programs have access to Division of Community Health and Prevention staff who are responsible for program monitoring and quality assurance. IDHS-funded programs also utilize the Cornerstone data system, which collects data on participant characteristics and program activities. As indicated in our Year 1 report, HFI programs also can participate in geographical cluster meetings facilitated by Prevent Child Abuse of Illinois. Parents as Teachers also looks to its funder and state office for technical assistance. In January 2011, the PAT National Center instituted revisions of its program model and curriculum necessitating the retraining of all PAT affiliates. Given these circumstances, the next section focuses on technical assistance for PAT programs.

### **A Focus on PAT**

Respondents who work with PAT programs also reported that their technical assistance services largely came from their program model.<sup>25</sup> One PAT respondent noted, “In the three years we’ve had PI [Prevention Initiative] I have never had a state representative or anyone from ISBE come down and visit me which is frustrating. Because then I ask a question, ‘Do they really support or know what I do?’”

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<sup>25</sup> ISBE funds the state office, which is different than NFP, whose national office offers technical assistance, or HFI, which has credentialing through HFA.

As of January 2011, PAT revised its program model and curriculum. While the model's four main components—personal visits, group connections, developmental screening, and resource network—have not changed, how those components are implemented has changed. As one respondent familiar with the new implementation explained,

They've also strengthened and changed the focus a bit of the group connection, as well as added an emphasis on each visit for family well-being. So, child development, parent/child interaction, and developmental parenting, so, actually being more intentional in talking with parents about behaviors that help children [and] parent behaviors. And then taking time on each visit to discuss family well-being, and actually setting goals. They're now requiring that each program do some type of family-centered assessment. It's really strengthening Parents as Teachers' ability to work with higher needs families.

The respondent continued to explain how monitoring and quality assurance practices were also improved upon in the new PAT approach.

They've put out a document that is a quality assurance document, to help people better understand how to implement the Essential Requirements, then their APR [Affiliates Progress Report] will actually reflect those Essential Requirements. So when they do their APR this year, they're going to be asked, "Are you doing this?" And you have to check "yes," or "yes, we plan to," "no, we're not, but we plan to," or "no, we're not going to do it." And if you aren't doing it, and you plan to, then you have to tell how you're going to meet compliance [standards].

These curriculum and monitoring changes require that all PAT affiliates are trained or retrained on the model. In Illinois, this means that approximately 700 parent educators have to be trained by 2014. The new trainings consist of a 3-day foundational training and a 2-day implementation training.<sup>26</sup> New affiliates will have to attend all five days of training; those who need to be retrained will attend the 3-day foundational training and then can complete the 2-day model implementation training online.

The ISBE funded state office for PAT oversees all training and technical assistance for the PAT programs in Illinois. The state office reviews each site's program plan and then conducts a site visit between three and six months after the initial trainings. Information from the site visit is utilized to develop a technical assistance plan for the affiliate. Additional technical assistance is available for affiliates through quarterly supervisory meetings and also one-to-one contact via phone, email and in-person. Being aware of the

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<sup>26</sup> Although the national PAT office is not offering funding for programs to receive the new trainings, they are keeping the training costs low—\$125 for the three-day training. Recognizing that even that cost would be difficult for affiliate programs, the state office and funders were in discussions about how to defray the affiliates' costs.

coming changes, the PAT state representatives focused their technical assistances this past year on a “model fidelity checklist,” which is based upon the essential requirements.

So, when we talk with programs, we want to talk with them to help identify in what areas they're reaching compliance, and in what areas they're having difficulty. Then we want to help formulate a plan, to make sure they're in compliance in all areas. And it's going to take some time, because some of the requirements – for instance, one is that they have an advisory committee. Well, hardly any of them have that, and they're not really sure how to approach that.

In talking about all of these PAT changes and the technical assistance that will assist the affiliates in the process, one respondent stated,

This is a significant change. It's like turning a huge ship, it's slow. It's going to take time for everyone to understand it.

A program supervisor spoke about her recent annual review with the PAT state office staff:

Through that process [annual review], we talked a lot about the new changes to Parents as Teachers - the new curricula. We talked about goal-setting for our program, what we need to do to make our program better. We did an evaluation form with her, kind of telling us about the program. We talked about things that we want to work on this year. They're really pushing for us to have a strength model rubric—that's not the word they're using right now—but to develop one of those. So we're developing some different things for her. Then we have to have two goals for what we want our program to work on next year.

In addition to the training and adherence to the Essential Requirements, MIECHV-funded programs will be expected to apply for commendation, the formal recognition of an affiliate's model fidelity. The PAT state office will also provide technical assistance to help affiliates prepare for commendation.

Several of the PAT affiliates in our sample spoke about these changes and the technical assistance that they have received. One supervisor explained that after attending a quarterly supervisory meeting, she formalized her supervision with her staff. In addition to having set times for reflective supervision, structuring the supervision has enabled her to work with her staff on a self-assessment and strategic planning. Likewise, the same program supervisor indicated that she had also received technical assistance regarding caseload size during a site visit from her PAT liaison. These examples also highlight the influence of Strong Foundations on increasing ISBE's role in providing technical assistance and support to increase the quality and model fidelity of the PAT programs it funds and oversees. As one of our informants explained,

I don't know that they would get down to the specifics of PAT requirements, but the issue of quality is certainly something that ISBE and others at the table are concerned about and are trying to put,



again, the infrastructure in place that will support quality implementation. When year after year you bring people to the table and start looking at how different models are or are not addressing those quality issues, then you look for ways to do it at the state funding level. Because if a funder says, “You’re going to do it,” then people will do it. So I was very pleased to hear that it’s a priority [for ISBE that programs] maintain affiliation with an evidence-based model.

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## **Contextual Factors Influencing Implementation and Quality**

A program’s administrative structure, program staffing, and funding are among the factors that directly impact its ability to provide high-quality, reliable services to its community. All 15 of the Evidence-Based Home Visiting (EBHV) programs that have participated in the Strong Foundations evaluation since 2010 operate within larger agencies; as such, each program is subject to the structural and/or policy level administrative changes of their umbrella agency as well as changes at the program level in staffing and other aspects. This section presents examples of the impact of these contextual factors on home visiting programs

### **Agency Restructuring**

In one instance the organization that houses an EBHV program made the decision to transition some of the services it had offered to other entities in its region, in part due to not receiving timely payment from the state. As a result of this decision, the entire organization was restructured and the agency as a whole experienced a large-scale staff reduction. As the structure of the organization changed, so did the staff leadership and departmental divisions. Senior administrative staff had to reapply for positions within the new departments and staff faced a new learning curve as they discovered their new place within the agency. As one senior staff member noted,

And then we had this reorganization, and now it’s all new on the management side. The [home visitors] keep doing what they’re doing. They know what they are doing. It’s the rest of us trying to gain some perspective, saying ‘okay, what is this all about’ [and] ‘let’s figure this out.’

While the home visitors did not have to reapply for their positions, most of the other agency employees did. Seniority played a factor in maintaining employment. One of the home visitor positions was filled by a more senior employee who had worked in a different department. Because that staff member was new to the EBHV program, she had to become familiar with the program’s EBHV model and attend all of the required trainings. Another home visitor who had been working full-time was offered a part-time position, but she opted to accept an outside full-time position.

In addition to the staffing changes during and after the reorganization, this particular program also experienced staffing and administrative changes prior to the reorganization. For example, a long-time

supervisor was on leave and did not return to the program, and the home visitors had to reduce their EBHV duties to 80 percent and devote the remaining 20 percent to other agency related duties. All of this led to feelings of uncertainty for the staff. As described by one staff member, “So much has happened, it literally feels like a bomb has hit, and we’re just trying to build it back and put the pieces together.” According to another, “The biggest challenge about last year was just the whole reorganization, the uncertainties of who was going to lose jobs and whether our program was still going to be here. They were making decisions about which programs were getting cut and which ones were staying, so we didn’t know that.”

Along with the staffing and organizational changes and the sense of upheaval they caused, the reorganization also led to a physical move—closing one office and moving to another. All of it was a bit overwhelming, as described by one program participant: “Then everyone here moved around physically; we spent the first couple of weeks literally having people pack up their offices, move into a new location, and unpack. Some people got a new computer or new phones. Everything had to happen, just everything moved.”

Another example of the impact of agency restructuring involves the site discussed in the first Strong Foundations report that joined a new parent organization and reopened after the fiscal crisis in 2008 had caused it to shut down. When the program first reopened, it had to operate with fewer staff because of the funding uncertainties. Although the new parent organization had not yet been paid by the state for their EBHV services, the program director was able to rehire a full-time bilingual home visitor, as well as a part-time home visitor for a specific geographic area, during the course of this past fiscal year. The new hires needed to receive the EBHV model training.

Staff members said the program’s transition into the new agency over the past year has been a “real education process” and the program, while grateful to be able to continue its work, has faced “challenges in bringing an impact program into another [agency’s] culture.” According to one staff member familiar with the transition,

We had kind of our own culture and then [there’s] another culture, and they’re not as compatible as I would have liked. I know that sometimes staff gets frustrated; they’ve made a lot of changes, kinds of things that we got at our old agency that we don’t get here and so staff are feeling no raises, no this, no that. So I think it’s hard to keep staff motivated under those conditions, especially doing the work that they do, which is really difficult.

While acknowledging that progress has been made during the transition, there is a feeling that the mutual adjustment process has been slower than anticipated. Staff expressed feelings of disconnectedness from

the larger agency: “I think internally our program’s really strong and we support each other, but we’re kind of like an island unto our own, if that makes sense.”

Bridging the gap to form a more cohesive agency in which staff across divisions have an understanding of and respect for their colleagues’ work takes time, patience, and effort. For example, the art of collaboration has been a core principle for this EBHV program and as such its staff sees the value in attending meetings and learning about other organizations’ work. When the program director realized that the new umbrella agency did not place as high of a value on collaborative work, she made it a priority to educate her colleagues about the benefit of collaboration.

One of the hard things about coming to [this agency] is that they’ve never done [collaboration]. They don’t talk to other people, so that’s been one of my challenges is to try to show them the value in that. Instead of them telling me I can’t go to meetings anymore, it’s like no, there’s value in going to meetings. So it’s getting organizations like that to see the value.

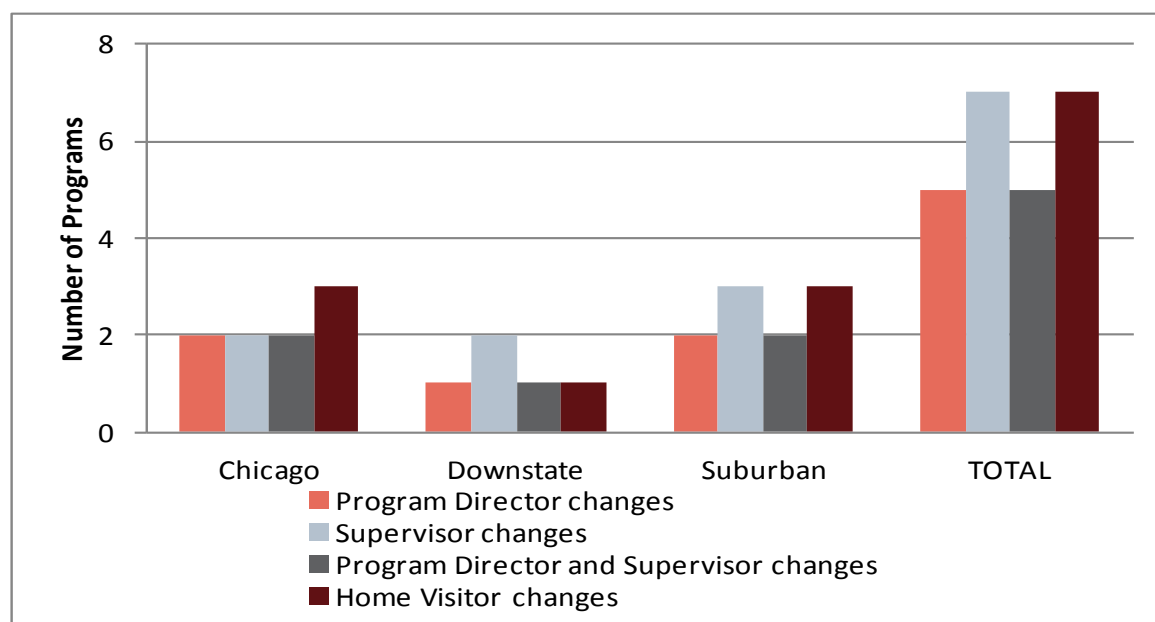
In another example of the impact on an EBHV program due to changes to its umbrella organization, the staff of one EBHV program that has been housed in the same large umbrella agency felt that changes within their larger organization led to fellow employees understanding their work better. In this situation, as a Federally Qualified Health Center (FQHC), the umbrella organization took on some additional direct mother and baby services for its county. The coordinator of the EBHV program was charged with coordinating some of the newly acquired services. This required hiring additional staff for the new program as well as some “shuffling” of existing staff in the EBHV program. After receiving supervisory training, a home visitor was able to reduce her caseload and take on the supervision of her EBHV colleagues. The new supervisor’s caseload reduction, coupled with changes among the clerical support staff and doulas’ full-time employment (FTE) status, resulted in the program being able to increase the home visitors’ FTEs from 80 percent to 100 percent. In addition to the staffing changes at the EBHV program and the new direct services, the umbrella organization also sought to increase the level of mental health services it offered to the community. The agency already employed several psychiatrists but wanted to expand to include counselors and case managers for mental health services. When asked about how all of these changes impacted the EBHV program a staff member explained that the changes have actually bolstered their work in the eyes of the agency: “Bringing [new services] into [umbrella agency] hasn’t impacted us in a bad way; it made us feel better, I think, because they realized that we are doing a good job, that they didn’t have to be behind us all of the time.”

### **Staffing Changes**

We were surprised to learn the extent to which staffing changes occurred within the study’s home visiting programs. Ten of the 15 programs in the study have contended with staff changes (see Figure 10). Of

particular note is that at seven of those sites, staff changes occurred on a supervisory and/or program director level. Four of the sites have different program directors than they did when the study began. In two of those instances, the program directors left their positions for external employment opportunities and home visitors were promoted from within their agencies to fill the position. The third site has had three program directors during the study time frame. At each of these three sites, the program directors' responsibilities include providing supervision for the home visiting staff. Consequently, the turnover affected supervisory practices as well. The fourth site is among those described above which experienced a complete agency-wide restructuring; as a result, the former program director heads a different division within the agency. Interestingly, there was some consistency to the supervisory practices at that particular site. Prior to the agency transition there were two supervisors for the EBHV program. As it happens, the long-time lead program supervisor went on leave prior to the agency's transition and did not return to her position. After the transition all supervisory duties for the home visitors were shifted to the remaining supervisor.

**Figure 10. Staff Changes in 15 Local Programs, July 2010–June 2011**



Three other sites also had supervisory changes during the study period. At one site, as mentioned above, the program coordinator's responsibilities expanded; in order to ensure fidelity to the model, a home visitor reduced her caseload and took on the responsibility of supervision for her peers. The program coordinator still provides supervision to the new supervisor/home visitor. The opposite situation occurred at another site—in that instance a supervisor moved out of state leaving her position open. While the program plans to hire a new supervisor when more information about the program's budget is known, the

program coordinator has shifted her responsibilities to include the direct supervision of the entire EBHV staff—something she had not been doing. Finally, at another site the staff member in the program director/supervisor position remained the same, but she was reduced to part-time status because of fiscal realities.

One of the EBHV programs involved with Strong Foundations, which faced fiscal challenges due to nonpayment from the state, had to lay off its two doulas and two of its home visitors in 2010. The doulas and one of the home visitors were able to be rehired, while the other had secured employment elsewhere. In July 2010 one of the doulas transitioned into the role of clerical support, but her doula position remained unfilled due to budget constraints. In October 2010, the larger agency determined that it needed to once again reduce the EBHV program staff due to the inability of the state to guarantee timely payment for services. Consequently the remaining doula and two home visitors had to be laid off again. Throughout state fiscal year 2011 (SFY2011), the program continued to operate with a skeleton staff of just 2 home visitors, one for each county served by the program. The former doula who is now clerical support and the program coordinator were both reduced to part-time status. In addition to the aforementioned program, six other programs also experienced turnover among home visitors. Reasons for those staffing changes include layoffs, involuntary separations, and staff leaving to pursue external job opportunities.

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## **Local Systems**

Whether for purposes of referrals, sharing resources, or other reciprocally useful functions, collaborating with existing programs can help strengthen the model in its local implementation. Thus, one of the goals of Strong Foundations is to enhance support for local communities to select the evidence-based programs that meet the needs of their families, to provide home visiting services in an efficient and coordinated manner, and to integrate home visiting programs into the full array of services for families with young children. Evaluation findings from the first year of Strong Foundations implementation indicated that improving service collaboration is a top priority among many home visiting programs. At least two-thirds of our sample of local programs was active in local collaborations around the issue of early intervention or services for infants and young children and their families. Most commonly, these activities were geared toward improving service collaboration. Other collaborative activities—sometimes dictated by limited budgets and scarce resources—included shared training and physical facilities.

One of the counties with programs participating in the evaluation of Strong Foundations has a particularly strong local collaborative effort, which we describe in more detail here. All of the home visiting programs that operate within that county are members of a Home Visitation Collaborative which meets regularly on

a quarterly basis. At the Collaborative meetings, members discuss the many shared issues that affect their home visiting programs—for example, the protocol to be followed if it is determined that two agencies are seeing the same client. Members of the Collaborative also participate in a home visitation referral and linkage system for that county’s eligible pregnant and parenting clients. During this past year, the agency that facilitates the Collaborative went through a major reorganization, which, among other changes, included the transfer of Family Case Management (FCM) services to three FQHCs. This reorganization has had a direct impact on each of the home visiting programs in the county since the Collaborative’s referral system utilizes the FCM intake as the point of additional eligibility screening and consent for contact from home visitation services.<sup>27</sup>

During the recent restructuring of FCM services, the Collaborative took the opportunity to review its referral process and institute some changes. The Collaborative updated its referral form to include eligibility criteria for any of the home visitation programs in the county, develop a universal flowchart (see Appendix E) and work with the FQHCs on the referral process. They also began to institute a cross-check mechanism so that the FCM agencies are contacted if the Collaborative does not receive the weekly referrals. As part of the cross-check mechanism, the home visiting programs are to provide enrollment feedback to the Collaborative, which will then share that information with the referring family case managers. (Additional information on the Collaborative’s home visiting referral process can be found in Appendix E.) As designed, the referral process relies upon family case managers to alert families who present with risk factors to home visiting services and obtain their consent for contact from a home visiting program. The case managers then fill out referral forms and forward them on a weekly basis to the facilitator of the Collaborative. Referrals are matched to the area’s programs based on eligibility criteria and geography. The home visiting programs track their referrals and provide monthly enrollment information back to the Collaborative, which shares that information with the initial FCM agency.

Through our interviews with the Strong Foundation programs involved in the Collaborative, we learned about the various perspectives of the home visiting programs and the impacts that the change in FCM has had on them. The most striking consequence was the impact on each of the programs’ referral processes. As explained by a member of the Collaborative, the new case management agencies had to get comfortable with just doing case management, so there was a bit of a lag before the Collaborative could provide instruction on the referral forms and get the referrals sent to them on a consistent weekly basis.

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<sup>27</sup> FCM has had caseload of at least 95 percent of the low- income, Medicaid-eligible families in the county, providing a robust screening system (personal interview, 07/11/2011).

This shifted the number of referrals members of the Collaborative received, as well as the need for direct marketing in their communities.

Prior to the restructuring, the agency that had had responsibility for FCM had been accustomed to having a steady stream of direct referrals from FCM, as well as from the pregnant women who came to their agency for additional services. They relied heavily upon those referrals in order to engage and enroll those families that qualified for their program while referring others to the Collaborative's member agencies. Without its FCM responsibilities, along with the fact that pregnant women were no longer coming directly to their agency for other services, that home visiting program lost its direct referral access points. To counter this change, the home visitors and supervisory staff began marketing their program directly at doctors' offices. They requested and received materials from their national program model, including counter displays, brochures, posters, and a standard letter template that they adapted for their program. According to program staff, having the home visitors meet with physicians increased their referrals.

Another member of the Collaborative, which neither lost nor gained FCM responsibilities, also reported that they perceived stark changes in their referral numbers during the restructuring. Whereas FCM had been the main referral source for its program, program staff reported that during the initial reorganization period they found themselves without enough referrals to enroll families and maintain their capacity. To counter that loss, their program staff also increased their direct marketing presence with physicians, social workers, and at schools. The program supervisor described one example in which a graduate of their home visiting program (after earning her high school diploma and then her Certified Nursing Assistant certificate) went to work at a local doctor's office. The graduate spoke very highly of her experience with the home visiting program to her employer; consequently, the doctor "fell in love with the program" and the program staff was able to arrange a meeting with him. The program is now looking to build upon that relationship and encourage that doctor and others in the community to champion their home visiting program. Interestingly, information from our quarterly data collection does not reflect the perceived change in the number of referrals to this program. This might be an example of where a strong program was able to weather a change in the local system and with new strategies, staff were able to bring their referral numbers up to the previous level in a short period of time.

The EBHV program housed in one of the FQHCs that acquired FCM responsibilities also saw changes in its referral systems. That program is housed within a facility to which many pregnant and parenting women go for other services; as such, those services already represented a rich source of referrals. By bringing in FCM services, the program gained another direct referral access point. It had to then learn

how to operate as a conduit of the FCM referrals for the Collaborative. As a program administrator explained:

We send the rest [of the referrals] back to the [Collaborative facilitators] and let them redistribute because they are more familiar with each of those programs and are concerned with where each family can best be fit. For example, [Program A] and [Program B] serve teens, so you want to refer the teens there. That's not because we don't serve teens, because we do, but they're going to get a longer service with them than if they stayed with us. So it's a better referral for them to go there.

While the program did receive an increase in the number of referrals from FCM once those services were co-located within their agency, the increase in referrals did not have as much of an impact on their home visitors' caseloads as the program's capacity and its current enrollment. As reflected in quarterly data reports from the 15 programs in our sample, the number of referrals is not a direct predictor of the number of families that actually enroll in a program.

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## Summary of Findings

In terms of program operations, quarterly reports from the 15 programs in our sample indicate that during SFY2010 (July 2010-June 2011), enrollment was almost always just below capacity. In addition, capacity and enrollment tended to stay fairly stable over time although the amount of month-to-month fluctuation among individual programs varied. Reasons for changes in capacity included the enrollment of new participants and closing of cases, changes in client levels and 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). The programs in our sample reported more changes in capacity during January and February and fewer in April, May, and July, but the reasons for the differences are not apparent.

Engagement and enrollment of new families varied widely from program to program because of differences in family needs and the eligibility guidelines and capacity of the three model programs. There also were seasonal and regional variations. The number of referred families eligible for services ranged from two to 30, with an overall mean of 6; this means that a little less than half of those referred were found to be eligible. The mean number of eligible families who enrolled in services ranged from 1 to 9 families per month with an overall average of just over 3 families per month.

Just as families enroll in the three home visiting models for a variety of reasons, they also leave the programs for a variety of reasons. The reasons for closing a case fluctuated month to month during this time period; the more commonly noted reasons are 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.

It goes without saying that a program's administrative structure, program staffing, and funding are among the factors that directly impact its ability to provide high-quality, reliable services to its community. The impact of the budget crisis in Illinois on the operations of home visiting programs during SFY2009 has been mentioned and will be discussed in relation to HFI programs statewide in the next chapter. However, we also found that a majority of the programs in our sample also experienced changes in other areas that affected the ongoing stability of their services. All 15 of the EBHV programs that have participated in the Strong Foundations evaluation since 2010 operate within larger agencies. As such, each program is subject to the structural- and/or policy-level administrative changes of their umbrella agency as well as changes at the program level in staffing and other aspects. Specifically, 10 of the 15 programs reported staffing changes during the past year. Of particular note is that for seven of those sites, staff changes occurred on a supervisory and/or program director level. Four sites have different program directors than they did when the study began, and one of these has had three program directors during the study time frame. At each of these three sites, the program directors' responsibilities include providing supervision for the home visiting staff; consequently, the turnover affected supervisory practices as well.

In addition, changes in local systems can affect program operations. A cluster of programs in the study that participate in a local collaborative also experienced changes in program operations with the introduction of changes in the Family Case Management (FCM) program. Most significant was the impact on each of the programs' referral processes. Because it took time for the new case management agencies to become comfortable with changes in their roles, there was a delay before the Collaborative could provide instruction on the referral forms and get the referrals sent to them on a consistent weekly basis. This shifted the number of referrals members of the Collaborative received, and made it necessary to directly market their program in their communities (e.g., with physicians, social workers, and at schools) to obtain enough referrals to enroll families and maintain their capacity. Interestingly, even though some programs report a decline in referrals during this time, our quarterly data collection does not reflect this perceived change. This might be an example of where a strong program was able to weather a change in the local system and with new strategies, staff were able to bring their referral numbers up to the previous level in a short period of time.

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# **Administrative Data Study: Baseline Trends in HFI Programs and Links to Child Maltreatment**

Strong Foundations is designed to enhance the state infrastructure of supports to home visiting programs and local system development, which, in turn, is expected 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.

This chapter presents an analysis of data on the Healthy Families Illinois (HFI) program drawn from the Illinois Department of Human Services (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 individuals (infants and children, parents, and home visiting program staff), creating a rich, potential information platform for pursuing many types of questions about the operations and service delivery of HFI programs and the recipients of HFI services. As this chapter will discuss, the identification of individuals also potentially allows for linking to other information systems. In this case, we include here a brief look at the contacts that participants in IDHS programs have had with investigations of possible child abuse and neglect pursued by the Illinois Department of Children

and Family Services (DCFS) during the 4-year period prior to the implementation of Strong Foundations.<sup>28</sup>

At this time, the direction of specific changes that might occur under Strong Foundations has not been fully determined. The primary task of the current data work is to demonstrate baseline information about the performance of HFI and the child outcome of interest during the period of time prior to programmatic implementation of Strong Foundations. Once we understand these trends for the state as a whole and then for different geographic regions and populations during a baseline period, we will be better prepared to make hypotheses about and interpret trends in subsequent data covering the period of Strong Foundations. For example, given that one focus of Strong Foundations is to increase the capacity of home visitors to work with high risk families, we might hypothesize an initial decrease in the number of families served and/or an initial increase in rates of child maltreatment associated with HFI program participants if such changes reflect changes in client populations. Longer term, we might predict trends that show more families receiving services as well as lower rates of child maltreatment after participating in the program.

The presentation of information drawn from administrative data sources in this report is a trial run in several ways. One reason is that it is not yet clear how to best apply these data to clarify trends and relationships in home visiting in Illinois, until we begin to discover what trends and patterns we should hope to be able to explicate with this information. Thus, we will describe certain trends and patterns and lay out a series of baseline results as a basis for future comparisons. In a sense, this section is as much a demonstration of capacity as a report of findings. As information continues to accrue, 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.

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## **HFI Caseloads and Clients, State Fiscal Years 2006-2010**

A basic picture of the Healthy Families Illinois program across the state is given in Table 8. This is a 5-year summary starting with the 2006 state fiscal year (July 2005), which shows that the combined HFI programs have an ongoing caseload of about 2,000 family units. There was modest growth from 2006 through 2008, followed by a small drop to just under 1,800 units in state fiscal year 2010 (SFY2010). The

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<sup>28</sup> Although we will report on Parents as Teachers program data in a subsequent report, it does not appear that a full client-based data system will be available, which precludes linking these data to DCFS outcome data. In the case of Nurse-Family Partnership (NFP) programs, a high-quality data system is maintained by the national office, but, again, does not provide access to client level data. In addition, during the time period of record here, only two NFP programs operated in Illinois, which poses issues regarding confidentiality of information.

activities we associate with HFI programs do occur regularly. The typical client family receives almost 2 completed home visits per month. Each child averages over 4 doctor visits per year, and is screened for developmental issues just under 3.5 times per year. 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 in 52 different local sites, and visits were made by almost 350 separate workers. In any given year there were between 45 and 48 sites and between 196 and 209 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.

**Table 8. Selected Characteristics of HFI Programs and Child Clients, SFY2006-2010**

Characteristic	State Fiscal Year				
	2006	2007	2008	2009	2010
Number of HFI programs operating	48	46	46	45	45
Monthly total caseload	1,856	1,973	2,056	2,128	1,795
Mean caseload size per program site	38.7	42.9	44.7	47.3	39.9
Total number of HFI workers during SFY	199	196	209	197	205
Mean number of workers per program site	4.1	4.3	4.5	4.4	4.6
Mean client caseload per worker	9.3	10.1	9.8	10.8	8.8
Total number of home visits per month	3,626	3,835	4,069	4,173	3,385
Mean number of visits per month per child	2.0	1.9	2.0	2.0	1.9
Total number of doctor visits during year	7,985	8,660	9,033	9,061	7,007
Mean number of doctor visits per year per child	4.3	4.4	4.4	4.3	3.9
Total number of developmental screenings per year	6,147	6,492	7,112	7,453	6,166
Mean number of developmental screens per year per child	3.3	3.3	3.5	3.5	3.4

The client population that is touched by these HFI programs is described in Table 9, which shows percent distributions of new enrollees on a variety of demographic and program characteristics, for the year in which the client started receiving HFI visits. 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, it should be evident in these characteristics. For example, these data show a sizable increase in the percentage of cases with care levels of “HFI1” and “Prenatal” in SFY2010. Other data suggest that some of the patterns that appear in these data may be changes in data coding rather than in actual underlying behavior, reflecting program staff

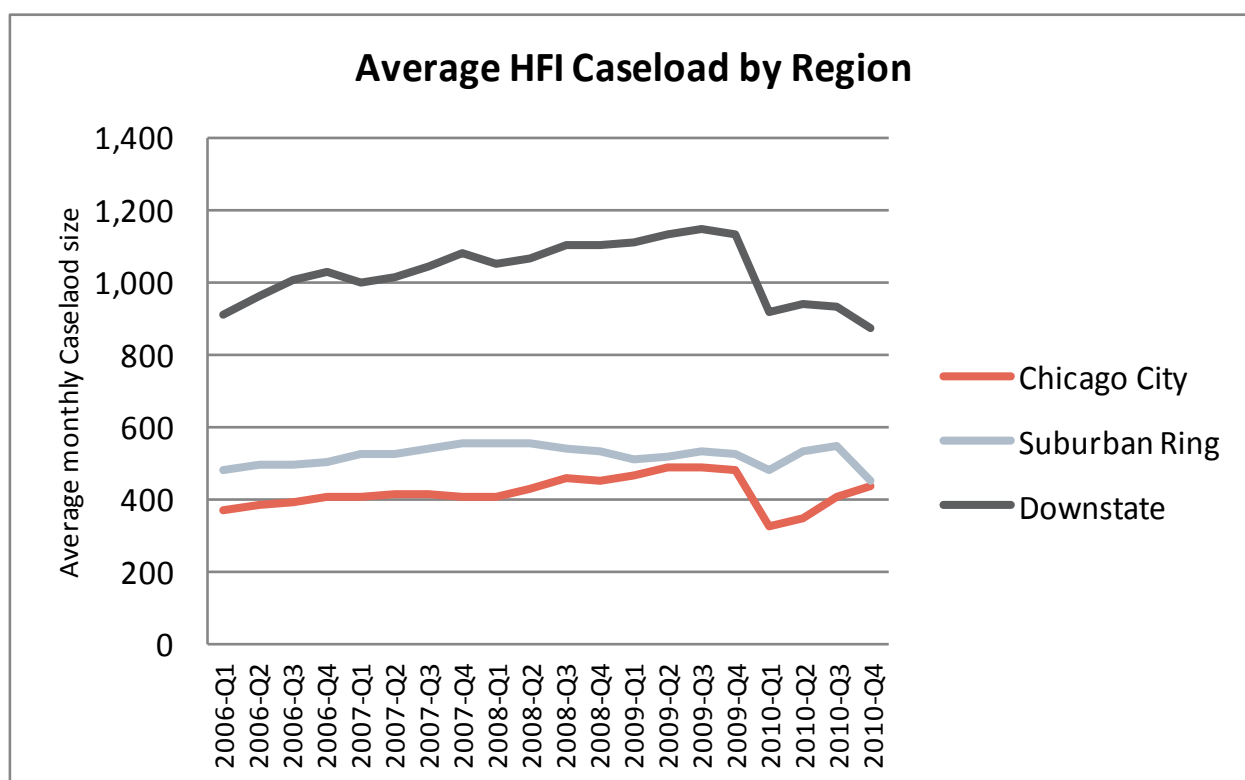
having learned to conform to appropriate coding protocols. Although this limits our ability to interpret trends in this information over the time period of interest, it also signals that the SFY2010 baseline data may be more accurate than those from preceding years.

**Table 9. Characteristics of Clients Entering HFI Programs, SFY2006-2010**

	State Fiscal Year					5-Year Total
	2006	2007	2008	2009	2010	
Number of new HFI clients (N)	718	947	955	895	935	4450
	%	%	%	%	%	%
<b>Race/Ethnicity</b>						
Black/African-American	30	30	31	27	30	30
Hispanic	34	36	34	41	34	36
White	2	2	3	3	5	3
Other	34	31	32	30	32	32
<b>Child's Birth Weight</b>						
Low	10	9	10	8	10	9
Normal	90	92	90	92	90	91
<b>Region</b>						
Chicago	29	25	28	27	31	28
Sub Ring	27	33	29	28	30	30
Downstate	44	42	43	45	39	43
<b>Mother's Age</b>						
Under 18 years	29	29	26	27	24	27
18-19 years	28	28	27	29	29	28
20-22 years	22	21	23	24	28	24
Over 22 years	21	22	25	20	19	22
<b>Mother's Education</b>						
< High School graduate	48	49	45	49	49	48
High School graduate	37	38	38	35	36	37
Post High School	14	13	16	13	14	14
Unknown	1	1	1	3	1	2
<b>HFI Level at First Home Visit</b>						
Outreach	39	38	30	25	9	28
HFI1	29	26	27	37	60	36
HFI2	7	12	22	23	7	15
HFI3	13	15	11	4	2	9
HFI4	6	2	1	0	0	2
Prenatal	6	5	5	6	20	8
Other	1	2	4	4	1	3
<b>Termination Reason (if episode closes)</b>						
Move	22	20	20	12	6	16
Other	12	15	15	19	5	13
Refuse HFI	16	14	13	14	6	12
Voluntary	14	13	9	7	4	9
Probably Closed	3	5	8	9	13	8
Normal	16	11	6	4	2	7
Lost	9	9	8	5	1	6
Not Yet Closed	8	14	20	30	63	28

The information in Figure 11 and Figure 12 point to a pattern of recent change in several indicators of caseload size and composition. The first figure presents time trends over quarters of fiscal years (3-month periods) 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 SFY2006 through the fourth quarter of SFY2009 in all three regions. Then an abrupt decrease in HFI caseload occurs during the first quarter of SFY2010, the period of July through September 2009. This drop is apparent in the Chicago and downstate regions, but not for the suburban ring areas. After this drop, the Chicago caseloads return to a level near their numbers during SFY2008 and 2009, while the downstate numbers stay low through the end of the observation period at the fourth quarter of SFY2010.

**Figure 11. Average HFI Caseloads per Fiscal Year Quarter by Region, SFY2006-2010**



The observed decrease might have been expected, because it occurs during a time of pronounced fiscal crisis in Illinois government. During the summer of 2009, funding for HFI programs was uncertain and unsettled. And, even when program allocations were made, payments to the agencies continued to be very slow. It is well-documented that the provider agencies were operating under pressure and with uncertainty, and that numerous staff reductions or cutbacks were made during this time. **Error!**

**Reference source not found.**Figure 12 shows the proportion of expected home visits that were actually completed, again by region. This is an important measure of fidelity to the HFI program model, because the prescribed number of visits are supposed to be made in order to properly implement the protocols of the evidence-based model program. For most of the five years, it appears that between 75 and 90 percent of the planned home visits actually did take place. Programs in the City of Chicago completed fewer visits. At the time of the fiscal crisis and the drop in caseloads, the completion level in Chicago dropped to its lowest level (70%), but rebounded during the final three quarters observed to about 85 percent. In contrast, the programs in the other two regions showed no shift in completion levels during the same time period.

**Figure 12. Expected Visits Completed per Fiscal Year Quarter, by Region, SFY2006-2010**

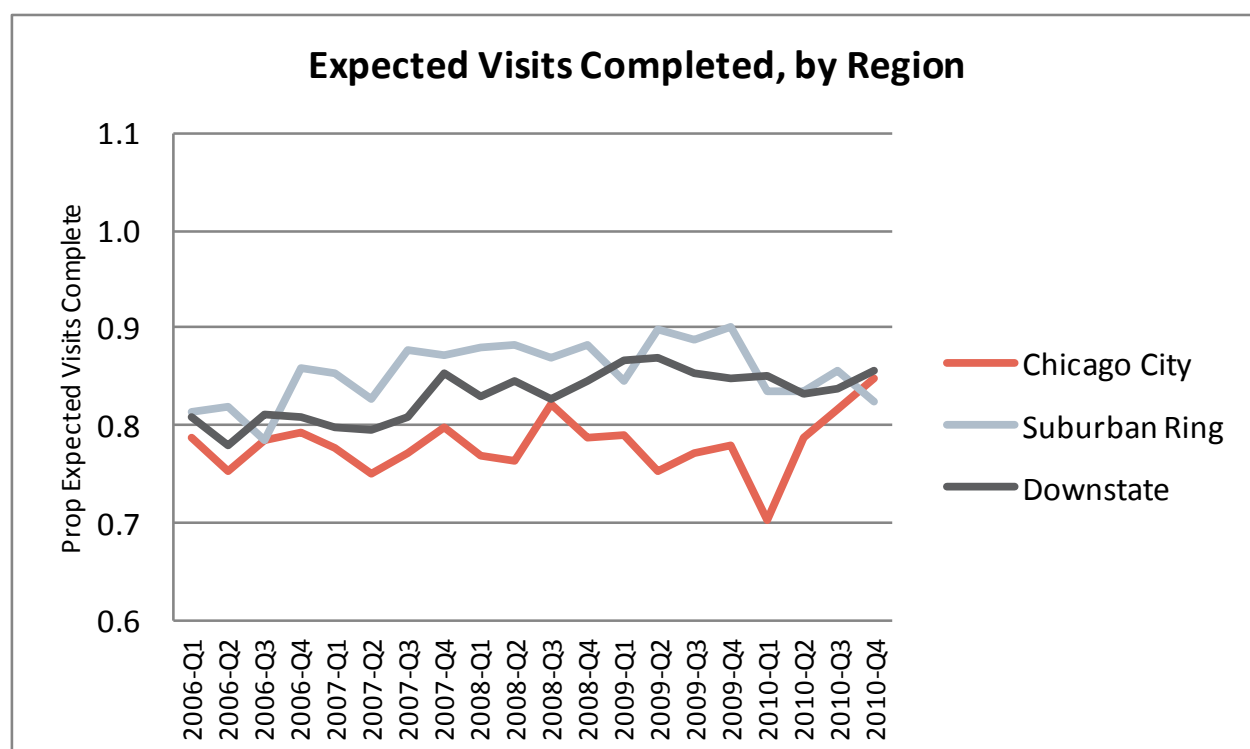
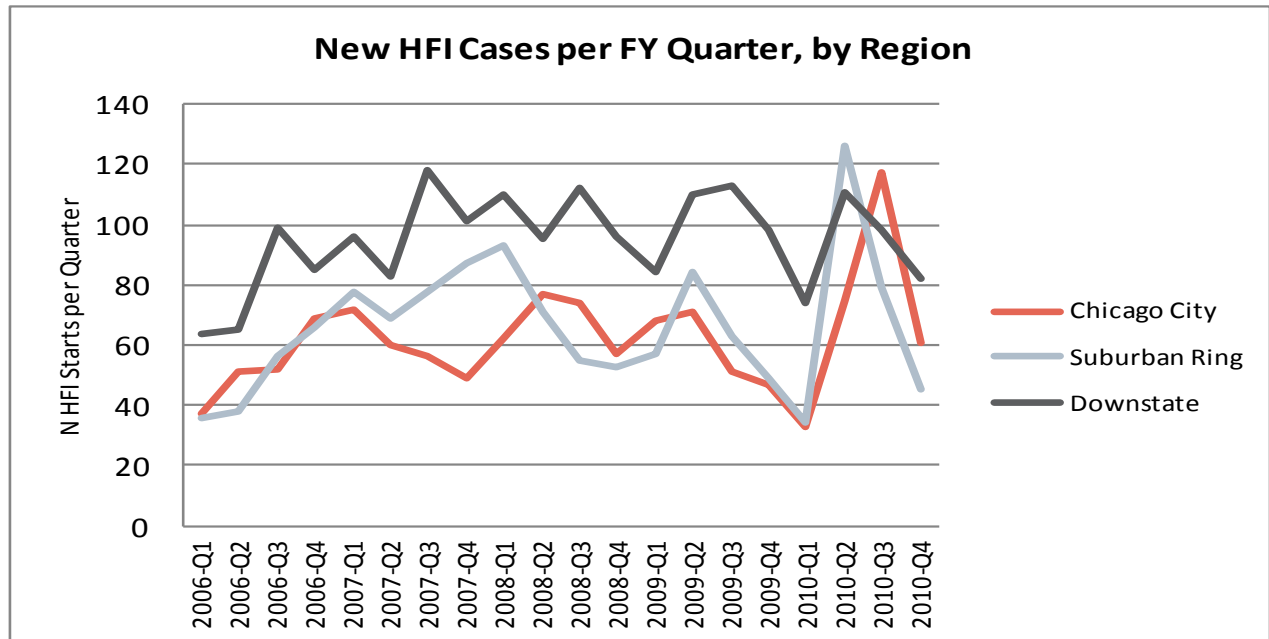


Figure 13, Figure 14, and Figure 15 contain graphs showing elements of caseload dynamics on a quarterly basis. These are new client HFI enrollments (entries), HFI exits, and the resulting net change in the caseload. Again, the summer and fall of 2009 stand out as having extremely different activity patterns. As seen in Figure 14, the number of case closings increased in the Chicago and downstate regions during the fourth quarter of SFY2009. In addition, all three regions show a decrease in recruitment of new cases during the first quarter of SFY2010. Because the number of new cases increased so quickly in the second quarter of SFY2010, there was virtually no overall change in the number of clients served in Chicago and

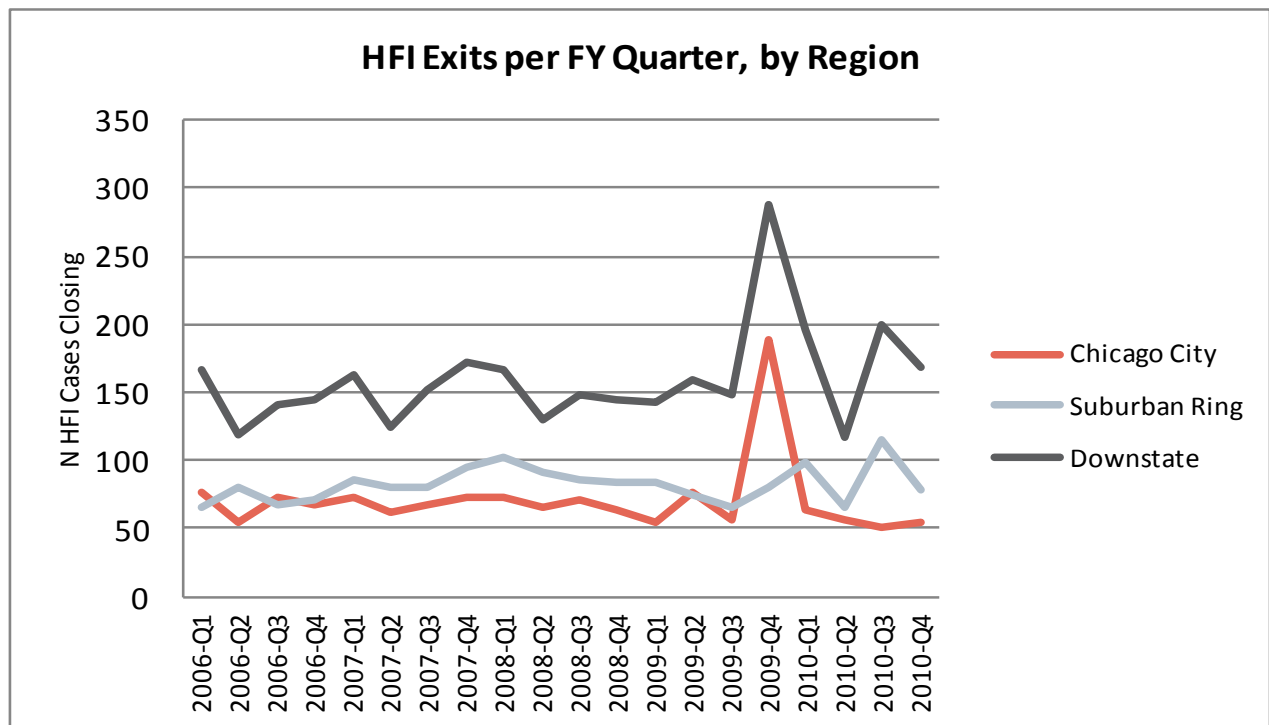
the suburban ring, and only a small cumulative decrease in the number of clients served by HFI programs downstate. But the “ripples” caused by a short period of unusually high exits followed by a period of active enrollment show instability in the caseload that is could be a problem. Rapid system change is not typically a hallmark of the stable provision of supports to client families.

**Figure 13. New HFI Cases per Fiscal Year Quarter, by Region, SFY2006-2010**





**Figure 14. HFI Exits per Fiscal Year Quarter, by Region, SFY2006-2010**



**Figure 15. Net Change in HFI Caseload per Fiscal Year Quarter by Region, SFY2006-2010**

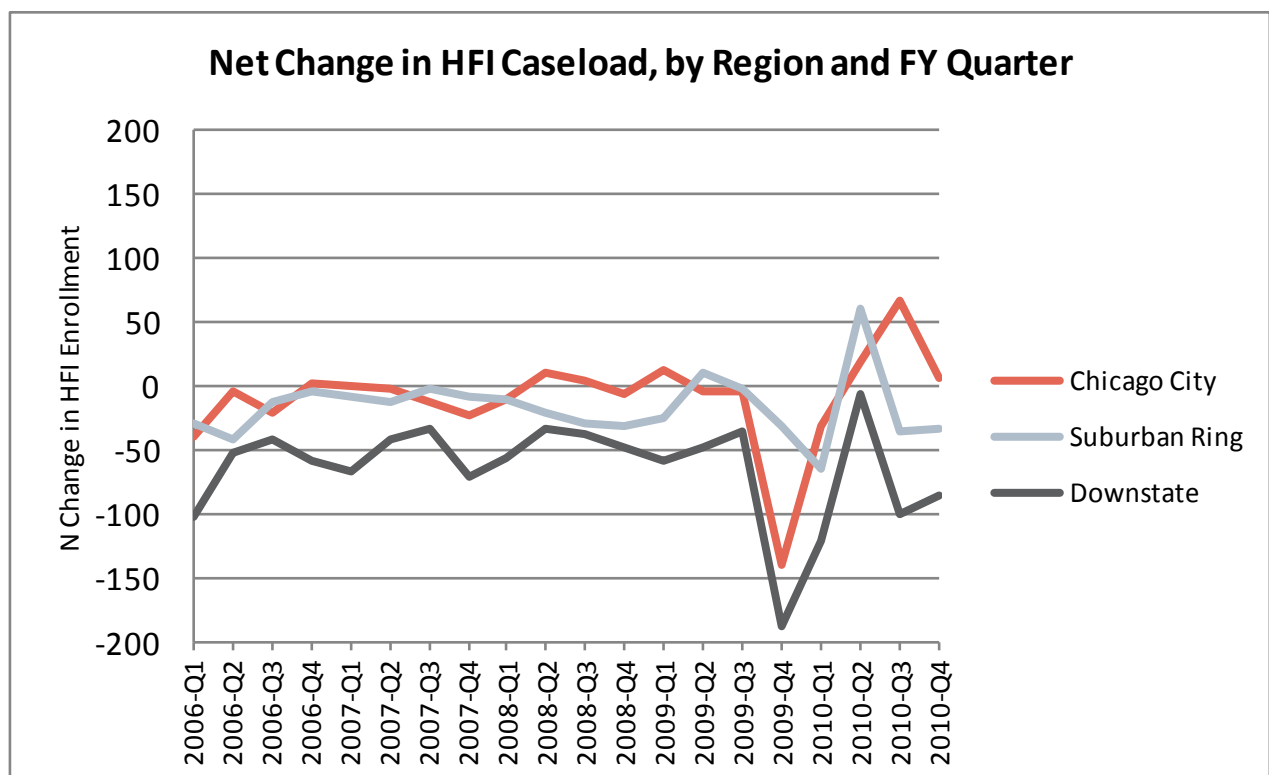


Figure 16 shows the compositional changes in levels of care assigned to HFI clients by program staff over time. These data are broken into smaller time segments than the previous graphs, showing monthly data for the most recent 18 month period from January 2009 through June 2010. This further details how HFI programs responded to the fiscal crisis. Whereas the previous charts showed that some programs expedited exits to reduce demands, Figure 16 shows a different strategy—some programs shuffled the way they served the cases that were retained through the period. Between June and July 2009, there was a large increase (from 200 cases to almost 600) in the “Other” group. This category combines cases that are “Suspended” and those for which the level of care is not coded at all, or left blank. The “bump” in cases coded “Other” lasted for 3 to 4 months, after which it returned to previous levels. At the same time, cases at all other levels decreased. Cases classified as “HFI1” are expected to receive a home visit every two weeks. Since the length of time between visits increases with level of care, cases classified “HFI2,” “HFI3,” and “HFI4” have visits less frequently. There is no evidence that level of care classes were changed strategically to reduce program demands. If all visits could not be fulfilled, it seems that the clients either got all of the visits scheduled, or none.

**Figure 16. HFI Caseload by Level of Care by Month, January 2009 to June 2010**

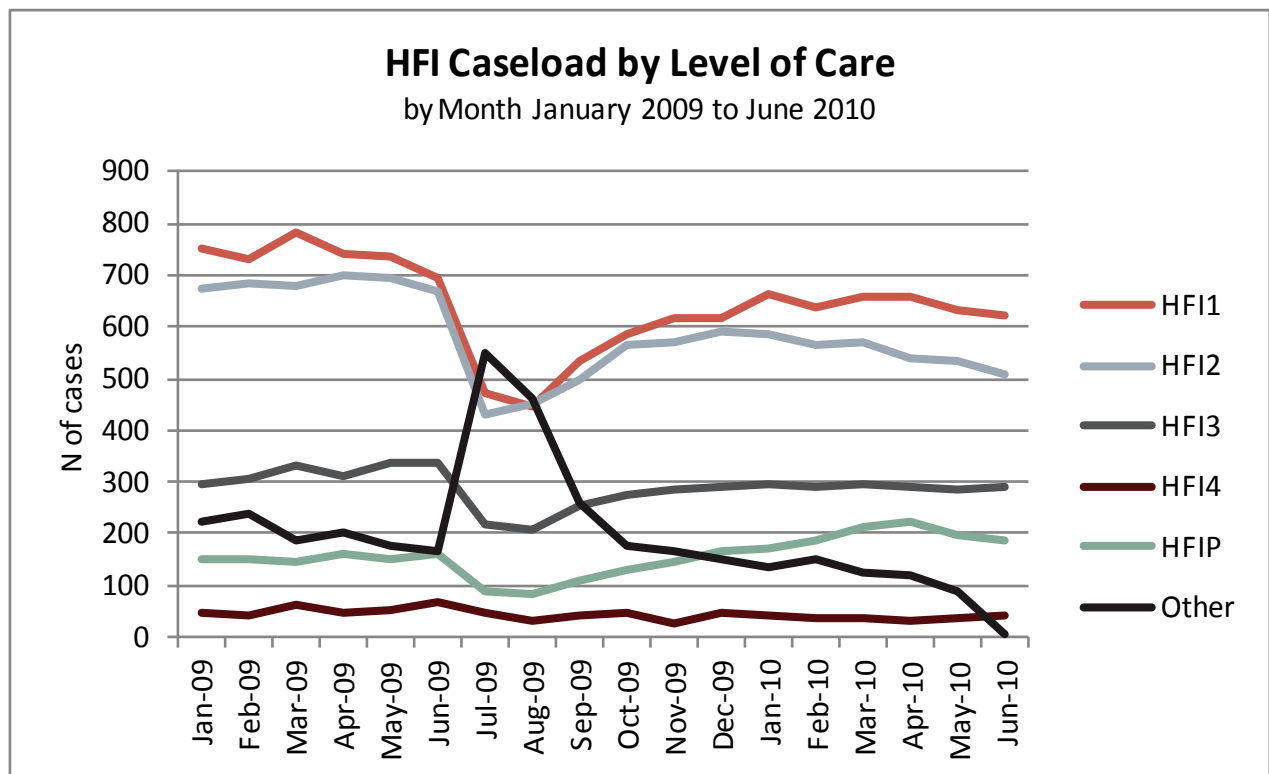
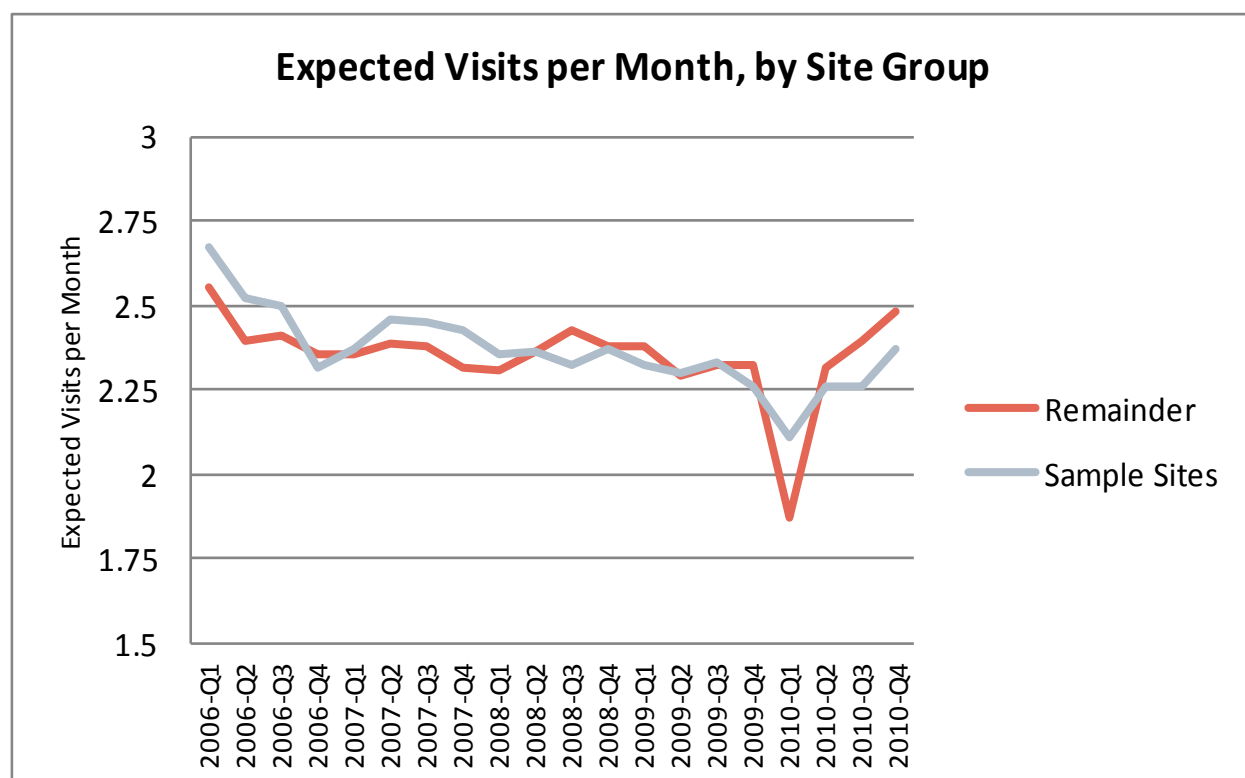
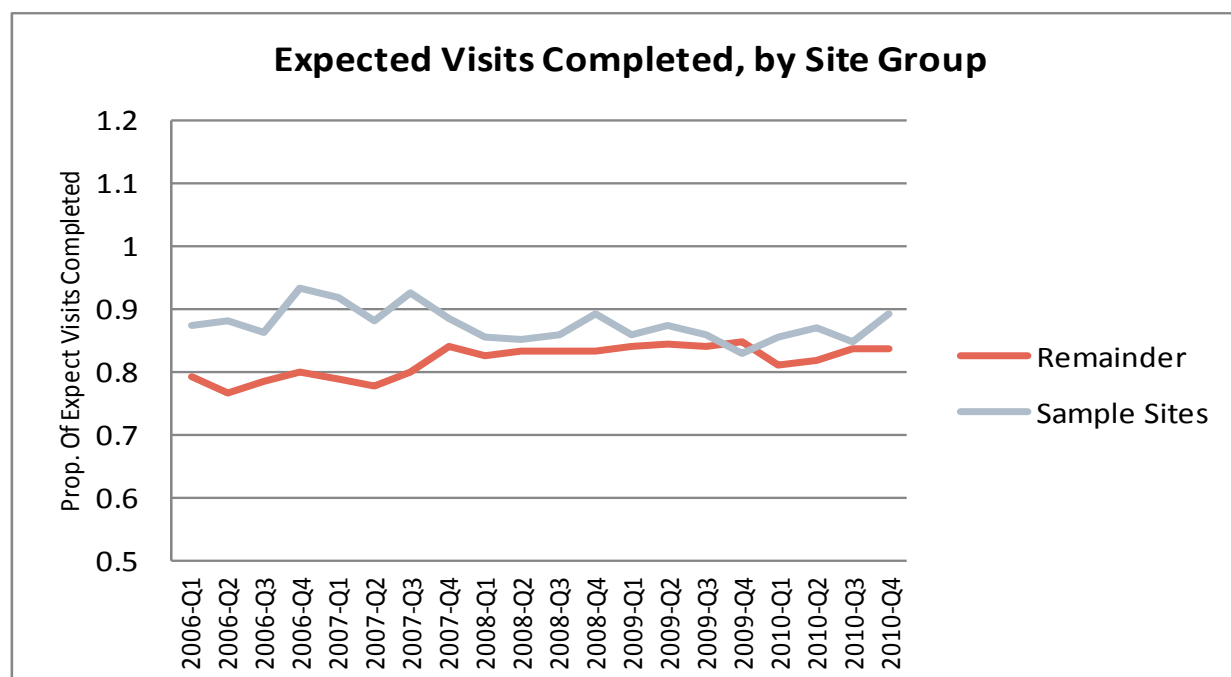


Figure 17 and Figure 18 provide another picture of the relative stability in HFI program performance. They separate the findings for the four HFI case study sites that report data in the Cornerstone system from the other sites in the sample. The sample sites are four of the HFI sites that were singled out for detailed examination by the Strong Foundations evaluation. (There is one more HFI program in our sample, but it does not report data in Cornerstone). The remainder sites are the 41 to 44 other HFI sites for which we have data. Comparing the sample sites to the remaining sites gives us an idea of whether or not the targeted sample sites are representative of the broader population of sites. The only nontrivial difference observed between the target sites and the others is that the target sites seem to have been slightly better insulated from the fiscal crisis. The expected number of client visits per month did not decrease in the way it did for the remainder sites. Figure 17 shows that the aggregate number of visits per month remained very stable across the five years, with the exception of a reduction in the first quarter of SFY2010. Figure 18 shows that not even the few months of fiscal crisis affected the completion rates for visits, which, for all programs (sample sites and remainder combined), remained just over 80 percent for the entire period.

**Figure 17. Expected Visits per Fiscal Year Quarter, by Sample Sites**



**Figure 18. Expected Visits Completed, by Site Group**



Another 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 “dosage” that has been shown to positively affect family outcomes in previous research. In order to do this, clients need to be retained for continuing service provision. Table 10 presents a comparison of program duration across two groups of families, one group that entered the HFI program (i.e., had their first home visit) prenatally, before the birth of a child, and one who had their first visit shortly after the birth of the child.<sup>29</sup> It should be noted that with active program data, duration is difficult to represent because many of the cases are

**Table 10. Duration of HFI Home Visiting Spells, by Year of Initial Engagement for Illinois HFI Programs, SFY2006-2010<sup>a</sup>**

	SFY Engaged in HFI				
	2006	2007	2008	2009	2010
<b>First visit after birth of child (postnatal)</b>					
<i>N</i> entries	247	359	356	339	397
<u>Proportion exit HFI within:</u>					

<sup>29</sup> The data show a third, smaller group of families that indicate that a home visit occurred but there is no record of the birth date of the child. (There were about 120 families, on average, during SFY2006-2009, but the number increased to 222 in SFY2010). In these cases, we cannot differentiate “prenatal” and “postnatal.” The best interpretation is, given that the majority of these cases last less than one month, these are largely families that appear as enrolled and that receive a visit, but are never fully engaged in the HFI program. We do not include these data in Table 10, but they are available from Chapin Hall upon request.

1 month or less	0.19	0.19	0.15	0.22	0.30
1 to 3 months	0.28	0.32	0.27	0.36	0.50
3 to 6 months	0.38	0.42	0.36	0.51	0.78
6 to 12 months	0.49	0.54	0.54	0.68	1.00
12 to 18 months	0.61	0.64	0.70		1.00
18 to 24 months	0.66	0.70	0.82	1.00	1.00
24 months or longer	1.00	1.00	1.00	1.00	1.00
<b>First visit before birth of child (prenatal)</b>					
<i>N</i> entries	355	454	472	448	316
Proportion exit HFI within:					
1 month or less	0.03	0.02	0.02	0.04	0.06
1 to 3 months	0.11	0.13	0.11	0.16	0.31
3 to 6 months	0.26	0.29	0.23	0.30	0.70
6 to 12 months	0.43	0.47	0.39	0.59	1.00
12 to 18 months	0.56	0.58	0.54		1.00
18 to 24 months	0.65	0.65	0.70	1.00	1.00
24 months or longer	1.00	1.00	1.00	1.00	1.00

<sup>a</sup>Shaded areas indicate partially (gray) or fully (black) “censored” data that are incomplete and likely to change.

still open. 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 should contribute to the comparisons, as ignoring them would have a biasing effect 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 SFY2009 and that is still open at the close of observation (in this case, June 2010) could not possibly show a duration of two years. In the same vein, all cases that started in SFY2009 and had durations of less than one year would be observed in these data.

A comparison of case durations between the prenatal and postnatal groups is instructive. It becomes apparent that program retention, at least as measured by elapsed duration of services, is noticeably greater for prenatal cases. This is consistent with anecdotal information from the field suggesting that mothers engaged in HFI prenataly 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, and only about one-quarter terminate by 6 months. In contrast, almost one-fifth of the cases in the postnatal group do not last past one month, and over one-third have terminated by 6 months. The SFY2010 results for both groups are

disturbing, because if the results hold up it will be the first time in five years with a noticeable increase in earlier exits. However, it is possible that this increase is an artifact of how the termination of visiting spells is defined here. It bears watching through SFY2011 data to see if these increases remain in subsequent data collection.

## HFI and other DHS Social Service Programs: WIC, FCM, and EI

The data presented thus far only involves information from Cornerstone about HFI. 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 other sources of information. One type of information introduced here is Illinois birth data, as published by the Illinois Department of Public Health. The other data sources are Cornerstone information for other 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. FCM should be provided to most families at risk of poor 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 risk.

Table 11 provides an enumeration of all live births in Illinois in 2009, categorized by race and ethnicity, region, and by teen mother and low birth weight indicators for four programs, HFI, WIC, FCM, and EI.

**Table 11. DHS Program Participation of Children Born in SFY2009<sup>a</sup>**

DHS Program		Race/Ethnicity					Teen Mother	Low Birth Weight
		Total	Black/African-American	Hispanic	White/Other			
Counts								
Illinois Births		171,077	30,186	40,369	100,522		16,376	14,372
WIC	<i>n</i>	98,645	27,742	37,208	33,695		16,217	9,284
FCM	<i>n</i>	85,868	21,685	30,657	33,526		14,156	8,248
EI	<i>n</i>	8,682	1,766	2,196	4,720		762	2,816
HFI	<i>n</i>	1,200	336	402	462		624	98
% Illinois Total		100	100	100	100		100	100
WIC	%	58	92	92	34		99	65
FCM	%	50	72	76	33		86	57
EI	%	5	6	5	5		5	20
HFI	%	1	1	1	0		4	1
% Within Program Total		100	18	24	59		100	100
WIC	%	100	28	38	34		16	9
FCM	%	100	25	36	39		16	10
EI	%	100	20	25	54		9	32
HFI	%	100	28	34	39		52	8

			Region			
			Chicago	Sub Ring	Downstate	Unknown
<b>Illinois Total</b>		<b>171,077</b>	44,449	71,586	55,042	—
WIC	<i>n</i>	98,645	28,478	25,683	28,797	15,687
FCM	<i>n</i>	85,868	22,948	21,684	29,215	12,021
EI	<i>n</i>	8,682	1,603	1,417	1,882	3,780
HFI	<i>n</i>	1,200	248	229	447	276
<b>% State Total</b>		100	100	100	100	—
WIC	%	58	64	36	52	—
FCM	%	50	52	30	53	—
EI	%	5	4	2	3	—
HFI	%	1	1	0	1	—
<b>% Within Program Total</b>		100	26	42	32	—
WIC	%	100	29	26	29	16
FCM	%	100	27	25	34	14
EI	%	100	18	16	22	44
HFI	%	100	21	19	37	23
<b>% Within Program Total (known geography only)</b>						
WIC	%	100	34	31	35	—
FCM	%	100	31	29	40	—
EI	%	100	33	29	38	—
HFI	%	100	27	25	48	—

<sup>a</sup>WIC = Women, Infants and Children; FCM = Family Case Management; EI = Early Intervention; HFI = Healthy Families Illinois

As this table indicates, although WIC and FCM each touch 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 one percent of all births, it has almost four percent of the births to teens. While black/African-American and Hispanic babies are somewhat overrepresented in HFI, WIC serves a disproportionate percentage of persons of color. EI includes a very high share of children born at a low birth weight.

## Links to DCFS Abuse and Neglect Investigations

HFI is an evidence-based program that seeks to improve parent-child relationships and to reduce the likelihood of child abuse and neglect; the target population for HFI services is mothers and infants at-risk for child abuse and neglect. Thus, a basic monitoring activity for HFI programs should be tracking the involvement of program clients in investigations of reported child abuse and neglect. To this end, we linked Cornerstone data to the Child Abuse and Neglect Tracking System (CANTS) data from the Illinois Department of Children and Family Services. CANTS includes detailed reporting of every investigation of abuse and neglect, including specific allegation codes, the findings of the investigation, the type of

person who reported the maltreatment, and identification of the alleged victims, caregivers, and perpetrators.

At the time of this report, we wish to demonstrate that a link between DHS service recipients and DCFS abuse and neglect investigations can be established and to produce a rudimentary baseline of data to guide future study. The information presented in Table 12 describes abuse and neglect investigations (both indicated and unfounded) during SFY2006-2009 for clients from HFI, WIC, FCM, and EI. We are primarily interested in what share of infant clients is alleged to be victims of child maltreatment.

Table 12 presents the percentage of children 3 years and younger in DHS programs who have ever been involved in an abuse and neglect investigation for a 4-year baseline period (SFY2006-2009) prior to the implementation of the Strong Foundations initiative. For newly enrolled infants, the risk period is very short. For longer-term child clients, there is a longer period of risk for maltreatment. Although we are still analyzing details about the outcomes of specific investigations and the timing of child protective interventions in relation to program participation, these results describe the period prior to Strong Foundations. Participants in WIC and FCM can be seen as “comparison” groups of other low-income or at-risk populations.

**Table 12. DCFS Investigations for Child Abuse and Neglect, Ages 0-3, for SFY2006-2009 (Combined)**

DHS Program	Enrollment Episodes <i>N</i>	Number of Infants (unduplicated)	Children as Alleged Victims		
			Number with A/N Investigations	% with A/N Investigations	% of Investigations Indicated
WIC	400,801	346,657	21,205	6	59
FCM	352,897	302,745	19,633	7	60
EI	67,951	39,464	5,709	15	70
HFI	5,988	4,751	447	9	58

Table 12 indicates that over the 4-year period, 9 percent of children enrolled in HFI programs were involved in an abuse/neglect investigation. Of these investigations, 58 percent were found to be 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 situations existed that were not found to be abuse or neglect. The number of investigations based on capricious reports is extremely small. The investigation rate was higher for HFI (9%) than for WIC (6%) and FCM (7%), but much lower than for EI (15%). This makes sense because the HFI clients are explicitly selected based on various risk factors, including their risk for



maltreatment. During the time 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—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.

We can also see that in most of these investigations, the client mother is included as an alleged perpetrator of the abuse and neglect (see Table 13). As we show later, it is also possible to examine intergenerational aspects of child maltreatment with these data, that is, the extent to which the clients who are mothers in the current program relationship were one-time victims of child abuse or neglect themselves in the past. What is particularly interesting is that of all of the four programs, HFI mothers had the highest link to maltreatment investigations during their childhood (see Table 13). Over one-quarter of HFI mothers were identified as having been an alleged victim within the DCFS child protective framework. About 20 percent of the mothers from the other three programs had contact with DCFS as an alleged victim in their childhood. Clearly, connections to maltreatment and maltreatment investigations are common within the population of HFI clients, which includes some current maltreatment of infants as well as an even more pronounced history of maltreatment experienced by some of the mothers themselves.

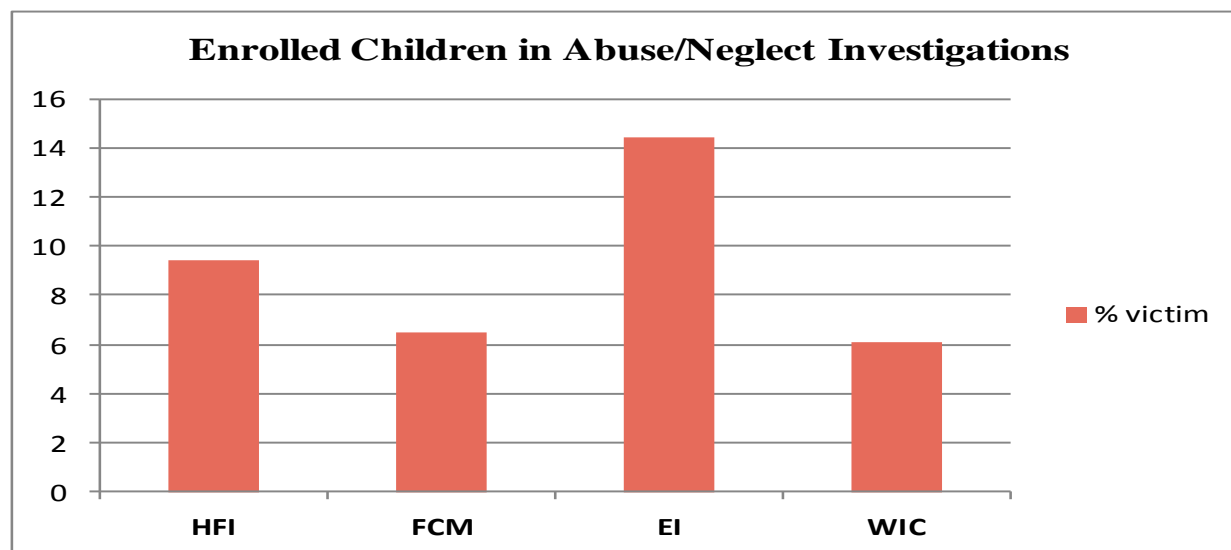
**Table 13. DCFS Investigations for Child Abuse and Neglect Among Mothers as Alleged Perpetrators and Victims, for SFY2006-2009 (Combined)**

DHS Program	Enrollment Episodes <i>N</i>	Mothers				
		As Alleged Perpetrators			As Alleged Victims in Childhood	
		Number (unduplicated)	Abuse/Neglect Investigations	% Investigations	Abuse/Neglect (unduplicated)	% Investigations
WIC	400,801	201,914	22,582	11	34,086	17
FCM	352,897	184,330	20,868	11	34,086	19
EI	67,951	22,064	4,126	19	4,638	21
HFI	5,988	4,320	444	10	1,132	26

Figure 19 shows the percentage of children, 3 years and under, who were enrolled in HFI, FCM, EI, or WIC and who have been the subjects of DCFS investigations during our baseline period, SFY2006–2009. While the number of children who are the subject of a DCFS investigation is rather small, a greater percent of investigated children are also enrolled in EI (15%). HFI, while targeting families at greatest risk for the maltreatment of children (e.g., teen mothers), also has a sizeable percent of children in its

program who are the subject of a DCFS investigation (9%). Children enrolled in FCM and WIC are less likely to also be the subjects of DCFS investigations (approximately 6% each).

**Figure 19. Percent of Children 0-3 Years Old Enrolled in DHS Programs in Abuse/Neglect Investigations, SFY2006-2009**



## Summary of Findings

The purpose of the administrative data study in this year's report was to establish baselines for a period of time prior to full implementation of Strong Foundations—including a baseline of HFI program characteristics and a baseline of child maltreatment investigations for clients in HFI programs—which can be used for comparison to trends during and after implementation. The analysis of a 5-year period beginning with the 2006 state fiscal year (which began in July 2005) shows that HFI programs collectively had an ongoing caseload of about 2,000 family units, with modest growth from SFY2006 through 2008, followed by a decrease to just under 1,800 units in SFY2010. The drop in caseloads in SFY2010 was marked during the first quarter of that fiscal year (July through September 2009), which coincided with the state budgetary 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 5-year period, HFI programs were run in 52 different local sites, and visits were made by almost 350 separate workers. In any given year there were between 45 and 48 sites and between 196 and 209 workers. There were small year to year changes in program sites, but substantially more changes occurred in staff numbers 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/African-American, 3 percent white, and 31 percent “other.” Over half (54%) of the mothers served were teen mothers. Just over half (52%) were high school graduates.

The percentage of expected home visits that were actually completed is an important measure of fidelity to the HFI program model. For most of the 5 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 the City of Chicago. At the time of the fiscal crisis and caseload decrease, the completion rate in Chicago dropped to its lowest level, 70 percent, but 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 SFY2009. All three regions showed increased recruitment of new cases during the months that followed, 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. This could potentially pose 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.

Over a 4-year baseline period (SFY2006–2009), 9 percent of children enrolled in HFI programs were involved in an abuse and neglect investigation. Of these investigations, 58 percent were found indicated, meaning that the investigation found credible evidence that abuse or neglect had occurred. The investigation rate was higher for HFI (9%) than for WIC (6%) and FCM (7%), but much lower than for EI (15%). This makes sense because the HFI clients are explicitly selected based on various risk factors, including their risk for maltreatment. For example, whereas WIC and FCM each touch 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.

Furthermore, it should be emphasized 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—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, our analysis of official reports of child abuse and neglect that involved clients of home visiting programs in Illinois is grounded in the idea that reduction of abuse and neglect is the primary long-term outcome of these programs. Thus, it is reasonable to look to changes in levels of child maltreatment as part of the evidence that efforts to improve the infrastructure of supports for home visiting programs are successful. In turn, these efforts positively influence the programs' quality and model fidelity—at least in the long term. It is also reasonable to look at trends in abuse/neglect levels to describe the distribution of risk groups and child maltreatment across Illinois, which should be used to 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 should not be interpreted as being a result of any of the initiative activities. Moreover, the fact that Strong Foundations is not implementing activities at the service delivery level means there is not a viable control group or population, a second challenge to analysis of individual level outcomes. 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. These clients are a special group of parents and children, not a random sample. They are, by definition, vulnerable and at high risk of abuse/neglect, yet they also have been referred to or recruited by a home visiting agency and have voluntarily agreed to participate in the program offered. Not having an experimental or quasi-experimental design, we cannot produce another control or comparison population against which to measure these outcomes.

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# Conclusions and Recommendations

Findings from the second year evaluation of Strong Foundations indicate progress in a number of areas of the system where home visitation occurred during the past year. The state system showed growth in the domains of training and technical assistance. This included the implementation of three of the Big Four trainings by the Ounce Training Institute to increase home visitors' capacity to work with families affected by perinatal depression, substance abuse, and domestic violence and plans to implement a fourth training for working with clients who have adult learning challenges, the following year. Each of these trainings provides a half day of education, and participant evaluations of the trainings' quality and relevance were very positive. In addition, the Strong Foundations leadership contracted with Prevent Child Abuse Illinois to offer training in the Happiest Baby on the Block curriculum, which gives families new ways to soothe their crying infants.

Most of our key informants could see that a much more comprehensive training and monitoring system has started to take shape. In their view, the system has been bolstered by the work of the new Strong Foundations Partnership in the Governor's Office of Early Childhood Development, which has oversight of both Strong Foundations and initiatives funded under the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. A few respondents noted the importance of Strong Foundations in building awareness of home visitation within the early childhood system as well as its many contributions to the growing early childhood system in Illinois. As one key informant described the impact of the initiative, Strong Foundations has transformed home visiting in the state from "a program initiative" to a "major building block of the early childhood system."

The MIECHV application process brought to the surface concerns about the extent to which the governance, leadership, and administration of the home visiting system were being shared among state-level administrators and other key participants in the system, and how these roles were being communicated to a broader audience of stakeholders. These concerns suggest a need for better communication about the process and decisions that were made than the quarterly Home Visiting Task Force (HVTF) meetings and occasional HVTF email updates. The fast pace of the work made more

frequent communication difficult but also emphasized the importance of other communication vehicles for reporting and explaining the planning and decision-making processes to the broader stakeholder group and providing opportunities to debrief on the way the process was managed.

Despite these concerns, there was a general sense of optimism 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). This optimism reflects the vision of the original Strong Foundations plan for shared leadership and accountability among these three organizations in the home visiting system. However, with regard to support for local system building, the general sense from our informants in the spring of 2011 was that there is still work to be done. Even though this component of the system continues to receive attention through the work of the Community Systems Development Work Group (CSDWG), local collaboration is complicated by the different funding streams that govern individual home visiting programs. Until there is better coordination among state agencies with respect to funding and monitoring, local communities are likely going to need additional support from the state to strengthen their local collaborations and systems. It is also worth noting that local system development is complicated and takes time; just as with the state system, it requires ongoing attention to multiple components.

The analysis of administrative data in this year's report was done to establish baselines for a period of time prior to full implementation of Strong Foundations—including a baseline of the Healthy Families Illinois (HFI) program characteristics and a baseline of child maltreatment investigations for clients in HFI programs—which can be used for comparison to trends during and after implementation. The analysis of a 5-year period beginning in July 2005 with the 2006 state fiscal year (SFY2006) shows that almost 50 HFI programs collectively had an ongoing caseload of about 2,000 family units, with modest growth from SFY2006 through 2008, followed by a decrease to just under 1,800 units in SFY2010. The drop in caseloads in SFY2010 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 5-year period, the typical client family received almost two completed home visits per month. Each child averaged over four doctor visits per year and received developmental screenings a little more than three 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/African-American, 3 percent white, and 31 percent “other.” Over half (54%) of the mothers served were teen mothers. Just over half (52%) were high school graduates.

The administrative data also provide an assessment of two aspects of program fidelity: the extent to which expected home visits are completed and the duration of program participation. For most of the 5 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 the city of Chicago. With respect to the retention of families, we observed during the period of study that those who entered the HFI program prenatally stayed in the program longer than those who had their first visit shortly after the birth of their child. In addition, the number of case closings increased considerably in Chicago and downstate regions during the fourth quarter of SFY2009, but was followed by increased recruitment of new cases in all areas. These trends are consistent with the reports from our 15 case study programs. Although these changes are 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 and raise questions about the system’s ability to provide stable services to families.

Among the 15 programs in our case study sample, quarterly reports for SFY2011 (July 2010-June 2011) indicate that enrollment was almost always just below capacity. In addition, capacity and enrollment tended to stay fairly stable over time although the amount of month-to-month fluctuation among individual programs varied. Reasons for changes in capacity included the enrollment of new participants and closing of cases; changes in client levels and 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). The programs in our sample reported more changes in capacity during January and February and fewer in April, May and July, but the reasons for the differences are not apparent.

The engagement and enrollment of new families varied widely from program to program because of differences in family needs and the eligibility guidelines and capacity of the three model programs. There also were seasonal and regional variations. On average, a little less than half of those referred were found to be eligible. The reasons for closing a case varied from month to month during this time period; the more commonly noted reasons for the fluctuations 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 Healthy Families Illinois and Parents as Teachers programs, the most commonly cited reasons for families leaving the programs was program completion, as well as families moving out of the program catchment area and programs not being able to locate the families. The Nurse-Family Partnership

programs, however, most often reported not being able to locate the families followed by reasons of program completion and declining further participation.

Finally, our case study sites also illustrate the impact on program operations, quality, and model fidelity that changes in administrative structure, program staffing, funding, and local systems have had. In addition to funding changes over the past two years, two-thirds of the programs in our sample reported staffing changes during the past year. Of particular note is that for seven of those sites, staff changes occurred on a supervisory and/or program director level. Four sites have different program directors than they did when the study began, and one of these has had three program directors during the study time frame. At each of these three sites, the program directors' responsibilities include providing supervision for the home visiting staff; consequently, the turnover affected supervisory practices as well.

In addition, a cluster of programs in the study that participate in a local collaborative also experienced changes in program operations with the introduction of changes in the Family Case Management (FCM) program. Most significant was the impact on each of the programs' referral processes. Because it took time for the new case management agencies to become comfortable with changes in their roles, there was a delay before the Collaborative could provide instruction on the referral forms and get the referrals sent to them on a consistent weekly basis. This shifted the number of referrals members of the Collaborative received, as well as the need for direct marketing of their program in their communities (e.g., with physicians, social workers, and at schools) to obtain enough referrals to enroll families and maintain their capacity. Interestingly, even though some programs report a decline in referrals during this time, our quarterly data collection does not reflect this perceived change. This might be an example of where a strong program was able to weather a change in the local system and, with new strategies, staff were able to bring their referral numbers up to the previous level in a short period of time.

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## **Building a Stronger System: Progress, Challenges, and Recommendations**

In conclusion, findings from the second year of the Strong Foundations implementation indicate progress in developing the system of supports for home visiting as well as ongoing challenges. These results suggest several conclusions to be drawn and recommendations to be made for building the supports for home visiting programs and, in turn, building the capacity of programs to meet the needs of their communities with evidence-based services. These conclusions and recommendations fall in the following areas:

- **Staff development and training.** The state system continues to demonstrate considerable capacity to provide basic training for a range of home visiting staff. It is encouraging that the importance of continuing to allocate resources to staff development and training across the state is also highlighted



in the MIECHV implementation plan. The plan also advocates that trainers maintain national standards. As a result of Strong Foundations, professional development to assist home visitors working with high-risk families in the areas of domestic violence, perinatal depression, substance abuse, and adult learning challenges is more available than in the past. It should be noted that the trainings that were offered during SFY2011 have been modified for the coming year (SFY2012) to incorporate more attention to the application of knowledge in home visiting settings. Additional professional development is being planned 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 from participants in the Strong Foundations evaluation for more comprehensive and deeper training targeted to the diverse needs of different staff. We trust that these steps will also help staff apply knowledge in the different cultural and regional contexts which programs operate.

- **Monitoring, program performance, and quality assurance.** Another important part of the infrastructure is the ability to collect common data across home visiting programs. Although few Strong Foundations resources have been directed at the development of a statewide monitoring and quality assurance infrastructure, a working group of the HVTF produced a set of recommendations towards such a system in the first year of Strong Foundations that provide a foundation for continued work in this area. MIECHV and other federal initiatives provide new incentives and resources to build a data system for the collection of common indicators or benchmarks of child, family, and community well-being. There is also greater interest among agencies in sharing data across systems. Illinois is making technological progress in integrating data from different systems in a form that can be used by multiple agencies. Based on our informant interviews, partners in the home visitation system also recognize the importance of data sharing and common or linked systems for data collection in building an effective system with demonstrable impacts. We urge Strong Foundations stakeholders to continue to explore ways to develop a system of common data elements for all home visiting programs in the state but also to integrate its efforts with existing systems (e.g., the Early Intervention (EI) system and the DCFS Statewide Provider Database) as well as those being pursued in other state initiatives (e.g., Illinois Project LAUNCH and the Healthy Beginnings II initiative of the Illinois Chapter of the American Academy of Pediatrics). Some of these initiatives include efforts to develop a common screen to be used to enter the system—another goal of the MIECHV implementation plan—and to track families throughout the system, in order to know when and where referrals are made and the outcomes of those referrals.

- **Communication and public awareness.** A key challenge in any complex system is communication. Our Year 1 interviews suggested that communication between the state and local communities and programs is not as strong as the communication between state agencies and advocates. Although structures and processes exist to facilitate communication across agencies and across levels of the system, it cannot be assumed that they work equally well at all levels. Participants at the higher levels of the system, in particular, need to be mindful of, and perhaps more intentional about, the way they reach out to and share information with those at the practice level, including frontline staff and families. In addition, findings from Year 2 suggest that in the context of responding to multiple MIECHV funding opportunities some stakeholders in the system did not feel included in the decision-making process or understand the process. We do not have enough information to evaluate the extent to which the governance, leadership, and administration of the home visiting system was being shared among state level administrators and other key participants in the system. However, concerns raised by some of our informants suggest a need for better forms of communication vehicles at different levels of the system to report and explain the planning and decision-making processes to the broader group of stakeholders in the home visitation system.
- **Local system-building.** There appears to be growing momentum to continue to foster local collaborations and partnerships. Thus, the importance of the Strong Foundations-supported community systems development work cannot be overstated. The effectiveness of home visitation as a strategy to improve family functioning and child development depends in part on communities' capacity to offer high-quality programs that meet the diverse needs of their families. It also depends on connections to other services and systems, including health and mental health care and early care and education programs. Staff of local programs in Years 1 and 2 expressed concern about the lack of resources, especially in the current economic climate, and a desire for more knowledge of and connections with other service providers to increase their capacity.
- **Funding strategies.** It goes without saying funding remains an ongoing challenge to the state system, yet any system faced with budget changes and delays in state payments to local providers needs to be flexible and resilient through resource-sharing, collaboration, and innovation. Although data collected for this evaluation provide a somewhat limited view of the impact of the state budget problems on individual home visiting programs, they indicate both staff and caseloads were reduced or reallocated in response to budget cuts, but also highlight some of the strategies that individual programs took to maintain the quality of services to families who remained on their caseloads. Given that the original Strong Foundations plan included a funding strategies subcommittee and the concern expressed by some of our informants about the lack of a solid, long-term plan for generating revenue for services in

the future, both advocacy to sustain current funding and efforts to look at long-term funding strategies are needed.

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

Even with these complications, the infrastructure in Illinois has several strengths that increase program quality and effectiveness. These include strong advocacy organizations; growing state-level collaborative leadership that includes state agencies but also the Early Learning Council (ELC), HVTF, Early Childhood Comprehensive Systems Initiative (ECCS), and other collaborative initiatives; emerging collaborations at the local community level; and sustained participation by a wide range of stakeholders.<sup>30</sup> In addition to Strong Foundations, the new MIECHV grants are bringing not only more financing for home visiting but are also providing support to ongoing infrastructure development. System-building takes time and challenges, particularly in the still-precarious economic climate, are likely to exist for the long term. Yet, our findings indicate that the state's home visitation system has made notable progress in several areas—for example, enhancing the training infrastructure and increasing collaboration among state level administrators—and that the system is increasing its resiliency and capacity to meet and respond to its challenges in an effective and sustainable way.

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<sup>30</sup> These are key system components that have been identified as necessary for “resilient systems” in recent writings applying the concept of “resilience” from the ecological and organization sciences to early childhood systems (e.g., Cobb, 2011).

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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?

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## **Appendix B: Year 2 Consent Forms and Interview Guides**

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## Consent for State Level Respondents, including Coordinating Agencies

### Informed Verbal Consent

Chapin Hall at the University of Chicago is an independent policy research center whose mission is to build knowledge that improves policies and programs for children, 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 30-50 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 30-50 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, at the Chapin Hall at the University of Chicago, 1313 East 60<sup>th</sup> Street, Chicago, IL 60628; 773-256-5187 or 1(800) 508-6023, [julies@uchicago.edu](mailto: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. 60<sup>th</sup> Street, Chicago, IL 60637, or email: [abg@uchicago.edu](mailto: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?

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## Interview Guide for State Level Respondents, including Coordinating Agencies

Thank you for participating in our study. This study is being done to learn more about home visiting programs in Illinois, the system that supports home visiting programs, and the Strong Foundations initiative, a state-wide plan to strengthen the infrastructure of supports for home visiting programs. It is focusing on three evidence-based programs: Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP). The study 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 learns 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 to be used as a guide to a semi-structured conversational interview. Sub-questions are included as possible probes to use if the respondent does not mention these topics; you are not expected to ask all sub-questions but should try to address each topical area. Because state informants vary, not all questions will be appropriate for all respondents. New relevant topic areas may also emerge during the course of the interview. The order of questions will also vary; e.g., you might start out some interviews talking about home visiting in general and then address Strong Foundations in particular, but for other interviews start by talking about Strong Foundations.]*

**Background** *[I'd like to begin by learning a little more about your background and how you became involved in home visiting services in the state.]*

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 is your role in relation to home visiting programs in Illinois? Has this changed since our interview last year?

**Strong Foundations** *[Now I'd like to talk more specifically about Strong Foundations.]*

2. ASK ONLY IF **NOT** INTERVIEWED LAST YEAR: How familiar are you with the Strong Foundations initiative?
3. What is your role in relation to Strong Foundations? Has this role changed since the beginning of the initiative?
4. 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.
5. What challenges have the Strong Foundations leadership encountered in the past year and how have they responded?
6. In your view, have the appropriate program models, coordinating agencies, state level departments, and other stakeholders had a voice in the development of Strong Foundations? If not, who else should be represented?

7. What is the role of partnerships in the implementation of Strong Foundations? Who are the Strong Foundations partners? How effective are the partnerships? What challenges have been experienced in developing partnerships to implement Strong Foundations? How have partnerships changed over time?
8. What is your understanding of the management and administrative structure used to develop and oversee Strong Foundations? Are you aware of any changes made to the structure of the Home Visiting Task Force or leadership regarding the EBHV or MIEC grants? If so, please describe. How effective has this structure been? How could it be improved?

**Home Visiting in Illinois** *[Next, I'd like to talk generally about home visiting services and how they are supported in Illinois.]*

9. What challenges does the state face in implementing and supporting evidence-based home visiting programs? How has the state responded to these challenges?
10. How are communities supported and assisted by the state in selecting evidence-based programs to meet the needs of their families? In what ways could they be better supported?
11. Are you familiar with the "State System Development Guide or Assessment Tool,"? which was revised last year by the Illinois Home Visiting Task Force. It has served as a guide to the Strong Foundations leadership in developing a network of supports for home visiting programs in the state. I would like your view of the extent to which the current supports for home visiting reflect the characteristics in this guide. In general, I would like to know:
  - Is this a characteristic the state currently does very well, is doing okay but there is room for improvement, or is not doing well
  - Have you seen changes in this area over the past year?
  - What are the current strengths and weaknesses of this aspect of the infrastructure?
  - Do you have any suggestions for improvement?

1. The first area is **governance: administration & strategic planning**. To what extent is there *an infrastructure that serves as a central administration to provide leadership and administrative support for the comprehensive state system and a strategy to sustain and/or expand multiple home visiting models in the state?* (This aspect includes a dedicated staff to oversee and manage the system at the state level, policies and procedures for local programs, an advisory group or task force that leads strategic planning, and a means for evaluating the leadership and governance structure.)

2. A second area is **workforce development, training & technical assistance**. To what extent does the state system *provide home visiting training and technical assistance for staff from all programs, accurately identify training needs, ensure that there is enough training to meet the needs of local sites, and has a process to ensure the quality of training?*

3. A third area is **collaboration, community planning & site development**. To what extent are there *strong and inclusive collaborations at the state level and in local communities as well as technical assistance for developing, sustaining and expanding home visiting?* (This includes a consensus about what is needed to promote and support quality community-based programs, leadership on the development of local collaborations and partnerships, a method to educate communities about home visiting, an effort to build on existing collaborations and services, and providing support to new programs.)

4. **Research, evaluation & continuous quality improvement/credentialing** is another area. To what extent has the state system *established criteria for quality assurance and a system to ensure these criteria are followed?* In addition, to what extent does the system collect data for program planning and evaluation purposes? (Key elements include a quality assurance plan, resources to meet data management needs, coordinated, confidential and consistent data collection across program funders and models, a self-assessment process used by programs to inform continuous quality improvement and result in the credentialing/certification/commendation of their chosen program model, a collaborative process to develop outcome measures (including impacts on families and children), a statewide evaluation, and a system to enhance communication between researchers and practitioners to enable best practices to be incorporated into service delivery.)

5. Another area is **communication, public awareness & outreach**. To what extent do *state and local program stakeholders have current and relevant information [about the importance of home visiting as an essential support for families in communities all over the state] to maximize their effectiveness?* (For example, do communication processes exist that connect program sites with one another, the state system, the national offices and other network members? Are regular outreach and public education efforts conducted? Have a diverse variety of spokespersons been cultivated and trained?)

6. **Funding and financing** is another area. To what extent is there *secure, sufficient funding to assure comprehensive quality services based on standards?* For example, are there diverse funding streams leveraged to assure adequate funding of Home Visiting services, program improvement, system infrastructure development, research and evaluation?

7. Another area is **evidence-based standards** for programs. To what extent are *standards aligned across the statewide system and reflect effective practices, programs and practitioners?* For example, do programs reflect the “Big Tent” and represent a diverse delivery of models to meet the varying needs of communities? Do these 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?

8. **Innovation** is a final area. To what extent does *Illinois invest in the development of innovative, evidence-based approaches to home visiting to support the diverse needs of at-risk families?* 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?

## 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!**

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

### **Informed Verbal Consent**

Chapin Hall at The University of Chicago is an independent policy research center whose mission is to build knowledge that improves policies and programs for children, 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 30-50 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 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 30-50 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, at the Chapin Hall at the University of Chicago, 1313 East 60<sup>th</sup> Street, Chicago, IL 60628; 773-256-5187 or 1(800) 508-6023, [julies@uchicago.edu](mailto: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. 60<sup>th</sup> Street, Chicago, IL 60637, or email: [abg@uchicago.edu](mailto: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?

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

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.]***

2. 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?
3. 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?
4. 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: check capacity of program prior to interview from quarterly 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!**

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## **Appendix C: Program Supervisor and Home Visitor Survey**

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## 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](mailto: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](mailto: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 program that \_\_\_\_\_ home visitors  
 you supervised this month?
22. What is the average number of hours you spend in direct one-on-one supervision \_\_\_\_\_ hours  
 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: \_\_\_\_\_

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

	<b>Very Dissatisfied</b>	<b>Dissatisfied</b>	<b>Satisfied</b>	<b>Very Satisfied</b>
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"/>
l. Administrative responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. 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:

	<b>Very Comfortabl e</b>	<b>Comfortabl e</b>	<b>Uncomfortabl e</b>	<b>Very Uncomfortable</b>
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

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.



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# Appendix D: Quarterly Data Collection Form

<b>Program Name:</b>				
<b>Home Visiting Model:</b>				
<b>Has your program been certified by your national model (<i>Please answer yes or no</i>):</b>				
<b><i>If yes, date of program certification:</i></b>				
<b>Q.</b>	<b>PART 1: PROGRAM-LEVEL INFORMATION</b>			
	<b><i>For each question below, please respond based on each month's information</i></b>	<b>Apr-11</b>	<b>May-11</b>	<b>Jun-11</b>
<b>Q.</b>				
1	What is your program's maximum capacity this month? ( <i>Please note if this is in <b>points</b> or number of <b>families</b>.</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	<b>IF your program uses points for capacity</b> , 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)? <i>*(Please answer <b>yes</b> or <b>no</b> - if yes, please see Q. 13)</i>			
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? <i>** (Please answer <b>yes</b> or <b>no</b> - if yes, please see Q. 14)</i>			
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? ( <b><i>Please break down hours</i></b> )			

	<i>by supervisor, if applicable.)</i>			
a.	Supervisor #1			
b.	Supervisor #2			
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:	<b>Apr-11</b>	<b>May-11</b>	<b>Jun-11</b>
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			
	<b>Total: (please note this number should match the number in Q.11)</b>			
*13	*If yes in line 3, please indicate why there was a change in home visiting capacity	<b>Month</b>	<b>Reason for change in capacity</b>	
		<b>Apr-11</b>		
		<b>May-11</b>		
		<b>Jun-11</b>		
**1 4	**If yes in line 7, please describe the planned program enhancements	<b>Month</b>	<b>Planned program changes</b>	
		<b>Apr-11</b>		
		<b>May-11</b>		
		<b>Jun-11</b>		

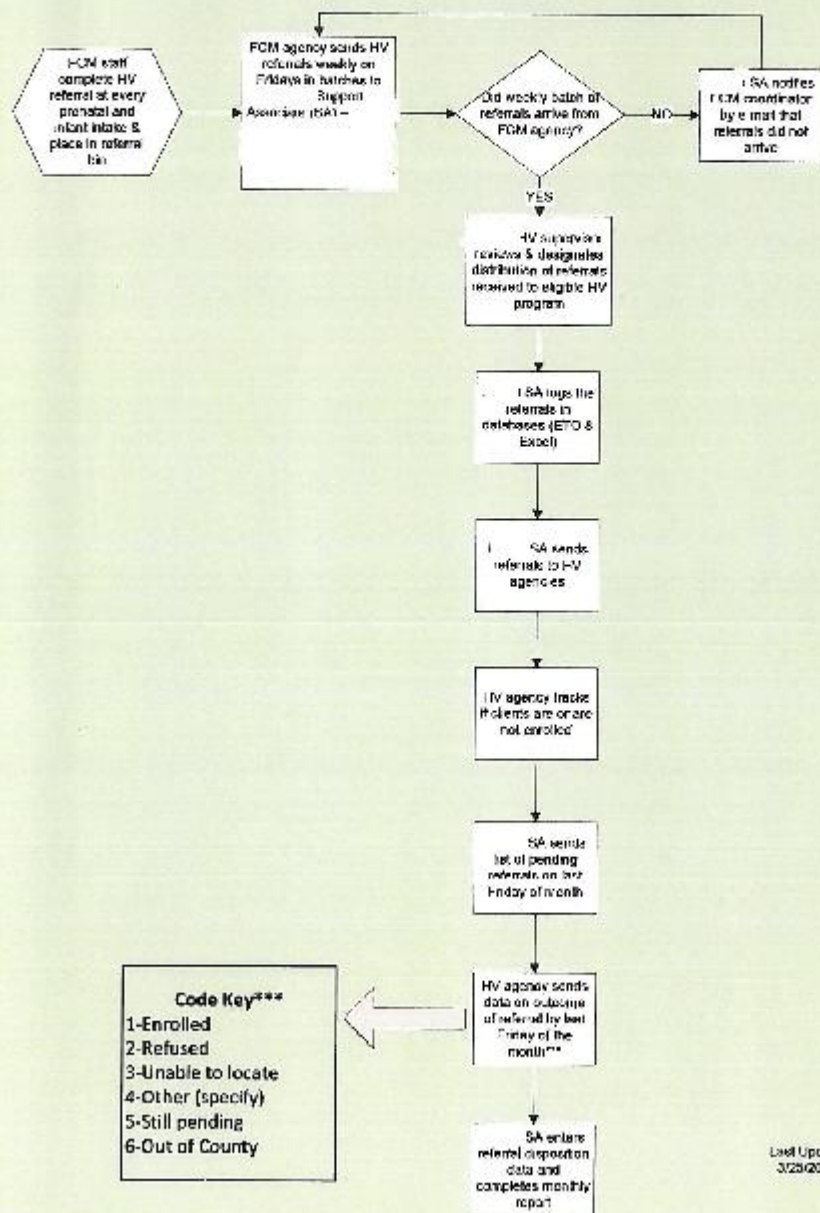
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# Appendix E: Collaborative Documents





## HOME VISITATION REFERRAL PROCESS



## Home Visitation Referral Process

The Home Visitation Collaborative seeks to serve as many clients as possible through the Home Visitation Programs in . Family Case Managers play a vital role in ensuring that families with risk factors are referred for these supportive services. For several years, a system of referral and linkage of FCM clients to the home visitation programs has helped to assure that all home visiting programs are full and that there is no duplication of services among the programs.

After initial FCM assessment of both pregnant mothers and infants, the case manager is in the best position to let the client know that home visit programs are available and to ask if she would like to be contacted by one of the programs. If the client agrees, the referral form is filled out, the client signs for release of her information to the Home Visitation Collaborative, and then the case manager checks off risk factors that apply, before placing the referral form in a designated place for submitting the forms in weekly batches. *The referral form has risk factors that match up with the eligibility criteria for the various home visitation programs.*

When the facilitator for the Home Visitation Collaborative receives the weekly batch, the referrals are distributed to the member programs in the Home Visitation Collaborative. The Programs contact the families and initiate services if the client still desires it. Once the family begins services, the member program will notify the home visitation facilitator, who in turn, will notify the original FCM agency so that the case manager is aware that services have started. When home visitation services end for any reason notice will also be given.

**When is the Home Visitation Referral Form filled out?** At completion of the initial FCM assessment of pregnant mothers and infants, (especially teen moms that have not finished high school or GED), with risk factors noted on the back of the referral form concerns.

**How is the form done?** One side is done with the client present, the other side, after the client is finished. With the client present, complete the front part of the form:

- Date – date of client assessment
- Name – name of client as enrolled into your program
- Address: City/Zip Code – client's current address, city of residence and zip code
- Phone – client's current phone number and emergency contact, if applicable
- First time mother (Y/N) – indicate by circling Y or N (this will be the client's first delivery)
- Attending school/GED (Y/N) – indicate by circling Y or N if the client is currently enrolled in a school program, and list which program on the blank line. Also indicate on the next blank line how many years of school the client has completed.
- Language – indicate by circling if the client speaks English or if the client has limited English skills, writing her primary language on the blank line
- EDC – if the client is currently pregnant, indicate her expected date of delivery
- Referred by – write the name of the person completing the assessment and the agency with which this person is affiliated

Assure that the consent is explained to the client and that she has the opportunity to review the information documented at the top of the form before she signs and gives the consent. Be sure to explain that this consent only allows her information to be given to the Home Visitation Collaborative, and she's under no obligation to accept the home visitor.

After the client leaves, complete the back part of the form:

On the back of the form, write the name of the client and check off all criteria that pertain to this client, based on the assessment you just completed. At the bottom of the form, if the client has children, write the number of children on the blank line and circle the number corresponding with the ages of the children. If there are other concerns that you wish to indicate on the form, list the Comments line at the bottom of the form to document those concerns. **Completed forms will be batched weekly and faxed or scanned and emailed to the**

**Collaborative Facilitator.**

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### **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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