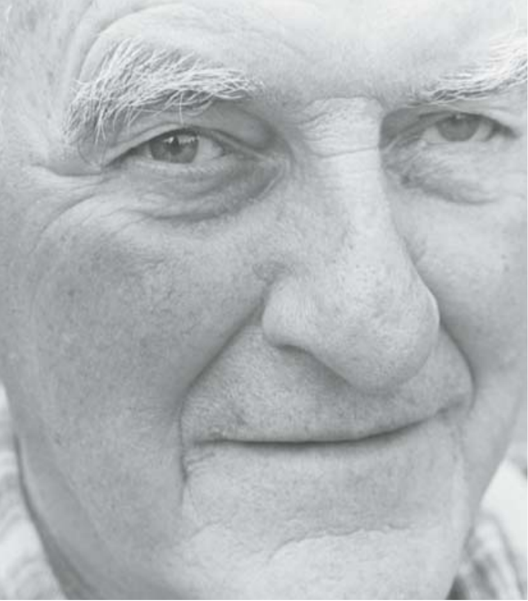

Georgia Health Policy Center

Process Evaluation of Georgia's Integrated Family Support Demonstration Project:
Findings from First Year Implementation Efforts

prepared for

The Georgia Department of Human Resources Division of Public Health

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Executive Summary

This report summarizes findings from process evaluation efforts performed for the Department of Human Resources (DHR) Division of Public Health on the Integrated Family Support Demonstration Project (IFS Pilot) in Cobb County. The goal of the IFS pilot was to reduce child abuse and neglect and improve child health by providing support to Georgia's families with infants and young children at highest risk for child maltreatment.

This report utilizes programmatic data collected on those enrolled in the IFS pilot from March 2007 through February 2008 in Cobb County to evaluate how well the pilot was implemented. This data is used to update findings from the evaluation of initial implementation efforts originally reported in August 2007 which combined early programmatic data with information gathered from over 20 key informants. Lessons learned through initial program planning to recommendations for improving program implementation were summarized in the initial report. Highlights from that report are repeated in this summary and implications for future IFS expansions to additional counties are discussed.

Lessons Learned from IFS Program Planning

One of the most significant lessons learned from the planning of the IFS pilot is to ensure early collaboration between the lead agency and the other agencies that will play a role in the success of the program. In the case of the IFS pilot, the Division of Public Health took the lead in developing the program but relied on input from state-level partners in the Division of Family and Children Services (DFCS) and the Division of Mental Health, Developmental Diseases, and Addictive Diseases (MHDDAD) on their role in referring clients into the IFS Program. Key informants indicated that DFCS and MHDDAD were involved in pilot site identification; however, little collaboration occurred when defining target populations and eligibility criteria. Further, state-level DFCS and MHDDAD staffs were not involved during the planning phase or initial implementation phase to foster collaboration between Public Health and their counterparts at the district and local levels. Informants felt that state-level direction to local staff would have been helpful to ensure buy-in from County DFCS and MHDDAD staff in the development of appropriate referral systems. Future inter-divisional projects should consider ways to align incentives across agencies and at the local, district, and state levels to foster these relationships during the initial planning phase of new projects.

Results from One Year of Program Implementation

Programmatic data collected from the Cobb County IFS program as of the end of the demonstration (February 2008) evidenced the following information about the eligibility category and source of referrals into the program (Table 1) as well as the type of enrollees who entered the program (Table 2).

Table 1: Referrals by Source and Eligibility Criteria

	Eligibility Criteria									
Referral Source	<18 single mom		<21 Multiparity		MH/SA		Unsubstaintiated		**Total**	
	#	%	#	%	#	%	#	%	**#**	**%**
Children 1st	13	41%	27	69%	3	60%	2	22%	**45**	**53%**
DFCS/CPS	0	0%	0	0%	0	0%	2	22%	**2**	**2%**
DFCS/TANF	0	0%	0	0%	0	0%	3	33%	**3**	**4%**
CSB/MH	0	0%	0	0%	1	20%	0	0%	**1**	**1%**
Other	19	59%	12	31%	1	20%	2	22%	**34**	**40%**
Total	**32**	**38%**	**39**	**46%**	**5**	**6%**	**9**	**11%**	**85**	**100%**

A total of 85 children were referred to the IFS pilot in Cobb County from March 2007 through February 2008. Most of the referrals came from the Children 1st program (53 percent) and other entities (40 percent) like hospitals and community clinics that are part of the Children 1st network. Consistent with the results of the initial process evaluation, most of the referrals were young, single mothers. Five children with caregivers undergoing treatment for mental health or substance abuse disorders and nine children with an unsubstantiated case of abuse or neglect were also referred.

Table 2: Enrollment by Source and Eligibility Criteria

	Eligibility Criteria									
Referral Source	<18 single mom		<21 Multiparity		MH/SA		Unsubstaintiated		**Total**	
	#	%	#	%	#	%	#	%	**#**	**%**
Children 1st	4	29%	13	62%	0	0%	0	0%	**17**	**40%**
DFCS/CPS	0	0%	0	0%	0	0%	2	33%	**2**	**5%**
DFCS/TANF	0	0%	0	0%	0	0%	3	50%	**3**	**7%**
CSB/MH	0	0%	0	0%	1	50%	0	0%	**1**	**2%**
Other	10	71%	8	38%	1	50%	1	17%	**20**	**47%**
Total	**14**	**33%**	**21**	**49%**	**2**	**5%**	**6**	**14%**	**43**	**100%**

Public health nurses were able to successfully enroll 43 of the 85 children referred to the IFS pilot at an enrollment rate of 51 percent. This exceeds the benchmark set at 50 percent.[1] Enrollees representing all eligibility criteria enrolled in the program and young, single mothers represented the largest categories of enrollment. For those individuals who did not enroll, 14 percent or 12 families could not be contacted or located for the initial home visit. Twenty five families declined to participate in the IFS pilot and were referred back to Children 1st or other public health program for monitoring and three families refused all programs. Two families were left on the waiting list; they were awaiting IFS materials to be translated into Spanish.

Program completion was defined as completing all 19 modules of the SafeCare curriculum. Nineteen of the 43 enrollees completed the IFS program, for an overall retention rate of about 44 percent. The SafeCare curriculum includes three separate training modules. According to the number of sessions completed, 65 percent of enrollees completed the *Treat at Home* module, 51 percent completed both the *Treat at Home* and the *Clean and Safe* module, and 44 percent completed all three modules including the *Parent-Infant Interaction*

[1] See Appendix D: IFS Benchmarks

module. Surprisingly, the higher risk families who enrolled under the mental health and unsubstantiated abuse eligibility categories were more likely to complete the program.

Being too busy was the most common reason cited by enrollees who failed to complete the full program (nine families or 21 percent); several mothers developed conflicts with their jobs. Six clients moved out of the county, and another four were lost to follow up. Three were administratively discharged and two stated that they were no longer interested in the program.

Table 3: Program Completion by Source and Eligibility Criteria

	Eligibility Criteria									
Referral Source	<18 single mom		<21 Multiparity		MH/SA		Unsubstaintiated		**Total**	
	#	%	#	%	#	%	#	%	**#**	**%**
Children 1st	0	0%	5	63%	0	0%	0	0%	**5**	**26%**
DFCS/CPS	0	0%	0	0%	0	0%	1	25%	**1**	**5%**
DFCS/TANF	0	0%	0	0%	0	0%	2	50%	**2**	**11%**
CSB/MH	0	0%	0	0%	1	50%	0	0%	**1**	**5%**
Other	5	100%	3	38%	1	50%	1	25%	**10**	**53%**
Total	**5**	**26%**	**8**	**42%**	**2**	**11%**	**4**	**21%**	**19**	**100%**

Recommendations for Improving Program Implementation

The full report discusses the facilitators and barriers to success identified by key informants on major topic areas important to the implementation of the IFS program including: staff hiring and retention, staff training, inter-agency collaboration, family enrollment and retention, and data collection and monitoring among others. Because similar themes and issues are repeated under multiple topic areas, this executive summary attempts to synthesize the feedback from key informants and discuss their recommendations in relation to the most important programmatic issues that will likely be addressed as implementation of the IFS program progresses and potentially expands to other counties in Georgia.

The ultimate success of the Integrated Family Support Program (IFS) is dependent upon DHR's ability to:

1) Enroll and retain the populations most at risk for abuse and neglect
2) Effectively deliver an evidence-based home visiting model with fidelity
3) Expand the program to other sites in Georgia
4) Document positive program impacts

Enroll and retain the populations most at risk for abuse and neglect
The target populations identified for inclusion in the IFS pilot program[2] include families with a child under the age of 12 months where there is:

1) an unsubstantiated case of abuse/neglect reported to DFCS
2) a caregiver undergoing treatment for a mental health or substance abuse disorder
3) a single mother age 21 or younger with two or more children
4) a single mother age 18 or younger (added in September 2007)

[2] See Appendix C: Eligibility Requirements for IFS

Key informants made several recommendations aimed at increasing and diversifying enrollment in the IFS program and retaining enrollees:

- ✓ Improve collaborations or referral system processes to ensure a greater percentage of each of the target populations are recruited and enrolled. In March of 2008, Cobb staff reported that relationships between DFCS and DPH were just starting to coalesce when the pilot ended.

- ✓ Expand or change the current eligibility criteria to increase numbers in the target population and/or more simply define the target populations. Requests from key informants for changes to the eligibility criteria are different depending on who made the recommendation. Recommendations include: (1) increase the age of the child, (2) increase the age of the parent, and (3) allow families to enroll more than one child. Program staff may need to revisit the literature review and seek input from public health, DFCS, and MHDDAD staffs on future eligibility changes to ensure the most at-risk populations are identified. This decision is critical for ensuring that the program is actually preventing child neglect and maltreatment. Only by insuring that the state is investing in the highest risk families, will the state save money on these children in the long run.

- ✓ Additional skills building for home visitors related to negotiating and/or motivational interviewing could be added to the core SafeCare curriculum. This model has been utilized in Oklahoma and by other home visiting programs to increase enrollment and retention when the programs are voluntary for participants.

Effectively deliver an evidence-based home visiting model with fidelity
Key informants were satisfied with the core SafeCare curriculum which they felt was an affordable, adaptable, and evidence-based intervention model. Fidelity monitoring by nurse supervisors has been successful and is occurring according to established protocols. Regarding effective delivery of the model, informants did indicate that little training or guidance was given to local staff on IFS recruitment and retention processes. Several recommendations from key informants were given related to this issue and discussions focused on strategies to motivate families to participate:

- ✓ Cobb County was able to create a recruitment process utilizing public health nurses to offer a standard Children 1st visit to potential IFS families. The nurse home visitors used the Children 1st visit to build rapport with families. Then, after a certain level of trust was established with families, the IFS program was offered. Cobb IFS staff felt this process was the key to successful recruitment and enrollment; it could be formalized and recommended to expansion counties.

- ✓ Sharing lessons learned from other home visiting programs could be added to the initial IFS training, including allowing new hires to "shadow" seasoned home visitors.

Expand the program to other sites in Georgia
The IFS program was initially implemented in two county sites in Georgia. The Cobb site had success implementing the program, but the Bartow site received very few referrals and failed to enroll any individuals. District staff decided to terminate the Bartow program after approximately two months of operation. Key informants identified several issues that need to be considered if the program is expanded to additional counties in the future.

- ✓ ***Staff recruitment and retention*** — Cobb demonstrated that public health nurses who already have

skills in home visiting are successful at enrolling clients into the IFS program. Whether or not similar individuals are available for hiring in other counties is unknown. Bartow hired health educators with little experience home visiting and their model did not work. DHR will need to decide if only nurses experienced in home visiting will be hired in future expansions or if other professional staff can be considered. Cobb was considering the addition of a social worker to their home visiting team when the demonstration came to an end in February 2008. They felt using a social worker to round out the team would allow them to better serve the diverse needs of IFS families.

- ✓ ***Size of Target Population —*** Another difference between Cobb and Bartow was the number of potentially eligible clients[3] in the target populations. Because Cobb is located in a more urban area, there are many more eligible individuals residing in Cobb than in the more rural Bartow County. DHR will need to decide if the size of the target population is a limiting factor when expanding the program to additional counties.

- ✓ ***Local site planning and collaborations*** — An additional issue raised by informants was the lack of local planning time prior to program implementation. Informants state that local-level collaborations require time to develop and the lack of planning time required that these relationships be built during implementation rather than beforehand. Alternatively, some informants felt that local areas should have Memorandums of Agreement (MOAs) in place to more clearly define the roles of local agencies in IFS implementation prior to submitting a pilot site proposal to the state. This option would require a more formalized process to apply for IFS start-up funding. Program staff should consider both options to improve local planning for expansion sites — either allow for a planning phase or require that planning be done prior to receiving start-up funding.

Document Positive Program Impacts

The data systems and processes that need to be in place to monitor program impacts were developed specifically for the process used in Cobb County. These programmatic data were used to report on the process measures included in this evaluation; however, data analysis of outcomes for documenting program impacts has not year occurred. Recommendations for a future impact assessment have been shared with DHR staff.

Key informants cited several barriers to building successful data capacity for this project. Informants mentioned problems accessing administrative data from both public health (EBS) and DFCS data systems to identify IFS referrals. They also spoke of dissimilar county data systems that will pose a challenge to data collection if the IFS program is expanded to additional sites. Informants made two recommendations to program leadership related to ongoing data collection and program monitoring:

- ✓ Ensure clear data procedures are in place prior to expanding the IFS program to additional county sites. This includes the user's mutual understanding of the data elements that need to be collected and a clear operational procedure for programmatic reporting.

- ✓ Plan to transition data entry and data integrity functions to DHR and away from an external data contractor to ensure sustainability of IFS data capacity.

In addition to these four key areas, key informants also made several additional recommendations that should be considered by program leadership:

- ✓ Develop program to accommodate Spanish-speaking clients

[3] See Appendix B: Target Areas for Home Visiting

- ✓ Consider hiring a dedicated Program Manager who is housed within DHR and has the authority to convene key stakeholders from all DHR Divisions and make decisions related to the implementation of the IFS program
- ✓ Consider revisiting the funding structure of the IFS program to get more local sites engaged.

Results of Program Implementation

This supplement utilizes programmatic data collected on those enrolled in the Integrated Family Support (IFS) pilot from March 2007 through February 2008 in Cobb County to evaluate how well the pilot was implemented. This data is used to update findings from the evaluation of initial implementation efforts originally reported in August 2007 which combined early programmatic data with information gathered from over 20 key informants. Lessons learned through initial program planning to recommendations for improving program implementation were summarized in the initial report. Programmatic data from the full year of the demonstration project is summarized in this supplement and updated in the full report that follows.

Overview of Implementation

After over a year of planning for the IFS pilot that included: an extensive review of the literature on home visiting programs, selection of a program curriculum (SafeCare), development of an initial program logic model, selection of county sites, and hiring and training of program staff, the IFS pilot began enrolling individuals in March of 2007. Because, the Division of Public Health chose to focus on primary prevention of abuse and neglect, the target population groups identified for inclusion in the IFS pilot program[4] included families with a child under the age of 12 months where there is:

1) an unsubstantiated case of abuse/neglect reported to DFCS
2) a caregiver undergoing treatment for a mental health or substance abuse disorder
3) a single mother age 21 or younger with two or more children
4) a single mother under age 18 or younger (*added in September 2007)

Operationally, the program was to piggy-back on the Children 1st screening and referral system operating in all counties in Georgia. Cobb was able to successfully use this system to refer clients into the program, especially in the third category of eligibility. After the five month review of IFS programmatic data, it was decided to add the fourth category of eligibility to meet the needs of the referring agencies in Cobb County and increase the number of referrals.

Initially, the IFS pilot was to be implemented in at least three sites in Georgia; however, only two sites: Bartow and Cobb were identified for initial implementation. While program staff were hired and trained in Bartow County, the site failed to enroll any clients and ceased the demonstration two months after initiation. The Cobb site represents an example of how the IFS program can be successfully implemented with fidelity to the SafeCare model; programmatic data collected from Cobb a year post implementation are presented to offer lessons learned to future IFS expansions. Specifically, information on the referrals received, enrollment, retention, referrals to community services, fidelity to the SafeCare model, and enrollee satisfaction are summarized. More qualitative data describing the results is available in the full report that follows.

Referrals

Programmatic data collected from the IFS program as of the end of the demonstration (March 2008) evidenced the following information about the target populations and source of referrals into the program (Table 1).

[4] See Appendix C: Eligibility requirements for IFS

Table 1: Referrals by Source and Eligibility Criteria

	Eligibility Criteria									
Referral Source	<18 single mom		<21 Multiparity		MH/SA		Unsubstaintiated		**Total**	
	#	%	#	%	#	%	#	%	**#**	**%**
Children 1st	13	41%	27	69%	3	60%	2	22%	**45**	**53%**
DFCS/CPS	0	0%	0	0%	0	0%	2	22%	**2**	**2%**
DFCS/TANF	0	0%	0	0%	0	0%	3	33%	**3**	**4%**
CSB/MH	0	0%	0	0%	1	20%	0	0%	**1**	**1%**
Other	19	59%	12	31%	1	20%	2	22%	**34**	**40%**
Total	**32**	**38%**	**39**	**46%**	**5**	**6%**	**9**	**11%**	**85**	**100%**

A total of 85 children were referred to the IFS pilot in Cobb County from March 2007 through February 2008. Most of the referrals came from the Children 1st program (53 percent) and other entities (40 percent) like hospitals and community clinics who are members of the Children 1st network. Outreach to network members initiated by IFS program staff engaged all network members in identifying and referring eligible families. IFS program staff also made concerted efforts to enlist the local DFCS office and Community Service Board in their IFS referral efforts, especially to refer children in the Unsubstantiated and MH/SA categories of eligibility, but only seven percent of referrals were received from these entities. Cobb staff stated that these new relationships were just starting to coalesce when the demonstration ended, reinforcing the finding from the initial process evaluation that referral networks take some time to develop.

Most of the individuals referred to the IFS program were young, single mothers (single mothers age 18 or younger and single mothers age 21 or younger with at least 2 children). Data available in Appendix B describe how the number of referrals compares to the size of the target populations. Thirty-nine referrals were received for the first target population — mothers 21 or younger with two or more children. According to the data used for planning, on average about 91TANF mothers meet this eligibility criterion and reside in Cobb County in any given month and repeat births to single mothers 21 or younger approaches 290 in Cobb County annually. Using TANF numbers, the IFS program has reached about 43 percent of the potential target population of eligibles in Cobb County. Using birth data to estimate the target population, the reach of the IFS program is approximately 13 percent (39/290).

Population data was not supplied for the age 18 and younger mothers, as this eligibility group was added in September 2007. Thirty-two of these mothers were referred during the last six months of the demonstration project.

Five referrals came from DFCS, in total nine referrals were received for mothers with an infant who had an unsubstantiated report of abuse or neglect. According to DFCS data used during the planning process, 135 cases of abuse or neglect in children less than 12 months were unsubstantiated in Cobb County in 2004. If these numbers are a good estimation for the numbers expected in 2007, then approximately seven percent of this target population has been referred into the program.

One referral was received from the local community service board for a mother in treatment for a mental health or substance abuse disorder and four referrals were received from other sources. No estimates of this population of mothers are available using administrative data, so the size of the potential target population is unknown.

Benchmarks were set at 25 percent (of the total number of referrals) for each of the three initial eligibility categories.[5] The Division of Public Health wanted somewhat equal representation from each category of eligibility. This benchmark was not revised when the fourth category was added, but programmatic data show that referrals were concentrated in the young, single mother categories of eligibility as they are reflective of the families being served by Public Health and the Children 1st Program. Future IFS expansions will need to consider whether or not these are the most "at risk" populations to target for IFS intervention efforts. These decisions have cost implications for any home visiting program.

Enrollment

Table 2 describes information about the referral source and type of enrollees who entered the program.

Table 2: Enrollment by Source and Eligibility Criteria

	Eligibility Criteria									
Referral Source	<18 single mom		<21 Multiparity		MH/SA		Unsubstaintiated		**Total**	
	#	%	#	%	#	%	#	%	**#**	**%**
Children 1st	4	29%	13	62%	0	0%	0	0%	**17**	**40%**
DFCS/CPS	0	0%	0	0%	0	0%	2	33%	**2**	**5%**
DFCS/TANF	0	0%	0	0%	0	0%	3	50%	**3**	**7%**
CSB/MH	0	0%	0	0%	1	50%	0	0%	**1**	**2%**
Other	10	71%	8	38%	1	50%	1	17%	**20**	**47%**
Total	**14**	**33%**	**21**	**49%**	**2**	**5%**	**6**	**14%**	**43**	**100%**

Public health nurses were able to successfully enroll 43 of the 85 children referred to the IFS pilot for an overall enrollment rate of 51 percent. This exceeds the benchmark set at 50 percent[6] and may have been higher if Spanish materials had been available for individuals on the waiting list. Enrollees representing all eligibility criteria enrolled in the program; however, young, single mothers represented the largest categories of enrollment (82 percent), followed by unsubstantiated cases of abuse (14 percent) and mothers receiving treatment for mental health or substance abuse disorders (5 percent).

For those individuals who did not enroll, 14 percent or 12 families could not be contacted or located for the initial home visit. Twenty-five families declined to participate in the IFS pilot and were referred back to Children 1st or other public health program for monitoring and three families refused all programs. Two families were left on the waiting list; they were waiting for IFS materials to be translated into Spanish.

Retention

Program completion was defined as completing all 19 modules of the SafeCare curriculum. Nineteen of the 43 enrollees completed the IFS program, for an overall retention rate of about 44 percent (see Table 3). This benchmark was set at 75 percent.[7] While the Cobb site did not reach this benchmark, a higher percentage of enrollees completed at least one of the three training modules that comprise the SafeCare curriculum. According to the number of sessions completed, 65 percent of enrollees completed the *Treat at Home* module, 51 percent completed both the *Treat at Home* and the *Clean and Safe* module, and 44 percent completed all three modules including the *Parent-Infant Interaction* module. Surprisingly, the higher risk families, who

[5] See Appendix D: IFS Benchmarks

[6] See Appendix D: IFS Benchmarks

[7] See Appendix D: IFS Benchmarks

enrolled under the mental health and unsubstantiated abuse eligibility categories, were more likely to complete the program.

Table 3: Program Completion by Source and Eligibility Criteria

	Eligibility Criteria									
Referral Source	<18 single mom		<21 Multiparity		MH/SA		Unsubstaintiated		**Total**	
	#	%	#	%	#	%	#	%	**#**	**%**
Children 1st	0	0%	5	63%	0	0%	0	0%	**5**	**26%**
DFCS/CPS	0	0%	0	0%	0	0%	1	25%	**1**	**5%**
DFCS/TANF	0	0%	0	0%	0	0%	2	50%	**2**	**11%**
CSB/MH	0	0%	0	0%	1	50%	0	0%	**1**	**5%**
Other	5	100%	3	38%	1	50%	1	25%	**10**	**53%**
Total	**5**	**26%**	**8**	**42%**	**2**	**11%**	**4**	**21%**	**19**	**100%**

The most common reason cited by enrollees who failed to complete the full program was they were too busy (nine families or 21 percent); several mothers developed conflicts with their jobs. Six clients moved out of the county, and another four were lost to follow up. Three were administratively discharged and two stated that they were no longer interested in the program. In the 2007 report that follows, staff made recommendations for improving retention rates. However, evaluations of nationally recognized home visiting programs also report that families receive about half the number of visits intended, and between 20 percent and 67 percent of enrolled families left programs before services were scheduled to end.[8] Completion rates of 50 percent may be common for voluntary home visiting programs targeting high risk families.

Referrals to other community services

Data collected from the Cobb site show that close to 950 referrals were made to local community agencies for a variety of services. Almost all enrollees were referred to a healthcare provider and many were referred to Medicaid offices. Health service referrals range from family planning, immunizations, and well child care to dental services. Families also received referrals for transportation, food, and parenting classes. After being screened for depression, four caregivers received a referral for mental health services. Regarding family planning, a total of 34 of the enrollees have been referred to family planning services: 13 to public services and 21 to private family planning services. According to administrative data, only seven enrollees have scheduled a family planning appointment.

SafeCare Fidelity

The Cobb IFS staff was monitored for fidelity to the SafeCare model. Programmatic data indicate that fidelity monitoring between nurse supervisors and home visitors was occurring as planned with each home visitor having approximately two visits monitored per month. This benchmark was met at 100 percent.[9] All but one of the fidelity scores were above 85 percent indicating that home visitors were covering at least 85 percent of the key information per session. The Marcus Institute successfully monitored ten of the nurse supervisor's reviews and in 95 percent of the cases this oversight was found to be consistent with the findings of the nurse supervisor.

[8] See the Executive Summary for Home Visiting: Recent Program Evaluations found in The Future of Children 9(1), Spring/Summer 1999 accessed at: http://www.futureofchildren.org/pubs-info2825/pubs-info_show.htm?doc_id=70386 on August 10, 2008.

[9] See Appendix D: IFS Benchmarks

Home Visits
In addition to monitoring data related to referral, enrollment, and fidelity monitoring, more detailed data was collected on client visits in the IFS database. Out of the 506 visits scheduled during the IFS Pilot, 72 were cancelled by the client for an overall cancellation rate of approximately 14 percent. The average time to complete a visit was 60 minutes and the average round trip time for a visit was about an hour and 45 minutes. This information could be used to estimate program costs per enrollee served if IFS expands to additional counties.

Participant Satisfaction
Data gathered from program participants indicates that overall participants are very positive about their experiences with the IFS program and are extremely satisfied with the home visitors. Satisfaction data from 24 of the enrollees, organized by question, is included in Appendix E. All 24 enrollees completed the health training satisfaction questionnaire, 12 enrollees completed the clean and safe questionnaire, and seven completed the Parent-Infant Interaction questionnaire.

Cost and Program Impact
The results reported in this supplement represent process measures developed to monitor IFS implementation in Cobb County. A complete evaluation of the pilot would also include an impact evaluation of the intervention. This could be accomplished by comparing outcomes like reported cases of abuse or neglect that occur in families enrolled in the pilot versus families who meet eligibility requirements, but who were not referred to the program. This comparison group could be created by merging administrative data from DFCS with data from the Division of Public Health's Women, Infant, and Children program. This impact assessment is key to ensuring that the program is actually preventing child neglect and maltreatment in the populations targeted. Only by insuring that the state is investing in the highest risk families, will the state save money on these children in the long run.[10]

[10] Olds, D.L., Henderson, C.R., Phelps, C., Kitzman, H., & Hanks, C. (1993). *Effect of prenatal and infancy nurse home visitation on government spending*. Medical Care, 31(2), 155-174.

Karoly, L.A., Greenwood, P.W., Everingham, S.S., Hoube, J., Kilburn, M.R., Rydell, C.P., Sanders, M., & Chiesa, J. (1998). *Investing in our children: What we know and what we don't know about the costs and benefits of early childhood interventions*. Santa Monica, CA: The Rand Corporation.

August 2007 Process Evaluation

Introduction

Child abuse and neglect are serious issues affecting more than 8,000 of Georgia's young children under the age of two in fiscal year 2004. Biological parents are most often the perpetrators of child maltreatment, and in Georgia 81 percent of child maltreatment involves neglect rather than physical abuse. Child abuse increases the risk for poor outcomes among Georgia's children, including death, injury, developmental delays, poor school success, and poor family health. Families at highest risk for child maltreatment require additional support through human service and public health agencies to ensure healthy outcomes for their children.

The Integrated Family Support (IFS) Home Visiting Demonstration Project (IFS Pilot) is designed to reduce child abuse and neglect and improve child health by providing support to Georgia's vulnerable families with infants at highest risk for child maltreatment.

The IFS Pilot was implemented with supervised Public Health nurses and Public Health Educators trained to provide frequent home visits with families of young children who are at risk for child maltreatment. The pilot uses standardized tools and curricula to teach parents about infant and child health, home safety and cleanliness, and parent-child interactions. The home visitors also provide families with information to promote family planning and child spacing; to support families with infants with chronic medical conditions; and to educate families on child development through the use of standardized developmental screening tools and other developmental guidelines. The IFS program has as its primary objectives the following outcomes:

- To decrease child maltreatment among families receiving the home visiting intervention;
- To reduce unintentional injuries among families receiving the home visiting intervention;
- To increase the number of children up-to-date on well-child and developmental screenings; and
- To increase child spacing between pregnancies to at least two years among families receiving the home visitation intervention.

The IFS Demonstration project was implemented in Cobb and Bartow counties in March, 2007.

First Year Process Evaluation

This report is a process evaluation of the IFS Pilot based on project planning and a year of implementation. Using both updated programmatic data and information gathered from over 20 key informants, the report will answer, from a preliminary standpoint, how well the pilot has been implemented. Lessons learned through initial program planning to recommendations for improving program implementation are discussed. Topics include staff hiring and retention, staff training, inter-agency collaboration, family enrollment and retention, and data collection and monitoring among others.

The ultimate success of the Integrated Family Support Program (IFS) is dependent upon the Department of Human Resources (DHR) ability to:

1) Enroll and retain the most at-risk populations
2) Effectively deliver an evidence-based home visiting model with fidelity
3) Expand the program to other sites in Georgia

4) Document positive program impacts

An evaluation of program outcomes is reserved for the impact evaluation planned to occur after the IFS Pilot has increased enrollment (360 proposed families) and families have been followed for up to five years.

Data Collection Methods and Analysis

In order to evaluate the implementation of the Integrated Family Support (IFS) Home Visiting Demonstration Project (IFS Pilot), evaluators first modified the programmatic logic model with input from the program planning team. Additionally, an evaluation framework which included process outcomes and evaluation questions was created. Data requirements were identified and gathered based on the evaluation framework. Primary and secondary programmatic data were collected by the following means:

1) Review of relevant IFS Pilot program materials from each of the local sites and the Georgia Division of Public Health;
2) Attendance at initial state and local working group and planning meetings;
3) Review of IFS Pilot plan, literature review results, logic model, the proposed home visiting model, meeting agendas and notes, key documented decisions, and other documents developed prior to and during the implementation phase;
4) Interviews with key informants involved in the project from the two pilot sites in Bartow and Cobb counties, state level representatives, and the developers and trainers of the SafeCare Curriculum;
5) Analysis of the IFS program database and a review of the programmatic reports submitted to the GADPH, including number of referrals, number of enrollees, number of sessions held and completed, and other process related quantitative data.

Information relevant to the IFS Pilot implementation process evaluation was reviewed and analyzed by the following major thematic areas:

- Program planning
- Staff hiring and retention
- Staff training
- Inter-agency collaboration
- Referrals to the IFS Pilot
- Family referrals to services
- Family identification, recruitment, and enrollment
- Family retention in the IFS Pilot
- Data collection and monitoring
- Local and State Working Groups

Key findings under each thematic area are discussed in relation to the process evaluation questions. For most of the major areas key facilitators and barriers to success are also discussed as well as recommendations for improving program implementation. Additional sub-themes that emerged during the analysis are addressed in the major thematic area. Findings across the various key informant groups including pilot site staff, state leadership, and the curriculum providers are compared to identify shared and diverging patterns of experiences and perspectives. A synthesis of the key findings is presented in the following pages.

Program Planning:
Evidence-based Program Planning and the Role of Data in Informing the IFS Program

The following section documents the Family Health Branch's (FHB) program planning activities and seeks to answer the following process evaluation questions:

1) Was there a clear process for identifying the populations targeted to receive the intervention?
2) Was there a clear process for identifying the county pilot sites chosen to receive the intervention?
3) Does the SafeCare curriculum address the child maltreatment-related risks and prevention education needs identified through the planning process?
4) Did the planning activities result in the desired target population receiving the intervention?

Identifying targeted risk groups for the IFS Program

Under the direction of the DHR Commissioner, the Division of Public Health spearheaded the evidence-based planning efforts that served to launch the IFS Pilot. After an extensive review of the existing literature on the predictors of child abuse and neglect, the planning team made the determination that the initial risk groups for inclusion in the IFS pilot program would include families with a child under the age of 12 months where there is:

- an unsubstantiated case of abuse/neglect reported to DFCS,
- a caregiver undergoing treatment for a mental health or substance abuse disorder, or
- a single mother, age 21 or younger with two or more children,
- **a single mother, age 18 or younger.**[11]

Representatives from the planning team felt that these inclusion criteria were appropriate because they mapped to the predictors of child maltreatment presented in the literature and could be pulled from current Public Health administrative data systems.[12] Members of the planning team also took into consideration those groups at risk for child maltreatment that are currently served by other public health programs. Informants stated that though having a child who is disabled is a key predictor of child maltreatment, this risk factor was taken out of consideration because "there are already home visiting programs that address that issue." Additionally, the risk groups were sufficiently targeted to ensure clear referral criteria for other agencies within DHR who would refer clients to the IFS program.

When interviewed about their role in planning the IFS Pilot, some members of the IFS inter-divisional state working group reported that the GADPH had "most of the target populations figured out already" when they began to participate in the state-level meetings. These informants felt that the criteria for the IFS program might be "too restrictive" to identify a large number of eligibles. Though agency representatives recognized the program's focus on prevention as the impetus for including those families with young infants, these informants reported that limiting participation to those families with children under the age of one would make it extremely difficult to identify and refer many families into the program.

> *One thing we disagreed about was the age requirement of having a child under 12 months…We thought that target population could be expanded and you could serve more people. It was going to be a hard criterion to meet. So we had given them feedback on that, that we didn't think that was going to be a great target population because of the age limit…although I understand that Public Health had chosen that group because they wanted to focus on prevention.*

[11] See Appendix D: Eligibility Requirements for IFS. To increase referrals and meet the needs identified by referring agencies, a 4th risk group was added to the IFS pilot in September, 2007.

[12] See Appendix A: Predictors of Child Maltreatment for this summary

Some members of the planning team also characterized the involvement of local agencies in the determination of eligibility criteria as limited. One informant described this limited participation as being motivated by the desire to target the program to the highest risk groups, as determined by evidence in the literature.

> *If it were not something that was done competitively, we would have done it differently. We probably would have involved local agencies in more of the decision-making and planning, but because there is going to be something that was going to be evaluated, it was going to be targeted; we didn't involve them the way that we normally involve them.*

Identifying the pilot sites to receive the intervention

Planning team members described the process through which pilot sites were identified for the implementation of the IFS program. These informants described the criteria through which they evaluated potential intervention sites prior to inviting Public Health Districts to respond to the Request for Proposals (RFP). Planning team members considered the following factors when evaluating counties as potential Pilot sites:

- County demographics and sufficiency of potential case referrals (e.g. DFCS data on the number of unsubstantiated cases of maltreatment among infants less than one year of age, number of births to single mothers 21 or younger who had at least one other child)
- Local capacity of Public Health district as measured by strength of Children 1st system
- Staff stability, strength of leadership, and service capacity of DFCS Office
- Staff stability, strength of leadership, and service capacity of local Community Service Board.
- History of inter-divisional collaboration at the regional and local levels

Informants reported that DFCS and MHDDAD were involved during the program planning phase to provide data on the sufficiency of cases at the county level (number of births, number of unsubstantiated cases of child maltreatment among infants less than one year old, single mothers under the age of 21 with one or more children). State-level representatives from these agencies also provided qualitative information on the "readiness" of the local DFCS and CSB offices in counties of interest. The determination of readiness described by one Informant was "what needs to be in place for the program to be successful." Another Informant described the process of identifying potential Intervention counties:

> *We looked at leadership and whether or not the counties had strong support systems in place. We had talked earlier about connecting into the existing system, so we knew that we wanted the local Children 1st system to be key in that. We wanted strong leadership in the project area [in Public Health] and a very strong Children 1st system. We applied that same criteria to a strong DFCS system in terms of leadership and a strong Mental Health system in terms of leadership.*

The planning team had originally hoped to implement the Pilot at three county sites in the State. Planning team members reported that they initially invited five to six counties to respond to the Request for Proposals. These counties were targeted based on their case numbers, history of inter-divisional collaboration, and strong leadership and systems capacity within the local Public Health districts, DFCS, and MHDDAD offices.[13]

Only two counties submitted proposals for consideration. Informants described three main reasons for the lack of county interest:

[13] Please see Appendix B: Target Areas for Home Visiting

- Funding
- Staffing capacity
- Lack of buy-in and appreciation for the program's focus and structure

Most informants stated that the principle reason so few counties applied was the local perception of lack of resources to adequately fund implementation of the IFS program. The IFS program, unlike the majority of other Public Health programs, is designed to reimburse the county once services are delivered to clients. One informant described the hesitancy on the part of counties to participate in a reimbursed program:

> *One of the [issues] is that we don't reimburse them for some of the services until they do them, and there is a big risk they felt with that. I felt like we did give them a pretty good amount of money to start with to cover the supervisor, an Administrative person, and other expenses, but they had to get the home visitor on staff without any sort of guarantee of money. There is a good amount of time on staff to do the training without any guarantee. It is a big commitment to try something new like this and not be guaranteed any kind of money to support those [home visitors] until they do some home visits.*

A second reason for lack of interest was local concern over staffing capacity. In the original program design, counties were required to hire Public Health Nurses as home visitors (this requirement was later revised to allow counties to hire Public Health Educators). One informant described the staffing challenge facing many counties in Georgia:

> *Not having nurses is a reason to back out of the program. People can't hire nurses because of the salary and the lack of public health nurses in the area.*

Recruiting and retaining Public Health nurses is an issue that goes beyond the scope of the IFS program. There is consensus among informants that Public Health Nurses are the ideal professionals to serve in the capacity of home visitors,[14], and the data on home visiting programs and the initial implementation of this program support that conclusion. If the expansion of the IFS program staffed by nurses is to continue, DHR officials at both the local and state levels must identify strategies for effectively recruiting and retaining public health nurses to staff the initiative.

Finally, a few informants described a lack of ownership on the part of some Public Health Districts for this prevention approach. One informant described what was perceived as a "lack of local buy-in" for the IFS model because there was not an immediate recognition of Public Health's role in what has historically been an area where DFCS practices:

> *We were very disappointed that many of the districts didn't even apply [to become a pilot site for the IFS program]. There didn't seem to be an appreciation of the Public Health role in prevention regardless of whether or not it was a Public Health program. It was like they didn't get the role, being inside of things, of the connectedness between child wellbeing and child health.*

Selecting an Approach to Preventing Child Abuse and Neglect

Members of the IFS planning team also researched different approaches to the prevention of child abuse and neglect. Their literature review found that home visiting is associated with improved outcomes for families. They found that family outcomes varied based on the type of home visitor (nurse home visiting programs often yield better outcomes than programs that utilize paraprofessionals as home visitors); length and intensity of home visiting program (successful home visiting programs are those with a high frequency and

[14] Findings on this issue are presently fully in the section on *Hiring and Retention.*

duration of home visits); and the fidelity to the program model are the factors most associated with better family outcomes.

Informants described their criteria for choosing an appropriate home visiting curriculum for child abuse and neglect prevention that could be adapted to Georgia's IFS program. The key factors in their decision included:

- *Cost:* available programs were within reach of the resources available to the GADPH
- *Record of Success:* curricula with proven successful outcomes (e.g. improved family outcomes) that are illustrated through vigorous program evaluation
- *Adaptability*: existing curricula were flexible enough to be adapted to Georgia's local reality and the outcomes of interest.

In addition to conducting a review of the peer-reviewed literature to identify existing home visiting models addressing child abuse and neglect, FHB planning staff met with representatives from the Centers for Disease Control and Prevention's Center for Injury Prevention. Researchers there had conducted extensive research on the different approaches to preventing child abuse and neglect and provided guidance on existing research in the area as well as existing models to address the issue.

After an RFP process, the FHB chose the SafeCare curriculum developed by the Marcus Institute. Project SafeCare targets parents with children between birth and five years old that have been reported for physical abuse or neglect. Participating families receive up to 24 weeks of home visitation designed to improve parenting skills in infant and child health care, home safety and cleanliness, and parent-child interactions in order to reduce future occurrences of maltreatment[15].

Informants reported that the SafeCare curriculum was chosen because of data showing positive effects on long term family outcomes. The literature reviewed by program staff showed that participation in the SafeCare curriculum resulted in parents' improved ability to identify children's health symptoms and seek treatment,[16] an increase in parents' use of planned activities and parent training techniques,[17] reductions in home hazards maintained at four-month follow-up,[18] families who completed all three training components less likely to recidivate,[19] and high levels of program satisfaction.[20] In addition, members of the planning team felt that the SafeCare curriculum was well-suited for success in Georgia:

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[15] Johnson, MA, Stone, S., Lou, C., Ling, J., Claasen, J., Austin, M. (2006) *Assessing Parent Education Programs for Families Involved with Child Welfare Services: Evidence and Implications.* The Center for Social Services Research, the School of Social Welfare at the University of California at Berkeley. Accessed on 8/15/07:
http://cssr.berkeley.edu/bassc/public/EvidenceForPractice5_Parenting_fullReport.pdf

[16] Bigelow, K., & Lutzker, J. (2000). Training parents reported for or at risk for child abuse and neglect to identify and treat their children's Illness. *Journal of Family Violence, 15*(4), 311-330; Gershater-Malko, R. M., Lutzker, J. R., & Wesch, D. (2003). Project SafeCare: Improving health, safety, and parenting skills in families reported for, and at risk for child maltreatment. *Journal of Family Violence, 18*(8), 377-385.

[17] Gershater-Malko, R. M., Lutzker, J. R., & Wesch, D. (2003).

[18] Mandel, U., Bigelow, K., M. & Lutzker, J. R. (1998). Using video to reduce home safety hazards with parents reported for child abuse and neglect. *Journal of Family Violence, 13*(2), 147-162.

[19] Gershater-Malko, R. M., Lutzker, J. R., & Wesch, D. (2002). Using recidivism data to evaluate project safecare: teaching bonding, safety, and health care skills to parent. *Child Maltreatment, 7*(3), 277-285.

[20] Taban, N., & Lutzker, J. R. (2001). Consumer evaluation of an ecobehavioral program for prevention and intervention of child maltreatment. *Journal of Family Violence, 16*(3), 323-330.

In Georgia, over 80 percent of the cases of substantiated abuse and neglect actually involve neglect rather than physical abuse, so neglect needed to be a central component of any visiting program

Informants also reported appreciating the flexibility allowed in adapting the curriculum to better focus on program goals. Planning staff added additional modules to the SafeCare curriculum related to birth spacing and family planning, child developmental screenings, and maternal depression screening.

In our literature review, we found that healthy birth spacing and preventing unintended pregnancies is a way to prevent child maltreatment. So it really made sense to pull that piece in. It connects what we do in Public Health to Family Planning. Marcus Institute was totally amenable to adding components to the SafeCare Model, so that is why they were a good fit, because they would allow us to add some pieces to it.

It was very important for us to add a developmental screening component to whatever we do with this program because we are very focused on early identification of kids with developmental disabilities. We have been doing a lot of work in Public Health in training our nurses and our other Public Health staff on how to complete standardized developmental screening tools and refer them to early intervention programs.

Informants who participated on the planning team also appreciated the focus on fidelity that the SafeCare curriculum had:

We thought that another thing that was really good about the SafeCare model was that it had a really strong fidelity piece and a supervision piece. The research we did showed that good supervision and fidelity to the program are really important to having a program work.

Impact of Planning Activities on Target Populations

A year after implementation of the IFS project, one of the target populations--mothers 21 or younger with 2 or more children—had 39 referrals and 21 enrollees. According to the data used for planning, on average about 91TANF mothers meet this eligibility criterion and reside in Cobb County in any given month and repeat births to single mothers 21 or younger approaches 290 in Cobb County annually. Using TANF numbers the IFS program has reached about 43percent of the potential target population of eligibles in Cobb County. Using birth data to estimate the target population, the reach of the IFS program is approximately 13percent (39/290).

Population data were not supplied for the age 18 and younger mothers, as this eligibility group was added in September 2007. Thirty-two of these mothers were referred and 14 enrolled during the last 6 months of the demonstration project.

For several reasons which will be discussed more fully in the rest of this report, the remaining two target populations have seen few referrals or enrollment. While 5 referrals came from DFCS into the program, in total 9 referrals were received for mothers with an infant who had an unsubstantiated report of abuse or neglect. Six of these mothers enrolled. According to DFCS data used during the planning process, 135 cases of abuse or neglect in children less than 12 months were unsubstantiated in Cobb County in 2004. If these numbers are a good estimation for the numbers expected in 2007, then approximately 7percent of this target population has been referred into the program.

One referral was received from the local community service board for a mother in treatment for a mental health or substance abuse disorder and 4 referrals were received from other sources. Two of these mothers

enrolled. No estimates of this population of mothers are available using administrative data, so the size of the potential target population is unknown.

Summary

Findings from the Key Informant interviews with members of the planning team and the State-level working group, as well as a review of IFS documentation suggest that a clear process was developed to identify eligible target populations and to identify the county sites selected to implement the IFS intervention. While many informants made recommendations to improve the process in the future, public health staff did undertake a comprehensive and informed planning process. One of the main recommendations from informants was to include the referring agencies (i.e. other Divisions) earlier in the planning process. Informants also believe that the SafeCare model can be modified and used to appropriately meet IFS program goals. A preliminary evaluation of program staff's experience with the SafeCare training and implementation of educational modules with participant families are presented later in this report.

Initial indicators from the programmatic data suggest that more work needs to be done to identify eligible individuals in all three target populations. The lack of referrals into the IFS program to date could be linked to some of the barriers mentioned by key informants when discussing the planning process. These barriers as well as facilitators are summarized below and are followed by lessons learned or recommendations for future expansion of the program.

Facilitators:

- **Focus on Prevention—**Targeting of at-risk young children
- **Evidence-based planning—**Target population planning was informed by an extensive review of the literature
- **Pilot Site selection—**Clearly identified criteria for county selection that took into consideration sufficiency of potential referrals, local data and service capacity, and strong leadership and inter-agency collaboration.
- **SafeCare Model—**An affordable, adaptable and evidence-based intervention model

Barriers:

- **Involvement of referring agencies and data in initial target population development—**Little weight was placed on the expertise of DFCS or Substance Abuse/Mental Health programmatic staff, and no state or county level data was used to identify Georgia-specific predictors of child maltreatment.
- **Resources—**Perceptions from the regions that insufficient resources were available from the State for IFS implementation
- **County staffing capacity—**Ability to recruit and retain qualified public health nurses in all Counties
- **Local buy-in —**Perception that districts may not be completely supportive of the intervention model

Lessons learned from key informants in the planning of the IFS Pilot:

- ✓ Involving referring agencies who are most familiar with the risk groups and potential referral systems (local DFCS offices, local CSBs, and Regional MHDDAD Offices) early-on in helping to translate the findings from the literature review into feasible eligibility criteria may have obviated many of the challenges that program staff and partner agencies are currently facing in identifying eligible families for referral into the program.

- ✓ Program staff may consider revisiting the funding structure of the IFS program and consider increasing the "guaranteed" program funding that each site receives up front in an effort to diminish the sense of risk perceived by county leaders.

- ✓ The perception of the lack of "buy-in" from Public Health Directors to the IFS model suggests that it may be beneficial for state-level representatives from GADPH, DFCS and MHDDAD, as well as current county-level program staff to visit potential expansion counties to talk about the role of Public Health in child maltreatment and describe the evidence-based design process for the IFS program.

- ✓ If the expansion of the IFS program staffed by nurses is to continue, DHR officials at both the local and state levels must identify strategies for effectively recruiting and retaining public health nurses to staff the initiative.

Staff Hiring and Retention

This section details staff hiring processes and staff retention within the IFS program thus far and attempts to answer the following process evaluation questions:

1) Is it feasible in Georgia to identify, recruit, hire, and retain competent professionals for the IFS Pilot?
2) Were nurse supervisors and home visitors hired in each pilot site county?
3) Are qualified staff staying on for the length of the program?

Early documents describing the IFS program show that the program was initially designed to be implemented by public health nurses as home visitors. The literature review conducted by the FHB planning team found that home visiting programs exhibit more significant improvements in outcomes of interest when implemented with nurses as compared to paraprofessionals. However, staffing capacity at the county level forced program staff to revisit the decision to use only public health nurses as home visitors. Informants from the planning team perceived that the original requirement that public health nurses be hired was a key factor in the counties' limited interest in the IFS program. One informant described the challenge of hiring Public Health nurses:

> *We initially started with the idea that the [home visitors] would be nurses, but unfortunately, our districts and counties have had extreme difficulty in recruiting and retaining nurses. One of the counties felt that they would not be able to participate if they had to use all nurses as visitors and supervisors.*

Bartow County, one of the pilot sites, originally turned the project down because of the hiring requirements, but later agreed to implement the program when they were told that they could hire public health educators. The other pilot site, Cobb County, was able to identify and hire two public health nurses from within the County Department of Public Health. In fact, all four individuals hired in Cobb County to staff the IFS program were internal hires already working for the county public health department. This suggests that internal staff retraining is an option to staff this program, but the external market for recruiting and hiring public health nurses and nurse supervisors is still unknown.

This internal retraining would also complement the view of multiple informants who perceive that there is a general trending away from public health in the provision of clinical services in the State. They described the IFS program as an opportunity to retrain public health nurses in community-based prevention education, a "core competency" of Public Health in the State. One informant described this trend:

> *There was a lot of talk about Public Health getting away from clinical services, and there was a concern about what we were going to do with all of these nurses that we might lose. So something that we really wanted to have come out of the [IFS program] as a byproduct was a way to keep nurses in Public Health doing some core Public Health work.*

However, program staff from both intervention sites, as well as from the FHB, perceive that one of the factors in the early termination of the program in Bartow County was the lack of Public Health Nurses to staff the program. Two informants describe the importance of implementing a program of this type with nurses:

> *I have learned that public health nurses are essential to this type of program and we must value and work to firm up the Public Health infrastructure.*
> *[In moving forward] I think that we have identified who needs to be put in place in the next county. Before we were*

saying, OK, well you determine who does this. I think that we are having good results with nurses.

Informants recounted other challenges in retaining staff in Bartow and Cobb Counties that could prove to be a challenge to other counties seeking to implement the program. Salaries for public health nurses are lower when compared to nursing jobs in the medical or private sectors. One informant suggested that the program can be successfully implemented only if the county is able to recruit public health nurses who have a personal affinity for home visiting.

> *It is a certain kind of nurse. It is hard. It is willing to take the money that is not so good and things like that. You only get people who their heart is in Public Health and those are the ones that you end up finding. The postings for the positions were posted, but I'm not sure if we got any outside interest. We probably didn't get any. They look at the salary and they don't necessarily want it. The nurses were hired [were from inside Public Health].They knew about the position and they knew about the program and they wanted it. We will have to continue to find nurses that already work for Public Health and who want to do this. You have to really want to do this. Going into these homes is never easy. Like I said there is a certain heart that is in people to do this kind of work.*

The two pilot sites also reported different experiences retaining project staff. Cobb County IFS staff report being very pleased with the program and motivated to continue, despite continued challenges with family referrals into the program. They are comfortable with making visits and recording the family sessions. In comparison, program staff from Bartow County reported taking issue with having to record family sessions. One informant in Bartow County perceived that there was a lack of buy-in from project staff into the program because of the rigidity of the curriculum and the limitations of the eligibility criteria.

> *[There is a struggle with the] staff here, they are not buying into this. So again that is another lesson learned it is like this is a curriculum that is different than anything else that you are going to use. You can still use your Public Health skills in this but if you don't see the benefits to this then you are not going to be able to relate that to the families and the families aren't going to buy into it either so you have got to have that from the very beginning. It has got to be there that they feel they can make a difference and by using whatever it is that we are using they can do that. I think that was the other thing that there just wasn't enough buy in to the model to feel that it was going to be effective.*

A Key Informant from the GADPH suggested that having the Cobb nurses mentor Bartow home visitors prior to or early in the intervention might have yielded more positive results in Bartow County. Informants at the state level as well as in Bartow County suggest that there was a lack of communication between the local and state-level program staff about program challenges in Bartow.

Summary

Nurse supervisors and home visitors were hired in each pilot site; however, differing experiences were reported by Cobb and Bartow Counties. While the Cobb site is still operational, Bartow County no longer participates in the pilot and newly hired staff found other employment.

There appears to be consensus among staff from both pilot counties as well as from state staff that public health nurses are best equipped to deliver the SafeCare curriculum through home visitation. If the model is to be expanded to other counties or within the present pilot site, staff at the local and state level must identify strategies for effective recruitment and retention of scarcely available public health nurses, or pilot the program using Social Workers, licensed family counselors or other professionals.

Facilitators:

- **Public Health Nurses—**Hiring and training experienced public health nurses with an affinity for home visiting.

Barriers:

- **Health Educators—**Little experience in home visiting and lack of buy-in into the IFS pilot.

Recommendations from key informants in the implementation of the IFS Pilot:

- ✓ As the program implementation progresses in Cobb and potentially expands to other counties, state program staff may consider building in additional training time for newly hired staff to allow them to "shadow" seasoned home visitors.

Staff Training on the SafeCare Curriculum

This section presents the findings from the Key Informant interviews related to the initial and on-going trainings on the SafeCare model, as well as a summary of training evaluations completed by IFS staff. This section seeks to answer the following evaluation questions:

1) Were the appropriate individuals present for the training?
2) Were home visitors and nurse supervisors adequately prepared to complete assigned tasks?

The IFS program planning team contracted with the Marcus Institute to conduct the curriculum training with the nurse supervisors, home visitors, and program assistants. The training was held over 13 days from January 24 to February 6, 2007. One portion of the training was held in Cobb County and the other in Bartow County. Training documents show that the training was attended by all IFS staff: the Project Manager, a representative from the FHB, two home visitors, as well as the nurse supervisors from each pilot county.

IFS program staff participants completed an evaluation of the SafeCare training experience. The results of the quantitative section of the training are presented below (n = 6).

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
I found this training experience valuable				4	2
I gained new knowledge from this training experience that I will use in the future				3	3
The information was presented in a clear and organized manner			2	3	1
The training experience included enough hands-on activities				2	4
Now that I have completed this training, I feel competent to implement this program			2	3	1
I would recommend this training experience to others			1	5	

Participant experience with the training was generally positive related to the information presented during the sessions and method of delivery of the training. Most of the participants found the role playing/modeling exercises to be helpful. One informant reported that "even though the modeling is uncomfortable, it was helpful to gain confidence."

Some of the informants critiqued the organization of the training manual. These informants reported that the training manual itself was "overwhelming" and not organized to follow the curriculum delivered to families. One informant described the training manual this way:

We felt like when we first walked in it was a huge book, I don't know how many pages, it was about a five inch binder

filled with everything…I think a lot of what we were learning was about how we were to teach these different sections and about what the concept was on the three different areas of training and I really think that it could have been done better. It wasn't very well organized so we spent a lot of our time flipping around and creating dividers and trying to reorganize the information and really once we got back here…we renamed the sessions. Even the labeling of the sessions was very confusing so we were struggling with that and finally ended up re-labeling how to number the sessions…it was very confusing because it didn't line up with the training numbers of the different sessions.

These informants reported that both the Marcus Institute and the FHB staff were amenable to the reformatting of the manual for easier use. Program staff in Cobb County mentioned that they have been able to take their questions and concerns to the Marcus Institute about the curriculum and training manual, including errors in the clinical information included in the training manual (e.g. how to take a child's temperature), and that their collaborators at the Institute have been open to making needed changes to the training manual.

I do want to say some really positive things about the Marcus Institute in all of their folks have done some tremendous work for us. They have been right there for us and very helpful and very good humored and understanding. They have been extremely positive on this and very good about when we tell them the issues with the manuals or whatever they have really been good about working on it and doing what they can.

When asked to make suggestion about how to improve the SafeCare training, some informants suggested that it would be helpful to have more opportunities to see the "application" of the methods and information presented during the training. One informant suggested that this could be done by showing videos of successful home visits. Another informant suggested that home visitors would benefit from going into a "practice" room to practice completing the cleanliness and safety evaluations as part of the training.

Informants from both pilot counties reported that the training assumes a certain level of capacity in home visiting. Inexperienced home visitors going through the SafeCare training would require additional training on home visiting approaches. One informant said that the course should be "presented from the perspective of someone who has no pre-existing knowledge about the program." This assumption of experience in home visiting strategies and confidence in family engagement resulted in a lack of attention given during the training to strategies for family recruitment, enrollment, and retention. Program staff reported that they did not receive any training on family recruitment or retention. Because family recruitment and enrollment into the program has proven to be a challenge in Bartow, informants from that county reported that they would have liked training on how to overcome barriers to recruiting families into the program. Some barriers to recruitment mentioned by home visitors and nurse supervisors include strategies for successfully enrolling families who are young and overwhelmed, families who don't see the value in the program, or those who see the program as too invasive.

Some informants expressed a desire to have additional "booster trainings" incorporated into the program calendar. Because the initial training is so lengthy and full of information, these informants suggested that holding booster sessions with program staff would provide an opportunity for implementers to seek clarity on issues they do not understand or provide a chance for staff to work through challenges with family engagement or delivery of the training session. One informant said:

I think that it is important to have boosters, an opportunity to come back together as a group after implementation and talk about what they are actually seeing in the homes. It was a lot of materials to digest over the thirteen days [of training] and I think that a lot of what they were digesting didn't surface until they actually started to do the work. In

future designs there should be a planned [session] after three weeks or a month, about getting referral, talking to people, the actual implementation…

Data gathered from program participants indicate that overall clients are very positive about their experiences with the IFS program and are very satisfied with the home visitors. Data from 24 of the enrollees is included, organized by question, in Appendix E. All 24 enrollees completed the health training satisfaction questionnaire, 12 enrollees completed the clean and safe questionnaire, and 7 completed the Parent-Infant Interaction questionnaire.

Summary

All newly hired staff from both Bartow and Cobb Counties attended the training. Overall, satisfaction with the training was positive, but informants did make recommendations to add more practical experience to the SafeCare training. Additionally, informants indicated that the curriculum assumed that trainees had experience in home visiting strategies and confidence in family engagement which led to a lack of attention given to strategies for family recruitment, enrollment, and retention.

Facilitators:

- **Adaptable SafeCare curriculum—**Public health staff have been able to make changes and additions to the curriculum in response to staff feedback and Georgia specific needs

Barriers:

- **Little training on home visiting strategies—**Informants would also like training on recruitment, enrollment and retention strategies which are not a part of the SafeCare curriculum

Recommendations from key informants in the implementation of the IFS Pilot:

- ✓ Recommendations for additions to the SafeCare training included adding videos of successful home visits, creating a practice room for safety and cleanliness, and additional booster trainings.

- ✓ Informants also requested initial training on how to overcome barriers to recruiting families into the program.

Encouraging Inter-agency Collaboration within DHR: The Role of IFS

A key outcome identified during the planning and implementation of the IFS program is increased collaboration among DHR agencies to better support families at-risk for child maltreatment. The process evaluation seeks to answer the following questions related to this outcome:

Were appropriate partnerships developed in the local community sites to:

1) Facilitate appropriate referrals into the Program
2) Ensure coordination and reduce duplication of services for the enrolled families,
3) Increase information sharing and collaboration among agencies serving families at risk for child maltreatment, and
4) Promote systems development at the State and Local levels for services to at-risk families?

Multiple informants described the IFS program as a vehicle for encouraging coordination and collaboration across agencies within the Department of Human Resources. One informant described the desire for increased collaboration across DHR Divisions:

> *There was recognition at the highest levels of leadership within the Department that the families that we work with in Public Health are the same families that we see in DFCS and that Mental Health, Substance Abuse and Developmental Disabilities is working with. The approach to this program is more of a systemic, integrated approach – getting people out of their silos to work across Divisions and share money, share some of the funding back and forth to make sure that these really at-risk families are getting the supports that they need.*

Informants at both the local and state levels recognized the importance of inter-agency collaboration if the IFS program is to be successful, and informants reported that much thought was put into the design of the program to encourage communication and collaboration among agencies. The program logic model contains both short and long term outcomes related to increased coordination among DHR Divisions for the purpose of developing service delivery systems to at-risk families and improved data collection capacity. Informants reported that a factor in identifying the program risk criteria for the IFS program was ensuring that the criteria for inclusion would encourage cross referral between agencies. One informant described the focus on designing a program that would enable and support collaboration:

> *There was a strong request to make sure that we were working with our Division partners, so when we looked at the risk criteria that is when we said, 'OK we can take referrals from DFCS on unsubstantiated abuse. We can take referrals from the Community Service Boards for those families in treatment for mental health and substance abuse issues.' It was like, OK, let's make sure that we have specific risk criteria that our partners will be able to refer into.*

The state-level working group that was tasked with planning the scope of the IFS program was originally made up of representatives from various agencies within the GADPH as well as representatives from MHDDAD and DFCS. Informants had different perceptions on the degree of inter-divisional participation in the program planning process. The majority of planning members characterized the participation of representatives from agencies outside of the GADPH as "limited." Inter-divisional participation in the early planning stages was mainly related to providing quantitative and qualitative descriptive data on the capacity and readiness of counties to implement the IFS program as well as county-level data on sufficiency of potential referrals. In later phases of the planning process, inter-agency partners provided contact information for local providers and staff and provided technical assistance to the GADPH in refining the planned eligibility determination and referral processes from the local DFCS offices and CSBs to the IFS program.

All of the informants characterized inter-divisional collaboration at the state level as very challenging. While all parties recognized the importance of collaboration and were clear on the mandate from DHR leadership that the IFS pilot was to be a collaborative effort, the reality is that it continues to be a challenge. Informants offered their perspectives on the barriers to collaboration:

> *We don't do coordination well. I would say that, in general, it is not the first thought. It is as if someone has to put the thought into your head. 'You know, you need to talk to Mental Health about it. You need to talk to DFCS about this.' There is always the need to force it so when people come to the table, even though they know that it is a coordinated effort, my sense is that it is, 'I sure hope they don't stick us with anything.' It is 'Tell me what you need me to do' when it should be something that is owned and valued.*
>
> *I think we have a systems issue and it goes beyond this project. The system issue is how different divisions work together in DHR. The relationships are not nearly as strong as they should be. I think that there is not nearly as much collaboration as there should be. I think that there is more lip service than there is actual practice.*

Regarding more specific system-level issues impeding collaboration, multiple informants at both the state and county levels observed that the IFS Pilot did not seem to have a "locus of control" – a single person who is empowered to make decisions about the program and who "is the one person responsible for the success of the program." Authority appears to be dispersed among multiple individuals, but none with final decision-making authority. This lack of a central authority appears to have resulted in unclear communication between IFS local and state counterparts on issues such as program participant eligibility criteria and other aspects of program design, data collection, and issues related to budgeting and reimbursement for program activities at the local level. One informant bemoaned the lack of a "dedicated program champion" with the authority to tell partnering agencies that this program needs to be of higher priority within their Division.

Though informants were almost all in agreement that the challenges to inter-divisional collaboration are significant, all interviewed were clear that there is a "strong mandate" from the DHR Commissioner and DHR leadership to improve communication and collaboration among DHR agencies at the state and local levels.

Inter-agency collaboration at the local level during planning and implementation was also characterized by many informants as lacking. Informants noted that the county working group meetings were often poorly attended by local referring agencies. Informants identified two key reasons for the difficulty pilot sites faced in scaling up the inter-agency collaboration: lack of time to develop local relationships and referral systems and a lack of a clearly communicated mandate from the state office to corresponding local agencies to prioritize the IFS program.

Representatives from county Public Health departments, DFCS, and CSB offices noted that the role of convening partner agencies leading up to and during initial program implementation was left to county Public Health staff. Most informants from referring agencies said that they were not advised of the IFS program from their agency's leadership at the State. One informant described the challenge of convening agencies without a clearly communicated mandate from their state-level counterparts:

> *Each county was given the task of identifying locally the [local contacts] and invite them to participate in the program working group. This is not the most ideal because those positions in the CSBs and in DFCS are very intense positions to start with, so I saw it being really hard for those individuals to pull away from existing positions to take on the job*

of learning about eligibility and communicating that information back to their staff…. I think that there needed to be more participation from the state level in order to give those local offices the support that they needed as well as the instruction or direction to make this program a priority. In other words, not just a Nurse Supervisor of a home visitor calling up and saying 'Hey we have this program that we can provide and we want you to give us referrals. It would have benefited the project better had that information come directly from their superior in each of their departments.

Informants from one state agency suggested that the state level leadership across the partnering agencies must work to communicate how the program would benefit their agency's clients at the regional and local level:

We need to get the key leadership buy-in, then the program staff buy-in from potential referral sources. They need to understand that this is the right think to do. If we included the regional partners, because we are twice removed from the ground level. We [at the state level] do a lot of state planning and bureaucratic things that deal with the Federal government, whereas the regional folks are right out there with the providers. They might be able to help promote from a different…instead of a 50,000 foot view, they might have a 10,000 foot view and they may know the key people to get involved better than we would.

These informants suggested that the state-level representatives may be better utilized as program champions with local counterparts than their role on the state inter-divisional working group currently dictates:

We could probably do more to work with the providers, if we were asked to do that. We were just asked to provide names and contact numbers. We could encourage our [local counterparts] to be part of the pilot sites. We might be able to involve them and have them know about the services and then help with those referrals as well.

A second challenge to building strong inter-agency collaboration at the local level was the lack of time allowed for those relationships to develop.

There have been insufficient referrals from DFCS, from TANF, from Mental Health. There was concern from the beginning about the strength of those [local] relationships and how the referrals were going to work. Those relationships needed to be built well in advance of when the referrals were to begin and that didn't happen. I think that people don't understand the amount of time it takes local folks to come together, to get to know each other, to agree to participate in each others' agency missions. I think that people need to understand that just takes time and that those relationships are really critical.

Summary
Intra-divisional collaboration, though considered important by program staff and collaborators, is one of the key challenges in the successful implementation of the IFS Pilot. It is one of the factors contributing to the low number of referrals into the program. Because these collaborations are still in their infancy especially at the local level, it is too early in the project to answer most of the evaluation questions.

Facilitators:

- **Leadership mandate—**Strong mandate from the DHR Commissioner and DHR leadership to improve communication and collaboration of DHR agencies at State and local levels.

Barriers:

- **System-level issues to interdivisional collaboration—**Organizational reporting structures, competing programmatic demands, and misaligned incentives are all system-level issues that impede effective inter-divisional collaboration.

- **Planning time for local sites—**Lack of planning time to develop local relationships and referral systems
- **Communication between state and local staff—**Lack of a clearly communicated mandate from state program officials to corresponding local agencies to prioritize the IFS program.

Recommendations from key informants in the implementation of the IFS Pilot:

- ✓ It was suggested by some informants that the members of the state level inter-divisional working group might be "better utilized" by the program lead agency to seek out local buy in for the program and "sell the program" to their local contacts.

- ✓ In addition, local staff may be encouraged to establish consistent communication with their state-level counterpart within the state working group to ensure that their concerns and suggestions are being heard by program leadership.

- ✓ The IFS program may benefit from a dedicated Program Manager who is housed within the state GADPH and has the authority to convene key stakeholders from other DHR Divisions and make decisions related to the implementation of the IFS program.

- ✓ In future programmatic expansion efforts, IFS leadership might consider requiring that applicant counties include as part of their application signed Letters of Support or Memoranda of Understanding from local referral agencies.

- ✓ Alternately, or additionally, leadership might consider building in a planning phase to the program implementation time line that would allow local agencies to come together to collaboratively work out the referral processes and inter-agency communication.

Referrals to the IFS Pilot

To ensure successful recruitment and enrollment of target families into the IFS Program, the Program's success is dependent upon the quantity and quality of the referrals received. While some of these referrals may come from public health programs, the plan to recruit each of the three target populations relies on referrals from other Divisions within the Department of Human Resources as well as other external partners. These referral systems are still being developed; therefore, this section attempts to answer from a preliminary standpoint the following process evaluation questions:

1) How were families referred into the IFS pilot? How did the referral process work?
2) Is the process for identifying and referring families into the program efficient and effective at enrolling families from each of the three target populations?
3) What issues need to be considered related to the referral process if the program is rolled out to other Georgia communities?

Referral Sources:
The model for the IFS Pilot includes referral sources such as the local mental health providers and Community Service Boards, the Division of Family and Children's Services, and Public Health's Children 1st program. The intention was that the program would encourage stronger relationships between these three agencies resulting in referrals into the IFS Pilot.

The Community Service Boards (CSBs), which are contractors of MHDDAD, were expected to refer mothers with infants who were in treatment for substance abuse or mental health diagnoses. The Division of Family and Children's Services was intended to refer unsubstantiated cases of abuse and neglect when there was a child under the age of 12 months. Public Health's Children 1st program would provide referrals of single mothers under 25 years of age with two or more children where at least one was under 12 months. The 25 year age threshold was decreased to age 21 or younger prior to implementation.

Although the CSBs are an expected referral source, in Cobb County the local Community Service Board has recently suffered a decrease in funding and a subsequent loss in staffing, and is under strain to perform their mandated services. Cobb County has not chosen to actively pursue referrals from the local CSB; however, one referral from the local CSB was received. Five referrals were received in Cobb County from DFCS. The percent of referrals coming from each of the referral sources is 1percent from the CSB and 6 percent from DFCS.

Children 1st provides most referrals (53%) to the IFS Pilot in Cobb County and also provided secondary referrals from other sources (34%). The home visitors receive referrals from the Children 1st Coordinator on mothers who appear eligible for the program. Additionally, the local staff in Cobb County searches other Public Health programs for potentially eligible families.

Local Public Heath sites were also able to identify other potential referral agencies and approach those agencies about the IFS Pilot.

The Referral Process:
The idea was that collaboration, relationship-building, and referrals to the program would come out of the local workgroups. However, local sites had difficulty encouraging attendance and participation in these local workgroups from the local referral agencies. The referral process was communicated to the local agencies

during workgroup meetings; however, the lack of attendance at the meetings may have made the referral process and eligibility criteria unclear to referring agencies. Please see the section of this report addressing local workgroups for more information on this aspect of the project.

> *I was concerned about the lack of buy-in or…I didn't put it that way…the lack of clear evidence that there were strong inter-divisional relationships that were being built to ensure referrals.*

> *I think you ought to lock all those people in a room together from the various divisions at the local level DFCS, which includes both Child Welfare and TANF, and anybody else who might possibly be a referral. I think you need the local CSB, and you need Mental Health at the local level in the room talking about how that referral process is going to work. I think that process needs to happen before they put in the proposal.*

The lack of referral agency involvement in the planning phase and local workgroups likely contributed to the absence of referrals into IFS from external partners. The IFS staff contacted the agencies to determine whether they had any referrals and in order to simplify referrals the IFS staff accepted referrals by fax or telephone. Additionally, staff searched through other Public Health programs and the Electronic Birth Records database for eligible families. Mothers dually eligible for the Children 1st and IFS programs were given to the Cobb County home visitors who completed the Children 1st referral and home visits and recruited participants into the IFS Pilot.

State Level Support:

The IFS Pilot program has demonstrated the importance that relationships, buy-in, and communication play in successfully implementing a program that relies on referrals from outside agencies. This was recognized and noticed by informants at both the state and local level. It was repeatedly mentioned that there is a need for support from state level MHDDAD and DFCS to encourage participation in the referral of families by local agencies.

> *I don't know what else to do. I think the big shots at the state that are on the state work group are going to have to come down and say 'okay you have to do this'.*

> *It's not in their heads yet. It's going to have be pushed into their heads*

> *It would have benefited the project much better had that information come directly from their superior in each other their departments.*

Staff in Bartow County had differing perspectives on the relationship with referral agencies. There were opinions that they had good relationships with their referral agencies and opinions that they could not get other groups to buy into the program even after going into the community presenting the program, and answering questions. No referrals came from the local CSB and only a few came from DFCS. Feedback from referring agencies was that the people they would refer do not meet the eligibility criteria.

Responses from some individuals at the state and local level provided a different view on how to approach agencies to gain support for the program. While several felt that the state agencies need to drive participation at the local level some felt that going directly to service providers was a more likely way to engage local agencies and encourage referrals.

> *I think it works better when you get to a lower level really at the ground level because they need each other so much*

more. And I think it's different because you see the clients that they are serving. There is a visual of why you need to work with someone else. I think it is just very different at the local level. My perception and my experience has been that it just doesn't work well at the state level but at the service level it works well because they know it is needed. And I mean really at the service level. I mean the nurse sitting with a client.

Target Population and Eligibility Criteria:
Referrals came most frequently from families meeting the two eligibility criteria consisting of young single mothers (21 years and younger with two children or 18 years and younger) with at least one child under the age of 12 months. Children 1st was the most common referral source for this population with a few being identified by the Electronic Birth Records. The Electronic Birth Record was not considered an efficient source for referral due to the lag between birth and entry into the electronic system. A challenge that may have impeded the number of referrals was the requirement that the child be under 12 months old.

Challenges around eligibility and program intensity were most commonly issues for those meeting the other two eligibility criteria and who would be referred from DFCS or Mental Health. This was mentioned by both local sites.

Training and Clarity:
Local agencies were invited to participate in local workgroups to build collaboration and learn about the program in order to gain referrals into the IFS Program. However, no formal training was provided or direction given by state officials to the local sites on building collaboration. Local sites reached out independently, in many cases, to the local agencies and that level of contact was primarily unsuccessful in motivating staff to send referrals.

It is more than just the call, it's somebody at the top told them you need to do this and then it trickled down to the right people. Having us just ask them to refer wasn't enough obviously because they didn't do it.

Summary
If the IFS program expands, additional counties may consider creating workgroups early in the planning process and including state leadership to lay the groundwork for enhanced referral systems into the IFS program. Additionally, it is important to understand the commitment and requirements of the SafeCare Curriculum in relation to the commitments and requirements of an individual undergoing treatment for a mental health issue or substance abuse. This pilot has demonstrated difficulty in getting referrals from the Mental Health agencies in particular. In addition to the issue of funding and staffing in Cobb's local CSB, another cause may be that there was not a clear set of criteria to measure whether a person was ready for the IFS program. Readiness was based on a subjective assessment of a treatment team, rather than any objective criteria that could be gathered from existing administrative data systems. The administrative data collected on individuals undergoing treatment for substance abuse or a mental health diagnosis does not include information on the client's children and thus cannot be used to identify eligible families.

The following are facilitators and barriers to the referral process for the IFS Pilot program based on the feedback received from key informant interviews and exit interviews.

Facilitators:
- **State-level leadership** – Once direction and priority is set by the state and communicated to the local levels, referrals do occur, particularly this has happened with DFCS.
- **Committed local staff** –Staff searched independently for referrals from accessible sources such as

Children 1st and Electronic Birth Records. Local staff also reached out to local agencies to build awareness and support for the program.

- **Children 1st** – Children 1st, as a single point of entry for the children 0 to 5 years old into MCH Public Health programs, is an effective way to identify potentially eligible mothers and has worked well in Cobb.

Barriers:

- **Eligibility criteria** –Agencies such as DFCS and CSBs found that few families met the eligibility criteria for the IFS Pilot or those families who did were committed to other treatment programs (CSBs).
- **Clear and consistent message** –Local sites, agencies, and community organizations did not have clear and consistent information on eligibility criteria and the referral process. No marketing materials were developed by the state to provide to local sites.
- **Training** –Local sites received very limited training on the referral process and due to lack of participation in local work groups, few individuals received the training.
- **Incentives**–Referring agencies have little incentive to refer eligible families to the IFS Pilot.

Recruitment and Enrollment Recommendations given by informants:

- ✓ Contact at the referring agencies should be identified by the state prior to implementation. The relationship and partnership should begin at the state level.

- ✓ County and state should be aware of other programs in the area providing a similar service.

- ✓ Eligibility criteria should be revised to be more inclusive--increase age of child, increase age category for parent, and allow families with only one child.

- ✓ Provide ongoing training of new staff and reminders for existing staff at referring agencies. Ideally the project would be institutionalized and part of the orientation of new employees so they know the eligibility criteria and how to make referrals.

Family Referrals to Other Agencies and Services by the IFS Pilot Home Visitors

One of the desired outcomes of the IFS Pilot is a better connection of families to needed services through referrals. Two process evaluation questions were asked related to this outcome:

1) Does the IFS Pilot program result in increased coordination among local public health agencies and other social service organizations serving at-risk families (through identification and strengthening of referral networks)?
2) Did home visitors assist families in receiving needed services identified in family assessments (and follow-up visits)?

Home visitors in the county that enrolled families into the program referred parents to and assisted families in accessing additional services in the community. Referrals were made based on the results of the family assessment and health assessment that were conducted upon admittance to the program. Additional referrals were made when a need was identified during the course of home visiting.

The home visitors provided their clients with appropriate telephone numbers to access services. When a client was unable to gain access to a service after several attempts the home visitor would further assist by making the call herself and helping the client navigate telephone systems, menus, and service agencies.

> *Like this girl I was checking on the phone with a while ago, the baby is now six months old and still does not have Medicaid for checkups and she is jumping through all the hoops that DFCS is asking her to jump through but this issue is coming up and that issue is coming up and she is not ready to give it up. Well I'm getting to the point of saying now we need to just go ahead and look at it a different way. Let's see if I can get an appointment with this baby at the Health Department to get this baby's checkup.*

The home visitors specifically mentioned that several referrals were made to a local agency called the Center for Family Resources which offers a range of social services including job training, GED training, a food pantry, and provides on-site daycare for parents attending classes.

Another outcome of the IFS Pilot is to have a positive impact on birth spacing as evidenced by increasing birth spacing to two years. As part of this goal, home visitors have also attempted to increase access to family planning services. However, the mothers they have referred have experienced several complications with accessing services. A few mothers have missed an appointment, could not secure transportation, or they arrived for their appointment to learn it had been changed. Due to the importance of this issue for their clients, the home visitors find they have addressed the issue three or more times with some parents and are still addressing the issue into the third module of the curriculum.

> *One girl that we were real concerned about that was having post partum problems, bleeding and problems and trying to get her in for medical care. I mean this was a serious issue. We are seeing everything we are hearing about the system having problems, there are problems, and these kids of course are going to run into it and they don't know how to function, how to get a hold of people if they keep getting a menu or keep getting a recording or something.*

Summary

Home visitors in Cobb County reported that while providing referrals to other community and agency services was a goal of the IFS Pilot, time was not allotted for that activity. The sessions were scheduled for the purpose of delivering the SafeCare Curriculum and any referrals that were done took additional time that

was typically not covered. Future implementation of the IFS program in other counties may consider building time in for the process of providing and managing referrals for families, as providing access to other services has been shown to be a key component in the retention of families in home visiting programs.

Quantitative data submitted from the local IFS Pilot site show that close to 950 referrals have been made to numerous agencies for a variety of services. Almost all enrollees have been referred to a healthcare provider and many have been referred to Medicaid offices. Services range from family planning, immunizations, and well child care to dental services. Families also received referrals for transportation, food, and parenting classes. Four enrollees received a referral to mental health services. Regarding family planning, a total of 34 of the enrollees have been referred to family planning services: 13 to public services and 21 to private family planning services. According to administrative data, only seven enrollees have scheduled a family planning appointment.

Family Recruitment and Enrollment into the IFS Pilot

Successful recruitment and enrollment of target families into the IFS Pilot is critical to program success. Process evaluation questions addressed related to enrollment include:

1) How were families recruited for the program (after a referral was made) and how did this recruitment process work?
2) Is the process for recruiting families into the program efficient and effective at enrolling families from each of the three target populations?
3) What issues need to be considered related to the recruitment process if the program is rolled out to other Georgia communities?

The two pilot counties had differing experiences in the recruitment and enrollment of target families. Much of the feedback received on recruitment was more surrounding the target population, eligibility criteria, and referrals into the program rather than the recruitment process itself. Secondly, there was the process of how to recruit and enroll families and the lack of training in that area.

Target Population and Eligibility Criteria:
Cobb County home visitors initially only had referrals from Children 1st and other public health programs. This population was the easiest to identify although the eligibility criteria set for the IFS Pilot are not completely aligned with the Children 1st eligibility categories. The program initially planned to include single mothers under age 25 with two or more children and one child under 12 months. The population of families eligible for the Children 1st visits made it an easier process for Cobb home visitors to gain access to parent's time and to their home. As nurses, in Cobb, the home visitors were able to go to new parents' homes and conduct the Children 1st assessment. This allowed not only for a relationship to begin, but for the eligibility to be confirmed, and a seemingly sensible continuation of public health services. The nurses did not mention the IFS Pilot when scheduling or talking about the Children 1st visit.

According to program data from Cobb County, the overall refusal rate for IFS pilot was 47 percent. Recruitment was a two-step process which first required contacting the client via phone to set us an appointment and second required an in-person visit to enroll clients. The overall refusal rate was partitioned into these two separate rates. The initial refusal rate of 16 percent captured the clients who refused the appointment, were unable to be contacted or failed to show for the initial visit. The secondary refusal rate of 31 percent captured the individuals who refused after having the IFS program explained to them in-person.

The enrollment rate in the IFS program is currently 53 percent with 2 individuals on the waiting list awaiting materials to be translated into Spanish. This rate exceeds the enrollment benchmark which was set at 50 percent.[21]

In Bartow County home visitors experienced difficulty identifying potential families to enroll, gaining access to their homes, and ultimately enrolling families. Informants indicated that people residing in Bartow may value their privacy and independence more than those living in a more urban county like Cobb. This need for privacy may make individuals less likely to enroll in an intensive program like home visiting.

The population targeted for the program was selected because they were considered at greater risk for child abuse and neglect. This population had a difficult time accepting the consent form for participation in the IFS Pilot and of being recorded during every session. The nurses and home visitors both noted this as an

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[21] See Appendix D: IFS Benchmarks

issue to enrolling eligible and otherwise interested families into the program.

A major barrier, according to the exit interviews and the key informant interviews with Bartow County staff, was the eligibility criteria. Initially, Bartow thought they would be able to get referrals from DFCS of substantiated cases (in addition to unsubstantiated cases). Both Bartow and Cobb counties found that the requirement of a mother having two children for eligibility restricted access to families who were interested and the total number of families they could attempt to recruit.

> *… my sister really needs this program. … I have my second child. I've already bumped through a lot of this the hard way…but I know my sister really needs this and she really wants to know because this is her first baby.*

Recruitment of families from the other expected referral sources such as DFCS and Mental Health and Substance Abuse have not been successful. It was suggested that families going through the requirements for DFCS, mental health treatment, or substance abuse treatment may not be willing or able to take on an additional program with a weekly requirement for 23 weeks.

After program implementation it was decided that the IFS Pilot in Cobb County could receive referrals of DFCS diversion cases. These cases are neither substantiated nor unsubstantiated and Counties have their own criteria for determining what constitutes a diversion case. In most cases, parents in diversion cases receive some follow-up, a home visit with a case worker or some other minimal intervention.

The Impact of Referrals on Recruitment:

A critical factor in recruitment of families into the IFS Pilot is the quality and quantity of referrals from agencies and community organizations. In order for home visitors to recruit families, families must first be referred to the IFS Pilot. Only one family was referred to the Bartow IFS Pilot. Only a few families outside of the Children 1st referral network were referred to the Cobb IFS Pilot. According to interviews, this was a result of the lack of buy-in and involvement of referral agencies. According to home visitors and supervisors, the program's priority and need for agency referrals should be established at the state level and communicated to local agencies. The topic of referral agencies is discussed in more detail in another section of this report, however, that process has a large impact on the success of the IFS Pilot and the number of families from which home visitors may recruit.

In Cobb County there seems to have been some push from the state level to the local level to increase participation in and referrals to the IFS Pilot. Additionally Cobb staff have contacted and visited many community agencies in order to build awareness for the program and encourage referrals to the program.

Clear and Consistent Message:

At the local level, a challenge emerged around having a consistent message given regarding eligibility, referrals, and materials. Prior to implementing the home visiting program clear criteria for eligibility were not communicated to the local public health site and to the local workgroups, agencies, and community organizations. Additionally, materials to market the IFS pilot were not developed at the state level for a consistent and accurate message to be shared with the community.

In Cobb County they have not actively recruited eligible Spanish-speaking families due to the lack of materials in Spanish. The SafeCare Curriculum, forms, and parent binder have not been translated into Spanish. Additionally, they must utilize their program assistant to translate during home visits with Spanish-speaking families.

Training on Recruitment and Enrollment:
The home visitors selected to implement the IFS Pilot in Bartow and Cobb all came from different backgrounds with different experiences. Two different models of home visiting were essentially established in Bartow and Cobb due to the differences in credentials and qualifications of the home visitors hired for the pilot. The home visitors in Bartow were Public Health Educators (PHEs) without home visiting experience. The two home visitors in Cobb were public health nurses with more than 10 years of home visiting experience and both had previously worked in pediatrics or child health.

Training on how to recruit and enroll families was not provided to home visitors in the IFS Pilot.

Summary
Future implementation of the IFS program in other counties may consider the use of nurses as home visitors, aligning the eligibility criteria with that of Children 1st, obtaining local agency buy-in through state level leadership early in the process, and providing local implementation sites, collaborating agencies, and home visitors with a clear and consistent message surrounding marketing, eligibility, and process earlier in the planning phase and prior to project roll-out.

The following is a summary of facilitators to recruitment and enrollment as well as barriers to recruitment and enrollment in the IFS Pilot.

Facilitators:
- **The use of Nurses** --The nurses in Cobb County were able to conduct Children 1st visits to families who met IFS Pilot eligibility criteria. Nurses had a level of credibility with families and built rapport during the Children 1st visits.
- **Experienced home visitors** --Home visitors who had previous experience in home visiting were able to adapt that experience to the IFS Pilot.
- **Children 1st --** Children 1st served as a vehicle to get home visitors (nurses) in the door of families eligible for the IFS Pilot.

Barriers:
- **Eligibility criteria**--Eligibility criteria prevented recruitment and enrollment of families with only one child and families who had children older than 12 months.
- **Clear and consistent message** –Local sites, agencies, and community organizations did not have clear and consistent information on eligibility criteria and the referral process. No marketing materials were developed by the state to provide to local sites.
- **Consent forms and recording--**Several home visitors reported losing potential enrollees upon reading of the consent form and communicating that they were mandated reporters and informing families that sessions would be recorded.
- **Non-English speakers--**The SafeCare curriculum and assessments are only available in English.
- **Training** --Home visitors received no formal training on how to recruit and enroll families in the IFS Pilot implementation.
- **Incentives--**Families had little reason to participate if being better parents was not a strong motivator.

Recruitment and Enrollment Recommendations Given by Informants:
- ✓ During planning phase involve state leaders in state and local level working groups. Buy-in needs to

occur at the local level and the importance of the project needs to be communicated first from the state leaders to the local agencies.

- ✓ Eligibility criteria should be revised to be more inclusive—increase age of child, increase age category for parent, allow families with only one child.

- ✓ Continue the process of slowly introducing the IFS Pilot. It is better received after an initial relationship is developed for another purpose (Children 1st).

- ✓ Provide training on how to recruit families, perhaps sharing lessons learned from other home visiting programs.

- ✓ Provide all materials in Spanish and other needed languages.

Family Retention in the IFS Pilot

The SafeCare Curriculum is designed to deliver three modules for learning over 19 to 26 family sessions. Each session may be completed over more than one family visit. It is believed that in order for families to receive the full benefit of the intervention, completing the program is necessary. Additionally, for the IFS Pilot to be properly evaluated for its impact on child abuse and neglect and other outcomes, a sufficient number of families must complete the program. The following process evaluation questions were posed in relation to client retention:

1) What strategies were used to retain families enrolled in the program? How did these retention strategies work to reduce attrition?
2) Were the strategies employed for retaining families effective at minimizing attrition from the IFS program?
3) What issues need to be considered related to retention if the program is rolled out to other Georgia communities?

When developing the evaluation plan around retention one of the intentions was to better understand the strategies used to retain families in the program. No protocol or strategy was designed prior to implementation for retaining families and minimizing drop outs. After a year of implementation, 24 clients have left the program prior to completion. The following represents a preliminary discussion of retention efforts.

Three primary areas will be addressed: First, current retention efforts and causes of attrition, second training on retention received by program staff, and third implications for statewide implementation. As Cobb County is the only county to enroll families, it will serve as the focus of the retention process evaluation.

Retention and Causes of Attrition:
As of February 29, 2009, in Cobb County 43 families have enrolled. Program completion was defined as completing all 19 modules of the SafeCare curriculum. Nineteen of the 43 enrollees completed the IFS program, for an overall retention rate of about 44 percent.

The SafeCare curriculum includes three separate training modules. According to the number of sessions completed, 65 percent of enrollees completed the *Treat at Home* module, 51 percent completed both the *Treat at Home* and the *Clean and Safe* module, and 44 percent completed all three modules including the *Parent-Infant Interaction* module. Surprisingly, the higher risk families, who enrolled under the mental health and unsubstantiated abuse eligibility categories, were more likely to complete the program.

The most common reason cited by enrollees who failed to complete the full program was they were too busy and could no longer meet the time commitments of IFS program (9 families or 21%); several mothers developed conflicts with their jobs. Six clients moved out of the county, and another 4 were lost to follow up. Three were administratively discharged and 2 stated that they were no longer interested in the program.

Home visitors in Cobb County provided further insight into the causes for program attrition. Informants speculated that children in the IFS Pilot were younger than children in the Fulton program and therefore these new mothers reach a point when they have to return to work. The question was posed as to whether they could accommodate visits on weekends and evenings, but program staff interviewed suggested that not only did families generally not want to give up this time, but that home visitors had some safety concerns

being in certain areas after hours and on weekends. Additionally, home visitors are not compensated at a rate high enough to be available for scheduling throughout the evening and seven days per week.

Home visitors received no training or standard protocol for retaining families enrolled in the IFS Pilot. The training that was provided was on the SafeCare Curriculum without additional training related to actual home visiting, recruitment, enrollment, or retention.

Summary

Families who seek and find employment, particularly during regular business hours, are at higher risk of attrition due to the difficulty in scheduling home visits when both the home visitor and the parent is available. Additionally, some find it difficult to meet the time commitments of the program once they have a full time job.

In considering a statewide implementation of the IFS program the state might consider providing training in addition to the SafeCare Curriculum that focuses on home visiting, recruitment, enrollment, and client retention. Additionally, developing a retention strategy and protocol that is taught during training might provide tools for home visitors to use when encouraging and motivating enrolled families to remain in the program. When staffing programs for larger enrollment it might also be considered that there be a home visitor who has a schedule that is different than the standard business hours to accommodate families who have or obtain jobs.

Data Collection and Monitoring

One of the key outcomes of the implementation of the IFS Pilot presented in the program logic model is enhanced data collection and evaluation systems for home visiting services. This section seeks to answer the following evaluation questions related to data collection and program monitoring:

1) Were necessary protocols established and followed related to program monitoring/tracking?
2) Were appropriate tools developed and utilized for monitoring and documenting program implementation?
3) Did active program monitoring result in efficient identification of issues and necessary program adjustments to address issues with implementation?

As part of the IFS program, program staff collect data on participant families at multiple points prior to and throughout a family's enrollment in the program. Data collected on hard copy sheets by program staff at the pilot site are sent to Marcus Institute for entry into the program database. The IFS Program Protocol stipulates that program staff at county Public Health Departments should provide data to the Marcus Institute on the 15th and the last day of each month. Informants reported that Marcus is responsible for cleaning and entering program data into the database and then sending the database to the FHB on a monthly basis.

Though the IFS protocol does specify the dates by which pilot sites must submit program data to the Marcus Institute, there does not appear to be a clear data flow spelled out in a data manual that program staff at the State and County, as well as at the Marcus Institute can follow. Informants reported multiple challenges related to the collection and use of program data as well as in the identification and use of available administrative data both to track program participants through and after implementation and to create matched controls for the purposes of program evaluation.

Differing data collection capacity across counties in the state as well as the utilization of different data systems among DHR Divisions make it difficult to collect data for programmatic use. Informants described limited capacity of the GADPH to access DFCS client data or Electronic Birth Records to search for eligible referral cases or track participant families during and after program participation. One informant described the multiple challenges of accessing reliable data in order to identify families eligible for referral into the IFS program and to create a control group:

> *In the case of the Children 1st System, which is a great place to begin with referrals, but as you know [some counties have] a very dysfunctional, for want of a better word, system of inputting the information and how it is maintained and how you could access it, so it was very hard to use [Children 1st] information, although, it was the most appropriate information to use. Electronic Birth Certificates was another idea and another good source of information, but the back log of inputting that information into a computer system made the information almost unable to be used because there was such a delay between when those birth certificates were created and when that information could be used.*

Multiple informants observed that the data challenges faced by IFS program staff are larger than the program. It was suggested by multiple informants that the lack of internal data capacity was the impetus for contracting with the Marcus Institute for program data entry and reporting. One informant described the reasoning behind the "outsourcing" of the data entry and reporting piece to the Marcus Institute:

> *Data doesn't work well anywhere on anything. We [within the State] are getting better, but it is a tough nut to crack. I*

think that as we thought about the [data collection and program monitoring piece], because we don't do it so well, people felt very comfortable having [the Marcus Institute] fill out a lot of the client-level data and pay them to report it. But we actually didn't do a good job in thinking through what we really want at the end.

One informant expressed concern over whether the current data entry and reporting system is sustainable. Because there is no data process flowchart that details how data are entered and analyzed, the state would not be able to take over these duties.

I think there should be more discussions with Marcus, and we ought to work closely with them and try to understand what the issues are and how they get the data and how they are entering the data and how do they resolve their issues… because if [the State] has to take over in the long run, if [the State] is to manage the data, we won't be familiar with whatever issues they are having on their end so that we can take care of the issue.

Informants at both pilot sites reported experiencing a lot of confusion related to the program data that they needed to collect and provide to the Marcus Institute for reporting purposes. They described how data requirements for the Marcus Institute for their own program evaluation purposes are different than the State data requirements and that it was difficult to get a clear answer from GADPH on which data points they need to receive. Two informants describe the difficulty in getting a clear idea of the data requirements from the GADPH:

The numbers and the information the [State] wants on a weekly basis, we didn't really know right off the bat. Like how many are enrolled, how many referrals did you get? I knew we would need to give that information but I think if they had had something set up some sort of a…something in writing as far as what the State wanted it would have been a little easier.

The organization in the beginning and then the data that we feel like we are trying to give to one person or the other. We feel like one person asks for it and then the other and it is like 'Do you two ever talk together?' You know, why do you keep getting the same questions from a different source?

At the time that interviews were conducted, program staff had not received any data reports from the program database. Nurse supervisors had been provided feedback on the fidelity monitoring conducted by Marcus Institute on the home visiting sessions. Informants report that the nurse supervisor provides regular feedback to the home visitors from the fidelity monitoring reports. One informant provided an example of a case when a finding from the fidelity monitoring session resulted in an intervention with the home visitors.

I think there were some difficulties in the beginning [with the] standardized assessments that are part of Safe Care protocol. They have names that are not things that [parents respond well to]… because nurses like to be very direct and open it was very hard for them to not tell the parent that this is a child abuse potential inventory. But when you say that to someone you put them on guard so then you give them 150 question questionnaires and there are questions on there like "I feel like I can't trust anyone." Well if you say that it is Child Abuse Potential Inventory I would probably say 'No I disagree,' even though I may feel that way. We don't say the names because we know that it puts people on defense.

Subsequently, programmatic data related to fidelity monitoring were analyzed for this evaluation report. The data indicate that fidelity monitoring between nurse supervisors and home visitors was occurring as planned with each home visitor having approximately two visits monitored per month. All but one of the fidelity scores were above 85 percent indicating that home visitors were covering at least 85 percent of the key

information per session. The Marcus Institute successfully monitored ten of the nurse supervisor's reviews and in 95 percent of the cases this oversight was found to be consistent with the findings of the nurse supervisor.

In addition to monitoring data related to referral, enrollment, and fidelity monitoring, more detailed data was collected on client visits in the IFS database. Out of the 506 visits scheduled during the IFS Pilot, 72 were cancelled by the client for an overall cancellation rate of approximately 14 percent. The average time to complete a visit was 60 minutes and the average round trip time for a visit was about an hour and 45 minutes. This information could be used to estimate program costs for IFS expansion.

The IFS database was created with the Cobb referral and enrollment process in mind and may need to be updated to accommodate additional counties.

Summary

Some protocols were established associated with the Marcus Institute's role in reporting data to GADPH; however, information shared with local staff related to their role in data collection and programmatic reporting was unclear. Tools (reporting forms) have been developed to track clients from initial referral through final program disposition. These tools have already been modified to assure more accurate reporting and will likely be revised again based on feedback from local staff post-implementation.

Key informants identified several barriers to the future success of data collection and programmatic monitoring. Informants suggested that additional work to assure accurate reporting and a mutual understanding of data needs is key to future program success.

Barriers

- **Internal data capacity** -- Lack of internal data capacity lead to unclear data requirements from GADPH, lack of mutual understanding between GADPH and the Marcus Institute related to IFS data elements, and confusion on data flow between local sites, the Marcus Institute, and State staff
- **Administrative data** -- Difficulty accessing administrative data to identify controls for program evaluation
- **Dissimilar county data systems** -- Varied data collection capacity and dissimilar data systems across counties will make expansion to additional counties challenging
- **Electronic Birth Certificate** -- Lag in receipt of EBC data at local county sites
- **Limited access to DFCS data** -- Inability of public health staff to access DFCS client data at the local sites
- **Sustainability** -- Questionable sustainability of IFS data collection capacity because it is currently accomplished through an external contract with the Marcus Institute
- **Local data reporting** -- Confusion in data reporting to Marcus Institute; possible conflict between data needed for research purposes and data needed for program monitoring

Recommendations from key informants related to ongoing data collection and monitoring:

- ✓ Clear data procedures should be in place prior to program implementation or expansion to additional county sites. Such a procedure should be specific to county data capacity (e.g. Children 1st system) and make clear to local staff exactly what data elements need to be collected and the processes for programmatic reporting.

- ✓ For purposes of program sustainability, the GADPH should consider bringing the data entry and data integrity functions "in-house." The Program Assistant in one intervention county created a local program database where IFS client data are entered for internal use. This suggests that county Public Health Departments may have existing capacity to enter client data into the IFS database.

IFS County and State Inter-Divisional Working Groups

As part of the planning and implementation of the IFS Pilot, IFS inter-divisional working groups were formed at the state and local level. As described earlier in this report, one of the key outcomes of the IFS Pilot is increased collaboration among DHR agencies to better support families at-risk for child maltreatment. This section seeks to answer the following process evaluation questions:

1) Were protocols established and followed for regular local and state-level working group meetings?
2) Were key partner agencies represented at working group meetings?
3) Did IFS working group meetings meet the objectives of communicating program process, soliciting input from collaborating agencies and improving coordination among local and state agencies?

***Established protocols for regular working group meetings*:**
Within Section III (DHR Partner Agencies) of the current draft version of the Integrated Family Support Program Protocol (version June 2007), the roles and responsibilities of the GADPH, DFCS, and MHDDAD as related to the county and state level working group are detailed. The protocol specifies that the State Office of the GADPH is responsible for "coordinating and participating in state office working group meetings." The protocol stipulates that the County Health Department at the IFS pilot site is responsible for creating and facilitating the local work group and specifies that the work group should meet at least quarterly "to ensure collaboration regarding referrals and status of DFCS and CSB clients." The protocol further details the roles and responsibilities of the Division of MHDDAD and DFCS at the state and local levels related to the IFS working group. The protocol specifies that each Division should "designate State and County Division staff to attend the State or Local IFS Working Group Meetings to ensure collaboration regarding client referrals."

The current version of the protocol does not specify the frequency with which state level working group meetings should occur, but Key Informants and a review of state working group minutes suggest that these meetings take place approximately monthly. From IFS program implementation in March of 2007 until mid July 2007, three State-level workgroup meetings have been held. Invitees include five staff from the Division of Public Health: four from the Child and Family Health Branch representing program operations, program planning, program evaluation, and data support, and one representative from nursing services. Additionally, one State-level staff person representing DFCS and two staff members representing the Division of MHDDAD (one with expertise in mental health and the other addictive diseases) complete the work group. Each of the invitees has participated in at least one of the meetings and several representatives, including DFCS, have attended all of the scheduled work group meetings.

Representatives from state agencies outside of the GADPH characterized the purpose of the meetings convened by GADPH staff as "informational" – an opportunity for GADPH to provide partner agencies with an update on the status of the program. They also reported that the working groups gave them the opportunity to provide information about their own agencies' systems and processes. One informant described the state working group this way:

> *The intention of the state working group is to monitor and support, ensuring accuracy in eligibility and in the understanding of the population, providing information about 'the system' – how DFCS works, how other agencies work to ensure the most appropriate interfacing between the IFS project and local activities.*

These informants described the working group meetings as "focused and well organized." Informants said

that the GADPH staff did a good job of soliciting input and feedback from partners at the state and local levels into the program implementation plan.

> *I think that the group that did this project was very organized. The meetings were very agenda-based, very structured. They did a really good job of honing in on what the topics are…The Public Health folks did a good job taking the lead in asking for input and trying to be inclusive."*

Key partner representation at working group meetings:

Members of the FHB IFS team and representatives from the partner agencies alike described challenges with getting key representatives from other DHR Divisions to participate consistently in both planning and working group meetings. As detailed in the finding under the Planning section of this report, this challenge seems to be systemic in nature and goes beyond the scope of the IFS pilot. Informants shared specific strategies for improving participation in and expanding the role of the state working group. One informant described a common theme for many informants – that other Divisions should be brought into the process at an earlier phase in planning and that their participation should be funded:

> *It is so hard when you have so many people in this huge agency and you are trying to mix us up. I think that sometimes we all get thrown into projects and we don't know exactly where it came from or what the initiative was of where the funding came from. So maybe if we were more involved in the inception of things, at the ground level… and collaboration should not only be funded by one thing. There should be multiple-tier funding, where the substance abuse providers have incentives, and the nurses involved have incentives and the DFCS workers have incentives. It is a huge issue when you start asking providers to do extra work – they see more paperwork, they see more time.*

Members of the state level working group and IFS program staff described the need for the state level representatives to take a more active role in marketing the program to their local counterparts. They suggested that the state partners' role could be better leveraged in addressing challenges at the local level related to inter-agency referral and collaboration.

Interviews with members of the Cobb County IFS working group and a review of meeting minutes show that the group met twice during the early phase of program implementation but has not held a working group meeting since March, 2007. Informants from the county working group described the lack of referral agency presence at the working group meetings. The agency representatives, who did attend a working group meeting, reported being surprised and disappointed by the lack of representation from other referring agencies. At each of the working group meetings held, only one agency outside of the Department of Public Health was represented.

IFS program staff report that working group meetings were suspended due to the lack of agency attendance at the meetings and the lack of referrals from other county agencies. A review of the county working group meetings suggest that barriers to convening regular meetings include competing priorities of local DFCS, mental health and addictive disease staff and their feeling that they would have few clients to refer to the IFS program because most mothers in mental health and/or substance abuse treatment have a substantiated DFCS case and most children under 12 months of age reported to DFCS become active investigations. While local staff felt like diversion cases would be a place to identify referrals, the State-level work group determined that because the State lacked a consistent definition of diversion cases, this would not be an eligibility criterion that could be uniformly implemented. However, this decision has been reversed.

Meeting the objectives of communicating program process, soliciting input from collaborating

agencies, and improving coordination among local and state agencies:
Informants representing partner agencies in Cobb County reported strong support of the mission and focus of the IFS program and appreciate the design that allows for intensive intervention with at-risk families. However, they reported that the eligibility criteria are too restrictive to be able to refer many families into IFS. This informant describes the perspective shared by collaborators at both the state and local level:

> *I think that the program is wonderful. It is great that they have follow up with the families. We [at our agency] are not able to provide clients with the follow-up to see if the program was successful or to provide further support and services to families, so the [IFS] program is wonderful in that regard. I would love to see it be successful, but the eligibility criteria limits their ability to refer in.*

Summary
A review of the program protocol shows that protocols were established for regular working group meetings at the state and local level. Findings suggest that state-level working group meetings are occurring on a regular basis and that partner agencies are generally represented at all meetings. However, interviews with Key Informants and a review of meeting minutes and attendance records suggest that the Cobb Department of Public Health struggled to convene key partners and has apparently suspended meetings due to lack of agency participation.

Though many state level working group members and IFS program staff interpret this lack of attendance as a lack of local buy-in and prioritization of the program, county staff at referring agencies report that it is the "limited" and "restrictive" eligibility criteria for the IFS program that limits their ability to refer their clients to the program. They report being fully supportive of the focus and mission of the program. Program staff might consider exploring other ways of convening partner agencies for working group meetings. Strategies like holding regular conference calls or meeting at a partner agencies' office might facilitate better participation. Parallel to county-level efforts, agency counterparts with the state working group might consider working in concert with regional and local agency staff to identify barriers to more effective collaboration, to "sell the program" to local and regional staff, and solicit input from their local counterparts on ways to improve program implementation and intra-agency collaboration.

Appendix A: Predictors of Child Maltreatment

Predicator of Child Maltreatment	Public Health Identification or Contact
Child-Related Risk Factors	
Low birth weight/ Prematurity[1, 2]	EBC, C1st S&R, CSN programs (CSN)
Disability[3, 4, 5, 6,7]	EBC, C1st S&R, MCH Assessment, CSN
Parent-Related Risk Factors	
Prenatal smoking[1]	EBC, C1st S&R
Substance Use[2,3,8,9]	EBC, C1st S&R, MCH Assessment
Mental Illness[2,3,8,9,10]	C1st S&R, MCH Assessment
History of being a victim of abuse [2,3,8]	MCH Assessment
Young maternal age [1,2,3,6,10]	EBC, C1st S&R
Low maternal education [1,6,9,10]	EBC, C1st S&R
Low income or utilizes public support programs[1,2,6,8,9,10]	EBC, C1st S&R, MCH Assessment
Unmarried or single parent[1,2,3,6,10]	MCH Assessment
Living arrangement with non-parent partner[2,6,10]	MCH Assessment
Large family size or many young children[1,2,3,8,910]	
Inadequate prenatal care[1]	EBC, C1st S&R
Short pregnancy interval[1]	
Lack of parenting skills[2,3]	MCH Assessment
Lack of coping skills[2]	
Lack of support[2,3,9]	MCH Assessment
Stressful life events[2]	
Low self-esteem, emotional immaturity[3]	
Unintended pregnancy and/or denial about pregnancy[3]	
Non-white race[3,6,10] (no association also found)[1]	EBC, C1st S&R, MCH Assessment
Community-Related Risk Factors	
Lack of social and/or health services[2,3]	MCH Assessment
Community violence, high crime rate[2,3]	
High unemployment rate[2,3]	
High poverty rate[2,3]	
Homelessness[2]	C1st S&R
Racism and discrimination[2]	
Poor schools and Environmental Toxins[2]	

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Appendix B: Target Areas for Home Visiting

TARGET AREAS FOR HOME VISITING - DRAFT

Counties are Listed by # of Unsubstantiated Cases, Highest to Lowest

	FY 2005	CY 2004	March, 2006	CY 2004	
County/PH District	**Unsubstantiated Cases <1**	**Repeat Births to Single Mothers <21**	**Single TANF Mothers <21 with >2 children (one an infant)**	**Births**	**District Children 1st System**
Fulton 3-2	394	650	450	12,628	Below Optimal
Bibb 5-2	218	210	150	2,433	Below Optimal
Dekalb 3-5	176	474	241	10,955	Below Optimal
Richmond 6	147	220	110	3,131	Optimal *
Cobb 3-1	135	290	91	10,609	Below Optimal
Gwinnett 3-4	130	303	62	12,971	Optimal *
Whitfield, 1-2	110	117	2	1,868	Below Optimal
Douglas 3-1	102	54	24	1,682	Below Optimal
Chatham 9-1	101	239	40	3,719	Below Optimal
Floyd 1-1	97	97	17	1,405	Optimal *
Muscogee 7	96	237	144	3,057	Below Optimal
Cherokee 1-2	84	56	4	3,042	Below Optimal
Liberty, 9-1	84	48	29	1,469	Below Optimal
Clayton 3-3	83	233	96	4,642	Below Optimal
Hall 2	81	141	8	3,070	Below Optimal
Dougherty 8-2	81	149	71	1,512	Below Optimal
Henry 4	75	65	24	2,601	Below Optimal
Paulding, 1-1	72	29	3	1,885	Optimal *
Clarke, 10	65	87	20	1,440	Optimal *
Houston, 5-2	63	82	45	1,849	Below Optimal
Barrow, 10	53	29		982	Optimal *
Carroll, 4	47	84		1,483	Below Optimal
Lowndes, 8-1	46	102		1,574	Below Optimal
Troup, 4	43	70		958	Below Optimal
Bartow 1-1	42	78		1,457	Optimal *
Polk 1-1	27	44		666	Optimal *

* Optimal means that the District Children 1st system for FY2005 and 1st quarter FY2006 reached at or close to the state average for all three indicators. These indicators include percent of infants identified, percents of infants and children assessed,

The counties highlighted were added after the analysis. The cutoff had been at Houston.

Appendix C: Eligibility Requirements for IFS

Updated August, 2007

All referrals must be submitted on a Children 1st Screening and Referral Form. Use the codes from the S/R form listed below to refer to IFS. Eligibility criteria for the IFS project varies slightly with the language on Children 1st S/R form. Use the criteria on this document to guide the referral process.

1. **Families with infants under the age of 12 months and are referred by DFCS due to Unsubstantiated case of abuse or neglect.**

   V61.21- Previous or current Child Protective Services/Foster Care - **Add the statement "Unsubstantiated" under Comments in Section G.**

   IFS project will accept referral on CPS investigation where allegations are unsubstantiated and diversion cases where the results are unsubstantiated. IFS project will not enroll families with a substantiated case of abuse or neglect, regardless of the severity or length of opened case.

2. **Families with infants under the age of 12 months and are referred by community Service Board where the parent is actively receiving treatment for mental health or substance abuse.**

   V61.4 - Maternal Substance Abuse (alcohol, street, prescription or OTC drugs as documented by self-report, drug screen or court record)

   Substance Abuse treatment

   The SA Treatment team will determine when to refer women for IFS project, based on individual readiness and treatment plan accomplishments. The SA case coordinator will be in contact with IFS once enrolled in the project. If a mom enrolled in IFS project drops out of SA treatment, IFS will be notified (or IFS will notify SA case Coordinator) and a decision will be made by both agencies about whether to continue family in IFS project.

   V17.0 - Maternal Mental Illness, Especially Depression

   Mental Health Treatment

   Women who are receiving case management services from a public mental health provider (including individual, group, or other consumer services) will be eligible for referral into the IFS project. The Community Support Worker will determine when to make a referral into the IFS project based on individual readiness.

3. **Families with infants under the age of 12 months and are referred by Children 1st, other public health or community programs where the mother is single, age 21 or younger, and has 2 or more children.**

   V61.5 - Multiparity in mother <20 Years (more than 3 pregnancies) – **Add language that mother is single, age 21 or under, and names and dates of birth of other children of the identified mother under Comments in Section G.**

4. **Families with infants under the age of 12 months and are referred by Children 1st, other public health or community programs where the mother is single, a first-time mother and age 18 or younger.**

   XXX.12 – Maternal age <20 Years – **Add language that mother is single, age 18 or younger and has only one child under Comments in Section G.**

Appendix D: IFS Benchmarks

Revised 5/2/07

1a) Percent of referrals to IFS that are unsubstantiated

Number of referrals to IFS that are unsubstantiated
Total Number of to IFS referrals

Benchmark: at least 25%

1b) Percent of referrals to IFS that are in MH/SA treatment

Number of referrals to IFS that are in MH/SA treatment
Total Number of to IFS referrals

Benchmark: at least 25%

1c) Percent of referrals to IFS that are single, ≤21, with 2 or more children

Number of referrals to IFS that are single, 21 or younger, with 2 or more children
Total number of referral to IFS

Benchmark: at least 25%

2) Percent of Clients Referrals to IFS that are enrolled

Number of clients enrolled in the IFS program
Total number of referral to IFS

Benchmark: at least 50%

3) Percent of Clients that Complete the SafeCare Curriculum

Number completed safecare curriculum (6months)
TOTAL NUMBER WHO ENROLLED

Benchmark: at least 75%

4) Percent of Fidelity Observation Completed by the Nurse Supervisor

Number of fidelity observations completed
Total number of fidelity observations expected

Benchmark: 100%

Appendix E: Database Reporting

The following statistics were obtained using the IFS Database Data as of March 8, 2008, and after a June 26, 2008 data Meeting with the IFS Staff in Cobb County.

1. REFFERALS INTO IFS PROGRAM:

REFERRALS BY REFERRAL SOURCE		
Referral Source	**#**	**%**
Children 1st	45	53%
DFCS/CPS	2	2%
DFCS/TANF	3	4%
CSB/MH	1	1%
CSB/SA	0	0%
Other	34	40%
TOTAL	**85**	**100%**

***** Referral Source is Obtained from the "Initial Contact Disposition" Form***

REFERRALS BY ELIGIBILITY CRITERIA		
Eligibility Criteria	**#**	**%**
$\leq$ 18 Single Mom	32	38%
$\leq$ 20 Multiparity	39	46%
MH/SA	5	6%
Unsubstantiated	9	11%
TOTAL	**85**	**100%**

***** Eligibility Criteria is Obtained from the "Children's 1st" Form***

a. **Benchmark #1a:** Percent of Referrals that are unsubstantiated

$$= \frac{\text{Number of unsubstantiated referrals}}{\text{Total Number of IFS Referrals}} = \frac{9}{85} = 11\%$$

b. **Benchmark #1b:** Percent of Referrals to IFS that are in MH/SA

$$= \frac{\text{Number of referrals to IFS that are in MH/SA}}{\text{Total Number of IFS Referrals}} = \frac{5}{85} = 6\%$$

c. **Benchmark #1c:** Percent of Referrals to IFS that are Single ≤ 21 with 2 or more children

$$= \frac{\text{Number of referrals to IFS that are Single} \leq 21 \text{ with 2 or more children}}{\text{Total Number of IFS Referrals}} = \frac{39}{85} = 46\%$$

d. **Benchmark #1d:** Percent of Referrals to IFS that are Single mothers age ≤ 18

$$= \frac{\text{Number of referrals to IFS that are Single mothers age} \leq 18}{\text{Total Number of IFS Referrals}} = \frac{32}{85} = 38\%$$

2. DISPOSITION AFTER REFERRAL:

INITIAL DISPOSITION CATEGORY		
Disposition Category	**#**	**%**
Did not enroll, referred to other PH program	25	29%
Enrolled in IFS	43	51%
Family refused IFS	1	1%
Family refused initial home visit	2	2%
In Process (disposition not yet determined)	0	0%
Unable to complete Home Visit	4	5%
Unable to Contact	8	9%
Waiting List	2	2%
TOTAL	**85**	**100%**

Disposition Category is Obtained from the "Initial Contact Disposition" Form

a. **Enrollment Rate** is defined as: $= \frac{\sum([\text{Enrolled in IFS}])}{\text{Total \# of Referrals}} = \frac{43}{85} = 51\%$

b. **Initial Refusal Rate:** The Initial level of Refusal takes place before an appointment is made, i.e. those people who refuse the program before ever speaking to anyone. The Initial Refusal Rate was defined as:

$$\text{Initial Refusal Rate} = \frac{\sum\left(\begin{array}{l}[\text{Family Refused Initial Home Visit}]\ \text{OR}\ [\text{Unable to Contact}]\ \text{OR} \\ [\text{Unable To complete Home Visit}]\end{array}\right)}{\text{Total \# of Referrals}}$$

$$= \frac{14}{85} = 16.5\%$$

c. **Secondary Refusal Rate:**

- **After Appointment, but Before Visit:** The Secondary level of Refusal consists of two parts. The first part of the Secondary level of refusal is made up of those people who refuse the IFS program after an appointment is made, but before the Home Visitor ever speaks to them. This portion of the Secondary Refusal Rate was defined as:

  Secondary Refusal Rate (after appointment, but before visit)

$$= \frac{\sum\left(\begin{array}{l}([\text{Contact Made scheduled Home Visit}]\ \text{AND}\ [\text{Did not Enroll in IFS}]\ \text{OR} \\ ([\text{Contact Made scheduled Home Visit}]\ \text{AND}\ [\text{Family Refused IFS}])\end{array}\right)}{\text{Total \# of Referrals}}$$

$$= \frac{26}{85} = 30.6\%$$

- **After Appointment and Visit:** The second part of the Secondary level of refusal takes places after the home visitor has spoken with the individual. For the numerator, this refusal accounts for the same individuals who

refused the IFS program after appointment, but before visit, but compares them to a subset of the referral population (those individuals who refused the IFS program after being visited by and speaking with a home visitor) as the denominator. This portion of the Secondary Refusal Rate was defines as:

$$\text{Secondary Refusal Rate (after appointment and visit)} = \frac{\sum\begin{pmatrix}\text{([Contact Made scheduled Home Visit] AND [Did not Enroll in IFS] OR} \\ \text{([Contact Made scheduled Home Visit] AND [Family Refused IFS])}\end{pmatrix}}{\text{Total \# of Referrals} - \sum\begin{pmatrix}\text{[Family Refused Initial Home Visit] OR [Unable to Contact] OR} \\ \text{[Unable To complete Home Visit]}\end{pmatrix}}$$

$$= \frac{26}{85-14} = 36.6\%$$

d. Total Refusal Rate: The Total Refusal Rate is defined as:

$$\text{Total Refusal Rate} = \frac{\sum\begin{pmatrix}\text{[Family Refused Initial Home Visit] OR [Unable to Contact] OR} \\ \text{[Unable To complete Home Visit]} \\ \text{OR ([Contact Made scheduled Home Visit] AND [Did not Enroll in IFS] OR} \\ \text{([Contact Made scheduled Home Visit] AND [Family Refused IFS])}\end{pmatrix}}{\text{Total \# of Referrals}}$$

$$= \frac{40}{85} = 47.1\%$$

e. Wait List Rate: The Wait List Rate is defined as:

$$\text{Wait List Rate} = \frac{\sum(\text{[Wait List]})}{\text{Total \# of Referrals}} = \frac{2}{85} = 2.4\%$$

TABLE 4: REFERRAL DISPOSITION RATES		
Description	**#**	**%**
Enrollment Rate	43	51%
Total Refusal Rate	40	47%
Wait List Rate	2	2%
Total	**85**	**100%**

Over half of the children referred to the IFS program were enrolled. Two children were put on the Waiting List, and two children did not enroll because they needed the IFS curriculum in the Spanish Language.

3. REASON FOR REFUSAL:

a. Family Refused Initial Home Visit = 2

- Reasons:
    1. "MOTHER IN SCHOOL; BABY AT GRANDPARENTS"
    2. "SAID SHE WAS NOT INTERESTED AND SHE HAS ALL SHE NEEDS"

b. Unable to Contact = 8

c. Family Refused IFS = 1

- Reasons: No Reason Given

d. Unable to Complete Home Visit = 4

- Reasons: (only 2 of the 4 individuals with this disposition gave a reason)
    1. "Client not at home, never responded to calls or letters"
    2. "no one home"

e. Enrolled in Another Program = 25
29% of Referrals that Did Not enroll in IFS Enrolled into another Program

- BCW = 1
- CMS = 0
- HRIFU = 0
- CHILDREN 1ST = 22
- Name of Other Program Not Indicated = 2

4. ENROLLMENT INTO THE IFS PROGRAM:

a. Benchmark #2: Percent of Clients Referrals to IFS that are Enrolled

$$= \frac{\text{Number of clients enrolled in the IFS program}}{\text{Total number referred to IFS}} = \frac{43}{85} = 51\%$$

TABLE 5: ENROLLMENT BY REFERRAL SOURCE		
Referral Source	**#**	**%**
Children 1st	17	40%
DFCS	5	12%
CSB/MH	1	2%
Other	20	47%
TOTAL	**43**	**100%**

**** Eligibility Criteria is Obtained from the "Children's 1st" Form***

TABLE 6: ENROLLMENT BY ELIGIBILITY CRITERIA		
Eligibility Criteria	**#**	**%**
$\leq$ 18 Single Mom	14	35%
$\leq$ 20 Multiparity	21	49%
MH/SA	2	2%
Unsubstantiated	6	14%
TOTAL	**43**	**100%**

**** Eligibility Criteria is Obtained from the "Children's 1st" Form***

b. Visit Cancellation Rate = $\frac{\text{\# of visits cancelled}}{\text{total \# visits scheduled}} = \frac{72}{506} = 14.2\%$

("# of visits cancelled" is defined as the visits from the Family Session Summary in the Database that have "No" checked next to "Appointment Kept." "Total # visits scheduled" is defined as all of the Family Session Summary records in the database.)

c. Average Time for Visits Made = 60.09 MINUTES

(Average Time for Visits is defined as the Average of all the values in the Database after subtracting Visit Stop Time from Visit Start Time from the Family Session Summary Form)

d. Average Round Trip Time = 1 HOUR 43 MINUTES

(Average Round Trip Time is defined as the average of all the values in the Database from the "Round Trip Time" variable on the Family Session Summary form)

e. Benchmark #4: % of Fidelity Observation Completed by the Nurse Supervisor

TABLE 7: FIDELITY MONITORING				
Home Visitor	**# Fidelity Checks Completed**	**% of Fidelity Scores that are 85% or above**	**Marcus Institute's Fidelity Checks**	**% in Agreement**
BECKY PALOMBO	21	100.00%	10	100%
MARTI MASTBROOK	22	90.90%	10	90%

$$\frac{\text{\# of fidelity observations completed}}{\text{total \# of fidelity observations expected}} = \frac{43}{44} = 98\%$$

f. Referrals to Other Programs

TABLE 8: REFERRALS FROM PAGE 3 OF THE MCH ASSESSMENT	
Referral Name	**Number of Referrals**
Family Planning	81
Immunizations	63
Health Care	61
Shelter/Environment	60
Alcohol/Drug/Tobacco History	60
Injury Prevention	60
Child/Youth Development	59
Employment/Income	59
Oral/Vision Health	58
Parent/Child Interaction	58
Family Relations	56
Father/Mother	55
Transportation	54
Nutrition	54
Family Education	53
Physical Activity	52

** Clients could be referred to more than one program*

TABLE 9: Standardized Assessments result based Referrals from Referral Disposition form Part b	
Referral Agency/Program	**Number of Referrals**
COBB MENTAL HEALTH	1
MCHC (PCP)	1
Mental Health	1
MENTAL HEALTH AT COBB HEALTH DEPT	1

TABLE 10: Family Planning based Referrals from "Family Planning Discussion Checklist"					
# Referred to Health Family Planning Clinic	# Referred to Private Family Planning	# Who Received a follow-ups about Family Planning Referrals	# Who Scheduled a follow up appointment	# Who Did not Schedule a follow-up appointment	# in Process
13	21	16	7	8	1

5. DISCHARGE AND COMPLETION

a. Discharge Disposition

TABLE 11: DISCHARGE DISPOSITION CATEGORY		
Discharge Reason	**#**	**%**
Completed 19 Sessions of the IFS Curriculum	19	44%
Administrative Discharge	3	7%
Moved out of county	6	14%
Too busy	5	12%
Other: CONFLICTING HOURS WITH WORK	3	7%
Not interested	2	5%
Other: Lost contact. MOM waiting for Spanish materials.	1	2%
Other: LOST TO FOLLOW-UP	2	5%
Other: RECEIVING PARENTING CLASSES 2X/WEEK AT TURNER CHAPEL DAYCARE. CLASSES ARE REQUIRED FOR DAYCARE SERVICES.	1	2%
Other: UNABLE TO CONTACT BY HV, PHONE OR MAIL	1	2%
TOTAL	**43**	**100%**

- **Discharge Rate** $= \frac{\text{Total \# Discharged}}{\text{Total \# Ever Enrolled}} = \frac{24}{43} = 55\%$

b. Last Session Completed for Discharged Clients

TABLE 11: LAST SESSION COMPLETED FOR DISCHARGED CLIENTS		
Last Session Completed	**# of Discharged Clients**	**Discharge Reason**
1	3	1-Too busy; 1-Other: Lost contact/Spanish materials; 1-Other: Parenting classes
2	4	1-Not interested; 1-Administrative Discharge; 1-Moved out of county; 1 – Too Busy
3	4	1-Administrative Discharge; 2-Moved out of county; 1-Other: CONFLICTING HOURS WITH WORK
4	2	1-Other: CONFLICTING HOURS WITH WORK; 1-Other: UNABLE TO CONTACT BY HV, PHONE OR MAIL
5	1	Moved out of county
6	1	Not interested
7	3	1-Too busy; 1-Other: LOST TO FOLLOW-UP; 1-Administrative Discharge
8	1	Lost to Follow-up
9	1	Moved out of County
10	1	Too busy
13	1	Other: CONFLICTING HOURS WITH WORK
14	1	Moved out of County
15	1	Too busy

c. **Completion or Retention Rate:** The Completion Rate is defined as the number of clients ever enrolled in the IFS program that complete 19 sessions of SafeCare Curriculum.

TABLE 13: PERCENT OF THE SAFECARE CURRICULUM COMPLETED BY ENROLLEES				
Last Session Completed	**% of SafeCare Curriculum Completed**	**# of Clients**	**% of Clients**	**Completion Rate of % of SafeCare Curriculum Completed**
1	5%	3	7%	100%
2	11%	4	9%	93%
3	16%	4	9%	84%
4	21%	2	5%	74%
5	26%	1	2%	70%
6	32%	1	2%	67%
7	37%	3	7%	65%
8	42%	1	2%	58%
9	47%	1	2%	56%
10	53%	1	2%	53%
12	63%	0	0%	51%
13	68%	1	2%	51%
14	74%	2	5%	49%
15	79%	0	0%	44%
17	89%	0	0%	44%
18	95%	0	0%	44%
19	100%	14	33%	44%
6 Week Follow-Up	100%	3	7%	12%
3 Month Follow-Up	100%	2	5%	5%
	TOTAL	**43**	**100%**	**Completion of 19 Sessions = 44%**

- **Benchmark #3:Percent of Clients that complete SafeCare Curriculum**

$$\text{Completion Rate} = \frac{\#\,\text{completed at least 19 sessions}}{\text{total}\,\#\,\text{ever enrolled}} = \frac{19}{43} = 44\%$$

- 65% Completed the “Treat at Home” Module
- 51% Completed the “Safety & Clean” Module
- 44% Completed the “Parent-Infant Interaction” Module

6. SATISFACTION SURVEY RESULTS

HEALTH TRAINING SATISFACTION QUESTIONAIRE

1. Caring for my child's health when he/she is ill has become easier

Opinion	Number	Percent
Strongly Agree	12	50%
Agree	11	46%
Neutral	1	4%
Disagree	0	0%
Strongly Disagree	0	0%
Total	**24**	**100%**

2. Recognizing that my child is ill has become easier

Opinion	Number	Percent
Strongly Agree	13	54.17%
Agree	11	45.83%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

3. Knowing when to take my child to the doctor has become easier

Opinion	Number	Percent
Strongly Agree	12	50.00%
Agree	11	45.83%
Neutral	1	4.17%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

4. It has become easier to recognize when my child needs emergency treatment

Opinion	Number	Percent
Strongly Agree	16	66.67%
Agree	6	25.00%
Neutral	2	8.33%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

5. As a result of this program, I am more confident that I am better prepared to care for my child when he/she is sick

Opinion	Number	Percent
Strongly Agree	14	58.33%
Agree	8	33.33%
Neutral	2	8.33%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

6. Buying medication and health supplies has become easier

Opinion	Number	Percent
Strongly Agree	12	50.00%
Agree	10	41.67%
Neutral	2	8.33%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

7. When talking to my child's doctor, I feel more confident than before

Opinion	Number	Percent
Strongly Agree	14	58.33%
Agree	8	33.33%
Neutral	2	8.33%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

8. I believe that this health training program would be useful to other parents

Opinion	Number	Percent
Strongly Agree	18	75.00%
Agree	6	25.00%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

9. I feel the health training program did not provide me with any new or useful information or skills

Opinion	Number	Percent
Strongly Agree	0	0.00%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	5	20.83%
Strongly Disagree	19	79.17%
Total	**24**	**100.00%**

Rate how useful each of these items were in helping you benefit from the services you received:

1. Counselor's explanations

Opinion	Number	Percent
Useful	23	95.83%
Somewhat Useful	0	0.00%
OK	1	4.17%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**24**	**100.00%**

2. Counselor's demonstrations

Opinion	Number	Percent
Useful	23	95.83%
Somewhat Useful	0	0.00%
OK	1	4.17%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**24**	**100.00%**

3. Practice during sessions

Opinion	Number	Percent
Useful	22	91.67%
Somewhat Useful	0	0.00%
OK	1	4.17%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**23**	**95.83%**

4. Practice outside of sessions

Opinion	Number	Percent
Useful	21	87.50%
Somewhat Useful	0	0.00%
OK	3	12.50%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**24**	**100.00%**

5. Counselor's feedback

Opinion	Number	Percent
Useful	22	91.67%
Somewhat Useful	1	4.17%
OK	1	4.17%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**24**	**100.00%**

6. Written Materials

Opinion	Number	Percent
Useful	22	91.67%
Somewhat Useful	1	4.17%
OK	1	4.17%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**24**	**100.00%**

Rate the counselor who conducted the Health Training program:

1. Was warm and friendly

Opinion	Number	Percent
Strongly Agree	22	91.67%
Agree	2	8.33%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

2. Was helpful

Opinion	Number	Percent
Strongly Agree	22	91.67%
Agree	2	8.33%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

3. Gave clear explanations

Opinion	Number	Percent
Strongly Agree	22	91.67%
Agree	2	8.33%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

4. Was knowledgeable

Opinion	Number	Percent
Strongly Agree	20	83.33%
Agree	2	8.33%
Neutral	1	4.17%
Disagree	0	0.00%
Strongly Disagree	1	4.17%
Total	**24**	**100.00%**

5. Was negative or critical

Opinion	Number	Percent
Strongly Agree	4	16.67%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	5	20.83%
Strongly Disagree	15	62.50%
Total	**24**	**100.00%**

6. Treated me fairly

Opinion	Number	Percent
Strongly Agree	21	87.50%
Agree	3	12.50%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

7. Was willing to spend extra time when I needed it

Opinion	Number	Percent
Strongly Agree	21	87.50%
Agree	3	12.50%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

8. Kept our scheduled appointments

Opinion	Number	Percent
Strongly Agree	20	83.33%
Agree	4	16.67%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

9. Was on time to scheduled appointments

Opinion	Number	Percent
Strongly Agree	21	87.50%
Agree	3	12.50%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

10. Interacted well with my child

Opinion	Number	Percent
Strongly Agree	22	91.67%
Agree	2	8.33%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**24**	**100.00%**

SAFETY AND CLEANLINESS SATISFACTION QUESTIONAIRE

1. Since I have completed the safety and cleanliness program, my home is

Opinion	Number	Percent
Much Safer	7	58%
Safe	5	42%
No Different	0	0%
Less Safe	0	0%
Much less Safe	0	0%
Total	**12**	**100%**

2. Conduction the safety program in other homes where small children live would be a

Opinion	Number	Percent
Very Good Idea	12	100.00%
Good Idea	0	0.00%
Neither Good Nor Bad Idea	0	0.00%
Bad Idea	0	0.00%
Very Bad Idea	0	0.00%
Total	**12**	**100.00%**

3. I am better able to identify safety hazards in my home

Opinion	Number	Percent
Strongly Agree	10	83.33%
Agree	2	16.67%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**12**	**100.00%**

4. I am better able to clean my home and keep it clean

Opinion	Number	Percent
Strongly Agree	7	58.33%
Agree	3	25.00%
Neutral	2	16.67%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**12**	**100.00%**

5. While having the individual who conducted the training look through my home, I felt

Opinion	Number	Percent
Very Comfortable	6	50.00%
Somewhat Comfortable	3	25.00%
Neither Comfortable nor uncomfortable	2	16.67%
Somewhat Uncomfortable	1	8.33%
Very Uncomfortable	0	0.00%
Total	**12**	**100.00%**

6. How much time did it take to make your home safe and clean for the children

Opinion	Number	Percent
Almost No Time	1	8.33%
Very Little	3	25.00%
Some	6	50.00%
A Lot	1	8.33%
Too Much Time	1	8.33%
Total	**12**	**100.00%**

7. From now on I plan to follow the recommendations of the safety and cleanliness program

Opinion	Number	Percent
Always	11	91.67%
Most of the Time	1	8.33%
Sometimes	0	0.00%
Seldom	0	0.00%
Never	0	0.00%
Total	**12**	**100.00%**

8. The safety devices I was given, such as locks for my cabinets were

Opinion	Number	Percent
Very Useful	10	83.33%
Useful	1	8.33%
Neither Useful nor Useless	0	0.00%
Useless	0	0.00%
Very Useless	1	8.33%
Total	**12**	**100.00%**

9. The amount of effort required to make my home safe and clean for children was acceptable

Opinion	Number	Percent
Strongly Agree	10	83.33%
Agree	2	16.67%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**12**	**100.00%**

10. I feel that the safety program provided me with new and useful skills for making hazards inaccessible

Opinion	Number	Percent
Strongly Agree	9	75.00%
Agree	2	16.67%
Neutral	1	8.33%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**12**	**100.00%**

11. I believe that the home safety program failed to address all of the hazards accessible to my children in my home

Opinion	Number	Percent
Strongly Agree	1	8.33%
Agree	4	33.33%
Neutral	7	58.33%
Disagree	0	0.00%
Strongly Disagree	0	0.00%

Total	**12**	**100.00%**

12. Since the training program, my child has been involved in a household accident

Opinion	Number	Percent
Never	12	100.00%
Once	0	0.00%
Twice	0	0.00%
Three times	0	0.00%
Four or More	0	0.00%
Total	**12**	**100.00%**

Rate how useful each of these items were in helping you benefit from the services you received:

1. Counselor's explanations

Opinion	Number	Percent
Useful	12	100.00%
Somewhat Useful	0	0.00%
OK	0	0.00%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**12**	**100.00%**

2. Counselor's demonstrations

Opinion	Number	Percent
Useful	12	100.00%
Somewhat Useful	0	0.00%
OK	0	0.00%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**12**	**100.00%**

3. Practice during sessions

Opinion	Number	Percent
Useful	11	91.67%
Somewhat Useful	1	8.33%
OK	0	0.00%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**12**	**100.00%**

4. Practice outside of sessions

Opinion	Number	Percent
Useful	12	100.00%
Somewhat Useful	0	0.00%
OK	0	0.00%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**12**	**100.00%**

5. Counselor's feedback

Opinion	Number	Percent
Useful	12	100.00%
Somewhat Useful	0	0.00%
OK	0	0.00%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**12**	**100.00%**

6. Safety Supplices

Opinion	Number	Percent
Useful	12	100.00%
Somewhat Useful	0	0.00%
OK	0	0.00%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**12**	**100.00%**

Rate the counselor who conducted the Health Training program:

1. Was warm and friendly

Opinion	Number	Percent
Strongly Agree	12	100.00%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**12**	**100.00%**

2. Was helpful

Opinion	Number	Percent
Strongly Agree	12	100.00%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**12**	**100.00%**

3. Gave clear explanations

Opinion	Number	Percent
Strongly Agree	12	100.00%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**12**	**100.00%**

4. Was knowledgeable

Opinion	Number	Percent
Strongly Agree	12	100.00%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**12**	**100.00%**

5. Was negative or critical

Opinion	Number	Percent
Strongly Agree	1	8.33%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	1	8.33%
Strongly Disagree	10	83.33%
Total	**12**	**100.00%**

6. Treated me fairly

Opinion	Number	Percent
Strongly Agree	12	100.00%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**12**	**100.00%**

7. Was willing to spend extra time when I needed it

Opinion	Number	Percent
Strongly Agree	12	100.00%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**12**	**100.00%**

8. Kept our scheduled appointments

Opinion	Number	Percent
Strongly Agree	12	100.00%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**12**	**100.00%**

9. Was on time to scheduled appointments

Opinion	Number	Percent
Strongly Agree	12	100.00%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%

Total	**12**	**100.00%**

10. Spent too much time looking around my home

Opinion	Number	Percent
Strongly Agree	2	16.67%
Agree	0	0.00%
Neutral	1	8.33%
Disagree	2	16.67%
Strongly Disagree	7	58.33%
Total	**12**	**100.00%**

PARENT-INFANT INTERATION SATISFACTION QUESTIONAIRE

1. The parent-infant interaction program has improved my relationship with my infant

Opinion	Number	Percent
Strongly Agree	2	29%
Agree	5	71%
Neutral	0	0%
Disagree	0	0%
Strongly Disagree	0	0%
Total	**7**	**100%**

2. I feel more patience toward my infant

Opinion	Number	Percent
Strongly Agree	3	42.86%
Agree	3	42.86%
Neutral	1	14.29%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

3. I would like more information and training in the parent-infant interactions program

Opinion	Number	Percent
Strongly Agree	0	0.00%
Agree	6	85.71%
Neutral	1	14.29%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

4. I enjoy the time I spend with my infant more now than before training

Opinion	Number	Percent
Strongly Agree	4	57.14%
Agree	2	28.57%
Neutral	1	14.29%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

5. My infant seems to enjoy playing together more now than before the training

Opinion	Number	Percent
Strongly Agree	2	28.57%
Agree	4	57.14%
Neutral	1	14.29%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

6. I have not experienced any differences in the way I interact with and play with my infant

Opinion	Number	Percent
Strongly Agree	2	28.57%
Agree	3	42.86%
Neutral	2	28.57%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

7. I would recommend the Parent-Infant Interactions Program to other parents

Opinion	Number	Percent
Strongly Agree	4	57.14%
Agree	3	42.86%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

Rate how useful each of these items were in helping you benefit from the services you received:

1. Counselor's explanations

Opinion	Number	Percent
Useful	6	85.71%
Somewhat Useful	0	0.00%
OK	0	0.00%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**6**	**85.71%**

2. Counselor's demonstrations

Opinion	Number	Percent
Useful	5	71.43%
Somewhat Useful	1	14.29%
OK	0	0.00%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**6**	**85.71%**

3. Practice during sessions

Opinion	Number	Percent
Useful	5	71.43%
Somewhat Useful	1	14.29%
OK	0	0.00%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**6**	**85.71%**

4. Practice outside of sessions

Opinion	Number	Percent
Useful	5	71.43%
Somewhat Useful	1	14.29%
OK	0	0.00%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**6**	**85.71%**

5. Counselor's feedback

Opinion	Number	Percent
Useful	5	71.43%
Somewhat Useful	1	14.29%
OK	0	0.00%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**6**	**85.71%**

6. Written Checklists

Opinion	Number	Percent
Useful	4	57.14%
Somewhat Useful	2	28.57%
OK	0	0.00%
Slightly Useful	0	0.00%
Useless	0	0.00%
Total	**6**	**85.71%**

Rate the counselor who conducted the Health Training program:

1. Was warm and friendly

Opinion	Number	Percent
Strongly Agree	6	85.71%
Agree	1	14.29%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

2. Was helpful

Opinion	Number	Percent
Strongly Agree	6	85.71%
Agree	1	14.29%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

3. Gave clear explanations

Opinion	Number	Percent
Strongly Agree	6	85.71%
Agree	1	14.29%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

4. Was knowledgeable

Opinion	Number	Percent
Strongly Agree	6	85.71%
Agree	1	14.29%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

5. Was negative or critical

Opinion	Number	Percent
Strongly Agree	3	42.86%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	1	14.29%
Strongly Disagree	3	42.86%
Total	**7**	**100.00%**

6. Treated me fairly

Opinion	Number	Percent
Strongly Agree	6	85.71%
Agree	1	14.29%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

7. Was willing to spend extra time when I needed it

Opinion	Number	Percent
Strongly Agree	5	71.43%
Agree	1	14.29%
Neutral	1	14.29%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

8. Kept our scheduled appointments

Opinion	Number	Percent
Strongly Agree	6	85.71%
Agree	0	0.00%
Neutral	1	14.29%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

9. Was on time to scheduled appointments

Opinion	Number	Percent
Strongly Agree	7	100.00%
Agree	0	0.00%
Neutral	0	0.00%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**

10. Interacted well with my child

Opinion	Number	Percent
Strongly Agree	5	71.43%
Agree	1	14.29%
Neutral	1	14.29%
Disagree	0	0.00%
Strongly Disagree	0	0.00%
Total	**7**	**100.00%**