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

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

## Findings from Year 4 of the Strong Foundations Evaluation

Julie Spielberger
Elissa Gitlow
Carolyn Winje
Allen Harden

2014

Building a System of Support for Evidence-Based Home Visitation Programs in Illinois: Findings from Year 4 of the Strong Foundations Evaluation

Julie Spielberger, Elissa Gitlow, Carolyn Winje, Allen Harden

**Recommended Citation**

Spielberger, J., Gitlow, E., Winje, C., & Harden, A. (2014). Building a System of Suppor*t for Evidence-Based Home Visitation Programs in Illinois: Findings from Year 4 of the Strong Foundations Evaluation.* Chicago: Chapin Hall at the University of Chicago.

ISSN: 1097-3125



Chapin Hall
at the University of Chicago
1313 East 60th Street
Chicago, IL 60637

773-753-5900 (phone)
773-753-5940 (fax)

www.chapinhall.org

## Acknowledgments

We would like to acknowledge several individuals and organizations that made this report possible. We appreciate the staff of the 15 home visitation programs who participated in this study. Although for reasons of confidentiality we cannot name them here, they welcomed us to their programs and openly gave of their time and information. We also thank the state leaders and participants in the initiative, including representatives of the Illinois Department of Human Services, the Illinois State Board of Education, the Illinois Department of Children and Families, the Ounce of Prevention Fund, and Voices for Illinois Children, among others who provided information and perspectives on the initiative. At Chapin Hall, we benefited from early guidance from Neil Guterman, who served as co-principal investigator for the first year and a half of the evaluation, as well as from members of an advisory group—Deborah Daro, Sydney Hans, Jon Korfmacher, and Cheryl Smithgall. We especially want to thank Adi Barak and Aaron Banman for their assistance with the analysis of data for this report. Finally, we are grateful to the Children's Bureau and the Illinois Department of Human Services for supporting this evaluation.

## Table of Contents

## List of Figures

## List of Tables

# Executive Summary

This report is the fourth in a series of reports documenting the work of Strong Foundations, Illinois's Evidence-Based Home Visiting (EBHV) initiative, which began in the fall of 2008 and concluded in the fall of 2013. Illinois was one of 17 grantees in 15 states to receive funding from the Children's Bureau to develop infrastructure to support the implementation, scale up, and sustainability of evidence-based home visiting programs for the prevention of child maltreatment. The Illinois Department of Human Services (IDHS) collaborated with the Illinois State Board of Education (ISBE), the Illinois Department of Children and Family Services (DCFS), and the Home Visiting Task Force (HVTF) of the Illinois Early Learning Council (ELC) to plan and implement Strong Foundations. IDHS contracted with Chapin Hall for the local evaluation.

The primary purpose of Strong Foundations was to enhance and strengthen the state infrastructure—governance, funding, monitoring and quality improvement, and training and technical assistance—that supports close to 200 evidence-based home visiting programs in Illinois. The initiative's underlying assumption was that a well-functioning and effective infrastructure at the state level will support and be reflected in a well-functioning and effective local system and the successful operation of program sites. Furthermore, if programs operate successfully, they will produce long-term positive outcomes for maternal life course, child development, and the prevention of child maltreatment that are similar to those observed in randomized controlled trials of evidence-based programs. Based on these assumptions, the two main goals for Strong Foundations were to implement activities to strengthen the infrastructure of supports for home visiting programs in Illinois and to ensure that programs operate with fidelity to their model and are supported with necessary training and resources. Although the long-term goal was to strengthen support for all evidence-based home visiting programs in the state, the initiative focused on three models of evidence-based home visiting programs in Illinois—Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP).

### Research Questions and Methods

The evaluation examined three areas: the state system, community partnerships, and program quality and fidelity. The primary research areas and questions for the evaluation were the following:

- **State system.** To what extent do state partners in the Strong Foundations initiative collaborate and implement an effective state infrastructure to support evidence-based home visiting programs? How do they address, for example, governance, funding, monitoring and quality assurance, and training?
- **Community partnerships.** How are communities supported and assisted by the state infrastructure in selecting evidence-based home visiting programs to meet the needs of families and in delivering services effectively?
- **Program implementation, quality, and fidelity.** Are home visiting programs being implemented and delivered in a way that is faithful to their program model? Do they address staff selection, training, and supervision; engagement, participation, and retention of families; intensity, length, and frequency of services; and links to other community services?

To address these questions, we designed a mixed methods evaluation with three primary components: (1) a process evaluation of the state infrastructure; (2) a study of training and professional development activities sponsored by Strong Foundations; and (3) an administrative data study of program performance, capacity, and fidelity indicators based on program records.

## Key Findings and Conclusions

In sharing key findings from the last year of the initiative, it should be noted that describing and evaluating a dynamic state infrastructure in the context of shifting system boundaries and relationships is no simple task. Since the start of Strong Foundations, important external factors have affected every level of the home visiting system in Illinois. These factors have presented both challenges and opportunities. They included an uncertain state economic climate and, specifically, budget crises in state fiscal years (SFY) 2010 and 2011; unexpected cuts to federal funding for Strong Foundations as part of a Congressional budget reconciliation process in late 2009; the creation of the Governor's Office of Early Childhood Development (OECD) in 2009; leadership shifts at IDHS, ISBE, DCFS, and OECD; and new federal initiatives such as the Maternal Infant Early Childhood Home Visiting (MIECHV) program in 2011 and the Race to the Top Early Learning Challenge (RTT ELC) in 2013.

Following an intensive planning year, participants in the Strong Foundations initiative implemented a variety of infrastructure-building strategies. We observed growth in the home visiting system in several areas, especially in the areas of leadership and governance, state-level collaboration and partnerships, and professional development and training. Strong Foundations also laid a foundation for considerable growth in other areas of the system that were the focus of the subsequent MIECHV grant, including continuous

quality improvement, community systems development, and sustainability. We also saw a number of ongoing challenges for the system—for example, in developing common monitoring and reporting requirements across program models and strengthening local service systems. We also observed how system-building and program implementation are affected by the larger political, social, and economic context, although the state system was able to be flexible and resilient in responding to both economic challenges and new resources.

## Leadership and Governance

Home visiting initiatives need strong leadership and strategic thinking in order to ensure home visiting strategies are represented and leveraged in other early childhood development systems initiatives in Illinois. Over the 5 years of Strong Foundations, there was a growing recognition of the value of partnerships and collaboration and the need to reduce silos for monitoring and reporting. Beginning with Strong Foundations and continuing with MIECHV, we saw a formalization occur within state-level partnerships that has resulted in an improved mutual understanding of goals and issues and has deepened relationships. The HVTF broadened its executive committee to ensure that it included representatives from all state and city agency funders who receive home visiting funding.

Analysis of interviews, surveys, and other data since the beginning of Strong Foundations reveals the extent to which this ability to come together has increased coordination and communication among system leaders and stakeholders at other levels of the system. When the initiative began, despite the long history of partnership in Illinois, stakeholders reported that home visiting was "siloed" by funding streams and program models, which, in turn, impeded cross-model communication and coordination of efforts. Although funding streams remain separated,[1] over the course of the evaluation informants reported that they have observed growth in levels of awareness of the different agencies that support home visiting programs, better understanding of other program models, and better coordination of efforts to advance the home visiting field in Illinois. More regular communication and increasing efforts to collaborate have also increased organizational and system resiliency. We observed greater shared understanding about what makes a good home visiting program and the infrastructure needed to support high quality services. Our informants also expressed greater confidence in the leadership and governance of the system, including the individuals who currently represent the public and private organizations responsible for implementation of home visiting services and oversee the development of the infrastructure.

[1] One informant commented that "siloed funding through separate line items and budget [is] a strength, not a weakness, of the system. To be significantly in two state agency budgets, as well as taking advantage of every federal initiative that we can, strengthens the potential for sustainability in funding."

## Community Systems Development

When Strong Foundations began, the HVTF's Community Systems Development Work Group was responsible for local and regional collaboration, community planning, and site development. In 2012 these responsibilities were incorporated into the ELC's Systems Integration and Alignment Committee (SIAC) and its Community Systems Development Subcommittee (CSDS). The CSDS currently serves as an advisory body for community systems work that is being implemented statewide through various grants and projects, including the recently completed SAC grant, the Strong Foundations Partnership (Strong Foundations and MIECHV), and the RTT ELC grant.

The CSDS also advises the HVTF on its work to enhance community systems, particularly improving coordination between home visiting programs at the state and local levels, and between home visiting programs and other community level services for children and their families. In SFY 2013, much of this work focused on community systems and collaboration within the MIECHV communities.

## Training and Professional Development

Training is a highly valued piece of the state infrastructure in the Illinois home visiting system, and developing the state's home visiting workforce has been a focus since the beginning of Strong Foundations. Through the initiative, Illinois offered training in four topics—domestic violence, substance abuse, perinatal depression, and young adults with learning challenges (YALC)—to any home visiting staff member regardless of their home visiting model. For the last 2 years, the Strong Foundations training umbrella also offered the Happiest Baby on the Block (HBOB) self-study certification program and Strengthening Families trainings on Protective Factors and Understanding Trauma. In the final year, SFY 2013, supervisor learning communities were added to increase content knowledge and strategies for providing effective supervision to home visitors around the topics of YALC and the Strengthening Families trainings. Analysis of pretest, posttest, and 3-month follow-up surveys from participants in the home visitor and supervisor trainings showed that overall attendees were pleased l with the quality of the training and its applicability to their work.

Nonetheless, although the trainings were well received, attendance at some of the trainings was disappointing, especially in the last 2 years of the initiative. Thus, in the final year, a decision was made to convert the four foundational training topics to an online series entitled "Home Visiting Challenges." The rollout of the online format will begin with the perinatal depression training, followed by domestic violence and substance abuse. Currently there are no plans to put the YALC training into an online format. Because of funding constraints, changes to home visiting curricula, and low enrollment, Supervisor Learning Communities trainings also will no longer be offered in the cross-model format implemented under Strong Foundations; rather they will be offered in a model specific format for home

visitor supervisors. Though there are valid reasons for these changes, one concern is that they might weaken progress made towards the original Strong Foundations goals of implementing common, evidence-informed, cross-model practices for working with families.. Still, evaluation results also suggest that Strong Foundations has helped to create a "culture of training and ongoing learning" that is increasingly being integrated into home visiting programs.

## Financing and Sustainability

Financing and sustaining Illinois's home visiting infrastructure and programming is complex. Since the beginning of the Strong Foundations initiative, Illinois has been experiencing a severe budget crisis. Despite over two decades of investment in research-based home visiting, funding remains a core challenge to sustaining home visiting infrastructure and programs. To address this vital issue, the HVTF's Sustainability Work Group was charged with maximizing sustainable funding opportunities. Members of the group met numerous times in SFY 2013 in order to seek solutions to the funding situation and review their ongoing work, which included exploring different ways to bill Medicaid for some home visiting services.

The ability to leverage new federal opportunities, such as President Obama's new Preschool for All initiative and a grant to organize the trauma-informed practice field for birth to three years olds, is considered an important support for the home visiting system. However, some informants expressed concern about relying too much on federal funding. Increasing public awareness is also viewed as vital to sustainability efforts.

## Program Implementation

Understanding the quality of program implementation is important for understanding the likelihood that evidence-based home visiting programs will achieve expected outcomes. Data for the evaluation on program implementation came from several sources—surveys and program records of our sample of 15 local home visiting programs and state-level administrative data for PAT and HFI[2] programs. Because only the HFI administrative data allowed us to analyze trends in program implementation and client characteristics over a period of time that began before the implementation of Strong Foundations, we focus on these trends in this report, highlights of which are included below.[3]

Over a period of 8 years (SFY 2006 to SFY 2013), there were modest changes in client characteristics and service delivery. The total number of families served increased between SFYs 2006 and 2009, but then declined. The percentage of cases located in Chicago also increased during this period, while the

[2] Healthy Families Illinois (HFI) is the name for programs in the state using the HFA model.
[3] See Spielberger, Gitlow, Winje, Harden, & Banman (2013) for the analysis of other program implementation data.

percentage of downstate cases declined. There was a corresponding increase in Hispanic clients and a decrease in white clients over time. Across the years, HFI programs successfully engaged mothers prenatally in about one-half of all cases. However, there was a clear positive trend towards increasing prenatal cases over time. In addition, program duration was longer and retention was greater for cases with prenatal enrollment than for cases enrolled after the baby's birth.

For most of the 8 years, between 80 and 90 percent of the planned home visits took place, with the lower completion levels occurring in programs in Chicago. At the time of the SFY 2010 (summer 2009) fiscal crisis, the completion level in Chicago dropped to its lowest level; however by SFY 2013 the visit completion rate for Chicago sites was higher than it was in the other regions. In contrast, programs in the other regions of the state showed a relatively small decrease in completed home visits during the fiscal crisis and, after that period, slower growth than in Chicago. Although the final result of these changes was small in terms of the reduced number of clients served, the fluctuations in enrollment and caseloads raise questions about the system's ability to provide stable services to families during uncertain economic times.

## Conclusions

During the 5 years of Strong Foundations, the state strengthened the infrastructure for evidence-based home visiting programs in several key areas—leadership and governance, collaboration and partnerships, training and professional development, and community systems development. Most visible was the development of the collaborative governance structure and communication processes that were evident in the HVTF, its executive committee, and a number of work groups focused on strengthening different infrastructure components. Another important strategy area was workforce development, particularly the development of cross-model training to enhance the professional skills of home visitors and supervisors working with high-risk families throughout the state. These and other strategies have heightened the visibility of home visitation as an important service for improving outcomes for vulnerable families and children. They also have helped to make home visiting an integral part of Illinois' early childhood system and better able to respond to funding and other resource challenges.

In the final year of the initiative, state informants continued to be optimistic about the increasing collaboration among the main state agencies involved in the home visiting system. Their confidence reflects the progress—described in this report—towards the vision of the original Strong Foundations plan for shared leadership and accountability among these organizations. Most stakeholders credited Strong Foundations with providing many of the initial supports needed to apply for and then implement MIECHV and keeping system-building as an integral part of efforts to expand services and improve the quality of program implementation. At the same time, our informants emphasized, system stakeholders

have to be careful and intentional in ensuring that home visiting issues continue to be integrated with other domains of the early child development system. In this regard, the HVTF and the HVTF Executive Committee play important roles in both allowing the state system to attend to needs in other areas of the system (e.g., the implementation of the RTT ELC grant) and making sure that home visiting is not a neglected part of the overall vision of the early childhood development system.

They also recognized the challenges to the state's home visiting system. Although Strong Foundations increased structures and processes for responding to funding and other resource challenges, insufficient resources continue to strain the system. There is still room to improve the training system and expand the reach, breadth, and depth of training. Improving communication at all levels of the system and strengthening community systems are some of the improvement efforts that are ongoing. There are also remaining challenges to improving the reach and quality of services, particularly in engaging and retaining high-risk families and ensuring families are connected to mental health and other needed services.

Bringing quality services to all communities in a large state—making efficient use of all the available resources and sources of talent, ensuring consistent quality of service, reaching the full range of racial and ethnic groups, and focusing particular attention on the most underserved families and regions—is an enormous strategic, organizational, and logistical task. Our analysis of administrative data, which showed some fluctuations in services around the time of the SFY 2010 fiscal crisis, suggested the importance of continuing to monitor trends in services over time to see whether the system, as it grows stronger, is less likely to experience fluctuations like these. Monitoring trends in a comprehensive way will require more integrated data on key indicators of quality and family characteristics.

# Introduction

This report is the fourth in a series of reports documenting the work of Strong Foundations, Illinois's Evidence-Based Home Visiting (EBHV) initiative. The initiative began in the fall of 2008 with a year of planning. That was followed by 4 years of implementation. The initiative concluded in the fall of 2013. Funded by the Children's Bureau, Illinois was one of 17 grantees in 15 states to receive funding for 5 years to develop infrastructure to support the implementation, scale up, and sustainability of evidence-based home visiting programs for the prevention of child maltreatment. Each grantee was expected to conduct local implementation and outcome evaluations, along with an analysis of program costs, and contribute information to a national cross-site evaluation. The Illinois Department of Human Services (IDHS) collaborated with the Illinois State Board of Education (ISBE), the Illinois Department of Children and Family Services (DCFS), and the Home Visiting Task Force (HVTF) of the Illinois Early Learning Council (ELC) to plan and implement Strong Foundations and contracted with Chapin Hall for the local evaluation.

As initially set out, the focus of the Strong Foundations planning and implementation efforts differed from the majority of the other grantees. Whereas most states focused on expanding services, either by starting new programs or enhancing existing programs, Strong Foundations focused its efforts on enhancing the existing infrastructure for the hundreds of home visiting programs in Illinois. The two overarching goals for the Strong Foundations initiative were to implement activities to strengthen the infrastructure of supports for home visiting programs in Illinois and to ensure that these programs operated with fidelity to their models. Although Strong Foundations specifically focused on three home visiting models—Healthy Families America (HFA), Nurse Family Partnership (NFP), and Parents as Teachers (PAT)—the overall goal was to enhance the state's infrastructure for the benefit of all evidence-based and evidence-informed models and to create a "big tent" for the state's home visiting stakeholders.

The HVTF was charged with advising the three state agency partners on Strong Foundations—IDHS, ISBE, and DCFS. The HVTF has grown from an 80-member body to one with close to 200 participants during the period of Strong Foundations. It originally formed six work groups to address the areas of infrastructure on which the initiative would focus: funding strategies, technical assistance to communities, monitoring and quality assurance, special needs training, public awareness, and research and evaluation (Illinois Department of Human Services, 2009). Over time, especially with the implementation of the federal Maternal, Infant, Early Child Home Visitation (MIECHV) program, this structure has changed. As of the writing of this report, there are three active HVTF committees: the Executive Committee, the Health Connections Committee, and the Sustainability Committee. There is also ongoing work on other ELC committees and subcommittees that impact home visiting, including the Community Systems Development Subcommittee (CSDS) of the System Integration and Alignment Committee (SIAC). Many of the 16 key state-level stakeholders interviewed for this year's report see the work in the six communities selected to receive support through the MIECHV program as a pilot for home visiting programs throughout the state. Much of the MIECHV work addresses infrastructure development, such as professional development, community systems building, continuous quality improvement, and service coordination. This report offers insight into the status of Illinois's evolving home visiting infrastructure.

## Evaluation Approach

Conducting a process evaluation of a state infrastructure initiative has presented many challenges, not the least of which has been reporting on a dynamic system. As Hargreaves (2010) underscores, system evaluations must be conducted with an understanding of "the system's boundaries, relationships, perspectives, dynamics, and ecological levels." Since the start of this evaluation in 2009, there have been major changes that impact every level of home visiting work in Illinois, and, indeed, the larger early childhood development system of which home visiting is a part. Examples of such change include: the state's uncertain economic climate and budget crisis;[4] unexpected, substantial funding cuts to the EBHV initiative as part of a Congressional budget reconciliation process in December 2009; the creation of the Governor's Office of Early Childhood Development (OECD) in 2009;[5] leadership changes at IDHS, ISBE, DCFS, and OECD; and other federal early childhood development system opportunities such as the Race to the Top Early Learning Challenge (RTT ELC) and MIECHV. Describing and evaluating a system with so many moving parts is not a simple, straightforward task.

[4] The state's budget crisis has significantly impacted home visiting programs. For example, in both state fiscal year 2010 (SFY 2010) and SFY 2011, two major funding streams for home visiting programs were subject to 10 percent cuts.
[5] While the OECD was created in 2009, it was not fully staffed for the Strong Foundations Partnership until 2012.

Our approach to the evaluation of Illinois's home visiting infrastructure was guided by the original logic model for Strong Foundations (see Appendix A); the "Healthy Families America State Systems Development Guide" (Healthy Families America, 2003) and its companion, "Home Visiting State Systems Development Assessment Tool," which was revised at the end of 2009 by the HVTF (see Appendices A and B); and by the actual work of the HVTF (and its sister ELC committees) as it unfolded over time. During the last two years of the evaluation, we also introduced the concept of resiliency in our key informant interviews. Recent research suggests that resiliency is an important factor to consider as part of an evaluation of systems and has identified several key characteristics of highly resilient organizations/systems (BUILD Initiative, 2011). These characteristics include the capacity to monitor internal and external indicators of change in order to identify disruptions in advance and be prepared for them; flexibility in terms of rules, funding streams, and leadership roles to help protect against changes or shifts in support; a culture of continuous innovation; and strong and extensive communication networks.

A multiyear evaluation affords the opportunity to review changes and progress, as well as any setbacks that have occurred, and use the experience to develop lessons. We approach this report hoping to do each of these things. We also want to evaluate the resiliency of the home visiting infrastructure. We will discuss many examples of how Illinois's home visiting infrastructure is resilient, but also examples indicating there is still room for improvement.

## Research Questions and Methods

The evaluation focuses on three models of evidence-based home visiting programs in Illinois: Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP). Our research questions addressed three primary areas:

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

To address these questions, we designed a mixed methods evaluation with three primary components, as follows:

- A process evaluation of the state infrastructure using the methods of (a) annual interviews and, in 2012 and 2013, a structured survey of collaboration factors; (b) interviews and surveys of program supervisors and directors of 15 local programs in different regions of the state in 2010, 2011, and 2012; (c) surveys of home visitors in the 15 programs in 2010, 2011, and 2012; (d) focus groups with the same home visitors in 2010 and 2012; and (e) three additional focus groups with a sub sample of home visitors to validate findings about how home visitors build relationships with families. In addition, we observed selected meetings of the HVTF and its subcommittees and conducted reviews of meeting minutes and other project materials.
- Surveys and interviews of participants in training and professional development activities sponsored by Strong Foundations.
- An administrative data study of program performance, capacity, and fidelity indicators based on program records of the 15 local programs and state data systems for Healthy Families Illinois (HFI) and PAT. [6]

The process evaluation used a purposeful sampling strategy (Coyne, 1997), which meant that the sample varied somewhat year to year depending on who was involved at different levels of the home visiting system. At the state level, a total of 32 informants representing public and private agencies involved in the implementation of home visiting programs and supports were interviewed during the course of the study period. Of those, eight informants were interviewed during all 4 years; one person was interviewed 3 of the 4 years; eleven people were interviewed 2 of the 4 years; and 12 people were interviewed only once.

At the local level, there were two waves of qualitative data collection with home visitors, supervisors, and program directors—one in the spring of 2010 (Wave 1) and one in the spring of 2012 (Wave 2). The combined sample from both waves consisted of 88 individual home visitors. The Wave 1 sample was made up of 67 home visitors: 26 home visitors from HFI, 27 from PAT, and 14 from NFP. During the second wave, the sample consisted of 66 home visitors, 26 home visitors from HFI, 27 from PAT, and 13 from NFP. The 2012 sample had 21 new participants and 45 who had been interviewed previously. Eighteen of these home visitors (four HFA staff members, seven PAT staff members, and seven NFP staff members) participated in a validating focus group in the spring of 2013.

In addition, Strong Foundations was also part of the Mathematica Policy Research-Chapin Hall national cross-site evaluation. More information about the evaluation methods can be found in previous reports.

[6] Healthy Families Illinois (HFI) is the name for programs in the state using the HFA model.

## Overview of this Report

This report draws primarily from interviews conducted in 2013 with 16 state-level informants, administrative data on HFI program services over the past 5 years, and surveys of staff who participated in trainings during SFY 2012 and SFY 2013. (It also references findings from previous years.) In the next chapter, we discuss perspectives on the state system. These perspectives include home visiting as a strategy and component of the broader early childhood development system; leadership, governance, and partnerships; and monitoring, fidelity, and continuous quality improvement. A large part of Strong Foundations and the evaluation focused on improvements to the professional development component of the infrastructure. In the third chapter, we present findings related to training and professional development. In the fourth chapter, we turn to the topic of program implementation, quality, and fidelity to assess how well the state infrastructure supports local programs, based on an analysis of administrative data on HFI programs. The final chapter offers conclusions about the growth of the system supporting home visiting programs in Illinois and implications for future system-building activities.

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

"Strong Foundations set the stage for us to start
even looking at ourselves as a partnership."
*~State level EBHV stakeholder (2013)*

In this chapter, we discuss the state's theory of change in developing infrastructure to support evidence-based home visiting programs. We also discuss the context in which the infrastructure is being developed, including its leadership and administration of the home visiting system. This section draws largely from 16 key informant interviews conducted in the spring of 2013; a concurrent survey on collaboration factors; observations of home visiting-related meetings; and documents created by the HVTF, the OECD, and the ELC.

To better understand the state's theory of change, we begin with a brief overview of recent developments in the state context in which the system operates. During the past 5 years, since the early days of the Home Visiting Task Force and the start of the EBHV Strong Foundations initiative, there have been many changes within the state's early childhood development system. These changes have occurred across a number of spheres that impact the ongoing development of the infrastructure that supports home visiting. Examples of such changes include the ELC's recently developed strategic plan and the corresponding changes to its committee structure; changes within key leadership positions at a number of state level agencies; developing lines of work through Race to the Top Early Learning Challenge (RTT ELC), MIECHV, and other funding opportunities; and the establishment of the OECD. All of this activity indicates that the creation and strengthening of an infrastructure that supports home visiting does not and

cannot happen in a vacuum. In other words, an assessment of the current status of the system components that were influenced by Strong Foundations over the past 5 years must take into account the changing landscape of Illinois's early childhood development system during that period.

## Home Visiting as Part of the Early Childhood Development System

Home visiting is one of a number of strategies employed by early childhood development stakeholders to improve outcomes for children, their families and communities. One informant emphasized this in her interview.

> Home visitation is a key strategy that should be used in the work that's being done around early childhood regardless of what the focus is. The visual I draw is one great big arrow that has all of these other arrows going in different directions inside it. The key point being that you want the family to be safe and healthy, and that's the big arrow. There are all of these other things happening inside [the big arrow] though. Home visitation is one strategy that you can use to pull it all together.

Several informants referenced this sort of "filtering" of a home visiting strategy across the various early childhood spheres.

> Home visiting is part of the larger picture. The Early Learning Council then makes the connection between home visiting and other early learning approaches that the state is committed to, such as center based, Head Start, childcare, basically any setting where young children are.

As part of the interview protocol in SFY 2014, respondents were asked about their perceptions of home visiting's role within the ELC and any observed changes in its role over the last 5 years. By and large, respondents agreed that home visiting was much more "knitted into the fabric" of the full early childhood development system than it has ever been. This view is illustrated by the following excerpts from two informant interviews:

> Home visiting used to stand very separately from the early childhood education field because that was always thought to be [center-based work]. And now … it's seen as very much part and parcel of the same. You've got the parent right there to be the child's teacher and you're the parent's coach. The two [spheres] seem to be drifting towards each other and now I think it is seen as two wings of the same bird.

> [Home visiting is] definitely more knitted into everything; if you look back 4 years, there's no question about it. We had a long discussion when we were restructuring the Early Learning Council about whether the Home Visiting Task Force was at the level of a standing committee and it was decided that it was. We're as wedded as we can be. Of course it's a continuous process and part of it is driven by the federal agenda. And the President's proposal has made it clear that home visiting is a birth to three strategy. The president's proposal is going to give even more stature to home visiting.

Respondents were well aware that much of the increased integration of home visiting into the early childhood system was the result of MIECHV as well as its predecessor, Strong Foundations. As one observed, "I think part of it is the fact that MIECHV has created a lot of activity and attention to home visiting in our state. The Home Visiting Task Force has a more prominent role in the Early Learning Council, whereas before it was part of a birth to three systems group." Our informants also recognized that although there is more awareness of home visiting and the connection between home visiting and other early childhood development domains is stronger than it was 5 years ago, the connection is not seamless. There is still work to do. As one informant indicated, stakeholders need to continue to represent home visiting perspectives and goals at the various early childhood development tables.

> The MIECHV grant ensured that the Home Visiting Task Force remained intact. We must be thoughtful as we work in these [ELC] work groups because some areas of work have shifted under different areas. We have to make sure that we work horizontally and think creatively. It's our responsibility to make sure that our sister work groups know our information.

Several respondents echoed this view. They indicated that despite, or perhaps because of, the existence of the HVTF, stakeholders have to be careful to ensure that home visiting issues continue to be integrated with other ongoing work and do not become, in the words of some informants, "siloed" again.

> We are at a point of needing to be careful and intentional. It's how we make sure that next steps continue to integrate, versus split or polarize. Because home visiting has its own management structure, you can see how Home Visiting Task Force conversations are very different from those that happen at any other ELC committee. But we don't want to make it so that people have it in their minds that [only] the Home Visiting Task Force will worry about [home visiting issues].

> Home visiting has a really prominent place in the Early Learning Council among all of the current aspects of the early childhood system in Illinois. It's important just to be considered equal to all of those other types of programs. Also, I think the fact that it is connected to a grant program makes it a little more powerful and [autonomous] because the ELC has a very specific structure and way of doing things. Because the Home Visiting Task Force is the strategic advisory body it has the unique opportunity to influence down and also raise issues up from the field and change policy based on that.

In addition, respondents made the point that the state's focus on the Race to the Top Early Learning Challenge (RTT ELC) during the past 2 years is another reason home visiting stakeholders need to continue to be intentional about ensuring home visiting is integrated into the early child development system. As they explained, on the one hand, the presence of the HVTF allows the RTT ELC to focus on other aspects of the RTT implementation plan, such as the state's new Quality Rating and Improvement System (QRIS). On the other hand, the HVTF also makes sure that home visiting is still part of the overall vision of the early childhood development system. As one informant stated, "Most of the [Race to the Top

Early Learning Challenge] funding goes to QRIS and doesn't include home visiting. Right now [the ELC] is very focused on Race to the Top." Another informant echoed this view that "the agenda of the Early Learning Council is heavily driven by the Early Learning Challenge right now." Yet, as a third informant explained:

> Illinois has a very strong, robust home visiting system, especially when compared to other states. However, I think that right now a lot of the [ELC] meeting content is about the Early Learning Challenge. But in people's minds home visiting is still important and that's why it's even more essential that we have the Home Visiting Task Force. My impression is that because the ELC knows that there is a Home Visiting Task Force that maybe they're freer to focus temporarily on implementing Race to the Top.

These statements reflect the view that home visiting initiatives need strong leadership and strategic thinking in order to ensure home visiting strategies are represented and leveraged in collateral early childhood work. The following section examines this area of the system in more depth.

## Leadership and Governance

As an example of how the early childhood system landscape has changed over the course of the Strong Foundations initiative, one can look to the Memorandum of Concurrence in support of the MIECHV program (Illinois Department of Human Services, 2011).[7] The ELC, along with the HVTF and its Executive Committee, the OECD, IDHS, ISBE, DCFS, Illinois Department of Healthcare and Family Services (HFS), and the Illinois Coalition Against Domestic Violence all signed on to the document, which delineates the expectations of the parties. This formalized agreement is a vast departure from the position taken at the outset of Strong Foundations. For example, the 2009 Strong Foundations implementation plan maintained that state collaboration did not require a memorandum of understanding:

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

Over the past 5 years, home visiting stakeholders have come to realize the value of formal agreements to increase accountability and shared understanding of quality. One informant explained:

[7] A Memorandum of Concurrence is a requirement of the MIECHV grant.

> There has been a more formalized approach to the public/private partnership through MIECHV and the home visiting work. It, across the board, increases quality and it increases everybody's understanding of what quality means in each program, so that we don't have one agency defining it one way and another agency defining it another way.

The Illinois Department of Human Services is the grantee for both the EBHV and MIECHV grants and therefore responsible for oversight and administration of the grants. The project director for the Strong Foundations Partnership works for the OECD and is responsible for the implementation of the two grants. When asked about leadership of home visiting initiatives in the state, the majority of stakeholders interviewed pointed to the shared work of the OECD's Strong Foundations Partnership and the HVTF Executive Committee. The Executive Committee itself is a collaboration, described by one informant as

> a public/private partnership that is led by the Governor's office, the Ounce of Prevention (the Ounce), and Voices [for Illinois Children] on behalf of a statewide collaboration that includes providers, advocates, state agencies, parents, community providers, city, local, and public partners, as well as university researchers and other private partners.

To ensure broader perspectives were represented, and to ensure equity on behalf of the 170 home visiting stakeholders of the HVTF, the HVTF's Executive Committee expanded during SFY 2013. The Executive Committee now includes the cochairs of the HVTF; the Strong Foundations Partnership Project Director (SFPPD); the acting chief of IDHS's Bureau of Childhood Development; the director of IDHS's Division of Family and Community Services; the director of IDHS's Division of Alcoholism and Substance Abuse; ISBE's Early Childhood Division administrator; the U.S. Department of Health and Human Services' (DHHS) Region V Office of Head Start program specialist; the new OECD executive director; the deputy director of the DCFS Office of Child Wellbeing; the deputy commissioner of Chicago's Department of Family and Support Services; and the early childhood officer of Chicago Public Schools. As a member of the Executive Committee explained:

> We wanted to make sure that we had representatives at the Executive Committee level from all of the funders of home visiting. Having representatives from all of the state and city agency funders who receive home visiting funding is really important because they have a lot of influence over decision making. So it's a very influential group, and I like that it's widely represented.

Given the current size of the full HVTF, the HVTF Executive Committee serves as a place "for those more substantive discussions," in the words of one informant. The Executive Committee meets before every HVTF meeting and creates much of the agenda for HFTV meetings. Another informant voiced appreciation for the Executive Committee's role in helping to implement the work of the Strong Foundations Partnership. The informant said, "The Home Visiting Task Force Executive Committee has

been wonderful. They've given us ways to reflect on our work. They've listened to us. They've problem solved with us and it's been a wonderful advisory body and we've got wonderful state leaders too."

Informants pointed to the Executive Committee as the body that conducts discussions on strategies and their implications. For example, the Executive Committee recognized the need to plan a comprehensive strategy for a sustained social media presence on home visiting. An informant described the Executive Committee's role in helping to strategize around such issues: "We're looking right now at social media, Facebook, a website for home visitors, and a website for all home visiting in general throughout Illinois. We are also looking at Twitter accounts, what would be necessary to sustain that social media, what we have to have day to day, and a general public awareness campaign."

The Executive Committee also serves an essential role in continuing to develop the state's home visiting infrastructure and sustaining partnerships. One informant stated the following:.

> By implementing MIECHV, the Governor's Office of Early Childhood Development continues to build through the Executive Committee and the Home Visiting Task Force a true interagency collaboration around really important questions about shared visions for the work, shared values, research, and program quality. There's really been a lot more communication on the [home visiting] program models and the funding streams. The Executive Committee, but also the full Task Force, serves as that forum.

Given the amount of work associated with the Strong Foundations Partnership, many of our interviews focused on leadership with regard to the MIECHV and EBHV initiatives. Our interviews particularly centered on the OECD as the agency responsible for implementation. The role is described on the OECD's website:

> The OECD provides support and leadership for an integrated system of early childhood services. It also coordinates and guides the work of the Early Learning Council (ELC) and provides overall coordination for the Strong Foundations Partnership (Home Visiting), convening the partners, ensuring that the work plan is accomplished and assuring that an adequate state-level infrastructure to support home visiting is maintained (Governor's Office of Early Childhood Development, 2014).

In light of these multiple roles, the OECD can help serve both as a "connector" between home visiting and other strategies pursued under the ELC, and as a "convener" of the various parties. For example, as one stakeholder noted:

> Having effective leaders in the OECD has been helpful, because it supports the interagency, intergovernmental approach that we want to take. You get the best leaders from each government agency. Leadership from the Governor's Office [OECD] helps convene and support that. We also use the Task Force and the private sector leadership to create another space where people are coming together.

Another informant described the OECD as "the sort of neutral party that could bring all of us together" and help stakeholders see the "common threads" across the different domains of the early childhood development system. A third respondent further noted that making the OECD responsible for implementing the two home visiting initiatives kept home visiting from being viewed as a "human services" program:

> It's a good thing with the advent of an OECD that we put our home visiting there. We could have decided to put it in IDHS and that could have undermined the idea that [home visiting stakeholders] are supposed to be working on the same things for the same population. It could have sent the impression that home visiting is only a human services issue versus an early childhood issue. We have to make sure we're working strategically. I think that messaging is good and becomes clear.

Thus far, we have focused on the roles of the Executive Committee and the OECD. This focus is not intended to diminish the important role of the full HVTF. As previously mentioned, the HVTF has grown substantially since it first began. It now has upwards of 170 participants from across the home visiting spectrum in Illinois. Several respondents noted that such a large committee presents an array of opportunities but also presents challenges. One informant described the opportunities and challenges as follows:

> The pluses are that [the HVTF] has representation from all over the state and from all levels of home visiting. There are parents and home visitors, all the way up to private funders; there are researchers and training teams; people who are thinking about specific parts of the state, and others who are thinking about specific aspects of home visiting—for example, community systems development; and we have people who are running programs and thinking about what their home visitors need to do their jobs better. The representation is awesome, and I'm always very impressed by the knowledge and expertise that people have. The other side of that coin is I wish more people had an opportunity to share their knowledge and that's hard to do in such big meetings.

At its most basic level, the HVTF is comprised of stakeholders who come together around a shared vision to stay abreast of quality initiatives and policy issues. The stakeholders also learn how their various home visiting components can work more effectively together for the betterment of children, families, and communities. An informant explained:

> The thing I love about the Task Force is that new people are constantly coming and every time we meet to teach the group and learn things. It is not a group that is appointed. They are there because they want to be there. I've always been impressed by how the group works for children and their families as a whole and everybody's not sitting there looking only for [their] piece of the pie.

The HVTF has served as an advisory body as well as a forum through which information is shared and connections strengthened. For instance, representatives of several MIECHV communities made

presentations about their work, challenges, and successes. Such presentations help disseminate information to a broad audience, but they also, in the words of one informant, are "evidence of communities coming together."

## Strengthening Leadership and Growing Partnerships

According to our informants, there is evidence of growing partnerships in the field of home visiting in Illinois since the start of Strong Foundations. There is also an increased understanding of shared goals and the impact of that on the field.. As noted by one informant, "Partnership has to be continually fed and nurtured or each government agency will revert back to their practice of making decisions independently. Partnership has to be constantly supported." Many stakeholders pointed to the forums for convening discussions around home visiting as the basis for the positive trend. One stakeholder said:

> Frankly, I think [our progress is the result of] having a forum at which to discuss these things and really having a framework. We always knew that the MIECHV communities were not the full story of home visiting in the state, but they offer a proving ground to talk about the issues that the Department of Human Services and the State Board of Education care about. The Home Visiting Task Force Executive Committee uniquely allows both entities to explore and share their values about this work, which is different from how we've worked before. There's more of an imperative for communication.

Some informants also noted that in addition to having regular structures or forums for meeting, the state's success is also the result of individual people who are committed to working together. One informant said:

> I'm always impressed by how people work together and really want to solve problem, and how people are able to be honest about what they think about a certain issue, and that there's no ramifications for expressing an opinion. Specifically [the Strong Foundations Project Director] and [the HVTF co-chairs] are really open to ideas and want to improve the home visiting system.

Analysis of interviews and notes since Strong Foundations began in 2009 reveal the extent to which this ability to come together has increased coordination among those in leadership roles and communication among stakeholders at different levels of the system. At the beginning of the initiative, despite the long history of partnership in Illinois, stakeholders reported that home visiting was siloed by funding stream and program model, and that there was a lack of coordination and communication across the funding streams and models. Funding streams remain separated.[8] However, over the 4 years of the evaluation our informants report that they have observed growth in levels of awareness of the different agencies that

[8] One informant commented that "siloed funding through separate line items and budget [is] a strength not a weakness of the system. To be significantly in two state agency budgets, as well as taking advantage of every federal initiative that we can, strengthens the potential for sustainability in funding.

support home visiting programs, understanding of other program models, and coordination of effort to advance the home visiting field in Illinois. As one informant told us, "Before this project, I guess I knew that [funding stream] had home visiting programs, but I didn't know much about theirs and they didn't know much about ours. Now we are saying this is ours." Another informant expressed a similar view:

> I think there's no doubt that there has been huge strides forward in terms of a recognition that [funding stream] is not the only game in town, and that they're not the only home visiting programs out there have goals for the families and communities. I think we have made huge progress in that shared understanding and the need to work together. I really do feel like we're on the cusp.

Several informants highlighted the relatively new, regular meetings of the various public agencies that support home visiting. One informant said:

> DHS, OECD, and ISBE have been having regular calls and meetings to make sure that we're aware of what's going on and that we're all on the same page. We have been connecting to touch base so that we can be coordinated at the state level on things that the Executive Committee wants to move forward or has questions about. We were also looking at if there are program issues that they can be resolved at our level before they need to go to a home visiting Executive Committee level.

These meetings, in the words of one informant, are "a big improvement over where things were prior to this project." According to another informant, "the progress is that conversations are happening at OECD that can really push that agenda. I think we're definitely on the way, but it's still a long haul."

Indeed, more regular communication and the ability to coordinate efforts are factors that lead to increased organizational and system resiliency and demonstrate leadership. One informant who is not a participant in these particular state-level meetings referenced the meetings, saying, "I look to leadership to break down silos and their commitment to get together regularly demonstrates that." Other informants noted that it can take a while to get everyone together with a project involving multiple partners and that it's not easy to align goals and vision among agencies that have individual mandates and missions, but the home visiting partners have made strides in this area. An informant said:

> As far as partners among the collaboration, it's as much as you could expect from people serving both individual organizations and agencies, and also being a part of a larger collaboration. Being able to fulfill both of those jobs is hard to do sometimes in terms of an agency or an organization having priorities and then a collaboration also having priorities, and the two not always aligning perfectly.

As indicated thus far, findings from interviews with state-level informants over the past 4 years point to increasing collaboration across the multiple agencies that implement and monitor home visitation policies and practices in Illinois and support local programs. These findings are also reflected in the results of a survey of state informants to assess aspects of their collaboration, which are presented in the next section.

## An Assessment of State-Level Collaboration Factors

In the last 2 years of the initiative, in addition to interviews, we also asked state informants to respond to an online structured survey to assess aspects of their collaboration. The online survey was the Wilder Collaboration Factors Inventory (Mattesich, Murray-Close, & Monsey, 2001). We administered the survey to 19 individuals identified by IDHS as participants in the state-level infrastructure, including members of the HVTF Executive Committee, in the spring of 2012. We received responses from 17 (89%). In 2013, we sent the survey to 17 individuals, and 12 (71%) responded. Because of some transitions in personnel or changes in responsibilities, only about half of the respondents in 2012 also responded in 2013. Three of the 12 respondents in 2013 were new to their positions.

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

Table 1 shows the mean ratings of the 20 factors on the 2013 survey; the ratings of the individual items that make up each factor can be found in Table B-1 in Appendix B. As shown in the table, the self-assessment of the state collaborative group touched on a number of different dimensions. Those that were evaluated most favorably are listed first in the table and can be considered strengths of the group at baseline. Those listed near the bottom of the table can be considered areas for improvement to be addressed in further development of the ELC. Because there was no opportunity for the members who completed the survey to help us interpret the assessment, we reviewed data from our key informant interviews to assist in the processing of the baseline assessment. Below we discuss some of the strengths and areas for improvement in the assessment with reference to findings from the interviews.

**Table 1. State Informants' Self-assessment on Wilder Collaboration Factors Inventory($N$ = 12)[a]**

| Factor | Mean[b] | *SD* |
|---|---|---|
| Members see collaboration as in their self-interest | 4.7 | *0.49* |
| Unique purpose | 4.5 | *0.62* |
| Established informal relationships and communication links | 4.4 | *0.48* |
| Favorable political and social climate | 4.3 | *0.44* |
| Skilled leadership | 4.2 | *0.39* |
| Members share a stake in both process and outcome | 4.2 | *0.41* |
| Adaptability | 4.1 | *0.51* |
| Shared vision | 4.0 | *0.86* |
| Concrete, attainable goals and objectives | 4.0 | *0.59* |
| History of collaboration or cooperation in the community | 4.0 | *0.92* |
| Appropriate pace of development | 3.8 | *0.78* |
| Ability to compromise | 3.8 | *0.58* |
| Appropriate cross-section of members | 3.7 | *0.75* |
| Flexibility | 3.7 | *0.62* |
| Mutual respect, understanding, and trust | 3.7 | *0.33* |
| Collaborative group seen as a legitimate leader in the community | 3.6 | *0.73* |
| Development of clear roles and policy guidelines | 3.6 | *0.73* |
| Open and frequent communication | 3.6 | *0.69* |
| Sufficient funds, staff, materials, and time | 3.4 | *0.80* |
| Multiple layers of participation | 3.1 | *0.70* |

[a] Several items reference "the community." Respondents were directed to "think of the community as all of the statewide partners involved in Strong Foundations."
[b] Based on a 5-point scale ranging from 1 ("strongly disagree") to 3 ("neutral") to 5 ("strongly agree"). Individual items that correspond to each of these factors can be found in Appendix B.

### Areas of Collaborative Strength

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

At the time of the survey, state agency heads and advocates were also convinced that participants in Strong Foundations wanted to "establish informal relationships and communication links." Of the two statements that make up this factor, there was fairly even agreement with the two statements that make up this factor: "Communication among the people in this collaborative group happens both at formal meetings and in informal ways" and "I personally have informal conversations about the project with

others who are involved in this collaborative group." Respondents also agreed that participants in the state-level system operate in a "favorable political and social climate." They indicated that "the political and social climate seems to be 'right' for starting a collaborative project like this one" and that "the time is right for this collaborative project."

Survey respondents also generally agreed that the following factors applied to the Strong Foundations state-level collaboration: "skilled leadership"; "members share a stake in both process and outcome"; "adaptability," meaning an ability to adapt to changes in funding, leadership, or political climate; a "shared vision"; "concrete, attainable goals and objectives"; and "history of collaboration or cooperation in the community."

At the same time, there was variability in the ratings of some of the individual items that make up these factors. For example, with regard to the factor "mutual respect, understanding, and trust," respondents were less likely to agree that the people involved in the collaboration always trust one another than they were to agree that they have a lot of respect for the other people involved in this collaboration. With regard to the factor "members share a stake in both process and outcome," respondents were more likely to agree that "everyone who is a member of our collaborative group want this project to succeed" but less likely to agree that "the organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts."

**Areas of Concern**

None of the factors and just two of the items on the Wilder survey received ratings below 3.0 (neutral). The lowest-rated factor was "multiple layers of participation," which includes statements about members having time to confer with their organizations about major decisions and having the authority to speak for their organizations. Responses to the "multiple layers of participation" factor suggest that some participants in the current collaboration do not feel that they were able to speak for their entire organization or that there is not enough time for participants to report back to their colleagues and discuss matters to be decided upon.

The next area of collaboration that was rated just above 3 (3.4) was the factor "sufficient funds, staff, materials, and time." Although survey respondents in 2013 agreed more often than disagreed with the statements, the lower rating suggests that inadequate funding and personnel still threaten the stability of the collaboration. Additional concerns were reflected in some of the indicators that make up factors that were rated above 3 overall. For example, the factor of "mutual respect, understanding, and trust" was rated fairly high. However, ratings of the individual components of this factor suggest that although most of the respondents to the survey "have a lot of respect for the other people involved in this collaboration,"

they disagreed on whether people involved in the collaboration "always trust one another" (see Appendix B).

**Comparison of 2012 and 2013 Results**

Overall, except for a few items, ratings of the collaboration factors were somewhat higher in 2013 than in 2012; however, there were no statistically significant differences between the ratings of the two years for either the full sample of respondents or for the nine individuals who responded to the survey both years.

## Supporting Quality

Partnerships within the governance and administrative structures of home visiting initiatives in Illinois are complex, and yet their ability to move the work forward through major transitions is a testament to their resiliency. One informant described the partnership:

> The OECD does the implementation. [OECD] reports updates and any challenges or best practices to the Executive Committee, and then they [Executive Committee] take that to the full Task Force. I think it's been a very important partnership to have, especially in figuring out how we can take the lessons learned from the MIECHV communities as sort of a pilot more broadly, statewide.

Indeed, although much of the work of the Executive Committee seems centered around MIECHV, stakeholders still recognize "that those [MIECHV] outcomes are not going to be attained unless [they're] developing the broader system as a whole and focusing on those infrastructure components that were at the heart of the original Strong Foundations." One component of the infrastructure component, to which a great deal of attention has been paid during SFY 2013, has been supports and resources for ensuring quality services through monitoring, fidelity, and continuous quality improvement.

### Partnerships and Monitoring

Since the implementation of the EBHV grant began, agencies that fund home visiting services in Illinois have had many more opportunities to come together and, as such, have deepened their mutual understanding about the various home visiting models in the state, how the models are similar, and how they differ. More recently, MIECHV has created additional reporting goals around which partners can convene. One effect of this has been that a broadening discussion has taken place about issues of data collection, monitoring, and fidelity. These topics were highlighted during the planning and first year of the initiative and have been consistently raised by home visitors, supervisors, and state-level stakeholders during our annual evaluation interviews and focus groups since 2010. As we indicated in our previous evaluation report, the funding agencies must coordinate their contracting, monitoring, and reporting. Until that coordination is established, the idea that the infrastructure being built fully supports the home visitor will not be a reality.

During the interviews in SFY 2013, a number of respondents continued to emphasize the burden on programs with multiple funding streams and the complexities of monitoring and reporting that are necessary for demonstrating fidelity. Here are the views of two respondents:

> It's important to folks that receive funding from more than one entity that they not jeopardize it. And then you have MIECHV and, my goodness, one program could be dealing with three state and one federal [set of requirements]. And they have to figure out which worker equals how many FTE and what's the percentage of this home visitor on something else. And then there's figuring out the percentages for the supervisor.

> I think of these supervisors and all that they try to coordinate. They provide the same service, but they have two different funders; and, how many different data systems do they have to have to enter [data into]. They need to collect this information for this home visitor, but not for that one. They need to make sure their files look like this for this one, but not for that one. There's always going to be differences between models and funders, but it would be nice if we came up with an integrated way to collect common information so that programs can have the ease of one home visitor funder report.

Some respondents suggested that to be effective, efforts to streamline reporting have to consider requirements of both program models and funders. As evidence of models' growing awareness of the national emphasis on evidence-based fidelity, several informants pointed to recent curriculum and implementation changes for PAT; new, soon to be released best practice standards for HFA; and discussions occurring with the BabyTALK[9] curriculum.

However, with their increased interactions in Illinois, stakeholders are learning that there were still "big discrepancies in monitoring and program requirements" across the state. One informant shared an example in which it came to light that a national program model considered a program fidelitous even if a supervisor had responsibilities for both many non-home visiting staff members as well as the maximum number of home visitors allowed by the model. According to this stakeholder, from a MIECHV fidelity perspective, this raises "a huge red flag" with regard to "the capacity to do [implement] quality, reflective supervision," especially for smaller programs with a supervisor who is pulled in many directions. This discovery led to broader discussions around next steps and a need to "get a clearer understanding by reaching out across funders and asking about monitoring requirements, performance standards, and performance outcomes for each of their programs." The stakeholder continued, "We started having these really bountiful conversations about what was missing, what was expected and what was not expected. We started to have talks about what could be done going forward that would reinforce the changes that MIECHV is initiating."

[9] For more information about BabyTALK see: http://www.babytalk.org/home-visiting

Other respondents shared their perspectives that there has been movement, at least in the commitment, to streamline the process and reduce burden for programs while attaining quality data.

> We see the need now to try and figure out how to get the home visiting funders on one page with regard to expectations around evaluation and quality assurance. It goes beyond data systems to programmatic expectations. The more that we can align ourselves as funders, the more we can say that we have a cohesive home visiting program as opposed to three different home visiting programs.

> The money is coming from IDHS, the Ounce, and ISBE, so we can really drive how these [home visiting] programs are going to operate. One of the challenges is just getting us all on the same page. We have talked about us all having at least have some data in common or an easier way to share data. I think developmentally the different funders are just at different stages as far as [quality assurance] and how they monitor [programs].

> We have had more meetings with CPS [Chicago Public Schools] and invited CPS to sit on the [HVTF] Executive Committee. We talked about what makes a program under CPS and how our MIECHV programs are similar and different. We discussed [CPS] program monitoring requirements which are very much in line with the MIECHV requirements, and we shared program monitoring documents. Going forward, we are going to have primary funder meetings with the Governor's office [OECD], [ISBE], and [DHS]. We are all going to meet to start conversations about how our programs can better align and how we can be more consistent about monitoring across programs and models.

These efforts are similar to those found within the "collective impact" approach to social change (Kania & Kramer, 2011). This approach includes: focusing on an overall issue rather than on individual grantees; paying attention to the relationships between organizations rather than the capacity of a single organization; thinking about long-term process and gradual impact rather than short-term solutions; and building knowledge and alignment through shared measurement systems, regular meetings, and backbone organizations. By coming together to focus, at least in part, on developing improved strategies for data collection, data reporting, and monitoring, the funding bodies and the Executive Committee embrace a collective impact approach. Complementing this work is the Strong Foundations Partnership's new scope of work around continuous quality improvement (CQI), inherent in which are issues of data collection, data reporting, and data utilization. The use of data to inform program and practice quality at the state, community, and local levels is the topic of the following section.

## Using Data to Inform Programming and Policy

### Developing Data Systems

Many states are moving toward the creation of unified data systems that support state early learning and development system goals (U.S. Department of Health and Human Services, 2011). Indeed, highlights from the federal Early Childhood 2010: Innovations for the Next Generation meeting included a number of recommendations focused on improving data systems and system capacity to collect and use data (see Box 1).

Given the enormity of data issues in Illinois's early childhood development system and its impact on quality service delivery, during our evaluation interviews we asked respondents about what type of information they think is important to collect, what gets documented, what happens with that information, and how they would like to see data used. We learned that our informants are also asking these questions of themselves and of each other. Our respondents also agreed that there is a renewed emphasis on data and that having access to quality data is critical for building and sustaining the home visiting infrastructure and delivery of services to families and communities. Whereas some informants focused on the "need to define outcomes more concretely to be able to get more funding and explain to legislators why this is so important," others stressed the need for more data on implementation and program quality. Two informants expressed the following views:

> If you think about government funding, in particular the strong emphasis on using data from randomized trials, as the driving force for determining public policy and funding allocation decisions, there's some movement across the country among some of the leading researchers in early childhood to say it's too narrow for growth and development. I hope that we'll have some opportunities for different kinds of evaluations and approaches. We should be doing implementation research on the programs themselves, so that we can understand what we should be doing a randomized trial on—that's where innovation comes from.

> There's so much more to learn. We need to be sure that as we expand our efforts, we continue to emphasize the importance of qualitative and implementation evaluation. We can't just focus on continuous

**Box 1. Early Childhood 2010 Recommendations***

• Assessing state data capacity to describe children, families, programs and progress:

Some states are determining current data capacity and options for integration. Tapping into a neutral agency devoted to data analysis is a strategy in several states.

• Investing in state data capacity to guide planning, policy, and continuous program improvement: State activities include determining how to collect and use child assessment data appropriately; building capacity to use assessment data to improve early childhood program practice; linking child, family, and provider level data to guide policy and target technical assistance that improves provider quality; and using data to inform families and the public.

• Leveraging federal investments in state education longitudinal data systems (SLDS) by including early childhood and workforce data: Some states are developing agreements to share data between child serving agencies; attaching unique student identifiers to early childhood datasets; including data from programs serving children birth to age 3; or linking data on the early

• Leveraging new federal investments in and building infrastructure to support home visiting: Some states are preparing to make the most of the new federal Maternal, Infant, and Early Childhood Home Visiting program by coordinating existing home visiting programs; developing a home visiting infrastructure (common quality standards, professional development and procedures for centralized intake, screening, referral and technical assistance); and considering how to integrate home visiting with early care and education services.

*Source: U.S. Department of Health and Human Services.

> quality data to improve performance; we also need to focus on how data and evaluation can drive innovation and development.

Other respondents pointed to the need for data on program participants and community needs, as illustrated by the following excerpt:

> Service data [can] help us understand if we are going in the right direction. You need to know: How big is your target community? How much of your target community are you reaching? Of the people you recruit, how many enter the program? Of the number who come into the program, how many drop out? When do they drop out? How intense are interactions with families, measured both by frequency and duration of participation in the program? If those numbers don't look right, you start unpacking: What's your relationship in the community? How are you perceived by the families? What's actually happening in your early interactions? Then you figure things out further: Do you need community partnerships; communications work in the community; supervisor staff development? And then the last part is always the training of the home visitors and helping them. That's the point of looking at that data—to understand what you're looking at, what it means, and what to do with it for it to be useful.

One respondent referred to the new MIECHV quarterly financial meetings to illustrate how data "moves conversations forward." She reported that as a result of the information collected and shared at the meetings "we learned that if you look at the spending trends across our coordinated intake agencies, across the state, you can gauge how much it costs to implement coordinated intake. Based on that information, we've been able to have conversations with agencies about their coordinated intake budgets."

Such sharing of information, "up and down," was another factor highlighted by most, if not all, stakeholders in order to for data to be used effectively to improve practice. As one respondent explained, "[Data and results] need to be published back out to everybody. One thing we can do for the field is to be sure that they know that they have a voice and that people are listening. We need to look at best practices and see what [the data are] telling us about competencies of home visitors for today."

Another informant noted the importance of data for communities that are engaged in continuous quality improvement (CQI) efforts:

> We want to make sure that we're pulling regular reports on the benchmarks and feeding that back to the communities on a regular basis so that they can use it for CQI purposes. There needs to be constant feedback about how things are going with different aspects of the program and looking at how we can make any improvements.

Despite the desire to use data effectively, there are a number of barriers to overcome. "There are a million ways to use the data," one informant told us, "but there's no statewide structured way of looking at it, because the data is not coming in in a consistent way."

**The View of Frontline Staff**

As discussed above, different funding streams and models look to capture different information about the provision of home visitation services and outcomes. However, during focus groups in the spring of 2013, home visitors raised additional concerns related to program monitoring; specifically, they raised concerns about whether their relationship-based work was captured appropriately, or at all, in the data reported back to their funders or models. In the focus groups with home visitors from NFP, PAT, and HFI programs, many of the home visitors shared their perception that their documentation requirements reflected an emphasis on "results" that did not capture the vital relationship-building work they performed. For example, one home visitor recounted a situation in which a mother with whom she worked contacted her on a weekend to ask for assistance leaving a domestic violence situation. The mother told the home visitor that she had the domestic violence/safety plan pamphlet that the home visitor had left for her and she needed to get out of the home. The home visitor made the decision to go and help the mother and child. She spent hours on that Saturday helping the mother achieve a major positive outcome—leaving an unsafe situation—but the home visitor noted that although she documented her efforts in her files, "it didn't count" as a home visit. According to another home visitor, "We document [our relationship-oriented] activities but when [program officials] come in to audit, that's not their focus. They don't really care about it; they are focusing on parent child interactions." A third home visitor shared similar views:

> They are looking for results to make sure that that mom, holistically, is going to be fit to raise her baby to school age. Our job is to put it in [the files] so when they come all they want is to see is in front of them. All the work that we've done, and we do get our fingernails dirty, picking up that phone, texting, driving our cars back and forth, it's serious; it's real work, and it can be very emotional too. We write it up, but there is no conversation about it.

In response to hearing about these findings during the evaluation interviews, most of the state-level stakeholders acknowledged that the relationships between home visitors and the families with whom they work are critical in order to achieve positive outcomes. However, it is challenging to capture these relationship-building activities in a data system.

In addition to addressing what documentation captures the nature of home visiting work and how data can inform practice and policy, there are seemingly ever-present technical issues that impose barriers to data efficacy. Several stakeholders described changes taking place that might begin to address these barriers.

For example, ISBE has modified their Student Information System (SIS) data system, which allows pregnant women to be added to the system and prenatal visits to be captured. During SFY 2013, ISBE also improved its data system to be able to connect each child with one or more caregivers who are entered into the system. They can then collect demographic information to "understand who the children are, what risk factors are present, and what potential risk factors are for the family in terms of education level and employment. That, along with the parent evaluation and the outcome measures, gives us much more information than we have had in the past." The vision is that "with our student information system, when we have a child that we're able to enter at birth, we can follow them then through the twelfth grade. Then we're able then to have that follow-up data at the other end of the spectrum, and look at how we connect with colleges and universities/higher-ed employment."

Another change implemented during SFY 2013 was to shift the provider of the MIECHV data system. Originally programs were using Social Solutions' Efforts to Outcomes. They changed to Visit Tracker, which is widely used by PAT sites in Illinois and by some HFI and CPS programs. It is noteworthy that at the outset of the initial Strong Foundations (EBHV) evaluation very few PAT programs utilized Visit Tracker. Indeed, when selecting PAT program sites for the process evaluation, there were not enough PAT programs using Visit Tracker to include data collection processes as a criterion. The increase in programs that use Visit Tracker demonstrates a move to a more formalized system of data collection and ability for more systemic tracking. However, barriers still remain. There have been discussions with the Ounce about the possibility of shifting their providers to Visit Tracker. As one informant described, "It's sort of the tail wagging the dog, since there are 30 [Ounce sites] and six [MIECHV communities]. But we're working with OECD to try and customize it and track as much as we can to accommodate things."

Having the ability to "peer into a data system on a state level" and having the ability for the various data systems to communicate with each other is a shared goal among the state-level stakeholders we interviewed.

> For now, we want to just get to a point where all the home visiting programs across funders are collecting close to the same information so that we could all provide similar statistics and pull data together and have numbers for the entire state of Illinois for home visiting. Right now that's difficult. We could really pull it together if we were all looking at the same data. I think the options really are endless.

Yet another factor is that IDHS will continue to use Cornerstone as its data system. As one informant acknowledged:

> Cornerstone is core to our service delivery system. We would have liked to have gotten MIECHV on Cornerstone, but that didn't happen. The challenge is getting people to see its potential. It's an

> antiquated system that's land-based, and almost useless. But they are working on putting some parts of it on a server in a cloud that's shared by multiple sites. It's really not pretty right now, but one day, it's going to grow up.

This view was echoed by another informant, who explained that integrating Cornerstone and the MIECHV system has proven to be more difficult than anticipated. However, Cornerstone will remain in use because the data it holds is comprehensive.

As mentioned above, one important purpose for data is to monitor program quality and discover areas for improvement. In the next section, we discuss the state's new emphasis on continuous quality improvement.

**Continuous Quality Improvement (CQI)**

During SFY 2013, the Strong Foundations Partnership began a new major component of its work: creating and implementing a CQI system beginning with the MIECHV communities. The Center for Prevention Research and Development (CPRD) has been contracted for the work and receives strategic oversight form OECD, IDHS, and the HVTF Executive Committee. Each MIECHV program received a memorandum of understanding (MOU)[10] that detailed what each site could expect from the state, from CPRD, and what would be expected of them as part of the CQI process (Center for Prevention Research and Development, 2013a).

As described in the Illinois MIECHV CQI plan. "for the purposes of programs in Illinois, continuous quality improvement is the complete process of identifying, describing and analyzing strengths and problems and then testing, implementing, learning from and revising solutions" (Center for Prevention Research and Development, 2013b). The goal of CQI is to value data and strive for process improvement for home visiting programs and optimal outcomes for families and ultimately institute a statewide CQI system (Home Visiting Task Force, 2013). Indeed several informants restated that goal. One said:

> Data should be used to drive improvement in practice. The Executive Committee has been advising on the CQI process. The mentality is very much about not just sucking up all of this data into systems and never having the people who are actually doing the work see it, but making sure that it's coming up and then it's coming back down to the providers to help them improve their practice.

To that end, the state views CQI as a mechanism to inform policy, but also to improve practice by making sure that the programs from which they gather the data also have the aggregate data so they can see how their local efforts improve home visiting as a whole.

[10] The memorandum of understanding was between CPRD, the University of Illinois, and a MIECHV-funded program.

CQI efforts "use statistical tools to understand subsystems and uncover problems…with an emphasis on maintaining quality in the future, not just controlling a process" (Center for Prevention Research and Development, 2013b). Respondents tended to agree that the EBHV grant afforded the state the opportunity to be in a stronger position in terms of being able to plan for and implement the CQI MIECHV component and think about spreading its reach statewide. One respondent stated, "[EBHV] allowed us to look at our infrastructure and think about what it really means. We would have been far behind in trying to implement a CQI process. We've been able to think about the different partners and the major funders [through EBHV]."

While reactions to CQI were mixed during interviews for this evaluation, several informants noted CQI's potential to improve home visiting for families, communities, and agencies in the state. One informant commented, "CQI affords a really interesting way to think about how data drives improvements in program and practice quality. It's a really great opportunity for the state and for the Early Learning Council to learn about opportunities for all of our evidence-based practices." Another respondent echoed this view, saying, "Being able to look at the data on a statewide level helps us pinpoint the areas where we need to do better. Looking at the data for CQI is not only for the local program and community level, but for us at the state level as well."

As set forth in the MIECHV CQI plan, CQI philosophy holds that most things can be improved and that one learns as much from challenges and failures as from successes. To inform stakeholders about the processes and facilitate thinking about how CQI can "provide regular feedback to communities about how things are going with different aspects of the program that can then be improved," CPRD conducted a number of presentations, facilitated stakeholder meetings, and disseminated written communication about Illinois's CQI plans with regard to the MIECHV communities.[11] One of the points emphasized in the communication was the distinction between CQI and a traditional quality assurance (QA) process—the difference being that CQI is "self-directed, self-determined change rather than [change] imposed by an external entity." Such is the case in applying CQI methods to the field of home visiting. As one informant explained, "[Traditional] quality assurance is more like model fidelity, 'Are you doing XYZ?' and then there's quality improvement, which is, 'How could you be doing this actual practice even better?'"

Stakeholders reported that reactions to the CQI information varied, in part due to the wide array of programs' experiences with aspects of CQI and QA. For example, one informant commented, "The array of the different programs, where they were at, was really interesting. Some of them are really far along in CQI. Some of them had never even heard of it." Another respondent contrasted a multisite agency that

[11] This communication included, for example, CRPD presentations at HVTF meetings, presentations at the Innovations in Quality Summit, presentations at the MIECHV program meetings, and the MIECHV CQI plan.

"hired a company to work with them on CQI [and already has] certain forms and protocols and a system with red, green, and yellow lights for issues and how they're handled" with other agencies that maintain and review their files when funders visit but do not use the information for planning or program improvement.

Given the wide range among the CQI audiences, there were also different reactions of how the information was perceived by stakeholders at the state and local levels. For example, this state-level informant shared her impression that the information was well received by programs.

> Initially [providers] came thinking, "Oh it's one more thing we have to do for MIECHV," but I think they walked away afterwards saying, "Okay, we can do this." We were talking to them about not reinventing the wheel. If some of these processes are in place at their agency, they can just hone them in specifically on home visiting.

However, another informant expressed surprise and disappointment with the CQI presentations. This respondent shared that, from her perspective, the technical assistance available to programs in the state is far different from traditional technical assistance, such as a 3 year regional audit. She found it offensive to people in the field who have been doing this work. She shared:

> The concept of CQI is great, but it's been framed as if what we've been doing is so different from what CQI is, and that's not true. They give the impression that state-level QA, delivered by masters-prepared people, who have worked in the field for 20 years as program managers, is being done wrong. So I worry more about CQI becoming a distraction. What we need to do … is to focus on how CQI has a theoretical approach that we already have some of the underpinnings for. Let's advance all the ways that we're already doing this, let's go back to the community systems. There's a continuum of everybody doing CQI, so let's find a way to bring along the whole system.

While this evaluation is not an evaluation of MIECHV or CQI, it is important to highlight this difference in perception as it relates to the EBHV grant's goal of creating an overall home visiting infrastructure for the state. The EBHV grant and the HVTF, as the implementing body, embrace a "big tent" approach and communication needs to be sensitive to a broad audience. How much CQI differs from existing efforts and the impact of the new CQI processes remain to be seen, as does the ability to take CQI statewide and include smaller home visiting programs. As one informant stated,

> We want to develop a plan of action that coincides with the CQI plan. As we look at system issues, we will have recommendations or at least a list of pros and cons to provide to the Executive Committee and then ask for their recommendations for next steps. We are really starting to build this effective system that I think was kind of all over the place before. There wasn't really anybody pulling these different factions together and now there are.

## Innovations in Quality

### Home Visiting Coach Quality Technical Assistance: Home Visiting Quality Project

The components of the home visiting infrastructure reviewed in this chapter so far share the common goal of providing high quality services to children, their families and communities (these components are: the broadening discussions regarding the complexities of shared monitoring and reporting; data collection; and continuous quality improvement strategies. Quality has been the focus of the Home Visiting Quality project, the home visiting component of the Illinois State Advisory Council (SAC) grant, a three-year effort that ended in SFY 2013. Though the SAC grant represents a separate funding stream from the EBHV grant, we are including this information on the SAC grant projects because it add to infrastructure development and therefore impacts Strong Foundations. Further, the evaluation has long included work under the purview of the HVTF, which includes the home visiting work of the SAC grant.

The Home Visiting Quality project supported program funders and models in their efforts to "upgrade existing tools in place to measure program adherence to quality standards and to strengthen the impacts of home visiting programs (Illinois Department of Human Services, 2013). To that end, ISBE, PAT, HFI, and BabyTALK each conducted a quality implementation project. ISBE worked with 14 programs across the state to develop a Prevention Initiative (PI) implementation manual that reflects the implementation needs of its PI programs using the HFI, PAT, and BabyTALK approaches to deliver quality services. Illinois's state PAT office partnered with the national PAT office in a quality assurance pilot. Fifteen of Illinois's PAT programs engaged in the testing of quality assurance measures, which provided guidance to the national system to support quality and fidelity. HFI offered programs technical assistance around program management and the HFA credentialing process. Also through the SAC grant, HFI was able to conduct a cost benefit analysis of a multisite credentialing process. BabyTALK worked with its evaluation team to engage 15 of its programs to review and modify the model's self-assessment process.

### Innovations in Quality: Home Visiting Summit

Quality was also the highlight of the first ever Innovations in Quality: Home Visiting Summit held in Illinois during April 2013. Approximately 600 home visiting stakeholders attended one of two daylong summits. The summits were held in Naperville (in the northern region of Illinois, in close proximity to Chicago and its collar counties) or in Bloomington (in central Illinois). One informant shared that home visiting stakeholders from Nebraska learned of the summit online. The Nebraska stakeholders reached out and asked to attend the summit in order to learn from Illinois's home visiting efforts. The summit content represented the findings of the aforementioned home visiting quality projects as well as the long-standing work that came out of the ELC's Infant-Toddler Committee (this committee no longer functions). The HVTF was an active partner in several of the infant toddler work groups; both the birth-to-three

monitoring and the community systems development work groups were joint workgroups of the Infant-Toddler Committee, the Oversight and Coordination Committee, and the HVTF.

As described in the federal SAC report, the summit's goals were to:

- recognize the essential elements of quality in current practices and build new knowledge through an exchange of expertise, experiences, and perspectives;
- introduce and explore practical home visitor and program resources informed by field studies and dialogue with home visiting programs; and
- renew a shared vision and commitment to collective and individual practices to provide the highest quality effective home visiting to Illinois's youngest children and families" (Illinois Department of Human Services, 2013).

Another motivation for those involved in planning the summit was to foster greater use of research and data for improving program quality. According to one informant,

> I realized in talking to the different agencies how many agencies don't look at research. And it surprised me and it worried me that they said the home visitors didn't look at research, their supervisors weren't pulling research and discussing it, and neither were their program managers. So these programs by and large may be doing a good job but really are in the dark right now. [And that was a point of the summit] and why we're having these discussions on quality, to get home visiting agencies to understand that the services are not the agency's, the services belong to the families and you have a distinct obligation to these families to provide good quality services.

There was consensus among our informants that the summit was positively received by attendees, which included home visiting funders, program administrators, and other home visiting stakeholders. Many stakeholders emphasized that the summit represented "the first time" that all of the models, funders, and stakeholders attended such a gathering in Illinois. It was also the first time they came together for conversation and workshops about quality in home visiting programs.

A number of respondents shared the perspective that the summit's primary goal was convening a diverse group of home visiting stakeholders in order to develop a shared understanding of quality and promote the idea of a shared responsibility for ensuring quality. One said, "The summit was specifically designed to have all these different audiences together. It was not an event just for home visitors or just for managers. We wanted to try to get everybody to think about how delivering quality is everyone's responsibility."

Another informant echoed the importance of the opportunity to meet with other home visiting stakeholders and added,

> Anytime you bring together the people who are actually doing the work, across models and across geographic locations, they are always better when the event is over, because they had the opportunity

> to identify issues that they may not have even have realized were issues. They were able to hear suggestions or ideas from a different perspective.

Our informants also made the point that learning not just about how an individual model or funder approaches quality but how the larger home visiting arena approaches quality increases the likelihood of "spillover effects" and positive outcomes for the field. As one informant explained, loyalty to a particular model might not help to develop a sense of shared responsibility for quality.

> The whole idea is to engage everybody in a conversation about what is quality outside of your own particular model. It can be a struggle to get a home visitor really excited about a different model. They go to their core training and drink the Kool-Aid of their model, and that's actually a really, good thing. But our goal [with learning opportunities such as the summit] is to try to help home visitors from whatever model [with which] they are aligned to feel supported in a learning experience and see connections with other work.

The summit was implemented as a participatory event. In addition to a plenary session, participants rotated through four sessions. (See Table 2 for a description of the summit's sessions.) During the sessions, participants broke into small groups in order explore the quality area of focus more deeply. In addition, the session presenters sought participant feedback before and after their presentations. At the close of the summit, participants were provided with the newly released Illinois Early Learning Guidelines as a professional tool to ensure quality (HVTF, 2013).[12]

[12] HVTF ELC Exec Update. (June 13, 2013). Available on: http://www2.illinois.gov/gov/OECD/Documents/Early%20Learning%20Council/Council/6.24%20ELC%20Email%20Handouts.pdf.pdf

**Table 2. Breakout Sessions from the Innovations in Quality: Illinois Home Visiting Summit[a]**

| Session | Facilitator | Description |
|---|---|---|
| **Essential Partnerships of Quality** | Positive Parenting DuPage and Healthy Family America Peer Reviewers | This session focuses on the fact that no one home visits alone. All programs, stakeholders and staff comprise a network of partners that affect the quality of home visiting. Discussion will include consideration of what we learn from each other to inform quality and how technical assistance supports bidirectional learning. |
| **Assessment of Quality** | BabyTALK evaluator and program manager | This session discusses the role of assessment to guide effective, outcome driven home visiting. What are the multiple methods used by programs to demonstrate quality practice through the assessment process? Additional focus of consideration will be on how programs can and should guide the content of tools designed to assess practice. |
| **Resources Essential for Quality** | DHS and ISBE | This session focuses on the layers of resources needed to deliver high quality programs. The role of funders in offering support and resources will be discussed, along with considering how the current Illinois structure of support systems functions and delivers on quality support. The role of program data as a resource for quality will be reviewed. |
| **Evidence of Quality** | Ounce of Prevention | This session will discuss and consider what proves home visiting works and why evidence is important. How does the evidence in quality in home visiting delivery support and inform practice? Discussion will include the role of home visiting model fidelity as an essential element of quality in practice. |

[a] Source: Handouts from the Innovations in Quality: Illinois Home Visiting Summit 2013

The summit provides a great example of how ongoing work can be adapted so that it can continue to be developed through changing structures, such as shifts in committees, personnel, or leadership staff. The funding for the summit may have come from the SAC grant, but the underlying values and goals that enabled the summit to be successful can be traced back to the shared work of the Infant-Toddler Committee and the HVTF. One informant with a long history of involvement with this work provided a helpful, detailed description of the progress the state has made from "monitoring for the sake of monitoring" and accountability to thinking about monitoring as a tool for ensuring quality programs for families. She explained:

> We have been working for many years to think about how we monitor our programs. A long time ago we [realized] that we were monitoring programs in such a way that it was almost impossible for them to deliver, because they were constantly being monitored by different funding streams. Programs had different contracts, managers, and requirements, but on the ground, they were delivering the same services. Monitoring isn't supposed to be about monitoring for the virtue of being monitored, [but] to make sure programs are equipped to deliver quality services and report on delivering those services to children and families. Fast forward a few years and we have the monitoring recommendations. It took

> so long for those recommendations to get out the door, but by the time they did MIECHV dollars had started to flow, and there was other system-level work being done around home visiting. We are very different in 2012 and 2013 than we were when EBHV was written in 2008 and 2009.

According to this informant, because of the growth in the home visiting infrastructure over the past 5 years, stakeholders shifted their focus from developing recommendations for better monitoring systems to thinking about ways to make sure services are being delivered with quality.

> That's where the summit came from. We thought there would be value in people learning about these approaches in quality from each other, because, hopefully, they might be able to pick up on strategies that they could apply in their own programs, with their own services to families, and within their own funding model.

In our interviews, our informants also discussed lessons learned from the summit and how those lessons would be communicated to the field. To date, because of a lack of funding, there has been no written report from the summit or from the four SAC-funded quality projects. According to our informants, this represents a lost opportunity to document the vast amounts of knowledge shared at the summit by its approximately 600 attendees. One informant, in sharing that she had expected information from the summit to "inform higher-level planning," emphasized the need to document and disseminate what was learned at the summit:

> People want to know how to define quality in the state, what quality means, and what people need to be able to produce to demonstrate quality in their programs and adhere to model fidelity. We want all of that information to trickle up and then trickle back down again throughout the state so that we really have excellence in what we do here. We don't have these meetings and network just to rest on our laurels; we want to have an impact on parents and kids.

Another informant highlighted the professional development information that could be gleaned from an analysis of the quality project work including the summit.

> We could look at best practices and see what that tells us about home visitors' competencies today. That would benefit any professional development provider and lead to an update of their competency-based training. It would also inform technical assistance. You could go back to the national models and say, "Look, this is how it's hitting the pavement in Illinois, we want you to know how it's working here."

Another informant suggested that the HVTF should be responsible for building on the work of the summit and for continuing to emphasize the importance of using data for planning and ensuring the quality of services.

> The Home Visiting Task Force would be a place to carry out the monitoring and advising of why it's important, and not let the concepts of the monitoring recommendation go away. MIECHV has gotten

> kind of caught up in the benchmarks and just trying to get a project implemented in local communities, but at the core, MIECHV's supposed to also change the way all of our funders, all of our models, all of our regions work together. As we think as a state about what MIECHV is helping us be, it's not just new funding for home visiting but systems-level thinking about how to implement.

This discussion of quality brings us to another key component of the state infrastructure, the community systems development work that goes hand in hand with the development of state level infrastructure.

## Community Systems Development

"The idea of real community systems building drives so many of the outcomes we want at the child and community levels."

*~State level stakeholder, 2014*

Another important part of an infrastructure that supports home visiting revolves around local and regional collaboration, community planning, and site development. This aspect has long been recognized by stakeholders and is included in the vision of the Home Visiting State Systems Development Assessment Tool, which was revised by the HVTF in 2009. This document asserts that, "There are strong and inclusive collaborations at the state level and in local communities. The statewide system provides technical assistance for developing, sustaining, and expanding home visiting." At the start of the EBHV grant, the community systems development work fell under the purview of the Community Systems Development Work Group (CSDWG), then a joint work group of the ELC's HVTF, infant toddler Committee, and the oversight and Coordination committee. In 2012, the community systems development work was integrated into the ELC's Systems Integration and Alignment Committee (SIAC) as a result of the ELC's (then new) strategic plan and subsequent change to its committee structure. The mission of the ELC's SIAC is broad and intended to be inclusive of each of the components that impact the early childhood development system, including home visiting (Systems Integration and Alignment Committee, 2012). Through the work of SIAC and its subcommittees, specifically the Community Systems Development Subcommittee, the work that had been under the purview of the former CSDWG continues.

**Community Systems Development Subcommittee (CSDS)**

As articulated at a CSDS meeting, "collaboration is the vehicle which drives community system development." Community systems work—that is, facilitating the growth and development of collaboration to support children and families—is intrinsically associated with state infrastructure development. As such, just as Illinois's early childhood development infrastructure has grown over the past two decades with the Early Learning Council, its committees, and the Office of Early Childhood, so have communities' infrastructures and collaborative work. The objective of the SIAC's Community Systems Development Subcommittee (CSDS) is to "support the ability of local community partnerships

to improve outcomes for children and families in their communities through effective state policies and practices" (Community Systems Development Subcommittee, 2013). To that end, CSDS serves as an advisory body to community systems work that is being implemented statewide through various grants and projects, including the ARRA State Advisory Council (SAC) grant, the Strong Foundations Partnership (between EBHV and MIECHV), and the Race to the Top Early Learning Challenge (RTT ELC) grant.

As part of the SAC grant, Illinois Action for Children in collaboration with the CSDS developed a consultation and technical assistance model for building and sustaining community partnerships, the Early Childhood Action Partnerships (ECAP) mini grant and technical assistance project (Illinois Department of Human Services, 2013). ECAP offered a "framework for providing locally responsive technical assistance to early childhood partnerships." ECAP partnered with the National Center for Children in Poverty's Pathways project and developed training and launched a set of interactive web-based tools for use in collaborative strategic planning (for additional information about Poverty's Pathways, see http://pathways.nccp.org). Most of the MIECHV community system developers participated in the ECAP Pathways training and also attended the ECAP conference last fall (Illinois Governor's Offices of Early Childhood Development, 2013. A state-level stakeholder pointed out the significance of the coordination of the ECAP and MIECHV work in that the two grants "leveraged each other and worked in tandem, as opposed to working against each other." Though the SAC grant ended at the end of SFY 2013, the state continues to prioritize the development of "local or regional infrastructure that weaves together the multiple programs, services, and resources for young children and their families," and, as of the writing of this report, is in the process of forming the Consortium for Community Systems Development (CCSD) (Illinois Action for Children, 2013). As defined in the CCSD Request for Qualifications, the task of the CCSD is to complete a strategic plan for community systems development, organizing and extending the state's current supports for local collaboration around early learning and development. In its advisory role, the CSDS has worked with Illinois Action for Children to build a foundation for the CCSD strategic plan. As it turns out, the CCSD RFQ also provides an example of the fluidity that goes hand in hand with systems building work. In August 2013, a decision was made to rescind the CCSD RFQ due to "an opportunity to fold this work into a larger state planning initiative, which will hopefully result in a more robust blueprint for community systems development and greater buy-in from key stakeholders" (CCSD, 2013). This decision also offers additional insight into the resiliency of Illinois's early childhood development system: the system is able to change course in order to leverage shared opportunities to effectuate change on a wider basis.

As indicated above, the CSDS also advises the HVTF on its work to enhance community systems to benefit children and families. The current HVTF work plan includes the broad goal to "improve coordination between home visiting programs at the state and local level, as well as between home visiting and the full range of services for infants, toddlers, and their families at the community level."[13] In SFY 2013, much of this work encompassed the significant focus on community systems and collaboration within the MIECHV communities. As emphasized throughout this report, the state views the MIECHV work as a pilot for work that, if funded, could be taken statewide and support a more comprehensive infrastructure for all evidence-informed and evidence-based home visiting programs. As such, the community systems work implemented under the purview of MIECHV has, in the words of one informant, "really embraced the collective impact model." Indeed, the community systems development work in the MIECHV communities to date also reflect principles of Kania and Kramer's (2011) collective impact approach. The OECD and IDHS have worked together to connect the MIECHV communities more closely with AOK Networks, Family Case Management, Early Intervention, Local Interagency Councils, and other existing infrastructures.[14] In appreciation of the fact that several of the MIECHV communities have burgeoning Latino populations, MIECHV representatives at the OECD have met with the Latino Policy Forum to discuss collaborating to provide support to MIECHV communities and to English language learners through the state.[15]

In addition, each MIECHV community has identified individuals to focus on the coordinated intake and community systems development. The coordinated intake component of the MIECHV initiative represents, in a way, a piece of community systems work. As intended, the coordinated intake process matches families with appropriate service providers. To function effectively, communities need to have networks of support to meet the needs of families by linking them with the most appropriate agency and streamline services. As a respondent described:

> Coordinated intake is an opportunity to assess the family's need and then direct them to the program or programs that best meet that family's needs. It supports the idea that services are available in the community on a continuum. You should look at an individual family and assess their needs and then determine where they fit on that continuum. That helps you avoid a situation where families are enrolled in multiple programs unnecessarily, which then frees up slots for families who may not have been served before because the slots were taken by [another] family.

---

[13] Home Visiting Task Force. (2013). Work Plan. Draft 4. Distributed at 1/29/13 HVTF meeting.
[14] Illinois Department of Human Services. (2013). ACF Performance Progress Report. State Advisory Council Final Report.
[15] OECD, (2012, Nov 2), Illinois MIECHV Update Retrieved from http://www2.illinois.gov/gov/OECD/Documents/HVTF_MIECHVP/MIECHVP/MIECHV%20Update%202012-11-02.pdf

According to respondents familiar with the work, the MIECHV communities' experiences with coordinated intake have been as varied as the communities themselves. One informant noted:

> The coordinated intake process has probably been the most difficult transition. We have different developmental stages in each of the communities. There have been difficulties in many of the communities. Although they see the need for [coordinated intake], part of the issue has been that if the community is not completely on board with coordinated intake across funders then you only have a small coordinated intake for one sect of participants.

This is one example of the necessity of aligning community systems development efforts and coordinated intake efforts. As the implementing body for MIECHV, OECD and its partners recognize that "the communities are all over the map as far as how it's working out and how they communicate with each other." Thus, as reported by one respondent, "We are working diligently in each of the MIECHV communities and will also be working with the volunteer communities [to provide technical assistance]."

As part of MIECHV, representatives of OECD and Children's Home and Aid have assisted the MIECHV community systems developers with a shared framework for their work. They visit each MEICHV agency at least once a month and may check in more frequently to help address issues as they arise. For example, the representatives have offered advice on raising an uncomfortable issue within an agency or facilitating an objective conversation within the local collaborative. In addition, representatives from ISBE and IDHS have reached out to their MIECHV-funded programs to "see how things were going and whether there were other supports that could provide help to them with the whole MIECHV initiative." Updates on the MIECHV collaboration and community systems work are regularly shared during full HVTF meetings and CSDS meetings. One respondent noted:

Figuring out how to offer equitable community systems development and collaboration support statewide is an ongoing topic of discussion and one that is impacted by a multitude of factors. Several informants referred to additional "volunteer communities," which will not receive MIECHV funding or be responsible for the benchmarks. The "volunteer communities" will institute coordinated intake and CQI processes and participate in MIECHV trainings as a bellwether for increased equity. One state-level stakeholder highlighted the shared recognition that "they wish there would be more support for non-MIECHV communities." She voiced her hope that the ELC's CSDS and SIAC work would "develop a shared understanding of what it means to be a high-quality community system for early childhood—what the components are, what the expectations are, how its measured, and how can we get there together" would have "broad impact." She continued:

> Once we have those kinds of guidelines in place we can share collaboration statewide, and share with all the state funders. I think we're also trying to engage the state funders in a conversation about what

> structures we have in place right now that support local community systems; what we are asking of them in contracts; how we can make that more cohesive; and how we braid or blend [funds] to make something stronger?

**Health Connections**

Concurrent with these developments, the HVTF focused considerable attention on connecting health systems with home visiting systems in SFY 2013. In response to great needs in the area of maternal child health, the HVTF created the Health Connections priority work area during its reorganization at the end of SFY 2012. The HVTF work plan specifically charges the Health Connections Work Group with improving coordination between health and home visiting systems. Much of the work group's focus since its inception has been developing recommendations for increased coordination between the maternal child health and home visiting systems.[16] At each meeting, small groups reported on findings and proposed recommendations for discussion on select health areas (e.g., oral health, medical home, breast feeding). A set of draft recommendations has been created and is still being refined. Once that process is complete, the recommendations will be delivered to the ELC's SIAC work group and then presented to the ELC. At the end of SFY 2013, the HVTF Executive Committee approved the work group's request to merge into the ELC's SIAC Health Connections Work Group after its recommendations were submitted.

According to HVTF's Health Connections meeting minutes, the work group also discussed the importance of home visiting programs being "actively involved in community systems, because although home visitors are not expected to be able to hold all the appropriate resource information for families, it is critical that they know *how* to get the right information and refer the family to that resource."[17] The meeting minutes also indicate support for the principles of coordinated intake:

> Home visiting models need to know about each other so they can work together to refer families to other, more appropriate home visiting models or other services in the community that better meet the needs of the family. Home visiting models should be able to find opportunities for families so that their needs can be met.

During SFY 2013, the Health Connections Work Group, together with the OECD, has served in an advisory capacity to the Illinois Chapter of the American Academy of Pediatrics' (ICAAP) work with the MIECHV initiative. Under MIECHV, ICAAP is working to connect home visiting programs and medical homes. Six ambassadors were hired from agencies working within MIECHV communities to serve as

---

[16] Home Visiting Task Force Health Connection Workgroup (sic). (2012, March 19). Meeting Minutes. Retrieved from http://www2.illinois.gov/gov/OECD/Documents/HVTF_MIECHVP/Health%20Connections/HVTF%20Health-Minutes-03%2019%2012.pdf

[17] Home Visiting Task Force Health Connection Workgroup (sic). (2012, Oct 15). Meeting Minutes. Retrieved from http://www2.illinois.gov/gov/OECD/Documents/HVTF_MIECHVP/Health%20Connections/Health%20Connections%20-%20Minutes%20-%2010%2015%2012.pdf

liaisons between home visitors and medical homes.[18] Concurrently, ICAAP provided technical assistance to the ambassadors and MIECHV staff on strategies to improve communication between families and primary care physicians. It also developed a draft tool kit for data sharing tools and processes.[19] For example, medical home referral and care coordination forms were developed and distributed to facilitate information sharing in compliance with HIPPA and FERPA standards. This work is ongoing. Once the HVTF's Health Connections Work Group is discontinued, the ICAAP updates will be made directly to the HVTF.

## Training and Professional Development

Through Strong Foundations, Illinois implemented a "big tent" approach, offering training in four topics—domestic violence, substance abuse, perinatal depression, and parental learning disabilities—to any home visiting staff member regardless of model, beginning in 2009. These training topics, collectively known as the Big 4, were based on specific needs identified in the research literature and by home visiting staff in the state. For the last 2 years, the Strong Foundations training umbrella has also offered the Happiest Baby on the Block (HBOB) self-study certification program, strengthening families trainings on protective factors and on understanding trauma, and supervisor learning communities. All of these trainings will be discussed in the next chapter.

The decision to suspend the HVTF's training work group left a void in the home visiting community—it no longer had a formal mechanism in place to raise questions about how new training topics would be determined and implemented. The current HVTF work plan includes the objective, "Develop and implement a consistent approach to competency-based professional development (training, technical assistance and consultation) that efficiently facilitates transfer of knowledge and best practices in home visiting throughout the State."[20] The OECD and the Ounce of Prevention's Training Institute (hereafter, "Training Institute") were given responsibility for the action steps to achieve that goal, to "ensure the various trainings and professional development opportunities are well coordinated and provided in an integrated framework to home visiting program staff." A state-level stakeholder again offered that "training and professional development strategies should be discussed at the Home Visiting Task Force level, even if the discussion is offering a strategic approach to make sure trainings are integrated at the [Ounce] Training Institute and then have the Institute report to the Task Force once or twice a year."

[18] HVTF Health Connections. (2012, Mar 19). Meeting Minutes. Retrieved from http://www2.illinois.gov/gov/OECD/Documents/HVTF_MIECHVP/Health%20Connections/HVTF%20Health-Minutes-03%2019%2012.pdf

[19] MIECHV Health Connections Update. (2013, Mar 7). Distributed at March 11, 2013 HVTF Health Connections meeting.

[20] Home Visiting Task Force. (2013). Work Plan. Draft 4. Distributed at 1/29/13 HVTF meeting.

During interviews in SFY 2013, respondents familiar with the work reported that, indeed, the HVTF executive committee, the Strong Foundations Partnership through OECD, and the Ounce of Prevention do regularly engage in discussions about training topics and implementation. As one participant familiar with such meetings shared, "Their mindset is about what home visitors need, and what they are experiencing, and then what we can give them as tools. They're going beyond just what the models require in terms of training and thinking about how to better prepare the population of home visitors to serve families." However, some stakeholders were not aware of these ongoing training discussions, which suggests that information about training strategies and implementation needs to be communicated more broadly and stakeholders need additional opportunities to give input.

Strengthening the state's home visiting training and professional development infrastructure has been a focus of Strong Foundations since its beginning because stakeholders consider it essential to improving the quality of services for families. The topic of training and professional development has also been a major part of the Strong Foundations evaluation. In the next chapter, we with further discuss specific findings on this topic.

## Financing and Sustainability

Financing and sustaining Illinois's home visiting infrastructure and programming is complicated. At the federal level, budgets face the threat of sequestration. For example, sequestration reduced MIECHV funding by 5.1 percent.[21] In Illinois, state-level stakeholders worked to minimize the impact of sequestration by changing work plans and not hiring for open staff positions. The state is fortunate to have over two decades of investment in research-based home visiting. In addition, Illinois has, as one informant noted, "a substantial home visiting commitment from both an education funding stream and a social human services funding stream." Another informant went further in discussing the multiple funding streams:

> Funding is siloed through the separate line items and budgets. Yes, those dollars still come through different budgets, but I think that's the strength of the system and a not a weakness of the system. I think to be significantly in two state agency budgets as well as taking advantage of a every federal initiative that we can we strengthens the potential funding sustainability.

However, as documented in the last several Strong Foundations reports, Illinois has a severe budget crisis that impacts the entire state. In April 2013, Illinois received an unexpected $1.3 billion as residents and

[21] http://www2.illinois.gov/gov/oecd/documents/early%20learning%20council/council/6.24%20elc%20email%20handouts.pdf.pdf

businesses took advantage of the 2012 federal tax rates.[22] While this influx of funds helped Illinois reduce its backlog of unpaid bills by $1.4 billion, there was still an estimated 6.1 billion dollar backlog at the end of SFY 2013 in June. Given the state's ongoing fiscal crisis, funding remains a core challenge to sustaining home visiting infrastructure and programs. To address this vital issue, the HVTF's Sustainability Work Group was charged to "identify opportunities to leverage existing money and expand state and federal funding for evidence-based home visiting programs."[23] This is yet another example of the resiliency of the systems building work. Raising questions and seeking innovative solutions is part of maintaining a resilient system. In order to maximize sustainable funding opportunities the ELC's Systems Integration and Alignment Committee's work plan included collaborating with the HVTF's Sustainability Work Group.[24]

Members of the HVTF's Sustainability Work Group met six times in SFY 2013 in order to seek solutions to the funding situation and review their ongoing work.[25] The group looked at the possibility of social impact bonds, a "financing model to accelerate social innovation and improve government performance."[26] Social impact bonds "inject private-sector capital into traditionally public sector activities producing more cost-effective practices in both sectors."[27] The Sustainability Work Group determined that social impact bonds were not a viable strategy at that point and continued to explore the possibility of billing Medicaid for home visiting work. During SFY 2013, Illinois's Comptroller prioritized payments to nonprofit organization and to agencies that received Medicaid dollars in order to take advantage of federal matching funds. [28] In addition there is the possibility of creating a "trust fund" or "lock box" to "capture the funds generated by billing Medicaid for home visiting [services] and ensure they are directed back into the [home visiting] programs instead of into General Revenue Funds."[29]

---

[22] Topinka, J. B. (2013, July). Bill Backlog Drops…For Now. The Illinois State Comptroller's Quarterly, 10. Retrieved from: http://www.ioc.state.il.us/index.cfm/resources/comptrollers-quarterly/quarterly-edition-10-july-2013-bill-backlog-dropsfor-now/

[23] Home Visiting Task Force Work Plan. (2012). Distributed at 7/9/12 HVTF meeting.

[24] Systems Integration and Alignment Committee Work Plan. (2012). Retrieved from http://www2.illinois.gov/gov/OECD/Documents/Early%20Learning%20Council/Sys%20Align%20and%20Integration/Systems%20Integration%20and%20Alignment%20Committee%20Work%20Plan.pdf

[25] See http://www2.illinois.gov/gov/OECD/Pages/HVTF-Sustainability.aspx

[26] Liebman, J. (2011, Feb 9). Social Impact Bonds: A Promising New Financing Model to Accelerate Social Innovation and Improve Government Performance. Washington, DC: Center for American Progress. Retrieved from: http://www.americanprogress.org/issues/open-government/report/2011/02/09/9050/social-impact-bonds/. Liebman specifically references the federal home visiting program as an example of a service that could benefit from social impact bonds.

[27] Roman, J. K. (2013, Feb 26). Social Impact Bonds. Retrieved from: http://www.urban.org/UploadedPDF/901558-Social-Impact-Bonds.pdf

[28] Lester, Kerry. (2013, June 10). Despite Windfall, Illinois Still to Lag on Bills. Retrieved from: http://www.nbcchicago.com/blogs/ward-room/Despite-Windfall-Illinois-Still-to-Lag-on-Bills--210752341.html#ixzz2Z9FtgsfI

[29] HVTF Sustainability Work Group Meeting Notes. (2013, May 23). Retrieved from: http://www2.illinois.gov/gov/OECD/Documents/Early%20Learning%20Council/HVTF/Sustainability/Sustainability%20WG%20Mtg%20May%2023%202013%20NOTES%20FINAL.pdf

Several informants share their impression that this "sustainability strategy has the potential to expand the capacity of home visiting programs to bill for the services they provide."

As our informants indicated, there is still a large amount of work to do before the Sustainability Work Group would be in the position to make Medicaid recommendations to the HVTF, but they hoped to do so by December 2013. Informants were candid in discussing the challenges presented in billing Medicaid for home visiting services. One informant stated:

> Many components of home visiting services can currently be billed under Medicaid but what's missing is the ability to bill Medicaid for the really essential component, which is the educational aspect of supporting the parents and creating a healthier early learning environment for their children. [For example,] teaching the parents a certain game that they can play with their children or a strategy to help their child stop crying or asking questions like, "Why do you think your child is crying?"

Another informant explained an additional challenge:

> Part of it is knowing what's billable and then it's also having the infrastructure in your agency to do the actual billing. We've heard that from agencies that are quite large that they wouldn't be able to do it—that it would be overly burdensome for them to bill Medicaid. So, there are practical considerations there, but it seems like a more viable option.

An analysis by the workgroup showed that approximately 42 home visiting providers in the state bill Medicaid.[30] These programs may have the infrastructure in place to be able to bill for some home visiting services. Some respondents who were less familiar with the ongoing work of the Sustainability Work Group questioned the Medicaid strategy. One informant simply stated, "I think if they're counting on Medicaid, that's just too limiting. The state's broke." Another expressed her concern that "many programs aren't equipped to bill for Medicaid." A third respondent questioned the equity of Medicaid billing across program models: "Medicaid is going to work for Healthy Family programs if they're based in facilities where they're already getting Medicaid for other things. How do you think that's going to fly in a school district [through which many PAT models are funded]?"

As stated earlier, looking at Medicaid is not the only avenue the Sustainability Work Group has pursued. One informant lauded the work group's efforts, saying, "They are looking at every possibility, at what other states have done, and they are revisiting some things we've looked at on and off for years but haven't been able to figure out a way to make it work. With the Affordable Care Act, there may be some new opportunities."

---

[30] HVTF Sustainability Work Group Meeting Notes. (2013, May 23). Retrieved from: http://www2.illinois.gov/gov/OECD/Documents/Early%20Learning%20Council/HVTF/Sustainability/Sustainability%20WG%20Mtg%20May%2023%202013%20NOTES%20FINAL.pdf

Many informants also mentioned the ability to leverage other opportunities and raise awareness as key components in the state's sustainability plans. One informant said, "It's really important that we leverage what we're doing against the other federal grants in the state. You've got to see how we fit together. How do your goals and activities help them achieve their goals?" Another respondent provided an example of this from a recent federal grant submission "to demonstrate the important concepts, the process, the content, and organize the Trauma-Informed Practice field for birth to three." The goals of this proposed initiative included organizing the trauma training field, building a shared definition of what trauma-informed practice is and what training should include, and creating common language to build more awareness and integrate it more into the domains of the early childhood system. The initiative would use the six MIECHV communities as pilots for training and staff capacity building.

Although the ability to leverage federal opportunities was considered important for sustaining Illinois's home visiting system, at least one stakeholder expressed concern about relying so heavily on federal funding: "It does worry me a little bit that we keep building this cross-state infrastructure on federal grant money. There is the danger then that the money goes away and then the infrastructure goes away. It's my experience that somehow, somewhere, there's always another federal grant to grab onto."

In line with incorporating home visiting into new grant opportunities and collaboration with the larger early childhood development system, a few informants spoke enthusiastically about the need to leverage President Obama's new support for early childhood education and home visiting services. According to one informant,

> The conversation rose to a much higher level when [President] Obama announced early childhood and Preschool for All. It was no longer just the early childhood community talking about the need for early childhood funding; it was a much bigger community. Although I haven't seen any immediate change, I don't think it's ever going to go back to a separate group; the understanding of the importance of early childhood is only growing.

Another informant attributed the new emphasis on home visiting to the ongoing ground work that has been done at the community and state levels:

> All these advocacy groups and all these states—Illinois is a big one, but all these other states too—have really stepped up. We started a national lobby effort and pushed it on certain congressmen and we did the same thing they've done in Illinois so well for so long to try to get the issue out there. And then it started to be picked up in the press.

Increasing public awareness is also vital to sustainability efforts. To advance the cause of home visiting, stakeholders and advocates continue to seek the engagement of the business community. As mentioned in previous Strong Foundations reports, a public awareness campaign was part of the initial implementation

plan; however, it was sidelined when the funding was cut. One stakeholder talked about the need to move forward with a public awareness campaign:

> After talking to several different states and getting technical assistance we realize that the public awareness is a huge piece that we need to get on board with and pursue. We're looking right now at social media, Facebook, a website for home visitors, but also a website for home visiting in general throughout Illinois, not just for MIECHV but for all programs. We're looking at Twitter accounts to sustain that day to day, and then also a general public awareness campaign. And if we start talking about the public awareness campaign it would be how can we get the best bang for our buck.

All of these components relate directly to sustainability of home visiting systems and indirectly to sustainability of actual home visiting programs. Likewise, issues that directly impact sustainability of home visiting programs affect the sustainability of a home visiting infrastructure. For example, several stakeholders raised the issue of low staff salaries, saying this makes it difficult for programs to maintain a well-trained workforce. According to one informant, "We've seen quite a bit of variation across the state on what they're paying home visitors. So it certainly isn't as easy as it sounds, but I think in order to maintain people in the field they need to be paid more than working at [fast food restaurant]." Another explained how wages affects staff retention and ability of programs to develop relationships with families:

> We know that home visiting is based upon engagement and retention in relationships. If you constantly have staff turnover, you don't have that. So how are you retaining your staff? It's wonderful and great to have a higher calling, but if you cannot pay your rent or buy groceries as a home visitor, you can't stay in the field, so we lose some very important people.

Another respondent shared that she had recently learned from a master's level supervisor that the supervisor's salary was only $25,000. The state-level stakeholder was appalled, explaining, "That's not a living wage. And that's a supervisor with a master's degree. That's insane. I don't know why she's still there. They don't pay them enough to retain them. So we spend all this money on training people and the local agencies are not paying them enough for them to be able to stay."

In the view of another informant, there did not appear to be an easy solution to this issue because there could be unintended consequences of recommending higher salaries.

> You can't require [higher salaries], or how hard it would be to have an agency with multiple funding streams pay their staff that are funded through one funding stream one salary, and the staff that works next to them and does the same thing a lower salary from a different funding stream. Look at how that would damage the fabric of the agency.

Even if funders agreed to have a certain minimum salary requirement, without additional funding to support higher salaries, there would be service reductions. Yet another informant said:

> Now you have to lay somebody off to cover the increased salaries. So how do you then demonstrate, or document for the legislators, who are the real funders, why your caseload dropped so significantly with the same funding level? Because to them, that means that the program is not working. Fewer families are being served and it's costing more.

Another aspect of maintaining a well-trained workforce has to do, of course, with the availability and appropriateness of the trainings offered to home visiting staff. In addition to the training and professional development issues covered in the next section of this report, changes imposed by national home visiting models also have an impact on the availability of training. For example, the PAT national model instituted substantial changes to its fee structure with increases of 280 percent.[31] Representatives from Illinois Birth-to-Three Institute (IBTI) and ISBE were successful in negotiating lower fees, not only for Illinois, but across the country.

## Summary

Throughout the evaluation of the Strong Foundations initiative, we observed growth in several domains that impact the state's home visiting infrastructure. Most notable was growth in the areas of leadership and governance, state-level collaboration and partnerships, and professional development and training, some highlights of which are below:

- Leadership and governance: a more formalized approach to public/private partnerships; an interagency, intergovernmental approach for home visiting work facilitated by the OECD and HVTF executive committee; a broadening of the HVTF executive committee to ensure broader perspectives were represented and equity on behalf of the home visiting stakeholders; and, a collective impact approach and renewed emphasis on developing improved strategies for data collection, data reporting, and monitoring.
- Collaborations and partnerships: increased collaboration across the multiple agencies that implement and monitor home visitation policies and practices; growing partnerships have led to an increased understanding of shared goals, which has impacted the home visiting field since the start of Strong Foundations.
- Professional development/training and supporting quality: evaluation findings reflect the state's efforts to create a culture of training and ongoing learning that is increasingly being integrated into home visiting programs; 600 home visiting stakeholders participated in Innovations in Quality: Home

[31] Home Visiting Task Force. (2013, April 9). Executive Committee Meeting Notes. Retrieved from http://www2.illinois.gov/gov/OECD/Documents/Early%20Learning%20Council/HVTF/HVTF%20Exec%209Apr2013%20NOTES%20FINAL.pdf

Visiting Summit, the first time that all of the models, funders, and stakeholders came together for a day of conversation and workshops about quality in home visiting programs.

We also saw a number of ongoing challenges for the system, for example, developing common monitoring and reporting requirements across program models and strengthening local service systems. We also observed how system-building and program implementation are affected by the larger political, social, and economic context. In addition, we found that the state system was able to be flexible and resilient in responding to both economic challenges and new resources.

# Training and Professional Development

Bolstering Illinois's home visiting training and professional development infrastructure has been an essential component of the 4-year Strong Foundations implementation. From the beginning, stakeholders have consistently shared a commonly held goal regarding the training of home visiting staff. In the words of one informant, "I want home visitors to go out and be equipped to deal with the issues that come up. There are certain aspects of home visiting that they need to be prepared to deal with. Research-based training leads to better outcomes and ultimately better lives for families." Another informant explained the importance and purpose of trainings developed as part of Strong Foundations as follows:

> Our goal [with regard to training] is to try to help home visitors from whatever model they are aligned with to feel supported in a learning experience and see connections. They should be able to see how every training experience they have connects to what they're required to do—not just by their model or by their supervisor, but by what they're experiencing in the field. Your goal is to get someone to feel like they've got the knowledge and the skills that match the complexity and difficulty of the task, and that's a hard thing to do.

The work of the Strong Foundations Partnership to cultivate a culture that supports quality, relevant, and accessible training is another characteristic of resiliency within the home visiting infrastructure. Through Strong Foundations, Illinois implemented a "big tent" approach, offering certain training topics to any home visiting staff member regardless of model, beginning in 2009. This big tent approach is consistent with the concept of collective impact (Kania & Kramer, 2011), which stresses the importance of increasing cross-sector alignment and learning among many organizations for large-scale impact. The Training Institute, in collaboration with the former training committee of the HVTF, developed the Strong Foundations training opportunities, collectively known as the Big 4, in response to specific needs

identified in the research literature and by home visiting staff in the state. The Big 4 topics address issues of domestic violence, substance abuse, perinatal depression, and parental learning disabilities.

For the last 2 years, the Strong Foundations training umbrella has also offered Happiest Baby on the Block (HBOB) certifications, a self-study program on an infant soothing technique. It also offered and Strengthening Families trainings on protective factors (which are designed to deepen the understanding between protective factors and prevention) and on understanding trauma (which looks at the relationship between exposure to trauma and child development and parenting). Supervisor learning communities (also referred to as supervisor learning networks) are yet another component of the Strong Foundations trainings that were offered over the last 2 years. These learning communities' trainings were facilitated to provide additional support to supervisors on the Big 4 and Strengthening Families topics and provide a venue for networking.

## Big 4 Training Opportunities

During the study period, the statewide training system for home visiting expanded the number of trainings offered and training locations throughout Illinois. Through Strong Foundations, the Ounce of Prevention's Training Institute implemented new trainings and supports specifically tailored for home visitors and their supervisors. These trainings, known as the Big 4, were facilitated by both a content expert and a home visiting expert with an eye towards the home visitor's role. In the first year of implementation, SFY 2010, perinatal depression trainings were facilitated two times in each of four different geographic regions. The following year, SFY 2011, domestic violence and substance abuse trainings were offered in addition to another round of perinatal depression trainings. Each of these three topics was offered once in the four geographic regions. In Year 3 of implementation, SFY 2012, young parents with learning challenges joined the course offerings; again, all of the trainings were scheduled once per each of the four geographic regions. In SFY 2013, as supervisor learning community opportunities increased, the Big 4 trainings were not offered as often as they were in prior years. Strong Foundations trainings on perinatal depression, substance abuse, and young adults with learning challenges were each offered twice in the Chicago region and once in Springfield during SFY 2013. The domestic violence curriculum Futures without Violence was offered to home visiting staff in MIECHV communities which factored into the decision to only offer the Strong Foundations domestic violence training once in Chicago in SFY 2013. Brief descriptions of the trainings can be found in Appendix C.

Through Strong Foundations, home visitors and supervisors were eligible to attend Big 4 trainings that address issues of perinatal depression, domestic violence, substance abuse, and young adults with learning challenges (YALC). Strong Foundations also provided supervisors with additional learning opportunities to help them support staff who work with families with Big 4 issues, while also offering an opportunity

them to network and learn from their peers. The Chapin Hall evaluation team conducted pretest, posttest, and follow-up surveys to study the impact of specific trainings on home visiting staff knowledge and skills and supervisor specific trainings held in SFY 2012 and SFY 2013.

## Participation in Big 4 Training

In January 2011, Chapin Hall began collecting sign-in sheets for all of the Big 4 trainings. As shown in Table 3, the substance abuse and perinatal depression trainings were each offered ten times over the three fiscal years for which we have sign-in sheet data, while the domestic violence training was offered nine times, and the YALC training, eight times. The substance abuse training involved the largest number of attendees.

Although not shown in the table, there were more attendees at the Chicago trainings than those at rural locations. This is partly explained by the higher concentration of programs near the Chicago training location and a larger number of initial training registrants. However, attendees located near the training location could "drop in" and sign up on the day of training, which occurred at many of the Chicago and Springfield trainings. We also noticed that for each of the fiscal years for which we have data, there were more attendees during the months of January through April than other months across all of the training topics. This might reflect the fact that home visitors and supervisors have more time for training during this time, or perhaps organizational budgets are in a better position to cover expenses related to training at this time compared to other times.

Based on sign-in sheet data collected from January 2011 through June 2013, 774 individuals signed in to at least one of the Big 4 trainings. Most people attended just one training (191 people), 122 attended two Big 4 trainings, 77 attended three Big 4 trainings and 27 attended all four of the Big 4 trainings offered. However, not all of these individuals completed their trainings' pre- and posttests. There are 64 individuals (most likely a duplicated count) who completed surveys at the time of their trainings, but did not provide any identifying information. Therefore, we are unable to determine if they attended other Strong Foundations Big 4 trainings or completed follow-up surveys.

The Big 4 trainings have a capacity of 40 people per class. As shown in Table 3, the classes were rarely filled to capacity. Attendance ranged from an average of 13 attendees for the three perinatal depression trainings held in SFY 2013 to a high of 31 attendees for the three substance abuse trainings held in SFY 2011. As indicated on the training sign-in sheets, those who preregistered did not always attend as scheduled. As a result, a training might appear full and closed to additional registrations, but then be half empty on the day of the training due to "no shows" or last minute cancellations.

**Table 3. Training Attendance by Training Topic [a]**

| | SFY 2011<br>01/01/11–06/30/11 | SFY 2012<br>07/01/11– 06/30/12 | SFY 2013<br>07/01/12– 06/30/13 |
|---|---|---|---|
| **Domestic violence** | | | |
| Total attendees | 82 | 59 | 27 |
| Total trainings offered | 4 | 4 | 1 |
| Mean (*sd*) attendees per training | 20.5 (*12.01*) | 14.8 (*10.21*) | 27 |
| Range of attendees per training | 11–36 | 9–30 | 27 |
| **Substance abuse** | | | |
| Total attendees | 92 | 91 | 53 |
| Total trainings offered | 3 | 4 | 3 |
| Mean (*sd*) attendees per training | 30.7 (*5.86*) | 22.8 (*11.38*) | 17.7 (*5.86*) |
| Range of attendees per training | 24–35 | 11–33 | 11–22 |
| **Perinatal depression** | | | |
| Total attendees | 75 | 58 | 40 |
| Total trainings | 4 | 3 | 3 |
| Mean (*sd*) attendees per training | 18.8 (*9.54*) | 19.3 (*8.50*) | 13.3 (*4.04*) |
| Range of attendees per training | 10–27 | 11–28 | 11–18 |
| **Young adults with learning challenges** | | | |
| Total attendees | — | 139 | 58 |
| Total trainings offered | — | 5 | 3 |
| Mean (*sd*) attendees per training | — | 27.8 (*8.84*) | 19.3 (*8.39*) |
| Range of attendees per training | — | 18–42 | 14–29 |

[a] The counts in this table include only those individuals who provided their names on the sign-in sheets.

Chapin Hall began tracking the Big 4 trainings in SFY 2011. However, that year was considered a pilot year for the training evaluation process.[32] Not all of the training topics were offered that year and the evaluation surveys were revised after being piloted in SYF11. Thus, the findings in this section are based on data collected only in SFY 2012 and SFY 2013. The Big 4 trainings were evaluated through multiple methods beginning in the second half of SFY 2011 and continuing through the spring of SFY 2013. The evaluation methods used included pre- and posttraining surveys at the time of training and follow-up surveys. In SFY 2010 and SFY 2012, focus groups and in-person interviews at the Strong Foundations study sites included a discussion of the Big 4 trainings offered to date. In addition, state-level respondents were asked about the Big 4 trainings and its role in the state's infrastructure beginning in SFY 2011.

Findings in this section are based on surveys collected during SFY 2012 and SFY 2013from 423 Big 4 training attendees. This was 81 percent of the total number of attendees who signed in to a training in SFY 2012 or SFY 2013. Follow-up surveys were collected from 189 attendees (36% of all attendees). Of the 423 initial survey respondents, 136 (32%) also completed a follow-up survey. The difference between the number of attendees who completed a follow-up survey and the number who completed both a day of and a follow-up survey is the result of efforts to increase the response rate for the follow-up surveys.

[32] Information about the SFY 2011 trainings can be found in Spielberger, Gitlow, Winje, Harden, & Banman, 2013.

Anyone who signed in to a training session was sent an invitation to participate in a follow-up survey, even if they did not complete the initial survey the day of the training. This resulted in an additional 53 follow-up surveys being collected which could not be matched to any day of surveys. There were also a small number of individuals, 64 in all, who completed the day of surveys, but did not provide any matching information.

**Results of the Strong Foundations Big 4 Pre- and Postsurveys**

Table 4 is based on the data collected in the demographic section of the day of survey. These surveys were provided to staff who attended any of the Big 4 trainings during SFY 2012 and SFY 2013. Although not significant, we found that home visitors made up the majority of the day of survey respondents and they primarily represented the Parents as Teachers and Healthy Families programs. Most of the survey respondents also reported having at least a 4-year college degree, which is beyond the educational requirements for home visitors in both the Parents as Teachers and Healthy Families programs. We also found that there were a few characteristics fairly evenly distributed among all Big 4 survey respondents. For example, the racial or ethnic group with which survey respondents identified was fairly evenly split among white, Hispanic, and black. With regard to age, survey respondents were fairly evenly split among all five categories. However, there were slightly fewer survey respondents who reported being 50 years old or older. It is also noteworthy that home visiting staff who primarily use Spanish in their work attended each training topic.

The significant difference we found with regard to survey respondent characteristics was the length of time survey respondents had been employed in their current positions. Overall, about 76 percent of survey respondents had been in their position for 5 years or less. However, a significantly greater percentage of staff who attended perinatal depression trainings (55%) had worked in their position for less than a year. Only between 27 and 37 percent of survey respondents for the other topics had worked in their position for less than a year.

## Table 4. Characteristics of Big 4 Training Participants

| Characteristics | Percent Completing Surveys on Day of Training[a] | | | | |
|---|---|---|---|---|---|
| | All trainings *N* = 423 | Substance abuse *n* = 132 | Domestic violence *n* = 64 | Perinatal depression *n* = 67 | YALC *n* = 160 |
| **Program model** | | | | | |
| Parents as Teachers | 45 | 46 | 43 | 52 | 41 |
| Healthy Families | 36 | 39 | 34 | 30 | 37 |
| Baby Talk | 5 | 6 | 7 | 2 | 4 |
| Nurse-Family Partnership | 3 | 3 | 3 | 5 | 1 |
| Early Head Start | 2 | 1 | 2 | 2 | 3 |
| Multiple models/Other model | 10 | 6 | 12 | 10 | 14 |
| **Role in organization** | | | | | |
| Home visitor | 69 | 71 | 66 | 73 | 67 |
| Doula | 5 | 4 | 2 | 10 | 6 |
| Supervisor | 4 | 4 | 3 | 6 | 4 |
| Program director | 1 | 1 | 0 | 0 | 2 |
| Center-based staff | 1 | 1 | 2 | 0 | 1 |
| Multiple roles[b] | 10 | 9 | 19 | 8 | 8 |
| Other[c] | 10 | 10 | 8 | 3 | 13 |
| **Race/ethnicity** | | | | | |
| White | 45 | 47 | 31 | 58 | 44 |
| Hispanic | 25 | 29 | 31 | 25 | 20 |
| Black | 23 | 20 | 31 | 9 | 29 |
| Asian | 1 | 1 | 2 | 2 | 0 |
| American Indian/Native American | 0 | 0 | 0 | 0 | 1 |
| Multiple races/ethnicities/Other | 6 | 4 | 7 | 6 | 7 |
| **Age** | | | | | |
| 20–29 years | 27 | 31 | 27 | 28 | 24 |
| 30–39 years | 25 | 24 | 32 | 23 | 24 |
| 40–49 years | 23 | 22 | 23 | 26 | 22 |
| 50 years or older | 25 | 23 | 18 | 23 | 31 |
| **Education** | | | | | |
| High school diploma/GED | 3 | 4 | 2 | 0 | 4 |
| Some college | 12 | 11 | 13 | 10 | 13 |
| 2-year college | 16 | 15 | 18 | 16 | 16 |
| 4-year college | 44 | 49 | 36 | 48 | 43 |
| Graduate school | 23 | 22 | 29 | 22 | 22 |
| Other | 2 | 0 | 3 | 3 | 3 |
| **Length of time in current position**** | | | | | |
| Less than 1 year | 35 | 33 | 37 | 55 | 27 |
| 1 to 5 years | 41 | 47 | 42 | 27 | 41 |
| 6 to 10 years | 14 | 11 | 15 | 9 | 18 |
| 10 or more years | 11 | 9 | 7 | 9 | 15 |

[a] These numbers are duplicated as survey respondents could attend more than one training and within some items respondents could check more than one item. The number of responses to each item ranged from 411 to 416.

[b] Forty-one respondents indicated more than one job title; of these 41, five indicated having three job titles. All others mentioned having just two. Only one of these respondents did not list home visitor as one of their job titles.

[c] Fifteen of the 40 individuals who noted "other" as their sole job title self-identified as either parent educator or family support worker rather than home visitor.

Chi square differences are statistically significant at $*p < .05$, $**p < .01$, and $***p < .001$.

## Big 4 Training Survey Respondents' Satisfaction Levels

At the close of the training sessions, all participants were asked to rate the degree to which they agreed with six statements about their satisfaction with the day's training. They responded using a scale of 0 to 4. While all of the responses were positive—between 3.4 and 3.7 and in the "strongly agree" range (see Table 5) we did find significant differences on four of the statements included in the satisfaction survey. For the items "the content was useful and relevant to my profession" and "the training increased my knowledge," we found that the domestic violence training was ranked significantly higher than substance abuse and YALC trainings. For the item "the content was useful and relevant to my profession," the perinatal depression training was ranked significantly higher than both substance abuse and YALC trainings. However, for "the training increased my knowledge," only perinatal depression ranked significantly higher than substance abuse. For the items "I plan to integrate what I learned today into my work" and "the content and material applies to the families with whom I work," perinatal depression training was ranked significantly higher than substance abuse. For the item "I plan to integrate what I learned today into my work," YALC training was ranked significantly higher than perinatal depression.

In addition, Table 5 shows significant differences on four of the statements included in the satisfaction survey. For example, for the items "I plan to integrate what I learned today into my work" and "The content and material applies to the families with whom I work," perinatal depression ranked significantly higher than substance abuse. For the item "I plan to integrate what I learned today into my work," YALC was ranked significantly lower than perinatal depression.

## Table 5. Participants' Perspectives on Training Content

| Survey item | Mean (*sd*) Rating of Agreement by Training Topic[a] | | | | |
|---|---|---|---|---|---|
| | **All trainings** ***N*** **= 423** | **Substance abuse** ***n*** **= 132** | **Domestic violence** ***n*** **= 64** | **Perinatal depression** ***n*** **= 67** | **YALC** ***n*** **= 160** |
| I plan to integrate what I learned today into my work | 3.7 (*0.51*) | 3.6 (*0.52*) | 3.7 (*0.48*) | 3.8 (*0.52*) | 3.7 (*0.50*) |
| The content of the training was useful and relevant to my profession | 3.6 (*0.56*) | 3.5 (*0.61*) | 3.8 (*0.37*) | 3.8 (*0.52*) | 3.6 (*0.56*) |
| The content and material presented at the training today applied to the families with whom I work | 3.6 (*0.56*) | 3.5 (*0.54*) | 3.7 (*0.58*) | 3.8 (*0.53*) | 3.6 (*0.56*) |
| The training increased my knowledge of the subject | 3.6 (*0.62*) | 3.4 (*0.66*) | 3.8 (*0.44*) | 3.7 (*0.58*) | 3.5 (*0.64*) |
| The training included new material that I had not heard before | 3.4 (*0.70*) | 3.3 (*0.75*) | 3.5 (*0.59*) | 3.6 (*0.64*) | 3.3 (*0.72*) |

[a] Respondents rated the extent to which they agreed or disagreed with each statement on a 4-point scale: 1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree. The number of responses to each item ranged from 413–421.
The Bonferroni post hoc tests indicate differences by training topic in: "the content was useful and relevant to my profession" between substance abuse and domestic violence ($p < .001$), substance abuse and perinatal depression ($p < .01$), domestic violence and YALC ($p < .01$), and perinatal depression and YALC ($p < .05$); in "the training increased my knowledge of the subject" between substance abuse and domestic violence ($p < .01$), substance abuse and perinatal depression ($p < .05$), and domestic violence and YALC ($p < .05$); in "I plan to integrate what I learned today into my work" between substance abuse and perinatal depression ($p < .05$), substance abuse and YALC ($p < .05$), and in "the content and materials applied to the families with whom I work" between substance abuse and perinatal depression ($p < .05$).

In addition to asking training participants about their satisfaction with the training topics, survey respondents were also asked to respond to eight questions about the trainers themselves (see Table 6). Their responses used a 4-point scale ranging from 1 ("strongly disagree") to 4 ("strongly agree"). The responses to these items were also very positive with all of the responses falling between 3.6 and 3.7.

There were some significant differences among the four training topics on four of the statements. We found that for the items "the presenters clearly communicated the subject matter," "the presenters made good use of examples and materials," and "the presenters kept the session alive and interesting" the domestic violence trainings ranked significantly higher than the YALC trainings. For "the presenters made good use of examples and materials," "the presenters possessed the appropriate qualifications and expertise on the topic," and "the presenters kept the session alive and interesting" the domestic violence trainings also ranked significantly higher than the substance abuse trainings. For the statement "the presenters possessed the appropriate qualifications and expertise" on the topic, the perinatal depression trainings ranked significantly higher than the substance abuse trainings.

## Table 6. Participants' Perspectives on Quality ofTraining

| Survey item | Mean (*sd*) Rating of Agreement by Training Topic[a] | | | | |
|---|---|---|---|---|---|
| | **All trainings** ***N*=423** | **Substance abuse** ***n*=132** | **Domestic violence** ***n*=64** | **Perinatal depression** ***n*=67** | **YALC** ***n*=160** |
| The presenters were well organized | 3.7 (*0.51*) | 3.7 (*0.51*) | 3.8 (*0.38*) | 3.8 (*0.53*) | 3.6 (*0.55*) |
| The presenters involved the group through discussion and/or other learning activities | 3.7 (*0.52*) | 3.7 (*0.51*) | 3.8 (*0.47*) | 3.7 (*0.58*) | 3.7 (*0.52*) |
| The presenters possessed the appropriate qualifications and expertise on the topic | 3.7 (*0.54*) | 3.6 (*0.65*) | 3.9 (*0.32*) | 3.8 (*0.49*) | 3.7 (*0.51*) |
| The presenters clearly communicated the subject matter | 3.7 (*0.55*) | 3.6 (*0.54*) | 3.8 (*0.39*) | 3.8 (*0.50*) | 3.6 (*0.61*) |
| The presenters made good use of examples and materials | 3.6 (*0.52*) | 3.6 (*0.54*) | 3.8 (*0.37*) | 3.8 (*0.53*) | 3.6 (*0.55*) |
| The training allowed time for participation, questions and discussion | 3.6 (*0.55*) | 3.6 (*0.48*) | 3.7 (*0.54*) | 3.7 (*0.55*) | 3.6 (0.60) |
| The training was well timed and coordinated | 3.6 (*0.56*) | 3.6 (*0.57*) | 3.8 (*0.44*) | 3.7 (*0.54*) | 3.5 (*0.59*) |
| The presenters kept the session alive and interesting | 3.6 (*0.57*) | 3.6 (*0.61*) | 3.8 (*0.39*) | 3.6 (*0.65*) | 3.6 (*0.55*) |

[a] Respondents rated the extent to which they agreed or disagreed with each statement on a 4 point scale: 1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree. The number of responses to each item ranged from 416 to 423.
The Bonferroni post hoc tests indicate differences by training topic for: "the presenters clearly communicated the subject matter" between domestic violence and YALC ($p < .05$); "the presenters made good use of examples and materials" between substance abuse and domestic violence ($p < .05$) and domestic violence and YALC ($p < .05$); "the presenters possessed the appropriate qualifications and expertise on the topic" between substance abuse and domestic violence ($p < .001$) and substance abuse and perinatal depression ($p < .01$); and "the presenters kept the session alive and interesting" between substance abuse and domestic violence ($p < .05$) and between domestic violence and YALC ($p < .05$).

Again, when training participants were asked to respond to statements about whether or not the training met its stated objectives, their ratings were fairly positive, ranging from 3.3 to 3.4 on a 4-point scale. However, survey respondents were less positive about the overall training and the trainers themselves. Significant differences were found between the four training topics on all four of the statements in this satisfaction scale (see Table 7). We found that perinatal depression trainings ranked significantly higher than substance abuse trainings and that domestic violence ranked significantly higher than YALC for all four statements. Additionally, domestic violence rankings were significantly higher than substance abuse rankings for all of the statements except "Identify appropriate community resources and procedures to inform and link families affected by [training topic]." Perinatal depression ranked significantly higher than YALC for all statements except "Identify the types, characteristics and causes of [training topic]." Finally, for the statement "Identify appropriate community resources and procedures to inform and link families affected by [training topic]," substance abuse ranked significantly higher than YALC.

### Table 7. Participant Views on Whether Training Met Objectives

| Training Objective | Mean (*sd*) Rating of Agreement by Training Topic[a] | | | | |
|---|---|---|---|---|---|
| | **All trainings (*N* = 423)** | **Substance abuse (*n* = 132)** | **Domestic violence (*n* = 64)** | **Perinatal depression (*n* = 67)** | **YALC (*n* = 160)** |
| Identify the types, characteristics, and causes of [training topic] | 3.4 (*0.61*) | 3.4 (*0.63*) | 3.7 (*0.44*) | 3.7 (*0.55*) | 3.3 (*0.61*) |
| Describe barriers to receiving help for [training topic] | 3.4 (*0.65*) | 3.2 (*0.69*) | 3.7 (*0.45*) | 3.6 (*0.57*) | 3.2 (*0.63*) |
| Describe appropriate actions and precautions in working with families affected by [training topic] | 3.4 (*0.62*) | 3.3 (*0.59*) | 3.6 (*0.56*) | 3.7 (*0.56*) | 3.3 (*0.63*) |
| Identify appropriate community resources and procedures to inform and link families affected by [training topic] | 3.3 (*0.71*) | 3.3 (*0.58*) | 3.6 (*0.56*) | 3.6 (*0.57*) | 3.0 (*0.78*) |

[a] Respondents rated the extent to which they agreed or disagreed with each statement on a 4 point scale: 1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree. The number of responses to each item ranged from 403 to 415.
The Bonferroni post hoc tests indicate differences by training topic for: "identify the types, characteristics, and causes of [training topic]" between substance abuse and domestic violence ($p < .001$), substance abuse and perinatal depression ($p < .01$), domestic violence and YALC ($p < .001$), perinatal depression and YALC ($p < .001$); "describe barriers to receiving help for [training topic]" between substance abuse and domestic violence ($p < .001$), substance abuse and perinatal depression ($p < .001$), domestic violence and YALC ($p < .001$), perinatal depression and YALC ($p < .001$); "describe appropriate actions and precautions in working with families affected by [training topic]" between substance abuse and domestic violence ($p < .01$), substance abuse and perinatal depression ($p < .001$), domestic violence and YALC ($p < .01$), perinatal depression and YALC ($p < .001$), for "identify appropriate community resources and procedures to inform and link families affected by [training topic]" between substance abuse and perinatal depression ($p < .01$), substance abuse and YALC ($p < .001$), domestic violence and YALC ($p < .001$), and perinatal depression and YALC ($p < .001$).

Survey respondents were asked to indicate how easy or how difficult the content and material presented in the training was on a five-point scale ranging from 1 ("too easy") to 5 ("too difficult"). The ratings ranged from 2.7 to 2.9 ("on target") across all training topics.

One of the last sets of satisfaction questions covered three topics. Survey respondents were asked whether they would recommend the course to others, whether they would need follow-up training on the topic just covered, and if the training increased the survey respondents' desire to stay in the home visiting field. The respondents were instructed to respond "yes," "no," or "maybe." As shown in Table 8, we found significant differences between training topics with regard to recommending the course to others and needing follow-up on the topic. We found that perinatal depression training survey respondents were significantly more likely to emphatically recommend the course to others and also significantly less likely to warrant follow-up training on their topic.

**Table 8. Participant Opinions of the Course**[a]

| | All trainings (*N* = 423) | Substance abuse (*n* = 132) | Domestic violence (*n* = 64) | Perinatal depression (*n* = 67) | YALC (*n* = 160) |
|---|---|---|---|---|---|
| **I would recommend this course to others**** | | | | | |
| Yes | 89 | 88 | 97 | 100 | 81 |
| Maybe | 8 | 9 | 3 | 0 | 13 |
| No | 3 | 3 | 0 | 0 | 6 |
| **I feel I need follow-up training on this subject**** | | | | | |
| Yes | 30 | 31 | 29 | 18 | 35 |
| Maybe | 34 | 35 | 34 | 24 | 36 |
| No | 36 | 34 | 37 | 58 | 29 |
| **Today's training has increased my desire to stay in this field** | | | | | |
| Yes | 78 | 71 | 79 | 88 | 80 |
| Maybe | 15 | 23 | 12 | 9 | 13 |
| No | 7 | 6 | 10 | 3 | 7 |

[a] The number of responses to each item ranged from 411 to 421. Each row indicates the percentage responding as indicated. Chi square differences statistically significant at *$p < .05$, **$p < .01$, and ***$p < .001$.

Survey respondents were also asked to rate opportunities for training on a five-point scale ranging from 1 ("poor") to 5 ("excellent"). Across the four training topics, ratings ranged from 3.6 to 4.0 ("very good"); substance abuse and perinatal depression training survey respondents rated training opportunities the highest.

## Big 4 Training Survey Respondents' Confidence Levels

Table 9 below summarizes average knowledge and confidence scores across the four trainings administered at two points in time—pretest and posttest. Pretest scores on all four training topics were significantly lower ($p < .001$) than posttest scores on a 1 to 5 rating scale for all four training topics. Pretest mean scores fell between 2.9 and 3.2 and indicated an average knowledge or confidence level of "not sure." However, at the time of the posttests, mean scores ranged from 4.0 for YALC to 4.3 for domestic violence and perinatal depression. This suggests that survey respondents were "confident" in their knowledge as a result of the training. The effect sizes, as measured by Cohen's *d* (mean scores relative to the pooled standard deviations of within group variation),[33] indicate very large effects for all four training topics. Therefore, it appears that the training positively impacted the survey respondents' confidence and knowledge levels on the subject.

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

**Table 9. Comparison of Participants' Pretest and Posttest Levels of Knowledge and Confidence[a]**

| Topic | *n* | Mean Rating: Pretest Mean (*sd*) | Mean Rating: Posttest Mean (*sd*) | *sig.* | Cohen's *d*[c] |
|---|---|---|---|---|---|
| Substance abuse | 129 | 3.2 (*0.84*) | 4.1 (*0.47*) | *** | 1.32 |
| Domestic violence | 64 | 3.2 (*0.95*) | 4.3 (*0.47*) | *** | 1.47 |
| Perinatal depression | 67 | 2.9 (*0.69*) | 4.3 (*0.42*) | *** | 2.45 |
| YALC[b] | 160 | 2.9 (*0.75*) | 4.0 (*0.54*) | *** | 1.68 |

Paired sample t-tests indicate pretest and posttest difference in rating is statistically significant at * p < .05, ** p < .01, *** p < .001.

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

[b] YALC survey respondents only completed 4 questions; all others completed 5 questions.

[c] We used an Effect Size calculator, available at: http://www.uccs.edu/~lbecker/

Next, we looked at the mean scores of those individuals who completed both a pretest at the time of the training and a follow-up survey approximately 3 months after the training (see Table 10. The sample sizes for these analyses are smaller than in the previous analyses due to the low response rates to the follow-up surveys. For these subsamples of survey respondents, the mean pretest score for all four training topics ranged from 2.8 to 3.2 ("unsure"). However, approximately 3 months after the training occurred, knowledge and confidence mean scores continued to be high—scores fell between 3.9 and 4.2 ("confident"). For these analyses, the pretest mean scores were significantly lower than the 3-month follow-up mean scores at p < .001 for all training topics except domestic violence. For that topic, the pretest scores were significantly lower than the follow-up means at p < .01. Again, the effect sizes for all four training topics is very large, which suggests that the training had a long lasting impact on the survey respondents' confidence and knowledge levels. (Results should be taken with some caution. The test questions were developed for the current study; they are not standardized and have not been tested for reliability.)

**Table 10. Participants' Levels of Knowledge and Confidence at Pretest and Follow-up[a]**

| Topic | *n* | Mean Rating: Pretest Mean (*sd*) | Mean Rating: Follow-up Mean (*sd*) | sig. | Cohen's *d*[c] |
|---|---|---|---|---|---|
| Substance abuse | 35 | 2.9 (*0.78*) | 4.0 (*0.52*) | *** | 1.66 |
| Domestic violence | 25 | 3.2 (*0.91*) | 4.0 (*0.36*) | ** | 1.16 |
| Perinatal depression | 19 | 3.1 (*0.60*) | 4.2 (*0.47*) | *** | 2.04 |
| YALC[b] | 57 | 2.8 (*0.76*) | 3.9 (*0.62*) | *** | 1.59 |

Paired sample t-tests indicate pretest and follow-up differences in rating is statistically significant at * p < .05, ** p < .01, *** p < .001.

[a] Respondents rated their knowledge and confidence level across 4 or 5 items on a 5 point scale: 1 = not at all confident, 2 = not very confident, 3 = not sure, 4 = confident, and 5 = very confident.

[b] YALC survey respondents only completed 4 questions; all others completed 5 questions.

[c] We used an Effect Size calculator, available at: http://www.uccs.edu/~lbecker/

Finally, we looked at the subsamples of training survey respondents who completed all three surveys (pretest, posttest and follow-up) and compared their mean knowledge and confidence scores at the three time points. As with previous analyses, we found that the pretest scores were fairly low—between 2.9 and 3.2 ("not sure") but at posttest, they had increased to between 4.0 and 4.3. Scores remained consistent at follow-up, with means ranging from 3.9 to 4.2. The differences between pretest and posttest were significantly different for all four training topics, but the differences between posttest and follow-up were not significantly different for any of the four training topics.

## Big 4 Training Survey Respondents at 3-Month Follow-up

On the follow-up surveys we also asked respondents three questions regarding how they use the information they gained at the trainings (see Table 11). Respondents used a four-point scale to respond to these questions ranging from 1 ("strongly disagree") to 4 ("strongly agree"). Rankings for all three items ranged from 3.1 to 3.3 ("agree"). We found three significant differences on two of the items. For the item "I shared the information I learned with my colleagues," we found that domestic violence ranked significantly higher than YALC. For the item "I have used information from the training in my work with families," perinatal depression ranked significantly higher than both substance abuse and YALC.

On all of the satisfaction items in the pretest, posttest and follow-up surveys, the YALC training was consistently rated lower than the other trainings (although ratings were still, overall, positive). However, it also had the highest attendance and follow-up response rates. These findings might reflect the fact that the YALC was the most recent addition to the training menu.

**Table 11. Use of Training Information from Long-term Follow-up Surveys[a]**

| | Mean (*sd*) Rating of Agreement by Training Topic[b] | | | | |
|---|---|---|---|---|---|
| | **All trainings (*N* = 165)** | **Substance abuse (*n* = 33)** | **Domestic violence (*n* = 32)** | **Perinatal depression (*n* = 34)** | **YALC (*n* = 66)** |
| I shared the information I learned with my colleagues | 3.3 (*0.72*) | 3.3 (*0.60*) | 3.5 (*0.72*) | 3.5 (*0.61*) | 3.1 (*0.78*) |
| I have used information from the training in my work with families | 3.2 (*0.71*) | 3.1 (*0.69*) | 3.2 (*0.77*) | 3.6 (*0.50*) | 3.1 (*0.74*) |
| This training has changed how I handle issues of [training topic] | 3.1 (*0.79*) | 3.0 (*0.81*) | 3.0 (*0.89*) | 3.4 (*0.67*) | 3.0 (*0.76*) |

[a] This table includes responses from all respondents in SFY 2012 and SFY 2013 who answered the follow-up questions, regardless of participating in the pre and postsurvey. Follow-up surveys were administered approximately 3 months after training. The number of responses to each item ranged from 157 to 165.

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

The Bonferroni post hoc tests indicate the following differences by training topic: in the "I shared the information I learned with my colleagues" item, between domestic violence and YALC ($p < .05$) and in the "I have used information from the training in my work with families" between substance abuse and perinatal depression ($p < .05$) and perinatal depression and YALC ($p < .01$).

## Supervisor Learning Communities

In SFY 2012, Strong Foundations established supervisor learning communities (SLCs) around domestic violence and perinatal depression in response to the unique training needs of supervisors. In SFY 2013 SLCs were offered around young adults with learning challenges and the two Strengthening Families trainings, protective factors and understanding trauma. Promotional materials for the SFY 2013 SLCs describe the goal of the training communities as follows:

> Our hope is to build strong supports for staff through highly effective supervisory reinforcement and encouragement. The intention and goal of this series of Learning Communities is to help mitigate the risk factors in the population we serve that often leads to discouragement, burn-out and high turnover rates. Supervisors play a critical role in "being there" for staff that may be well trained, but need their resolve bolstered from time to time when serving families who are overburdened, under stress and present risk. The learning communities will also provide an overview of three of the topic areas covered last year through training for direct service staff (Ounce of Prevention, 2012).

Appendix C provides a brief description of these trainings.

During SFY 2013, we evaluated the Strong Foundations home visiting supervisor learning communities. We used similar methods as those used for evaluating Big 4 trainings, that is, pre- and postsurveys at the time of the sessions and follow-up surveys approximately 3 months later. As with the Big 4 trainings, state-level respondents were asked about their views on the training system and its role in the state's infrastructure. Findings in this section are based on surveys from 40 duplicated supervisor learning community attendees at baseline (93% of the 43 attendees who signed in to a training completed a pre– or posttest or both) and 24 duplicated follow-up surveys (56% of the 43 attendees who signed in to a training completed a follow-up survey). There were also two individuals who completed the day of surveys, but who did not provide any matching information. Thus, we may have follow-up surveys for these individuals but are unable to match it to the day of surveys. Twenty-five people attended just one Strong Foundations home visiting supervisor learning communities training and nine people attended two.

Chapin Hall collected sign-in sheets for all supervisor learning communities trainings offered in various locations throughout Illinois. As indicated in the state systems chapter, there were twelve supervisor learning communities trainings scheduled during SFY 2013. Due to low enrollment, seven sessions were cancelled. The protective factors training was completed once during the fiscal year and understanding trauma and young adults with learning challenges trainings were each completed twice during the year. The Strong Foundations home visiting supervisor learning community on YALC had the most attendees; a total of 26 people attended the two sessions (see Table 12).

**Table 12. Strong Foundations Home Visiting Supervisor Learning Communities Training Attendance[a,b]**

| | SFY 2013 (7/1/2012–6/30/2013) |
|---|---|
| **Protective factors** | |
| Total attendees | 7 |
| Total trainings | 1 |
| Mean (*sd*) attendees per training | N/A |
| Range of attendees per training | N/A |
| **Understanding trauma** | |
| Total attendees | 12 |
| Total trainings | 2 |
| Mean (*sd*) attendees per training | 6 (*0.00*) |
| Range of attendees per training | 6 |
| **Young adults with learning challenges** | |
| Total attendees | 26 |
| Total trainings | 2 |
| Mean (*sd*) attendees per training | 13.0 (*1.41*) |
| Range of attendees per training | 12–14 |

[a] Counts may not be accurate due to people attending a training, but not signing in.
[b] The counts in this table include only those individuals who provided their names on the sign-in sheets. Anyone who attended a training but did not sign in is not included in these counts.

## Supervisor Learning Communities Pre- and Postsurveys

Due to the small sample size, we combined the results from all three training topics for the analysis of the supervisor learning communities' survey data. As shown in Table 13, the majority of the participants in the supervisor learning communities were from Parent as Teachers or Healthy Families programs and were supervisors in their respective programs. However, close to a quarter of survey respondents noted that they held multiple roles in their organizations.

Almost half of the survey respondents were white and a third were Hispanic. Over two-thirds of the participants were between the ages of 30 to 49 years. Over three-quarters of survey respondents held either a bachelor's degree or a graduate degree, which is consistent with the educational requirement for supervisors in both Parents as Teachers and Healthy Families programs. Three-quarters of survey respondents have held their current position for 5 years or less. Survey respondents indicated that they supervise three home visitors (on average) and spend about 13 hours per month in supervision. This is also consistent with both the Parents as Teachers and Healthy Families model, which require 4 hours of supervision per home visitor per month.[34]

[34] Information comes from: SFY 2010 Compliance Chart for HFI and Essential Requirements 09052012 for PAT.

## Table 13. Characteristics of Supervisors Learning Communities Training Participants

| Characteristic | Percent (*N* = 40)[a] |
|---|---|
| **Program model** | |
| Parents as Teachers | 40 |
| Healthy Families | 37 |
| Baby Talk | 13 |
| Early Head Start | 5 |
| Nurse-Family Partnership | 0 |
| Multiple models | 3 |
| Other | 3 |
| **Role in organization** | |
| Supervisor | 47 |
| Program director | 18 |
| Home visitor | 8 |
| Doula | 3 |
| Multiple roles[b] | 24 |
| **Race/ethnicity** | |
| White | 45 |
| Hispanic | 34 |
| Black | 18 |
| Multiple races/ethnicities | 3 |
| **Age** | |
| 20–29 years | 13 |
| 30–39 years | 37 |
| 40–49 years | 32 |
| 50 years or older | 18 |
| **Education** | |
| High school diploma/GED | 3 |
| Some college | 5 |
| 2-year college | 13 |
| 4-year college | 34 |
| Graduate school | 45 |
| **Length of time in current position** | |
| Less than 1 year | 24 |
| 1 to 5 years | 51 |
| 6 to 10 years | 16 |
| 10 or more years | 8 |
| **Number of home visitors currently supervising** | |
| Mean (*sd*) | 3.0 (*1.80*) |
| **Hours spent in supervision each month** | |
| Mean (*sd*) | 12.7 (*11.55*) |

[a] These numbers are duplicated, as survey respondents could attend more than one training. In addition, within some questions respondents could check more than one item.
[b] Nine respondents indicated more than one job title; of these nine, two indicated three job titles while all others mentioned just two.

Half of the survey respondents reported that they had attended a previous supervisor learning community during SFY 2013. Half of these respondents had attended a domestic violence session. Just over a third had attended the perinatal depression, substance abuse, or YALC supervisor learning communities trainings and 5 percent had attended a SLC on the topic of trauma-informed care.

**Prior Experience and Expectations**

Prior to the day's training, survey respondents were asked about the relevancy of the training topic to their day-to-day work and the frequency of opportunities to enhance their supervisory skills or network with other supervisors. As indicated in Table 14, participants highly rated the relevancy of the topic. With regard to opportunities to enhance their own supervisory skills—either through additional trainings or through networking opportunities—respondents indicated that they "sometimes" have these opportunities.

**Table 14. Pretraining Perspectives on Supervisor Learning Communities Training(*N* = 40)[a]**

| Characteristics | Mean (*sd*) |
|---|---|
| How relevant is today's topic for home visitors in your agency? | 3.7 (*0.53*)[b] |
| How relevant is today's topic in your supervision of home visitors? | 3.7 (*0.48*)[b] |
| How often do you interact or network with other home visiting supervisors? | 3.0 (*0.92*)[c] |
| How often have you had the opportunity to receive supervisory skills training outside of introductory or core model-specific training? | 2.5 (*0.88*)[c] |

[a] This is a duplicated count
[b] Respondents were asked to rate each statement on a 4-point scale: 1 = not relevant, 2 = rarely relevant, 3 = sometimes relevant, and 4 = frequently relevant.
[c] Respondents were asked to rate each statement on a 4-point scale: 1 = never, 2 = rarely, 3 = sometimes, and 4 = frequently.

Again, prior to the start of the day's training, survey respondents were asked why they decided to participate in the Strong Foundations home visiting supervisor learning community training (see Table 15). The majority (83%) of the survey respondents reported that they would like to gain specific supervisor skills related to the topic, and over half said they would be interested in follow-up trainings on the day's topic.

**Table 15. Reasons for Participating in Supervisors Learning Communities Training (*N* = 40)**

| Characteristic | Percent |
|---|---|
| I would like to gain specific supervisor skills related to this topic | 83 |
| I am interested in additional training on this topic | 58 |
| I would like to network with other supervisors who use the same home visiting model | 50 |
| My service population has increased needs on this topic | 43 |
| I would like to network with other supervisors who use a different home visiting model | 23 |

We also asked participants in the supervisor learning communities before the training if they hoped to meet, network, or consult with other home visiting supervisors who were at the same session. Nearly all (88%) responded affirmatively, while the others responded "not sure." After the session, we asked the same question of the participants. Again, a large majority (80%) percent reported that yes, they still would like to meet, network, or consult with the other survey respondents. Fifteen percent said they were "not sure," and 5 percent (two respondents) said "no," that they would not want to meet, network, or consult with the other survey respondents.

**Knowledge and Confidence Levels**

Table 16 summarizes knowledge and confidence mean scores across the four trainings administered at three points in time—pretest, posttest, and 3-month follow-up. The pretest mean score from the Strong Foundations supervisor learning communities was 3.7, just under "confident" on a 1 to 5 rating scale. However, at the time of the posttest, the mean score of 4.2 was significantly higher ($p < .001$), suggesting that survey respondents were a little more than "confident" in their knowledge as a result of the training. The effect sizes, as measured by Cohen's *d* (mean scores relative to the pooled standard deviations of within group variation) indicate very large effects for the Strong Foundations home visiting supervisor learning communities between pretest and posttest. [35]

**Table 16. Change in Participants' Levels of Knowledge and Confidence**

| | | Mean Rating | | | |
|---|---|---|---|---|---|
| **Topic** | ***N*** | **Pretest Mean (*sd*)** | **Posttest Mean (*sd*)** | **Sig.** | **Cohen's *d*[b]** |
| All trainings | 32 | 3.7 (*0.50*) | 4.2 (*0.46*) | *** | 1.04 |

Paired sample *t*-tests indicate pretest and posttest differences in rating is statistically significant at * $p < .05$, ** $p < .01$, *** $p < .001$.

[a] Respondents rated their knowledge and confidence level on a 5-point scale: 1 = not at all confident, 2 = not very confident, 3 = not sure, 4 = confident, and 5 = very confident.

[b] We used an Effect Size calculator, available at: http://www.uccs.edu/~lbecker/

We also looked at the mean scores of those individuals who completed both a pretest at the time of the Strong Foundations home visiting supervisor learning community training and a follow-up survey approximately 3 months after the meeting (see Table 17). The sample size for this analysis is smaller than in the previous analysis due to the low response rate to the follow-up surveys. For this subsample of survey respondents, the mean pretest score was 3.7 or just less than "confident," and approximately 3 months after the training occurred, the mean score was slightly higher (4.1) but continued to be in the

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

"confident" range. For this analysis, the pretest mean score was significantly lower than the follow-up mean score and the effect size for this analysis is large. A straightforward interpretation is simply that survey respondents indicated more confidence in their knowledge at follow-up than they did at pretest. Results should be taken with some caution, as the test questions were developed for the current study; they are not standardized and have not been tested for reliability.

**Table 17. Change in Participants' Levels of Knowledge and Confidence; Pretest and Follow-up[a]**

| Topic | *N* | Mean Rating: Pretest Mean (*sd*) | Mean Rating: Follow-up Mean (*sd*) | Sig. | Cohen's *d*[b] |
|---|---|---|---|---|---|
| All trainings | 23 | 3.7 (*0.52*) | 4.1 (*0.53*) | * | 0.76 |

Paired sample *t*-tests indicate differences in pretest and follow-up ratings are statistically significant at * $p < .05$, ** $p < .01$, *** $p < .001$.
[a] Respondents rated their knowledge and confidence level on a 5 point scale: 1 = not at all confident, 2 = not very confident, 3 = not sure, 4 = confident, and 5 = very confident.
[b] We used the Effect Size calculator available at http://www.uccs.edu/~lbecker/

Finally, we looked at the subsample of survey respondents who completed all three surveys (pretest, posttest, and follow-up) and compared their mean knowledge and confidence scores at each of the three time points. As in the previous analyses, we found that the pretest scores were lower than the post and follow-up scores, but mean scores at all three time points were in the "confident" range.

### Satisfaction and Evaluation

At the end of the training, we asked participants about their satisfaction with six items. Table 18 shows the responses to the six satisfaction items. Again, the levels of satisfaction reported by the survey respondents of the Strong Foundations Home Visiting Supervisors Learning Communities was rather high, ranging from 4.5 to 4.8 on a five-point scale, with 1 being "below average" and 5 being "excellent". The highest rated item was "[The day's trainers] showed enthusiasm and interest" while the lowest rated item was "[The trainer] was well organized."

**Table 18. Participant Satisfaction with Supervisors Learning Communities, Posttraining**

| Characteristics | Mean (*sd*)[a] (*N* = 37) |
|---|---|
| Trainer showed enthusiasm and interest | 4.8 (*0.50*) |
| Trainer kept the session alive and interesting | 4.7 (*0.53*) |
| Trainer involved the group through discussion and other learning activities | 4.6 (*0.68*) |
| Trainer clearly communicated the subject matter | 4.5 (*0.73*) |
| Trainer made good use of examples and materials | 4.5 (*0.77*) |
| Trainer was well organized | 4.4 (*0.77*) |

[a] Respondents were asked to rate each statement on a 5-point scale: 1 = below average, 2 = between below average and average, 3 = average, 4 = between average and excellent, and 5 = excellent.

One of the last sets of satisfaction questions on the day of postsurvey covered four topics. Participants in the Strong Foundations home visiting supervisor learning communities were asked to state if the information presented was new, whether they would recommend the course to others, whether they would need follow-up training on the topic just covered, and whether they would be able to apply the course material to their jobs. Participants were asked to answer "yes," "no," or "somewhat." The responses are shown in Table 19.

**Table 19. Participants' Satisfaction with Strong Foundations Home Visiting Supervisor Learning Communities Offerings**

| Characteristic | Percent (*N* = 38) |
|---|---|
| **The information presented was new to me** | |
| No | 16 |
| Yes | 24 |
| Somewhat | 61 |
| **I would recommend this course to others** | |
| No | 0 |
| Yes | 87 |
| Somewhat | 13 |
| **I feel that follow-up training on this subject is needed** | |
| No | 30 |
| Yes | 35 |
| Somewhat | 35 |
| **I will be able to apply this course material to my job** | |
| No | 0 |
| Yes | 81 |
| Somewhat | 19 |

## Supervisor Learning Communities Survey Respondents at 3-Month Follow-up

The follow-up survey also asked respondents about the impact of the Strong Foundations Home Visiting Supervisors Learning Communities 3 months after the meeting (see Table 20). With regard to whether survey respondents' awareness or knowledge (or both) of referral sources for families had increased, about three-quarters reported that it had increased at least "somewhat." This was also indicated in our analysis of the pretest to follow-up mean scores. With regard to whether survey respondents' interaction with other had changed, a little over a third reported that their interactions had increased.

**Table 20. Results of the Strong Foundations Home Visiting Supervisor Learning Communities**

| Characteristics | Percent (*N* = 24) |
|---|---|
| **Since the Supervisor Learning Communities meetings this past year, has your interaction with other home visiting supervisors changed?** | |
| No, my interaction with other home visiting supervisors has not changed | 58 |
| Yes, I interact more | 38 |
| Yes, I interact much more | 4 |
| **Since the Supervisory Learning Network meetings this past year, has your awareness/knowledge of referral sources for families increased?** | |
| No, my awareness/knowledge has not increased | 25 |
| Yes, somewhat | 63 |
| Yes, a lot | 13 |

# Other Learning Opportunities for Home Visiting Program Staff

## Happiest Baby on the Block (HBOB)

At the end of SFY 2011, Strong Foundations, in partnership with Prevent Child Abuse Illinois, began to offer home visiting programs the opportunity to have staff participate in the Happiest Baby on the Block (HBOB) certification process. Strong Foundations also provided HBOB with materials for participating programs' lending libraries, as well as parent kits and swaddling blankets for families. HBOB was developed as an approach for calming young children and, in turn, relieving parenting stress and promoting positive child and caregiver relationships. Developed with the intention of helping families avoid conflict with their young children around issues of crying, HBOB techniques facilitate infants' ability to self-soothe.

The HBOB component of Strong Foundations reaches only a small number of home visitors and their programs. In addition to the 26 home visitors from SFY 2011 and SFY 2012, 10 home visitors from HFI, PAT, and Early Head Start (EHS) participated in the program in SFY 2013. Nine completed the certification process. In SFY 2014, another 10 home visitors from each of the aforementioned models and from BabyTalk are expected to participate in the program. In addition, home visitors who were certified in SFY 2011 will be responsible for completing the recertification process as required every 3 years. Prevent Child Abuse Illinois continues to provide parent kits and swaddling blankets to certified home visitors for distribution to their families and is seeking additional funding to ensure sustainability of this component.

Prevent Child Abuse Illinois also provides technical assistance to the certified home visitors and their programs through newsletters and quarterly HBOB Advisory Committee meetings, in which all certified home visitors are encouraged to participate. SFY 2013 also brought additional technical assistance for the supplemental HBOB toolkit, which is comprised of a PowerPoint presentation that could be adapted for personal use during trainings, a presentation "Tip Sheet," and a sheet to help identify various available resources for the home visitor.[36] Twenty-seven people participated in the two teleconferences to learn more about the toolkits and to network with their fellow HBOB-certified colleagues about useful hints, challenges, and strategies. According to one informant familiar with the teleconferences, participants expressed their satisfaction with the HBOB technique and were appreciative of the ability to receive the parent kits and swaddling blankets for their families. Questions were raised about connections between the HBOB technique and the Fussy Baby Network, which is offered to some programs via MIECHV. As more home visitors are trained in both HBOB and Fussy Baby, it may be useful to have the administrators of both programs (Prevent Child Abuse Illinois and The Erikson Institute) collaborate on a document that explains both approaches. Another issue raised in the teleconferences was the new DCFS licensing standards which prohibit swaddling when putting a child to sleep. The new standards conflict with the Strong Foundations components of HBOB and Fussy Baby, which both encourage swaddling. Given this discrepancy, it may be beneficial to have a higher level discussion about the implications of the new standards with DCFS and Strong Foundations stakeholders.

### Strengthening Families

While Strengthening Families trainings on protective factors and understanding trauma have been offered under the Strong Foundations umbrella, data from these primary trainings were not collected as part of the Strong Foundations evaluation. (A small sample of training data pertaining to the SLCs on Strengthening Families topics was collected in SFY 2013, but not on the home visitors' trainings in these topics.) It was explained that due to several factors—including that Strengthening Families was in the midst of a transition due to a loss of DCFS funding and organizational restructuring—these trainings would not continue under Strong Foundations at this time.

### Children's Mental Health Services

Mental health has been identified as an area of high need throughout the evaluation of Strong Foundations. Illinois's early childhood development system, including the Strong Foundations Partnership, is committed to seeking pathways for improving access to children's mental health services. One state-level informant could not have stressed the importance of this area more when she stated:

[36] Prevent Child Abuse Illinois. (2013). Happiest Baby on the Block, Strong Foundations Summary SFY 2013.

> If I could do one thing in the rest of my career it would be to make mental health consultation a critical element in all the Home Visiting programs in Illinois. Without it there is a huge loss, while with it there are such huge gains. We've spent years through the [Illinois Children's Mental Health] Partnership building the network of consultants, but what we don't have is the funding mechanism to be able to provide for it. It is an essential and critical element of any home visiting program to have access to mental health consultation where the consultants are also able to provide trauma-informed guidance and training and transfer that knowledge to the home visiting staff. I think it is the number one issue in the home visiting, as far as I'm concerned.

The desire to increase children's mental health services was reflected in several of the 2013 evaluation interviews. Another informant said, "We want to continue to increase funding for infant mental health consultations even though we're being hit by sequestration."

Children's mental health work is being approached from several different perspectives to build that aspect of Illinois's home visiting infrastructure. The Illinois Children's Mental Health Partnership (ICMHP) is involved with home visiting and strengthening the home visiting infrastructure. As described in the project summary, the goal of the HFI/PTS Mental Health Consultation is to build and enhance home visiting programs and staff capacity to respond to the mental health needs of young children ages 0–5 years old and their families.[37] The project serves to raise awareness and increase understanding of program staff around issues including: appropriate interventions regarding specific behavioral concerns, postpartum depression and parent's mental health concerns, social and emotional development in early childhood, and many others. All of the involved programs received direct case consultation, trainings on topics requested by home visiting staff, home visit observations, facilitation of group work or play therapy, and reflection consultation with regard to how to improve upon the work of early childhood mental health. In addition, family consultation has been made available to programs that participated in latter cohorts of the HFI/PTS Mental Health Consultation work. This work includes reflective consultation to the family before or after treatment occurs (or both before and after), helping the home visitor connect a family to an appropriate provider, explaining expectations for participants who may seek treatment, and providing additional support to the home visitor.

In addition to the HFI consultation, ICMHP provides consultation to the six MIECHV communities. As described in last year's report, one home visiting program in each community was able to receive the full ICMHP model, while the other agencies in the communities receive reflective supervisory support and consultation. In SFY 2013, the majority of MIECHV sites were able to receive the full model. A respondent familiar with the work shared:

[37] Illinois Children's Mental Health Partnership. (2012, March, 26). Mental Health Consultation to HFI Strong Foundation Sites.

> Just about every [MIECHV] agency is getting the full model. The [Illinois Children's Mental Health] Partnership has been wonderful about using different creative methods in order to make sure that these agencies are supported. Of all the services that we've provided, the one consistent comment that we have heard back is that infant mental health consultation has made a difference in their practice. A huge difference; everyone loves it. Even the ones who originally were hesitant to get started because MIECHV already added a lot to their plates, are now saying, "Why wasn't I involved in this years ago? Thank you for bringing this to the community. It's been great."

The Fussy Baby Network component of MIECHV also plays a role by providing an infant mental health consultant. A respondent familiar with the work noted that while these types of consultation were complementary, there were differences between the two. She offered, "The Fussy Baby consultant works more closely with the individual home visitors, while the Partnership works more closely with the supervisor on reflective supervision and with the team as a whole." Also, outside of Strong Foundations, the Ounce of Prevention offers an infant mental health learning community. Given the group's popularity and targeted topic, leaders of the Strong Foundations Partnership indicated that they would like to see an additional infant mental health learning community offered.

### MIECHV Learning Communities

Finally, although not directly supported by Strong Foundations—and perhaps beyond the scope of this evaluation—we thought it was important to include information on learning communities offered to MIECHV home visitors, coordinated intake workers, and community systems developers. Beginning in SFY 2013, the Ounce Institute facilitated MIECHV learning communities to provide a supportive environment to enhance professional development and confidence. As described in the Ounce's course guide, the learning communities:

- provide a venue to discuss the unique elements, challenges, and strengths of the MIECHV program requirements;
- support and encourage shared learning experiences;
- create open and ongoing dialogue regarding each role and the responsibilities pertaining to that role; and
- focus on advancing best practices in the field of home visiting.

## Future Development of the Training Infrastructure

In this section, we briefly reflect on the successes and challenges for the training sector of the home visiting infrastructure during SFY 2013. We also consider what supplemental home visitor training—that is, training which is beyond the models' core requirements—looks like after the EBHV grant ends.

## Big 4 Topics[38]

The Big 4 trainings will not continue as cross-model, in-person trainings into SFY 2014. Instead, these trainings will be converted to an online series entitled, "Home Visiting Challenges." The rollout of the online format will begin with the perinatal depression training and be followed by domestic violence and substance abuse, which mirrors how the in-person trainings were rolled out. (There are currently no plans to put the Young Adults with Learning Challenges training into an online format.) Several factors influenced the decision to move these trainings online, the main factor being funding. Another reason cited was the need to "refresh" the trainings offered. State-level informants were quite candid in their desire to sustain the content and move forward with other needed training topics.

> I think the fact that they're going online, at least we have something. I do think there's something to be said for being in a room with other home visitors having a conversation. Things can get lost in translation online. I think that we need to figure out at a higher level how to continue those trainings because we know how important it is. We know that home visiting doesn't work unless you address those issues.

Another reason for changing to an online format may come from the steadily declining number of participants in the Big 4 trainings over the past 3 years. As shown in Table 3, the number of participants in the perinatal depression training dropped from 75 in SFY 2011, to 58 in SFY 2012, and to 40 in SFY 2013. That trend occurred across each of the training topics. Substance abuse had 92 and 91 participants in SFY 2011 and SFY 2012 respectively, but dropped to 53 participants in SFY 2013. The domestic violence training was only offered once during SFY 2013, which contributed to the number of participants dropping to only 27, down from 82 in SFY 2011 and 59 in SFY 2012. The young adults with learning challenges trainings included 139 participants in SFY 2012 and 58 in SFY 2013. This type of information should be part of the data that informs the future direction of the training infrastructure for home visiting. One respondent questioned why this decrease occurred:

> Is it that people feel that they've gotten the training and they need a deeper dive into it? I mean what is the reason, is it just not appealing? What's going on? Why aren't things being utilized? Maybe the Home Visiting Task Force needs to recommend that some of the questions are integrated into a survey document.

At the same time that the Big 4 trainings are transitioning from a traditional format to an online presence, MIECHV trainings are offering some overlap and support in some of the Big 4 areas, particularly domestic violence, mental health issues, and substance abuse. As mentioned above, the Big 4 domestic

[38] See the Program Quality and Fidelity chapter on training for more information on the Big 4 and Supervisory Learning Communities.

violence training was only offered once during SFY 2013. Part of the reason for that was that the Futures Without Violence training, a domestic violence curriculum specifically for home visitors, was offered to MIECHV sites in SFY 2013 (Futures Without Violence, 2011). The Strong Foundations Partnership is working with the Futures without Violence Train the Trainers program to train master's level staff at IDHS and ICADV and bring the training statewide. The Futures without Violence curriculum is available at no cost. It will be offered to MIECHV and non-MIECHV home visiting staff through IDHS and the Illinois Coalition Against Domestic Violence (ICADV). According to a state-level key informant familiar with the MIECHV work, "We want to institutionalize the Futures without Violence curriculum within the home visiting programs across Illinois, not just for MIECHV. Everything we are doing now—everything is open."

In SFY 2014, another curriculum is being offered to the home visiting community through MIECHV. This curriculum was developed in response to communities having difficulty accessing mental health resources for mothers (Home Visiting Task Force, 2013). Mothers and Babies is a curriculum developed at Johns Hopkins University which addresses mental health. One informant described the curriculum:

> Mothers and Babies is aimed at preventing the onset of perinatal depression and improving the mental health of families. While initially done with clinicians, the developers have now worked with home visitors who have the support of clinical staff. Three randomized control trials have indicated this intervention has positive outcomes. The developers will train home visiting staff as well as the Illinois Children's Mental Health Partnership (ICMHP). Infant mental health consultants will provide clinical support.

Mental Health First Aid (MHFA) is another training offered through MIECHV that supports home visitors in the area of mental health. A respondent described MHFA as "a training for non-mental health professionals on strategies to work with families who are in a mental health crisis—when you're there in the moment and something happens. What do you do?" During SFY 2013, MHFA was offered on three occasions, first to MIECHV sites and then to other home visitors as capacity allowed. However, training was not offered in all regions of the state. Going forward in SFY 2014, the goal is to offer MHFA in each of the geographic regions and to all home visitors. Funding and logistics may impede that goal.

In the area of substance abuse, during SFY 2013, home visiting staff within MIECHV communities were offered training on the 4P's Plus, a revised version of the 4P's (Parents, Partners, Past, and Pregnancy) screening tool. The tool includes questions regarding mental health, domestic violence, and substance use. While trained staff are able to use the screening tool and MIECHV is able to receive data on the number of positive screens, demographics, and number of referrals for families, budget constraints have prevented additional training on the 4P's Plus at this time.

As more trainings and other resources for professional development—for example, EBHV funding has helped support the Prevent Child Abuse Illinois conference and provided home visitors scholarships to attend—become available to the home visiting community at large, families and communities benefit from the shared knowledge of home visitors and their agencies. This developing infrastructure also helps to foster communication, sharing of ideas, and a general culture of learning in and among home visiting programs across the state.

### Supervisor Learning Communities Trainings

Twelve Supervisor Learning Communities trainings were scheduled for SFY 2013. Seven of the 12 were canceled due to low registration. This included all of the SLCs that were scheduled in the downstate region and one SLC in Springfield. Interestingly, the SLCs had been moved to the downstate locations in response to requests from the field. A respondent familiar with the challenges in meeting geographical needs commented:

> The field will push and push to have training in these remote locations and then –well there's just fewer people there. So it's a no-win situation. If you don't do it, they're mad; if you do do it, they don't show up, or there are not enough people to show up, and we go around and around. *Having to cancel is frustrating, but it's going to push us to greater innovation.*

Innovation is needed to ensure that effective, appropriate training opportunities are offered equitably throughout Illinois. GIS mapping of 2012 training locations in relation to home visiting programs in our previous report (Spielberger et al., 2013) indicated that sparsely populated areas of the state do not receive many training opportunities.[39] Recent news reports indicated that in Illinois "child abuse and neglect deaths in 2013 are occurring faster than at any time in 18 years, with more fatalities in Southern Illinois than in heavily populated northern communities."[40] Without access to training, not just SLCs but all relevant training, home visitors are ill-equipped to contend with the myriad of serious issues they confront on a regular basis.

Due to funding constraints, changes to home visiting curricula, and the low enrollment, Supervisor Learning Communities in SFY 2014 will not be offered in the same format as they have been these past 2 years. Instead of having learning communities across the home visiting models, the new SLCs will be offered by home visiting model. One reason for these changes is the lack of time supervisors have for additional meetings: "Supervisors have so much on their plates; it was hard for them to get to another

---

[39] Nor, as indicated in previous reports, do home visiting staff think there are adequate mental health services to which they can refer families.

[40] Metro, Gary. (2013, August 7). Child abuse and neglect deaths on the rise in state. The Southern Illinoisan. Retrieved from http://thesouthern.com/news/local/child-abuse-and-neglect-deaths-on-the-rise-in-state/article_ff8715a4-ff1c-11e2-bab4-0019bb2963f4.html#.UgJop6AWc-E.email

thing. They have MIECHV meetings, Fussy Baby meetings, Children's Mental Health Partnership meetings, and their regular cluster meetings. We have to look at what will work for them without making it harder." One informant suggested that supervisors are more interested in model-specific training rather than cross-model training: "Given how professional development is funded right now and because of the criteria and the kinds of information and skills home visitors need to be successful in the implementation of their models, we have to target an approach through the program models." Other informants said:

> We had at least a two hour conversation about how do we engage, especially supervisors. We came up with a few different strategies. One is that we do regionally based supervisor learning communities because there are so many model changes being rolled out. I think people might be driven together by virtue of the changes. Another strategy is to engage through existing venues on a regional basis.

> We're going to launch live learning communities around the home visiting models. So Healthy Families Illinois supervisors will have their own learning community four times a year, and Parents as Teachers will continue their regional networks four times a year. We are going to work with Baby Talk on some kind of regional meeting or regional networking for their model. And we're going to try to have some sort of coordination so that these learning communities can be: a combination of new learning and subject matter; a discussion about the future of home visiting in Illinois; and reflective practice so that supervisors can have a chance to meet with one another in a peer formation and talk about how reflective supervision is going with their own staff.

While these are all valid reasons for moving forward with model-based Supervisor Learning Communities, this shift also raises questions. Moving to model-based Supervisor Learning Communities still enables them to meet its objective of providing supervisory reinforcement to help support and retain well trained home visitors who contend with families facing certain risk factors. As one informant stated:

> We stress peer cooperation and peer collaboration and even peer supervision. If people are not getting supervision from on-high, come together with somebody that's a peer of yours just to discuss issues that you're not able to talk to anybody else about. And then it's nice to have people from another program that you can bounce your ideas off and so forth and so on.

However, returning to model-based services is a move away from the Strong Foundations' "big tent" approach. Such a change could result in creating more separation than integration of the different program models. A charge of the Strong Foundations EBHV grant was to build home visiting infrastructure specifically around three evidence-based programs—PAT, HFI, and NFP—but also with an eye towards creating a "big tent" for all home visiting programs in the state. Collaboration with NFP has not been as robust as was initially hoped. Indeed, when asked about the ability for NFP programs to participate in the new model-based SLC, one participant explained, "We don't have economies of scale for Nurse-Family Partnership." Although the number of NFP participants was low across all of the Strong Foundations training, this new direction removes the possibility of NFP home visitors having the ability to participate

in this supervisory support. Furthermore, by providing supervisors from different models with the opportunity to meet each other, network, and learn about their commonalities, cross-model SLCs had the potential to increase community collaboration. Indeed, as Daro noted in a 2012 presentation, "Expanding and sustaining an effective level of support for all families within the current fiscal climate requires thinking 'beyond the model'" (Daro, 2012). As discussed in more detail in the Community Systems Development section, community systems building is a large factor of infrastructure development. It is worth contemplating if the SLCs could somehow be linked to any of the ongoing community systems development work, so as not to lose any momentum gained by having cross-model opportunities. Although at least one informant shared her perception that the funds for community collaboration work were "pretty siloed" and therefore unavailable for such integrated work. As mentioned in the introduction to this report, analyzing systems work is tricky because of the interconnectedness that is, by definition, inherent within systems. An important part of building and maintaining resilient systems is the ability to view issues from multiple vantage points to gain insight and encourage innovative solutions. Perspective is gained when communication networks are extended and information shared. Recognizing how various aspects of the work can be leveraged against each other can help to break down silos to build a solid infrastructure, such as cross-model training, community systems development, and monitoring, data and CQI.

## Summary

Training continues to be a highly valued and noted piece of the state infrastructure across the home visiting system in Illinois. Both qualitative and quantitative results reflect how the state of Illinois is creating a culture of training and ongoing learning that is increasingly being integrated into home visiting programs. Training and professional development can take various forms, and the Training Institute is only one source for training. Our findings indicate that as a result of Strong Foundations, home visiting program staff in Illinois have increased opportunities for training, that these opportunities are considered of high quality and are valued by home visiting staff, and that training is also effective in bringing new knowledge to home visiting staff and increasing their confidence and knowledge in specifically targeted topics.

In follow-up interviews conducted several months after training, respondents who were working with families who experience one or more of the risk factors addressed in the trainings responded overwhelmingly that they used the knowledge or information from the training in their work. They explain that they were working with families experiencing one or more of the risk factors addressed by the training topic and able to apply strategies learned and make referrals when necessary. Several

respondents reported referring clients to appropriate resources and others reported growing confidence as a result of training.

At the same time, barriers remain to expanding trainings to support regional training needs and reduce barriers to participating in training. Illinois is a large state and funding limits extensive growth in training location offerings. Strong Foundations sponsored trainings helped reduce certain resource limitations by covering the training costs for the participants as did support for attending state conferences and meetings. However, the Training Institute and state administrators are also taking steps to expand online resources and trainings available throughout the state. The HBOB self-study program illustrate another approach to strengthening professional skills without having to arrange to attend in-person training in a particular location, although learning the skills depends on individual motivation and time to complete the program. It is also not clear whether knowledge gained through an individual learning experience will be transferred to other program staff.

As mentioned in the previous chapter, the HVTF does not currently have a formal mechanism to discuss how new training topics would be determined and implemented in order to meet the changing needs of the home visiting workforce. Also noted earlier, the OECD and the Training Institute are responsible for coordinating the various trainings and professional development opportunities and providing them "in an integrated framework" to home visiting program staff, and they meet regularly with the HVTF executive committee to discuss about training topics and implementation. However, some stakeholders were not aware of these ongoing training discussions, which suggests that information about training strategies and implementation needs to be communicated more broadly with opportunities for additional input from stakeholders.

# Program Implementation: Administrative Data Study of Trends in HFI Services and Clients

Strong Foundations was developed with the purpose of enhancing Illinois's infrastructure of supports to home visiting programs and supporting local system development. The initiative was designed to improve the implementation and quality of home visiting services as well as to extend families' access to other community-based services. In the long term, improvements in program quality and service access were expected to result in better outcomes for families. Thus, one component of the Strong Foundations evaluation was an examination of available administrative data on home visiting program characteristics (e.g., caseloads and family demographics), use of other early childhood services, and child outcomes over time before and during the initiative.

Using administrative data records to track home visiting program practices and the implementation of evidence-based models in Illinois is not an easy task. Strong Foundations initially focused on the implementation of three separate program models, each of which occur on different scales in the state and have different data collection procedures. The NFP program maintains high quality data covering a broad array of background information and program activities. However, because NFP operated only two sites in Illinois during the study period, it is not included here because it would be difficult to ensure appropriate levels of client privacy.

The PAT program is the largest of the three models, touching almost five times as many children at any given time as the HFI program, the next largest. Although PAT has been working to encourage use of a centralized data collection system, not all local programs participated in the system during the study period. Thus, the only state-level data available for this program model were internal annual aggregate

reports generated within the PAT system. Although these reports do not provide details on service delivery trends over time, an analysis of 3 years of data from the PAT aggregate annual reporting forms indicated modest changes between SFY 2009 and SFY 2011 in client characteristics. These included a decrease in the total number of families served, but small increases in the percentage of families designated as "low-income" (74% to 84%), the percentage of single parent households (35% to 50%), and parents who were teens (22% to 27%), and the percentage of Hispanic families served (20% to 23%). The changes suggest that PAT programs in Illinois are increasingly serving a higher risk population.[41]

The HFI program presents our best data resource for understanding program implementation before and during the period of Strong Foundations, because IDHS tracks a lot of program activity in its Cornerstone database at the level of individual clients. Thus, for practical reasons, data on HFI implementation is the focus of this chapter. We begin with an analysis of administrative data, drawn from the Cornerstone data system, which describes the HFI program performance. We then discuss relationships between the HFI program data and child maltreatment based on data from the DCFS system.

## HFI Caseloads and Clients, State Fiscal Years 2006–13

This section presents analysis of information drawn from the IDHS Cornerstone data system to describe the HFI program. Cornerstone data are also used to look at basic enrollment information for three other social service programs: Women, Infants and Children (WIC); Family Case Management (FCM); and Early Intervention (EI). The value of the Cornerstone data is that it tracks the participation of individual persons (infants and children, parents, and home visiting program staff) in the program context. The data create a rich information platform for pursuing many types of questions about the operation and service delivery of HFI programs and the recipients of HFI services. This identification of individuals also allows for potentially linking to other information systems. In this case, we include a brief look at the contact that participants in IDHS programs have had with investigations of alleged child abuse and neglect as documented by the Illinois Department of Children and Family Services (DCFS), both during the time prior to the implementation of Strong Foundations and the immediate years since.

The presentation of information drawn from administrative data sources in this report is exploratory in several ways. It is not clear how to best apply these data to clarify trends and relationships in home visiting in Illinois; therefore, much of this work is descriptive in nature. A basic picture of the Healthy Families Illinois program across the state is given in Table 21. This is an 8-year summary starting with the 2006 state fiscal year (July 2005–June 2006), which shows that the combined HFI programs

[41] Our previous report (Spielberger, et al., 2013) provides more details on the analysis of data from the PAT aggregate annual reporting forms for SFY 2009 and SFY 2011.

maintained an ongoing caseload of about 2,000 family units during this period. There was modest growth in the total statewide HFI caseload size from 1,856 to 2,150 during the first four years from 2006 through 2009, but this entire gain was lost by a decrease in 2010, and the last three years show a small but continuing reduction to an average enrollment of just fewer than 1,700 by 2013. The number of workers tends to adjust with changes in the client population, so the average caseload for each home visitor varied between 9 and 11 each year, with no apparent trend. This number is somewhat smaller than might be expected because some of the workers are not full-time HFI employees.

Table 21 also shows that the activities we associate with HFI programs did occur on a regular basis during the period studied. The primary activity is home visits. The typical client family received about two completed home visits per month, with a slight upward trend apparent from 2010 (1.82 visits) through 2013 (2.09 visits). While the number of visits per month varies over clients based on their assigned care level category, the expected number of monthly visits for each program site can be computed. During the eight years observed, the percentage of expected visits that were actually completed increased from just less than 80 percent to just over 87 percent, which suggests that, as a whole, the HFI programs gradually improved their performance in meeting their own standard for numbers of visits.

**Table 21. Healthy Families Illinois Program Components, SFY 2006–13**

| | State Fiscal Year | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** |
| Average monthly HFI caseload | 1,856 | 1,984 | 2,067 | 2,150 | 1,854 | 1,811 | 1,779 | 1,688 |
| Mean home visits per month | 3,612 | 3,817 | 4,055 | 4,168 | 3,383 | 3,572 | 3,668 | 3,527 |
| Mean visits per case per month | 1.95 | 1.92 | 1.96 | 1.94 | 1.82 | 1.97 | 2.06 | 2.09 |
| Expected home visits per case per month | 2.44 | 2.37 | 2.35 | 2.30 | 2.19 | 2.33 | 2.37 | 2.40 |
| Percent of expected visits completed | 79.9 | 81.3 | 83.3 | 84.3 | 83.4 | 84.7 | 86.9 | 87.1 |
| Number of doctor visits during year | 7,978 | 8,659 | 9,041 | 9,088 | 7,271 | 6,912 | 5,545 | 4,388 |
| Mean doctor visits per case per year | 4.30 | 4.36 | 4.37 | 4.23 | 3.92 | 3.82 | 3.12 | 2.93 |
| Developmental screenings per year | 6,144 | 6,489 | 7,114 | 7,468 | 6,307 | 5,996 | 5,680 | 5,221 |
| Mean screenings per case per year | 3.31 | 3.27 | 3.44 | 3.47 | 3.40 | 3.31 | 3.19 | 3.44 |
| Number of HFI Programs operating | 48 | 46 | 46 | 45 | 45 | 40 | 40 | 40 |
| Mean caseload size per program site | 38.7 | 43.1 | 44.9 | 47.8 | 41.2 | 45.3 | 44.5 | 42.2 |
| HFI workers employed during year | 201 | 199 | 211 | 199 | 208 | 168 | 184 | 162 |
| Mean HFI workers per site | 4.2 | 4.3 | 4.6 | 4.4 | 4.6 | 4.2 | 4.6 | 4.1 |
| Mean client caseload per HFI worker | 9.2 | 10.0 | 9.8 | 10.8 | 8.9 | 10.8 | 9.7 | 10.4 |

The home visiting frequency does show a pattern over the course of the enrollment period. During the first 6 months after entry (postnatal cases) or birth (prenatal cases), the average number of visits per client per month increases from just over 2.5 to almost 3. For the remained of the enrollment period, the number of visits per month gradually decreases, so that after one year duration, a client typically is visited fewer than two times per month. This pattern holds equally true for both prenatal and postnatal enrollments.

Each HFI child averaged more than 4 doctor visits per year, although the frequency of these well-care visits decreased to around 3 visits per year for 2012 and 2013. Similarly, each child was screened for developmental issues a little more than 3 times per year. Unlike doctor visits, this rate showed no clear upwards or downwards trends over the 8-year time period.

HFI programs were run at a total of 52 different local sites, and home visits were delivered by almost 350 separate workers. In any given year there were 40 to 48 sites and 168 to 208 workers. There were small year-to-year changes in program sites (four new sites started home visiting while seven sites terminated their visiting programs), but substantially more circulation among workers. There has been a drop-off in the number of active sites and in the number of workers for the most recent years observed. The largest major decreases came during the year between 2010 and 2011, which saw a reduction of 11 percent of HFI programs and 19 percent of enrolled clients.

Table 22, which shows percent distributions of new enrollees on a variety of demographic and program characteristics. These are classified for the year in which the client starts receiving HFI visits. The level of care measure is taken at the time of the first home visit, and the termination reason is determined only when the home visiting enrollment is finally completed. If there is substantial change in the nature of the population of families referred to (or recruited by) HFI, or if there is a clear shift in how the clients are classified by the programs, it should be evident in these characteristics. For example, these data show a sizable increase in the percentage of cases with care levels of “HFI1” and “Prenatal” in 2012. Other sources suggest that some of the patterns that appear in these variables may reflect changes in data coding rather than actual underlying behavior, as program staff learn to conform to appropriate coding protocols. This limits our ability to explain certain trends and reminds us that all interpretation should be made with caution.

Table 22 shows characteristics of clients entering HFI programs. There are several patterns that merit highlighting. The biggest change over the 8 years is in the geographic location of clients. In 2006, 28 percent of HFI cases were in Chicago, 28 percent in suburban Chicago, and 45 percent in the remainder of Illinois. By 2013, Chicago had 37 percent of HFI cases while downstate areas had decreased in share to 36 percent. Corresponding to these area shifts, we can see an increase in the percentage of Hispanic clients and a reduction in the percentage of white clients during the same time, with the black clients staying relatively unchanged over time.

The other clear changes are the characteristics of the mothers. The percentage of teen mothers has decreased from almost 30 percent to fewer than 20 percent during these 8 years, with the share of mothers over 22 years of age simultaneously increasing from around 20 percent to 30 percent of HFI enrollees. Mothers between 18 and 22 years old compose about one-half of all HFI mothers in all 8 years. Maybe because they are becoming somewhat older, the HFI mothers are also becoming somewhat better educated at the time of enrollment. The share of mothers who had not completed high school at enrollment dropped from 47 percent in 2006 to 41 percent in 2013, while the percent that experienced some education beyond high school increased.

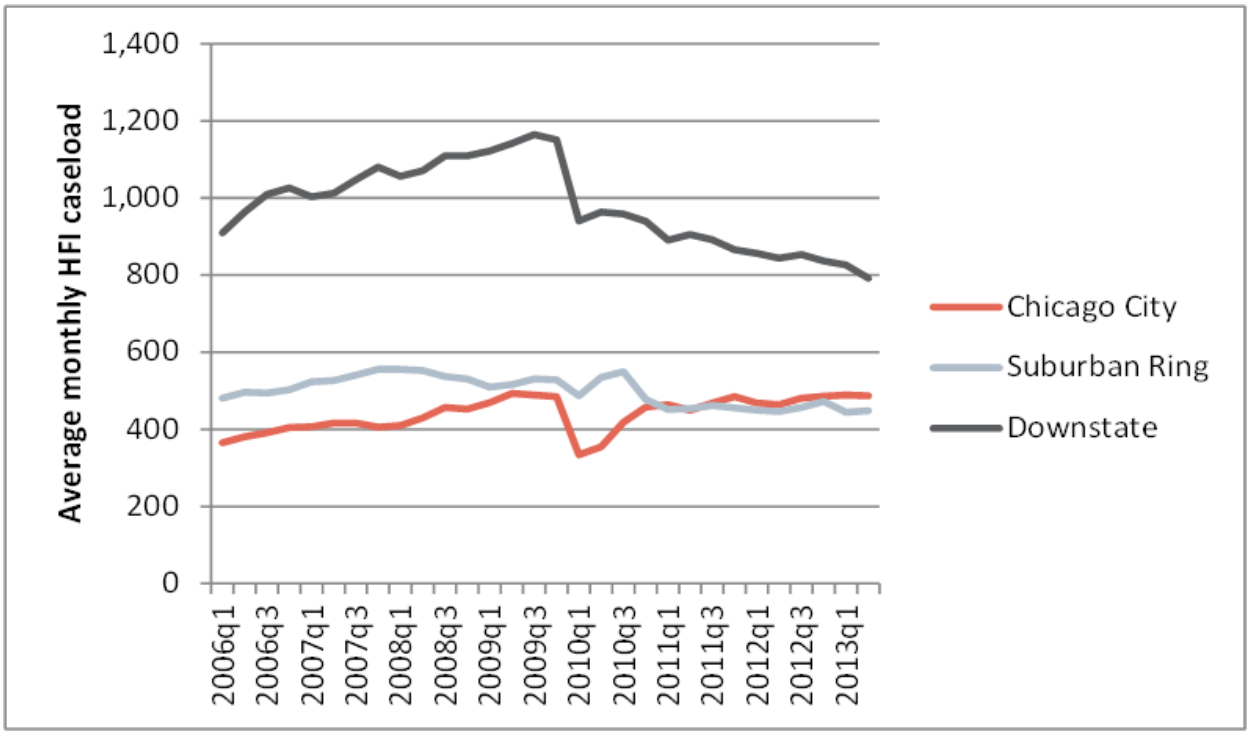
## Table 22. Characteristics of Clients Entering Healthy Families Illinois Programs, by SFY 2006–13

| | State fiscal year of initial HFI enrollment | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** |
| **New Enrollments (*N*)** | 691 | 933 | 939 | 887 | 927 | 743 | 751 | 512 |
| | % | % | % | % | % | % | % | % |
| **Race/ethnicity** | | | | | | | | |
| Black | 29 | 30 | 31 | 27 | 30 | 29 | 31 | 26 |
| Hispanic | 34 | 36 | 34 | 41 | 34 | 39 | 38 | 40 |
| White | 34 | 31 | 32 | 30 | 31 | 29 | 26 | 29 |
| Other | 3 | 3 | 3 | 3 | 4 | 3 | 4 | 5 |
| **Birthweight** | | | | | | | | |
| Low | 11 | 8 | 10 | 8 | 9 | 8 | 9 | 10 |
| Normal | 89 | 92 | 90 | 92 | 91 | 92 | 91 | 90 |
| **Region** | | | | | | | | |
| Chicago city | 28 | 25 | 28 | 26 | 31 | 34 | 38 | 37 |
| Suburban ring | 28 | 33 | 28 | 28 | 30 | 27 | 27 | 27 |
| Downstate | 45 | 42 | 44 | 45 | 39 | 39 | 35 | 36 |
| **Mother's age at enrollment** | | | | | | | | |
| Under 18 years | 29 | 29 | 26 | 27 | 23 | 22 | 21 | 18 |
| 18-19 years | 28 | 27 | 27 | 29 | 30 | 28 | 26 | 24 |
| 20-22 years | 22 | 22 | 23 | 24 | 28 | 25 | 27 | 27 |
| Over 22 years | 21 | 22 | 25 | 20 | 19 | 26 | 26 | 31 |
| **Mother's education** | | | | | | | | |
| < high school graduate | 47 | 48 | 44 | 47 | 47 | 42 | 42 | 41 |
| High school graduate | 37 | 38 | 39 | 36 | 38 | 37 | 37 | 40 |
| Post high school education | 15 | 13 | 16 | 14 | 14 | 19 | 20 | 17 |
| Unknown | 1 | 1 | 1 | 3 | 1 | 2 | 1 | 1 |
| **HFI level at first visit** | | | | | | | | |
| Outreach | 39 | 37 | 31 | 28 | 25 | 25 | 12 | 6 |
| HFI1 | 28 | 27 | 28 | 33 | 33 | 29 | 53 | 63 |
| HFI2 | 6 | 9 | 16 | 13 | 17 | 28 | 22 | 3 |
| HFI3 | 13 | 13 | 13 | 12 | 14 | 9 | 3 | |
| HFI4 | 7 | 6 | 5 | 3 | 3 | 0 | | |
| Prenatal | 6 | 6 | 5 | 6 | 6 | 7 | 8 | 28 |
| Other | 1 | 2 | 4 | 5 | 3 | 3 | 2 | 0 |
| **Termination status** | | | | | | | | |
| HFI visits terminated | 92 | 87 | 78 | 74 | 62 | 52 | 27 | 15 |
| Probably over (no reason) | 1 | 1 | 5 | 7 | 20 | 28 | 26 | 8 |
| HFI not completed | 8 | 12 | 17 | 19 | 18 | 20 | 48 | 77 |
| **Termination reason (if services ended)** | | | | | | | | |
| Voluntary or Normal | 38 | 33 | 27 | 23 | 24 | 27 | 23 | 31 |
| Moved from area | 23 | 24 | 26 | 20 | 26 | 26 | 24 | 30 |
| Client lost to HFI | 11 | 10 | 11 | 10 | 10 | 13 | 10 | 11 |
| Client refusal | 16 | 16 | 17 | 20 | 22 | 20 | 23 | 15 |
| Other reason | 12 | 17 | 19 | 26 | 17 | 13 | 19 | 13 |
| **Timing of HFI start** | | | | | | | | |
| Before birth of child | 51 | 48 | 51 | 51 | 47 | 49 | 49 | 29 |
| After birth of child | 36 | 39 | 38 | 38 | 43 | 39 | 37 | 36 |
| Child not enrolled | 13 | 13 | 12 | 11 | 10 | 13 | 14 | 35 |
| **Timing of HFI start (child only)** | | | | | | | | |
| Before birth (prenatal) | 59 | 55 | 57 | 57 | 52 | 56 | 57 | 44 |
| After birth (postnatal) | 41 | 45 | 43 | 43 | 48 | 44 | 43 | 56 |

Note that the final two characteristics are influenced by time constraints, especially in more recent years.
Note: Shaded cells are incomplete due to time constraints.

The information presented in Figure 1 through Figure 5 illustrates patterns of recent change in several indicators of caseload size and composition. The first figure presents time trends over quarters of fiscal years (3-month periods) for three separate geographic units: Chicago city, the suburban ring around Chicago, and the remainder of downstate Illinois. These caseload graphs show a pattern of small growth and relative stability from the first quarter of SFY 2006 through the fourth quarter of SFY 2009 in all three regions. An abrupt decrease in HFI caseload occurs during the first quarter of SFY 2010, which represents July through September 2009. This drop occurs for the Chicago and downstate regions, but not for the suburban ring areas. After this drop, the Chicago numbers appear to return to a level near their prior value, while the downstate numbers stay low and continue to decrease slightly through the end of the observation period in SFY 2013.

**Figure 1. Average Monthly HFI Caseload, by Region and SFY Quarter**




This observed decrease might have been predictable because the single sharp drop in enrollment occurs during the time of pronounced fiscal crisis in Illinois. During the summer of 2009, funding for HFI programs was unsure and unsettled. Even when program allocations were finally made, payments to the agencies were very slow. It is well documented that the provider agencies were operating under pressure and uncertainty and that numerous staff reductions or cutbacks were made during this time.

Figure 2 shows the average percentage of expected home visits that were actually completed each month, again by region. This is an important measure of fidelity to the HFI program model, because the

prescribed number of visits (usually two per month) must be completed in order to properly implement the protocols of the evidence-based model program. For most of the 7 years, it appears that most expected home visits actually do take place. During the time of the fiscal crisis, the average percentage of completed home visits dropped about 5 percent in each region, only to rebound again to earlier levels. This figure captures an interesting dynamic among HFI programs. The downstate programs have tended to have relatively high percentages of completed home visits, steadily improving from around 80 percent to over 85 percent. The Chicago HFI programs started at lower rates of visit completion from SFY 2006 into SFY 2010 (between 75 and 80%) and dropped sharply to 70 percent at the time of fiscal crisis. Since SFY 2010, the visit completion percentage in Chicago city shows a steady increase, and by SFY 2013 the rate of completion for Chicago sites were higher than for the other two regions, around 90 percent. The suburban ring HFI programs started at higher visit completion rates than the other regions, reaching 90 percent by SFY 2009. These also fell during the fiscal crisis, and unlike at Chicago city sites, they never rebounded. So between SFY 2010 and SFY 2013, the suburban rates remained at about 85 percent. In summary, during the 8 years observed, there were different patterns in each region, but the aggregate performance on visit completion has gradually improved so that by SFY 2013 all three regions were at 85 percent or better compliance rates with their visiting standard.

**Figure 2. Percentage of Home Visits Completed, by Region and SFY Quarter**

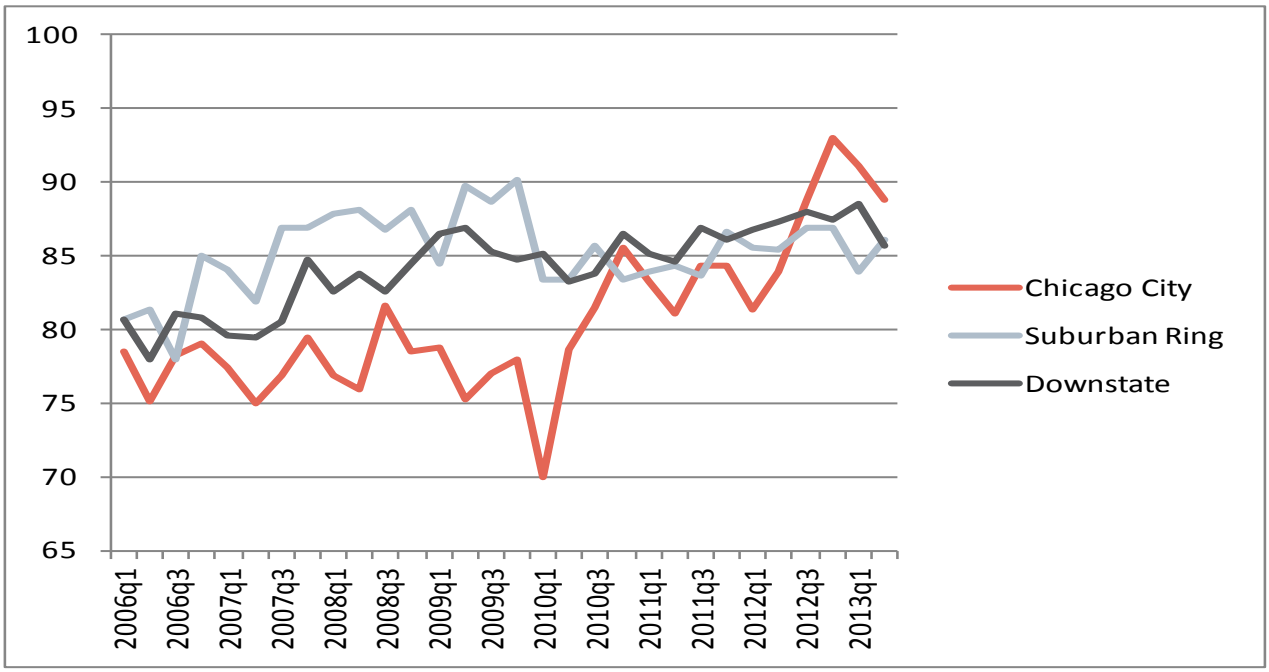



Figure 3 through Figure 5 contain graphs showing elements of caseload dynamics on a quarterly basis. The figures show new client HFI enrollments (entries), HFI exits, and the resulting net change in the caseload. Again, the summer and fall of 2009 stand out as being times of extremely different activity

patterns. Increases in the number of case closings are quite apparent for Chicago and downstate regions during the fourth quarter of SFY 2009. In addition, all three regions show increased recruitment of new cases during the following months in early 2010. At the end of the observation period, there was virtually no overall change in the number of clients served in Chicago and the suburban ring and a small cumulative decrease in the number of clients served by HFI programs downstate. But the "ripples" caused by a short period of unusually high terminations followed by a period of active enrollment show instability in the caseload that is potentially a problem. Rapid system change is not typically a hallmark of the stable provision of supports to client families.

**Figure 3. New Enrollments in Healthy Families Illinois Programs, by Region and SFY Quarter**

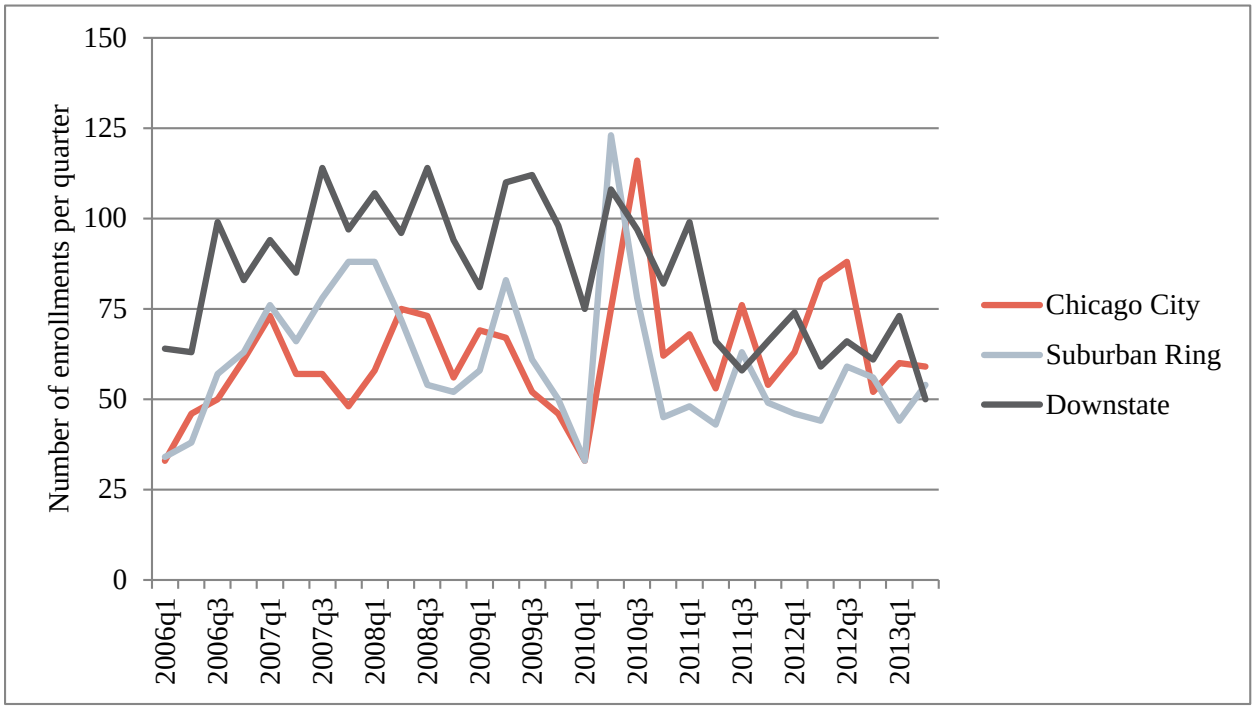


**Figure 4. Terminations from Healthy Families Illinois Programs, by Region and SFY Quarter**

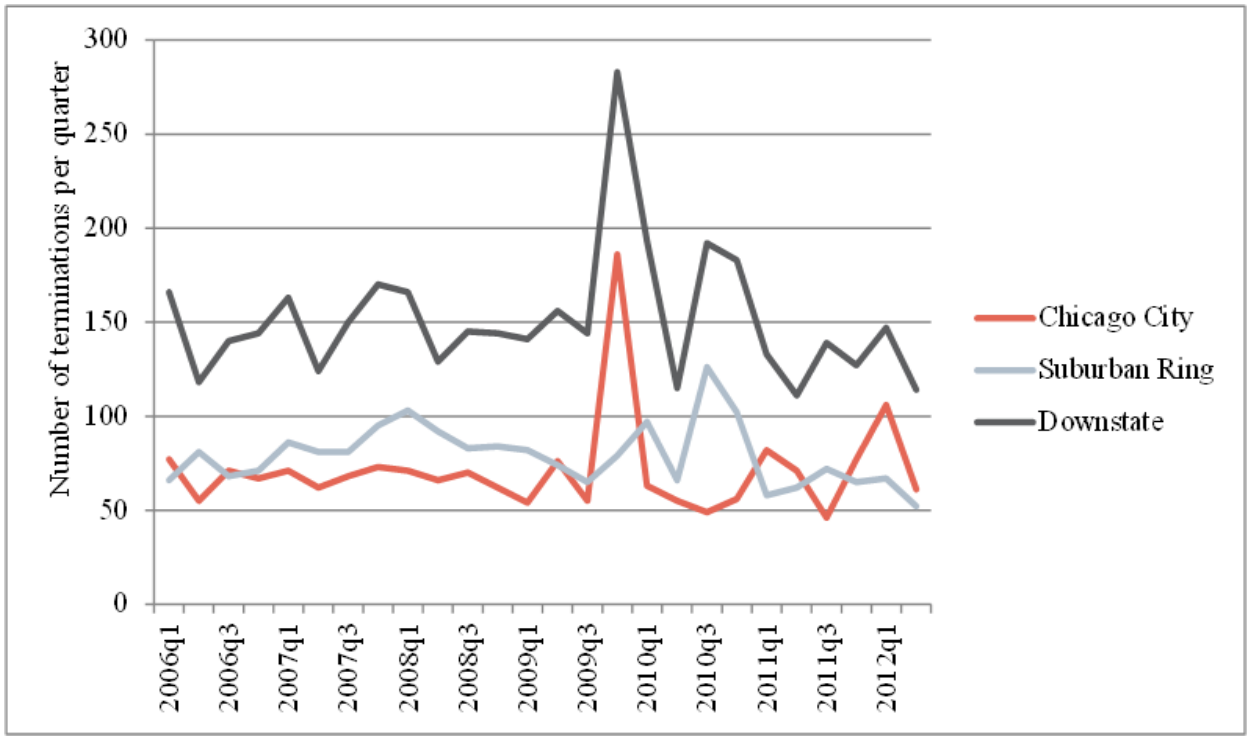
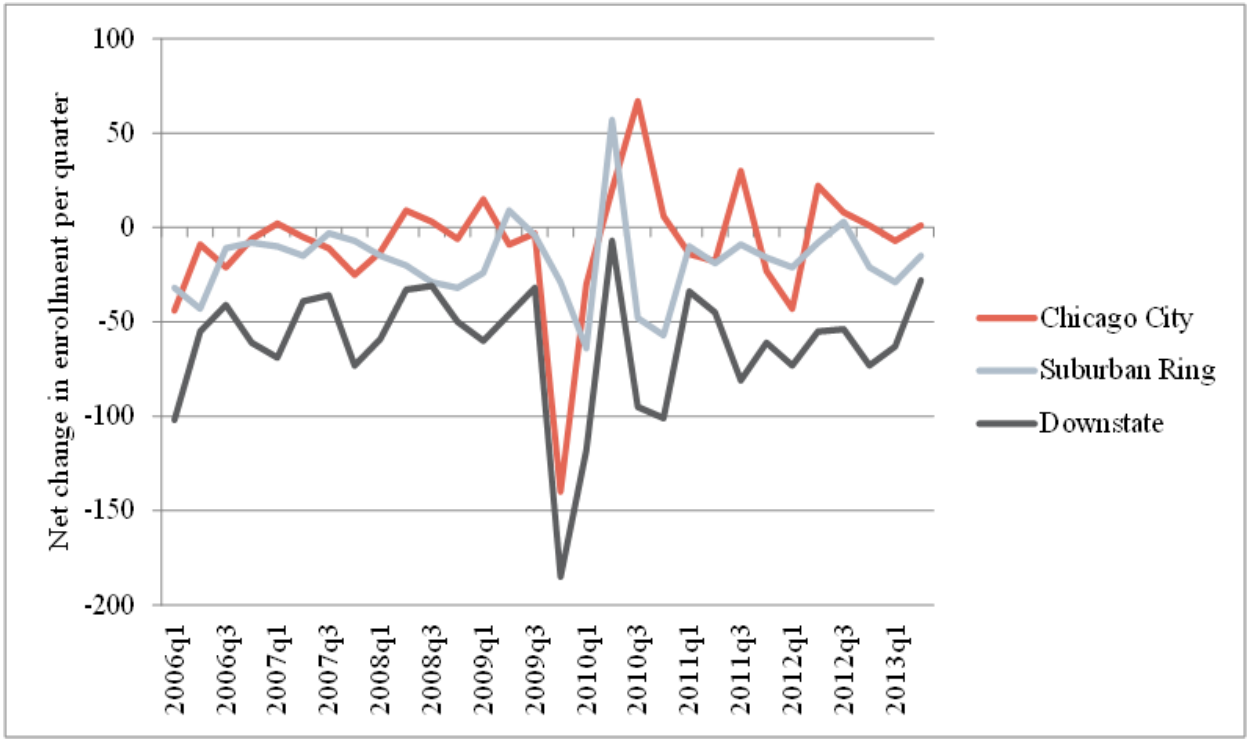



**Figure 5. Net Change in Healthy Families Illinois Caseload, by Region and SFY Quarter**



Home visiting planners increasingly believe that interventions become more effective when they are initiated earlier in the parenting process. The engagement of mothers during pregnancy, rather than after birth, is a preferred HFI practice. Table 23 follows maternal enrollment patterns over time and by region. There is one small difficulty with using these data to define whether an enrollment is prenatal or not. We prefer to rely on a comparison of the child's birth date and the date of the first home visit to determine whether an enrollment can be considered as prenatal practice. The complication is that in some cases, no child record ever appears. Mostly, these are from cases that never really get started after the initial enrollment. However, any case without a child record "looks" prenatal, because there is never a defined event of the child being born. This creates a serious methodological problem only in the final year of observation, where the data provide no criteria to clearly distinguish "true" prenatal cases from those cases that will never show a child's engagement. So, we choose to list the "child never enrolled" category separately from the prenatal category, realizing that in the most recent year, this category may include many cases that will soon be identifiable as prenatal. Therefore, we warn against careless interpretation of recent observations. We then present the same statistics for the statewide total and each region with the "child never enrolled" cases excluded.

**Table 23. Timing of Enrollment in Healthy Families Illinois Programs, by Region and SFY, 2006–13**

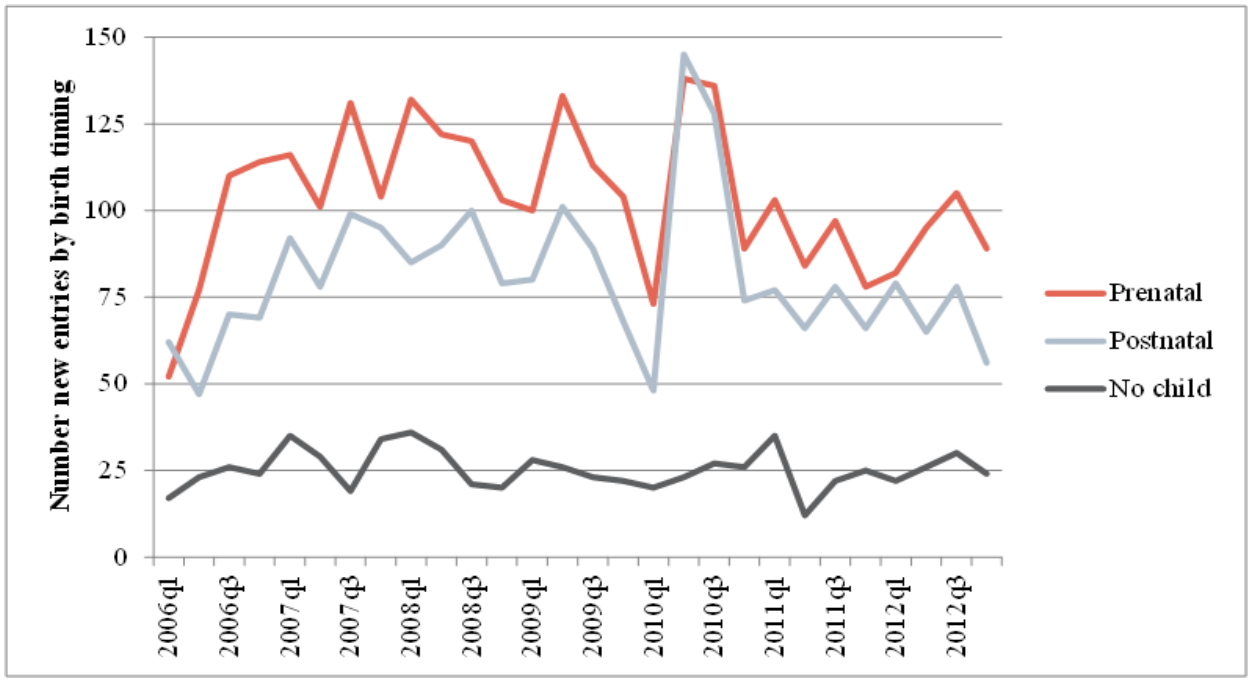
| | SFY of enrollment in HFI | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** |
| **All HFI cases** | | | | | | | | |
| Enrollments (*N*) | 691 | 1,275 | 1,273 | 1,209 | 1,186 | 1,024 | 1,031 | 701 |
| Enrolled prenatally (%) | 51 | 49 | 52 | 52 | 48 | 51 | 51 | 31 |
| Enrolled postnatally (%) | 36 | 39 | 37 | 36 | 42 | 37 | 35 | 36 |
| No child birth reported (%) | 13 | 12 | 11 | 12 | 10 | 12 | 13 | 33 |
| **Chicago city sites** | | | | | | | | |
| Enrollments (*N*) | 190 | 272 | 305 | 282 | 318 | 285 | 313 | 206 |
| Enrolled prenatally (%) | 51 | 49 | 47 | 46 | 56 | 54 | 56 | 32 |
| Enrolled postnatally (%) | 29 | 31 | 38 | 38 | 31 | 30 | 23 | 24 |
| No child birth reported (%) | 20 | 19 | 15 | 17 | 12 | 16 | 21 | 44 |
| **Suburban ring sites** | | | | | | | | |
| Enrollments (*N*) | 192 | 375 | 319 | 308 | 323 | 252 | 250 | 175 |
| Enrolled prenatally (%) | 51 | 46 | 57 | 56 | 39 | 43 | 44 | 24 |
| Enrolled postnatally (%) | 38 | 43 | 29 | 34 | 53 | 46 | 45 | 47 |
| No child birth reported (%) | 11 | 11 | 14 | 10 | 8 | 12 | 11 | 29 |
| **Downstate sites** | | | | | | | | |
| Enrollments (*N*) | 309 | 628 | 649 | 619 | 545 | 487 | 468 | 320 |
| Enrolled prenatally (%) | 51 | 50 | 52 | 53 | 49 | 53 | 52 | 34 |
| Enrolled postnatally (%) | 39 | 40 | 41 | 37 | 41 | 37 | 38 | 38 |
| No child birth reported (%) | 10 | 10 | 7 | 10 | 10 | 11 | 9 | 28 |

Note: shaded cells do not include all births in 2013 because of delays in registrations.
The "no child birth reported" occurs when mother is enrolled but the case terminates before mother-child visits occur.
All "prenatal" enrollment cases initially appear as "no child birth" cases, but many of those in SFY 2013 will shift to the "prenatal" category once the child is born and registered in Cornerstone.

The first column for all HFI cases in Table 23 shows that the mother is engaged prenatally in about one-half of all HFI cases, and that in about 10 percent of the cases, a child is never enrolled. The remaining 40 percent are initiated after birth of the child. These patterns have been fairly stable over time. The data in the regional rows (which now exclude the "no child" cases) show a more dynamic situation. Table 23 highlights an important regional difference in the percentage of HFI cases that start prenatally, before the child is born. About 51 percent of HFI enrollments are made prenatally (these compose 58 percent of enrollments where a child is identified). In SFYs 2006 and 2007, all regions of the state looked similar on this measure. However, between 2009 and 2010, the percentage of prenatal cases in Chicago increased and the percentage of prenatal cases in the suburban areas decreased. Both of these changes continued through 2013. So, by 2012, 56 percent of families enrolled in Chicago enrolled in HFI prenatally and 44 percent of families enrolled from the suburbs enrolled prenatally. The downstate percentage of prenatal cases did not change noticeably during the same time.

Figure 6 gives a picture of enrollments over time, classified as either prenatal, postnatal, or "no child." There are usually more new cases that start prenatally than those that begin after birth, but they tend to follow the same basic patterns over time. There are many fewer "no child" cases and the number of new cases per quarter remain fairly stable at around 25 cases. The one major anomaly occurs during the period of the state fiscal crisis. Both prenatal and postnatal entries drop markedly in the first quarter of SFY 2010, as might be expected. However, the postnatal cases show a larger increase in the second quarter. Based on the data, we believe this increase was due to timing: a number of would-be "prenatal" entrants were likely delayed by program instability that made it difficult to enroll clients before they gave birth. By the time they were able to enroll later in the fall of 2009, their babies had been born already, and hence enrolled postnatally.

**Figure 6. Enrollments by Timing of Childbirth, by SFY Quarter**




One important indicator of program fidelity is the extent to which cases are retained after the initial engagement and enrollment. The HFI model dictates that services be provided at a "dosage" that has been shown in previous research to positively affect family outcomes. In order to do this, clients need to be retained for continuing service provision. The first section of Table 24 shows the distribution of the duration of enrollment spells for all HFI programs combined. There is no fixed standard for how long a client should engage with home visitors; the right length of time is determined based on progress. However, the time of an HFI engagement should be at least 6 months and usually over one year. Table 24 shows no major change between 2006 and 2013 in enrollment times. Each number in the table is the percentage of cases that have been terminated by the elapsed time noted in the leftmost column. Thus, in the first section of the table, 45 percent of all HFI entrants from SFY 2006 left HFI by 6 months, and 56 percent by one year. In brief, somewhere around one in six HFI cases end before one month, while two or three out of ten last over two years. (As might be expected, SFY 2009 shows more rapid terminations, and therefore shorter enrollment periods, than other years).

The remaining sections of Table 24 present a comparison of program duration across several groups of families: those that had their first home visit prenatally, those that had their first visit after the birth of the child, and families that enrolled in HFI but never reported the birth or presence of a child. It should be noted that with active program data, program duration is difficult to represent. For many of the cases with longer enrollment periods, the termination event did not occur during the period of observation. However, the fact that they are still enrolled at the end of the observation period is meaningful, as it allows us to

observe the time accrued by these cases, which remain open. Ignoring them—in effect, removing the longer episodes—would bias our results by. In these tables, all numbers that are not shaded should be considered as "fair" bases of comparison. All cells that are shaded lighter grey are partially censored (meaning that the final values will probably increase), and the darkened cells are fully censored. Thus, a case that started in SFY 2012 and that is still open at the end of the observation period (here in 2013) could not possibly show a duration of two years. In the same vein, those cases that started in SFY 2011 and had durations of less than one year would be fully observed, and could be compared to the "under one year" cases for other years.

Comparing HFI enrollment durations between the prenatal and postnatal groups is instructive. The comparison shows that program retention, at least as measured by elapsed duration of services, is noticeably greater for cases where visiting is initiated before the birth of the infant (in other words, for prenatal cases. This is consistent with anecdotal information from the field suggesting that mothers engaged in HFI prenatally tend to have a more positive program experience. (The data do not suggest whether this is a program effect or a selection effect). At all levels, the prenatal group shows stronger program retention than the postnatal group. Almost none terminate in the first month, only about one-quarter terminate by 3 months, and one-half make it to one year or more. In contrast, almost one-sixth of the cases in the postnatal group do not last past one month and almost one-half have terminated by 6 months. The category of cases that show HFI enrollments with "no child reported" tend to close rapidly; over 60 percent terminate within the first month. Presumably, these are mostly clients that disappeared prior to real participation, maybe after just one visit.

**Table 24. Duration of Healthy Families Illinois Programs Home Visiting Spells, by Year and Birth Timing, SFY 2006–13**

| | SFY of Enrollment | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** |
| **All HFI enrollments** | | | | | | | | |
| Number of new cases | 691 | 1,275 | 1,273 | 1,209 | 1,186 | 1,024 | 1,031 | 701 |
| Cumulative % terminated in: | | | | | | | | |
| Under 1 month | 17 | 16 | 14 | 17 | 17 | 17 | 20 | 40 |
| 3 months | 35 | 38 | 33 | 40 | 38 | 37 | 37 | 82 |
| 6 months | 45 | 47 | 41 | 52 | 46 | 45 | 48 | 100 |
| 12 months | 56 | 60 | 55 | 65 | 58 | 57 | 81 | 100 |
| 18 months | 65 | 67 | 67 | 72 | 67 | 65 | 100 | 100 |
| 24 months | 70 | 73 | 75 | 79 | 71 | 87 | 100 | 100 |
| **Prenatal enrollments** | | | | | | | | |
| Number of new cases | 353 | 622 | 664 | 629 | 570 | 518 | 529 | 216 |
| Cumulative % terminated in: | | | | | | | | |
| Under 1 month | 5 | 5 | 4 | 6 | 6 | 4 | 5 | 14 |
| 3 months | 23 | 25 | 21 | 26 | 25 | 19 | 20 | 66 |
| 6 months | 35 | 36 | 28 | 40 | 34 | 30 | 34 | 100 |
| 12 months | 48 | 50 | 43 | 55 | 49 | 44 | 77 | 100 |
| 18 months | 59 | 59 | 57 | 64 | 60 | 56 | 100 | 100 |
| 24 months | 66 | 66 | 67 | 71 | 66 | 84 | 100 | 100 |
| **Postnatal enrollments** | | | | | | | | |
| Number of new cases | 248 | 496 | 472 | 440 | 495 | 380 | 365 | 254 |
| Cumulative % terminated in: | | | | | | | | |
| Under 1 month | 17 | 17 | 16 | 22 | 19 | 21 | 23 | 35 |
| 3 months | 32 | 39 | 34 | 46 | 39 | 41 | 42 | 81 |
| 6 months | 43 | 48 | 42 | 57 | 48 | 48 | 53 | 100 |
| 12 months | 52 | 61 | 58 | 69 | 58 | 60 | 82 | 100 |
| 18 months | 63 | 68 | 72 | 76 | 67 | 67 | 100 | 100 |
| 24 months | 66 | 74 | 78 | 82 | 70 | 87 | 100 | 100 |
| **Enrollments with no child reported** | | | | | | | | |
| Number of new cases | 90 | 157 | 137 | 140 | 121 | 126 | 137 | 231 |
| Cumulative % terminated in: | | | | | | | | |
| Under 1 month | 62 | 54 | 59 | 55 | 62 | 61 | 66 | 68 |
| 3 months | 91 | 85 | 88 | 85 | 95 | 94 | 91 | 98 |
| 6 months | 93 | 90 | 93 | 93 | 97 | 97 | 95 | 100 |
| 12 months | 96 | 96 | 96 | 96 | 98 | 97 | 97 | 100 |
| 18 months | 97 | 97 | 97 | 99 | 98 | 97 | 100 | 100 |
| 24 months | 98 | 99 | 99 | 100 | 98 | 100 | 100 | 100 |

Note: Shaded cells are partly censored (light gray) or fully censored (dark gray) due to insufficient time having elapsed for full observation.

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

All data description thus far only involves information drawn from Cornerstone to describe Healthy Families Illinois. In order to place these HFI findings in a broader context, and to demonstrate the relative scale of HFI, it is useful to consider these data in combination with other sources of information. One type of information introduced here is Illinois birth data, published by the Illinois Department of Public

Health. The other data sources are Cornerstone information for other related programs, namely Women, Infants and Children (WIC), Family Case Management (FCM), and Early Intervention (EI). WIC is a means-tested nutrition support program, and serves well as an enumeration of poor families with children. FCM should be provided to most families at risk of poor outcomes. It is closely related to, but not identical to, WIC. Theoretically, most HFI referrals should originate from FCM caseworkers. EI is designed to provide direct service to young children with diagnosed disabilities or delays. While WIC, FCM, and HFI all can begin early (often prenatally), children will not be referred to EI until they are diagnosed with a condition or risk.

Table 25 starts with an enumeration of all live births in Illinois in 2009, categorized by race and ethnicity, region, whether there is a teen mother and whether there is a low birth weight flag. The table primarily presents contextual information about relative scale.[42] While over one-half of all children born in the state use WIC and FCM, HFI programs enroll less than one percent of all infants (0.7%). HFI programs do enroll a disproportionate number of cases with teen mothers. Over one-half of all HFI cases involve teen mothers, compared to 10 percent statewide. HFI, WIC, and FCM all engage a larger proportion of black and Hispanic families. EI includes a very high proportion of children born at a low birth weight.

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

## Table 25. All Births in Illinois during 2009 by DHS Programs, Race/Ethnicity, Teen Mother, and Birth Weight

| | | Total | Race/Ethnicity Black | Hispanic | White/Oth | Teenage mother | Low birth weight |
|---|---|---|---|---|---|---|---|
| **Counts** | | | | | | | |
| Illinois births | | 171,077 | 30,186 | 40,369 | 100,522 | 16,376 | 14,372 |
| IL WIC (*N*) | | 98,645 | 27,742 | 37,208 | 33,695 | 16,217 | 9,284 |
| IL FCM (*N*) | | 85,868 | 21,685 | 30,657 | 33,526 | 14,156 | 8,248 |
| IL EI (*N*) | | 8,682 | 1,766 | 2,196 | 4,720 | 762 | 2,816 |
| IL HFI (*N*) | | 1,200 | 336 | 402 | 462 | 624 | 98 |
| **% of statewide total** | | | | | | | |
| Illinois total | | 100 | 100 | 100 | 100 | 100 | 100 |
| IL WIC | % | 58 | 92 | 92 | 34 | 99 | 65 |
| IL FCM | % | 50 | 72 | 76 | 33 | 86 | 57 |
| IL EI | % | 5 | 6 | 5 | 5 | 5 | 20 |
| IL HFI | % | 1 | 1 | 1 | 0 | 4 | 1 |
| **% of within program total** | | | | | | | |
| Illinois Total | | 100 | 18 | 24 | 59 | 10 | 8 |
| IL WIC | % | 100 | 28 | 38 | 34 | 16 | 9 |
| IL FCM | % | 100 | 25 | 36 | 39 | 16 | 10 |
| IL EI | % | 100 | 20 | 25 | 54 | 9 | 32 |
| IL HFI | % | 100 | 28 | 34 | 39 | 52 | 8 |

## Table 26. Program Enrollees from Infants Born during SFY 2009, by Geographic Region

| | | Total | Chicago | Sub Ring | Downstate | Unk. Geo |
|---|---|---|---|---|---|---|
| **Counts** | | | | | | |
| Illinois Total | | 171,077 | 44,449 | 71,586 | 55,042 | -- |
| IL WIC | *n* | 98,645 | 28,478 | 25,683 | 28,797 | 15,687 |
| IL FCM | *n* | 85,868 | 22,948 | 21,684 | 29,215 | 12,021 |
| IL EI | *n* | 8,682 | 1,603 | 1,417 | 1,882 | 3,780 |
| IL HFI | *n* | 1,200 | 248 | 229 | 447 | 276 |
| **% of statewide total** | | | | | | |
| Illinois Total | | 100 | 100 | 100 | 100 | 100 |
| IL WIC | % | 58 | 64 | 36 | 52 | 34 |
| IL FCM | % | 50 | 52 | 30 | 53 | 33 |
| IL EI | % | 5 | 4 | 2 | 3 | 5 |
| IL HFI | % | 1 | 1 | 0 | 1 | 0 |
| **% of within program total** | | | | | | |
| Illinois Total | | 100 | 26 | 42 | 32 | -- |
| IL WIC | % | 100 | 29 | 26 | 29 | 16 |
| IL FCM | % | 100 | 27 | 25 | 34 | 14 |
| IL EI | % | 100 | 18 | 16 | 22 | 44 |
| IL HFI | % | 100 | 21 | 19 | 37 | 23 |

## Links to DCFS Child Abuse and Neglect Investigations

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

At this time, the intent is to demonstrate that the link between DHS service recipients and DCFS child abuse and neglect investigations can be established and to produce a rudimentary baseline of data to guide future study. The information presented in Table 27 shows abuse and neglect investigations (with both indicated and unfounded findings) during SFY 2006–13 for clients using HFI, WIC, FCM, and EI. The primary link of interest is the share of infant clients alleged to be victims of child maltreatment. This table shows how many infants were investigated by DCFS (at any time through 2013), and of those, the proportion of cases that were indicated as being child abuse or neglect upon investigation. Also reported is the percentage of investigations that were for reasons of infant drug exposure at birth. We can also see the related linkage where the client mother, in most of these investigations, is also included as an alleged perpetrator of the abuse or neglect involving her child. Additionally, there is a third connection of interest here, which is the extent to which the client mothers in the current programs were themselves child victims of child abuse or neglect. Thus, the intergenerational aspects of child maltreatment can also be considered with these data.

Table 27 presents the percentage of children 3 years old and younger in DHS programs who have ever been involved in an abuse or neglect investigation. For newly enrolled infants, the risk period is very short. For older child clients, there is a longer period of risk for maltreatment. WIC, EI, and FCM serve as “control” groups of children from other poor or at-risk populations.

Over these four years, 18 percent of the children enrolled in HFI programs were involved in an abuse or neglect investigation. Of these investigations, 42 percent were found to be indicated, meaning that the investigation found credible evidence that abuse or neglect had occurred. Even unfounded investigations often point to substantial protective issues—sometimes maltreatment may have occurred but not been proven, and in others situations existed that were not found to be child abuse or neglect. The number of investigations based on unreliable reports is extremely small. The investigation rate was higher for HFI (18%) than for WIC (11%) and FCM (12%). However, the investigation rate for HFI was lower than for

EI (22%). This makes intuitive sense because the HFI clients are explicitly selected based on various risk factors, including their risk for maltreatment. During the time examined, HFI entry was contingent on having a high risk score during an assessment screen at the time of enrollment.

**Table 27. DCFS Investigation of Alleged Child Abuse and Neglect for DHS Program Enrollees[a]**

| DHS Program | Enrolled infants born FY2006–13 | Infants with Abuse/Neglect Investigations | | Of those involved in an Abuse/Neglect investigation | |
|---|---|---|---|---|---|
| | *N* | *N* | % | % indicated | % SEI[b] |
| WIC | 655,820 | 73,887 | 11 | 43 | 4 |
| FCM | 554,555 | 66,226 | 12 | 48 | 4 |
| EI | 64,363 | 13,872 | 22 | 52 | 8 |
| HFI | 7,552 | 1,380 | 18 | 49 | 1 |

[a] Children in this sample were born between SFYs 2006 and 2013 and enrolled in programs during the same time period.
[b] SEI refers to substance exposed infants (those with observed drug exposure at birth).

Table 28 shows that the likelihood of a child's involvement with DCFS is often reflected by whether the mother perpetrates abuse or neglect. What is particularly interesting about this data is that the mothers involved in HFI were more likely to be involved in maltreatment investigations during their own childhoods; in comparison to mothers from WIC and FCM (complete data on EI mothers was not available). Over 30 percent of HFI mothers were involved in alleged child abuse or neglect investigations as children. Fewer than 20 percent of the mothers in the other programs were allegedly victims of abuse or neglect during their childhood. Because of the tendency for child abuse and neglect to manifest across generations, the high level of previously abused mothers in the HFI population suggests that the intention to target women and children at risk of child abuse is probably succeeding. It also suggests that the HFI group has more complex needs than those who only meet the needs-tested qualifications for WIC.

**Table 28. DCFS Investigation of Alleged Child Abuse and Neglect for DHS Mothers in DHS Programs[a]**

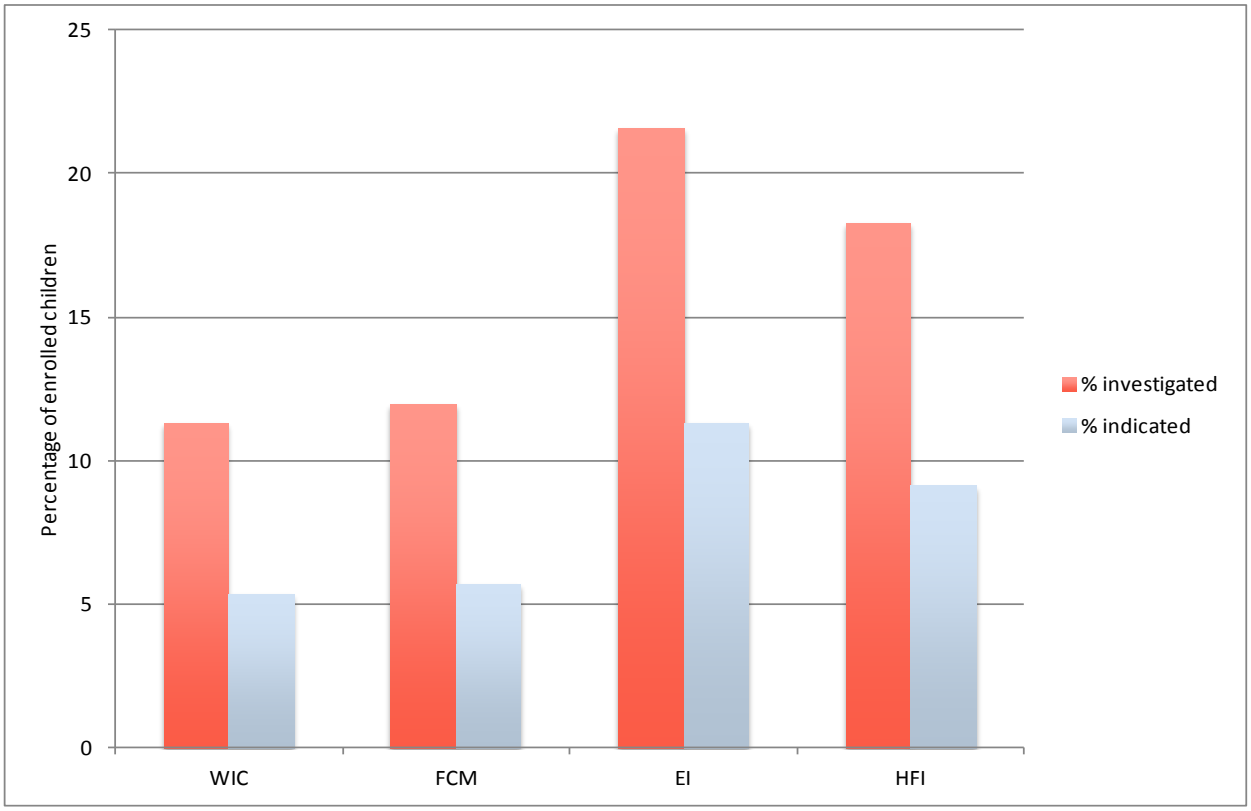
| DHS Program | Mothers w/ child born SFY 2006-2013 | Mothers involved in A/N Alleged as Perpetrators | | Mothers involved in A/N Alleged as Victims | |
|---|---|---|---|---|---|
| | *N* | *N* | % | *N* | % |
| WIC | 404,720 | 56,404 | 13.9 | 45,791 | 11 |
| FCM | 390,007 | 55,767 | 14.3 | 43,972 | 11 |
| EI | -- | -- | -- | -- | -- |
| HFI | 9,094 | 1,856 | 20.4 | 1,899 | 21 |

[a] Children in this sample were born between SFYs 2006 and 2013 and enrolled in programs during the same time period.
Note: Mothers as alleged perpetrators as investigated in current cases involving their own children, while mothers as alleged victims are identified based on their own prior childhood history.

Figure 7 shows the percentage of children, 3 years and under, who were enrolled in HFI, FCM, EI, and WIC and who have been the subjects of DCFS investigations. While the number of children who are the

subject of a DCFS investigation is rather small, most investigated children are also enrolled in EI (22%). HFI, while targeting families at greatest risk for the maltreatment of children (e.g., teen mothers), also has a sizeable percent of children in its program who are the subject of a DCFS investigation (18%). Children enrolled in FCM and WIC are less likely to also be the subjects of DCFS investigations (approximately 12% each).

**Figure 7. Enrolled Children in Investigations of Child Abuse and Neglect, SFY 2006–13**




There is little evidence pointing to a substantial decrease in the level of abuse and neglect among HFI clients during the period of time of the Strong Foundations evaluation. Figure 8 and Figure 9 show the percentage of HFI children who were the subject of a DCFS investigation. Figure 8 shows the percentage that were investigated within one year of birth, while Figure 9 shows the percentage investigated within two years. Each figure indicates whether the child was enrolled in HFI prenatally or postnatally. Several things are clear from the data presented: First, while the rate of enrollment is very dynamic, there is no clear direction upwards or downwards over time. Since the movement is not consistent, other factors are involved. Second, it is clear that there is ongoing child abuse or neglect for some members of the HFI client group. While an average of around 6 percent of the HFI children are investigated during their first year of life, another 4 percent or so are added on during the second year of life. A third observation is that there are differences among subgroups. Here, it is apparent that the HFI postnatal population has

consistently higher levels of involvement with DCFS than those that enroll prenatally. These findings are consistent with HFI guidelines. However, the likelihood is prenatal and postnatal enrollees have other differences. We must consider the possibility that those clients who engage with HFI during pregnancy are somehow less at risk from the start.

**Figure 8. Enrolled Children Investigated by DCFS within One Year of Birth**

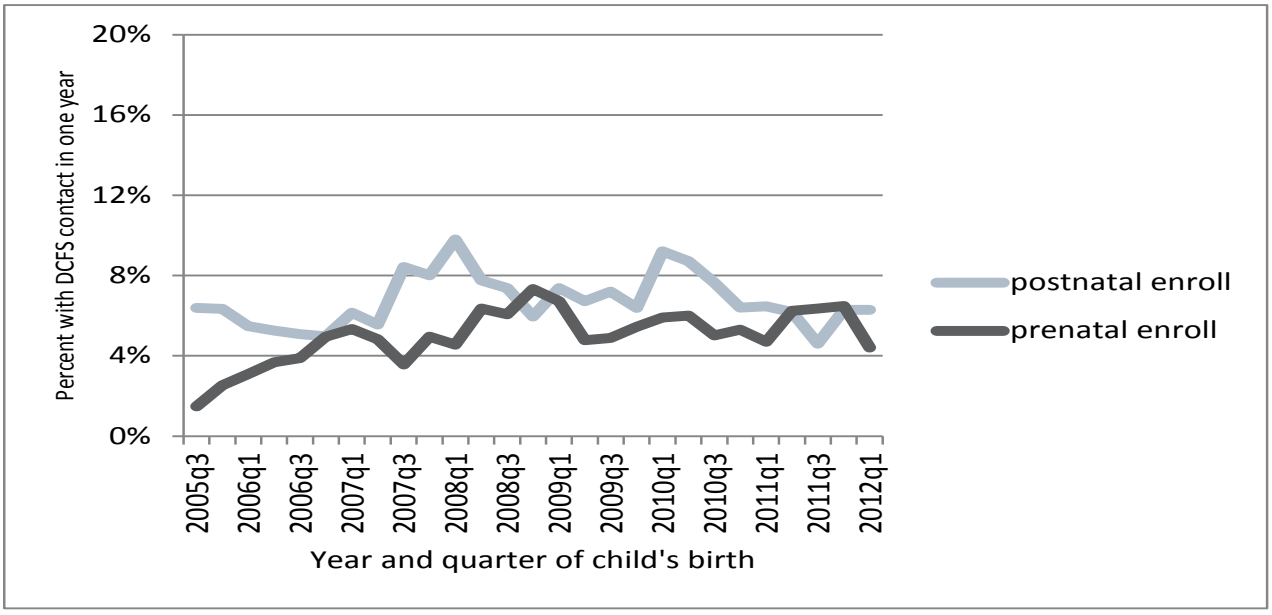
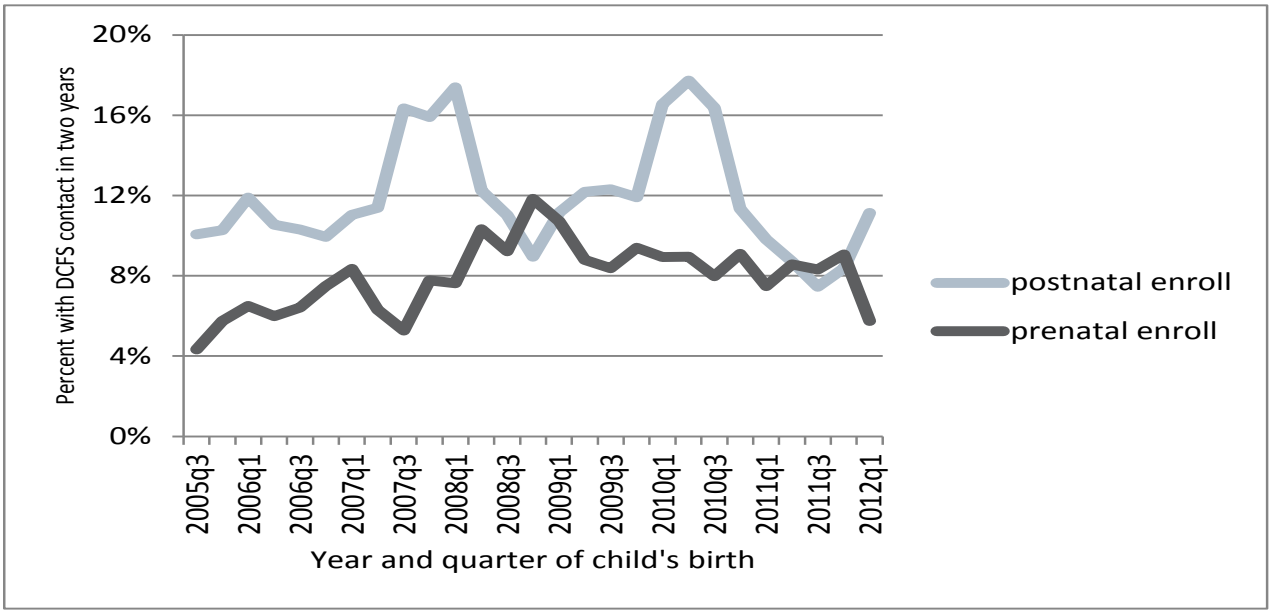


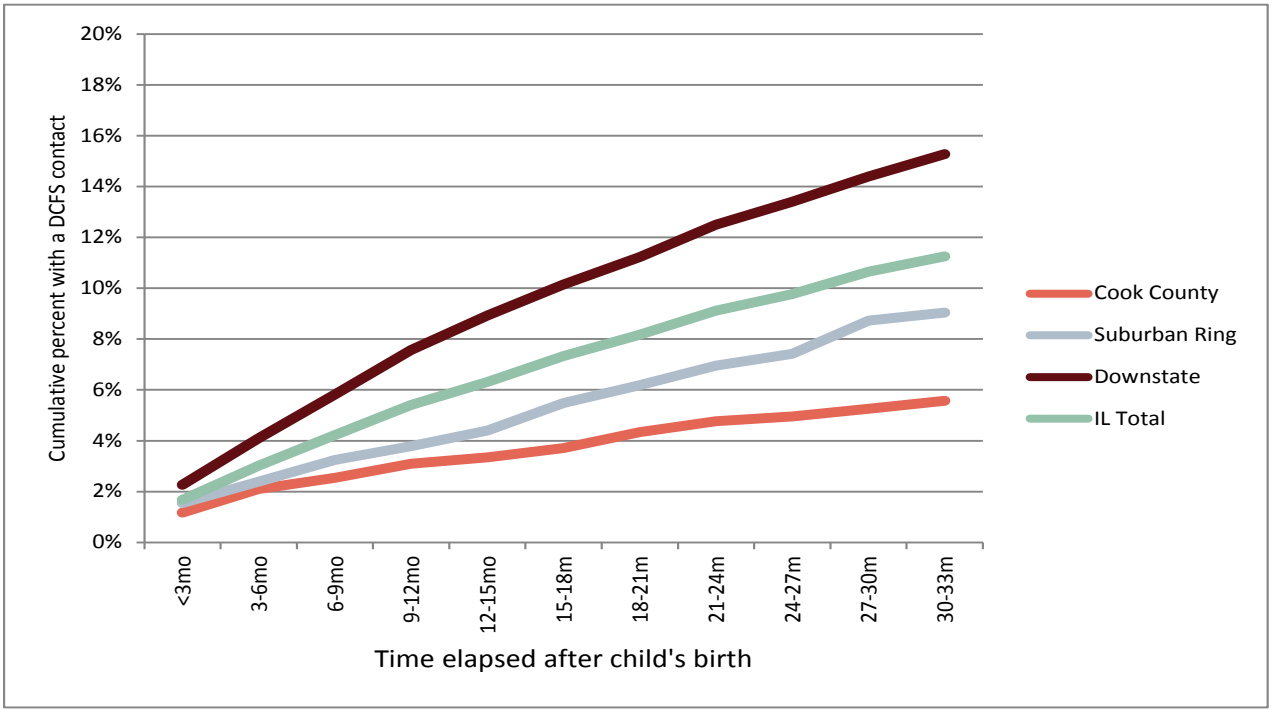

**Figure 9. Enrolled Children Investigated by DCFS within Two Years of Birth**



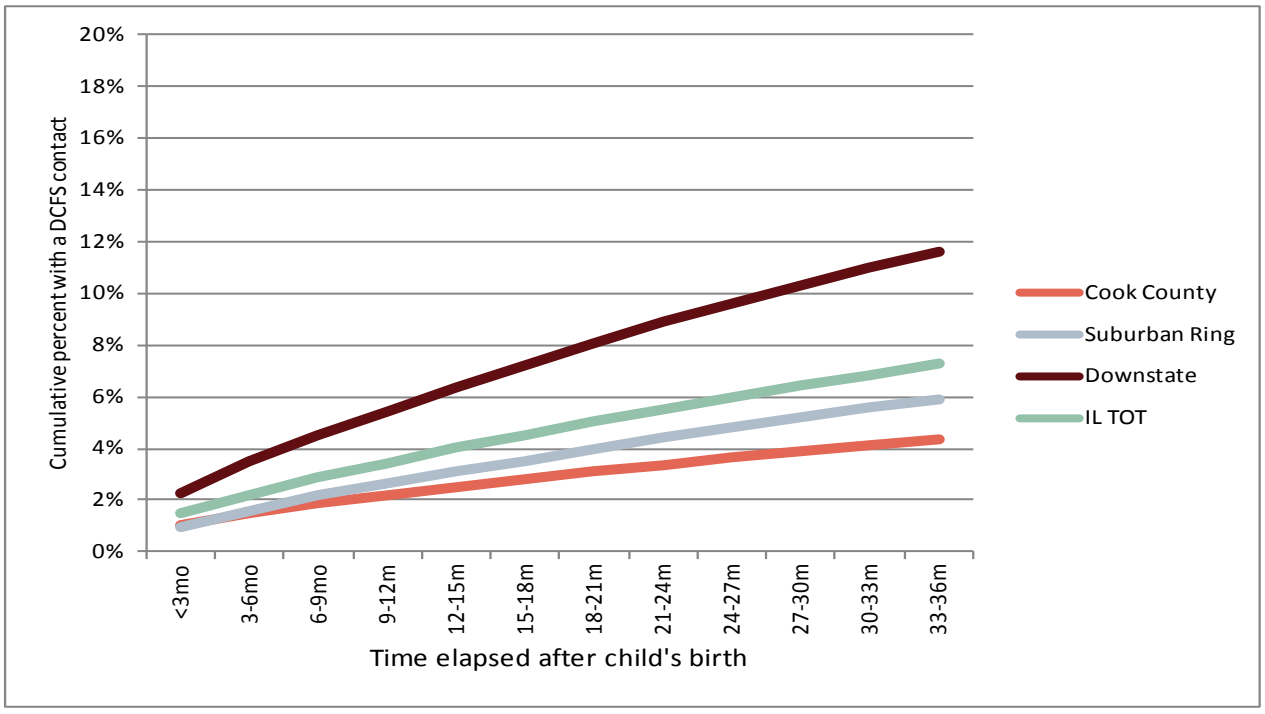
We also compared the speed at which clients of the four DCFS programs became involved with DCFS. Department statistics show that DCFS involvement is now higher in downstate areas, so we separated regions to partially control for the influence of geography on outcomes. Figure 10 shows the HFI client population. The regional differences are striking. By the time they are 3 years old, over 15 percent of downstate HFI clients have experienced a contact with DCFS, while fewer than six percent of HFI clients in Cook County have experienced such a contact. The suburban counties around Chicago and the statewide total fall in between. This figure again shows that the timing of when a client becomes involved with DCFS is not sporadic. It might be expected that HFI clients become engaged with DCFS early on or that HFI and the presence of a home visitor would help buffer the families during their period of enrollment, but that DCFS contact might accelerate after these supports were terminated. However, the data reflect neither of these patterns. The factors that influence contact with DCFS extend beyond program enrollment and we see no evidence of HFI impact. That does not mean that HFI does not have an impact on child maltreatment. Without the home visiting program, it is possible that more families would be involved in DCFS investigations. However, we cannot show that with our data.

Figures 11, 12, and 13 present similar data for WIC, EI, and FCM. The overall levels are consistent with what we have seen, in that children enrolled in EI have higher maltreatment rates, while WIC and FCM are lower than both EI and HFI. The regional differences we see in the HFI chart are mostly preserved across all programs. All four programs show much higher DCFS contact is for downstate clients. However, in Cook County and suburban counties, families involved in WIC, EI, and FCM are less likely to become involved in a DCFS investigation.

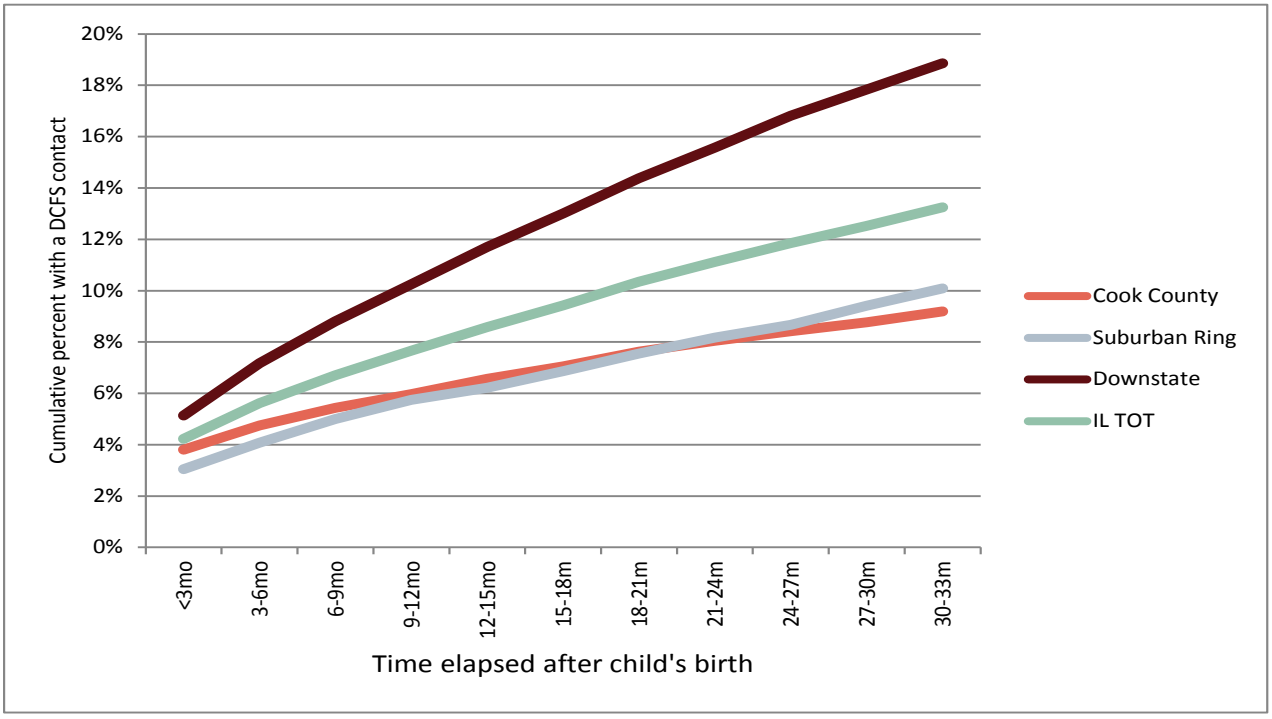
## Figure 10. Cumulative Proportion of HFI Clients Involved in DCFS Investigations



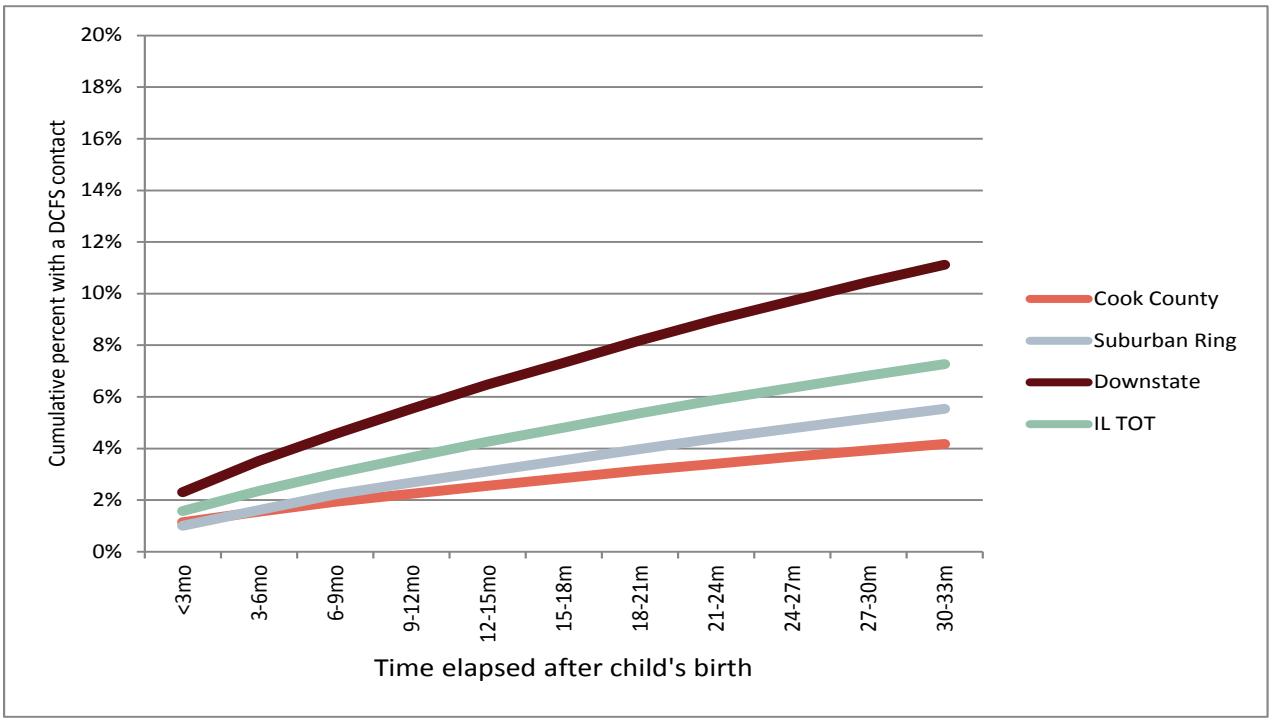

## Figure 11. Cumulative Proportion of WIC Clients Involved in DCFS Investigations



## Figure 12. Cumulative Proportion of Early Intervention Clients Involved in DCFS Investigations




## Figure 13. Cumulative Proportion of Family Case Management Clients Involved in DCFS Investigation



## Summary of HFI Administrative Data Findings

The analysis of data from an 8-year period—beginning with the 2006 state fiscal year (July 2005)—shows that HFI programs collectively had an ongoing caseload of about 2,000 family units, with modest growth from SFY 2006 through 2008, followed by a decrease to just under 1,700 units in SFY 2013. The drop in caseloads in SFY 2010 was marked during the first quarter of that fiscal year (i.e., July through September 2009), which coincided with the state of Illinois budget crisis. It was especially apparent in programs in the Chicago and downstate regions, whereas programs in the suburban ring appeared to be little affected.

During the 8-year period, HFI programs were run in 52 different local sites, and visits were made by almost 350 separate workers. In any given year there were between 40 and 48 sites and between 190 and 208 workers. There were small year-to-year changes in program sites, but substantially more changes occurred in staff during this time. The typical client family received an average of almost two completed home visits per month. Each child averaged over 4 doctor visits per year and received developmental screenings a little more than 3 times per year. The demographic characteristics of families varied somewhat year to year, but overall the characteristics were fairly stable over the period of study. Thirty-six percent of the families were recorded as being Hispanic, 30 percent as black, 30 percent as white, and 3 percent as "other." Initially, over half of the mothers served were teen mothers, but that number has decreased to less than half in recent years. Just over half were high school graduates, but over 40 percent enroll in HFI programs without having earned a high school degree.

The proportion of expected home visits that are actually completed is an important measure of fidelity to the HFI program model. For most of the 8 years, it appears that between 80 and 90 percent of the planned home visits took place, with the lowest completion levels historically occurring in programs in the City of Chicago. At the time of the fiscal crisis (the beginning of SFY 2010), the completion level in Chicago dropped to its lowest level, although it rebounded quickly. In contrast, programs in the other regions of the state showed only a minor shift in completion rates during the same time. In the most recent two years, the Chicago completion rate has improved to the point where all regions are performing equally on this measure. In addition, the number of case closings increased considerably in Chicago and downstate regions during the fourth quarter of SFY 2009. All three regions show increased recruitment of new cases during the following months, early in SFY 2010. Although the final result of these changes is small in terms of the number of clients served, the fluctuations caused by a short period of an unusually high number of terminations followed by a period of active enrollment reflect instability in caseloads. This instability potentially poses a problem for the system's ability to provide stable services to families.

Another important indicator of program fidelity is the extent to which cases are retained after initial engagement and enrollment. A comparison of program duration across two groups of families—those who entered the HFI program prenatally and those who had their first visit shortly after the birth of the child—suggests program retention as measured by elapsed duration of services is noticeably greater for prenatal cases. There is a substantial number of cases (about 10%) which never seem to start, in that a child is never enrolled in the Cornerstone system. These cases tend to end abruptly.

Of all observed HFI children, 18 percent became involved in a child abuse or neglect investigation at some time before SFY 2013. Of those investigated, almost half (49%) were indicated victims, meaning that the DCFS protective investigators found credible evidence that they had experienced child abuse or neglect. The investigation rate was higher for HFI (18%) than for WIC (11%) and FCM (12%), but much lower than for EI (22%). This makes sense because the HFI clients are explicitly selected based on various risk factors, including their risk for child maltreatment. For example, whereas one-half of all children born in the state enroll in WIC and FCM, HFI programs enroll less than one percent of all infants. HFI programs also enroll a disproportionate number of cases with teen mothers.

Furthermore, it should be emphasized that this is a very basic description of the link between families who participate in HFI (or one of the other IDHS programs analyzed here) and DCFS investigations. Timing of enrollment and the intensity and duration of services vary widely across these programs. For HFI children, having a first DCFS contact before enrollment is rare (3% of cases). Having a first DCFS contact during the HFI enrollment period is more common (38% of those with a contact). Most HFI clients who are involved first become so after completing their HFI enrollment (59%). Because the time of observation was limited, we could only observe the DCFS history of clients for periods of time from one year (for SFY 2013 entrants) to eight years (for SFY 2006 entrants).

Finally, analyzing official reports of child abuse or neglect that involved clients of home visiting programs in Illinois as part of this evaluation is grounded in the idea that the goal of the programs is the long-term reduction of child abuse or neglect. Thus, it is reasonable to look at changes in rates of child maltreatment to help determine the success of efforts to improve the infrastructure of supports for home visiting programs. These changes should also be used to determine how to positively influence the programs' long-term quality and model fidelity. It is also reasonable to look at trends in child abuse or neglect rates to describe the distribution of risk groups and child maltreatment across Illinois, which should be used to inform the ongoing planning of services and resources.

However, because the changes being implemented under Strong Foundations are structural and much more likely to influence system- and program-level outcomes—rather than individual family or child outcomes—during the period of the initiative, any observable changes in child abuse or neglect rates

could not be interpreted as a result of any of the initiative activities. Strong Foundations is not implementing activities at the service delivery level. This means there is no viable control group or population to use in analyzing individual level outcomes. Even if we were to measure child abuse or neglect outcomes for home visiting clients and their families, we are not in a position to provide any controls for the composition of this group. These clients are a special and nonrandom group of parents and children. They are, by definition, vulnerable and at high risk of child abuse or neglect, yet they also have been referred to or recruited by a home visiting agency and they have voluntarily agreed to participate in the program offered. Without an experimental or quasi-experimental design, we cannot produce another control or comparison population against which to measure these outcomes.

# Summary and Conclusions

This report is the fourth and final one in a series of reports documenting the work of Strong Foundations, Illinois's Evidence Based Home Visiting (EBHV) initiative. The initiative began in the fall of 2008 and concluded in the fall of 2013. Illinois was one of 17 grantees in 15 states to receive funding from the Children's Bureau to develop infrastructure to support the implementation, scale up, and sustainability of evidence-based home visiting programs for the prevention of child maltreatment. The Illinois Department of Human Services (IDHS) collaborated with the Illinois State Board of Education (ISBE), the Illinois Department of Children and Family Services (DCFS), and the Home Visiting Task Force (HVTF) of the Illinois Early Learning Council (ELC) to plan and implement Strong Foundations. IDHS contracted with Chapin Hall for the local evaluation.

The primary purpose of Strong Foundations was to enhance and strengthen the state infrastructure—governance, funding, monitoring and quality improvement, and training and technical assistance—that supports close to 200 evidence-based home visiting programs in Illinois. The initiative's underlying assumption was that a well-functioning and effective infrastructure at the state level will support and be reflected in a well-functioning and effective local system and the successful operation of program sites. Furthermore, if programs operate successfully, they will produce positive long-term outcomes for maternal life course, child development, and the prevention of child maltreatment, similar to those outcomes observed in randomized controlled trials of evidence-based programs. Following these assumptions, the two overarching goals for Strong Foundations were to implement activities to strengthen the infrastructure of supports for home visiting programs in Illinois and ensure that programs operate with fidelity to their model and are supported with necessary training and resources. Although the long-term goal was to strengthen the system that supports all evidence-based home visiting programs in the state, the initiative focused on three models of evidence-based home visiting programs in Illinois: Parents as Teachers (PAT), Healthy Families America (HFA), and the Nurse-Family Partnership (NFP).

## Key Findings

We observed growth in the home visiting system in several areas, especially in the areas of leadership and governance, state-level collaboration and partnerships, and professional development and training. We also saw a number of ongoing challenges for the system—for example, in developing common monitoring and reporting requirements across program models and strengthening local service systems. We also observed how system-building and program implementation are affected by the larger political, social, and economic context. In addition, we found that the state system was able to be flexible and resilient in responding to both economic challenges and new resources.

### Leadership and Governance

With respect to the role of home visiting in the early childhood development system—and changes in that role over the past 5 years—our informants agreed that home visiting is much more knitted into the fabric of the system than it has ever been. They attributed this growth to Strong Foundations but also to the subsequent federal the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative. Implementing MIECHV is the responsibility of the Strong Foundations partnership director in the Governor's Office of Early Childhood Development (OECD). At the same time, despite a stronger connection between home visiting and other early childhood development domains than ever before, our informants emphasized that stakeholders have to be careful and intentional in ensuring that home visiting issues continue to be integrated with other domains of the early child development system. In this regard, the HVTF and the HVTF Executive Committee play important roles in both allowing the state system to attend to needs in other areas of the system (e.g., the implementation of the Race to the Top Early Learning Challenge grant) and making sure that home visiting is not a neglected part of the overall vision of the early childhood development system.

Home visiting initiatives need strong leadership and strategic thinking in order to ensure home visiting strategies are represented and leveraged in other early childhood development systems work in Illinois. Over the past 5 years, home visiting stakeholders have come to realize the value of formal agreements to increase accountability and shared understandings of quality. The memorandum of concurrence[43] in support of the MIECHV program is an example (this memorandum is a requirement of the MIECHV grant). This document was signed by representatives of the ELC, the HVTF, the HVTF Executive Committee, the OECD, IDHS, ISBE, DCFS, Illinois Department of Healthcare and Family Services (IDHFS), and the Illinois Coalition Against Domestic Violence. This formalized agreement is a vast

[43] Illinois Department of Human Services. (2011, June 1). Memorandum of Concurrence in Support of the Federal Maternal, Infant and Early Childhood Home Visiting Program.

departure from the position taken at the onset of Strong Foundations At that time, the Strong Foundations implementation plan maintained that because of a long history of working together, key stakeholders at the state level "do not require or consider interagency agreements or memoranda of understanding to be necessary in order to establish or formalize working relationships."

To ensure broader perspectives were represented and to ensure equity for the 170 home visiting stakeholders of the HVTF, the HVTF's Executive Committee expanded during SFY 2013. The Executive Committee now includes the cochairs of the HVTF, the OECD's SFPPD, the acting chief of IDHS's Bureau of Childhood Development, the director of IDHS's Division of Family and Community Services, the director of IDHS's Division of Alcoholism and Substance Abuse, ISBE's Early Childhood Division administrator, the U.S. Department of Health and Human Services' (DHHS) Region V Office of Head Start program specialist, the new OECD executive director, the deputy director of the DCFS Office of Child Wellbeing, the deputy commissioner of Chicago's Department of Family and Support Services, and the early childhood officer of Chicago Public Schools (CPS).

**Strengthening Leadership and Growing Partnerships**

According to our informants, since the start of Strong Foundations there has been evidence of growing partnerships and increased understanding of shared goals. These changes have had an impact on the field of home visiting in Illinois. Many stakeholders pointed to the forums for convening discussions around home visiting as the basis for the positive trend. Some informants also noted that, in addition to having regular structures or forums for meeting, the state's success is also the result of individual people who are committed to working together.

Analysis of interviews and other data since the beginning of Strong Foundations reveal the extent to which this ability to come together has increased coordination among those in leadership roles and communication among stakeholders at different levels of the system. At the beginning of the initiative, despite the long history of partnership in Illinois, stakeholders reported that home visiting was "siloed" by funding stream and program model. They also reported that there was a lack of coordination and communication across the funding streams and models. Although funding streams remain separated,[44] over the 4 years of the evaluation our informants reported that they have observed growth in levels of awareness of the different agencies that support home visiting programs, better understanding of other program models, and better coordination of efforts to advance the home visiting field in Illinois.

[44] One informant commented that "siloed funding through separate line items and budget [is] a strength not a weakness of the system. To be significantly in two state agency budgets, as well as taking advantage of every federal initiative that we can, strengthens the potential for sustainability in funding."

More regular communication and the ability to coordinate efforts are factors that lead to increased organizational and system resiliency and demonstrate leadership. Interviews with state-level informants over the past 4 years point to increasing collaboration across the multiple agencies that implement and monitor home visitation policies. Survey results indicate that respondents agreed that the work of Strong Foundations would not be possible without collaboration.

In brief, during the period of Strong Foundations, we have observed growth in shared understanding about the importance of home visiting across funding streams and program models . We have also observed greater shared understanding about what makes a good home visiting program and the infrastructure needed to support high quality services. Our informants also express greater confidence in the leadership and governance of the system, including the individuals who currently represent the public and private organizations responsible for implementation of home visiting services (i.e., IDHS, ISBE, DCFS, and, more recently, CPS) or overseeing the development of the infrastructure (ELC, HVTF, OECD, and the Strong Foundations Partnership).

## Supporting Quality

Partnerships within the governance and administrative structures of home visiting initiatives in Illinois are complex, yet their ability to move the work forward through major transitions is a testament to their resiliency. One component of the infrastructure to which a great deal of attention has been paid during SFY 2013 has been supports and resources for ensuring quality services through monitoring, fidelity, and continuous quality improvement.

### Partnerships and Aligning Monitoring Requirements

Illinois is similar to many other states that are moving toward the creation of unified data systems that support state early learning and development system goals (U.S. Department of Health and Human Services, 2011). Since the implementation of the EBHV grant began, agencies that fund home visiting services in Illinois have had many more opportunities to come together. As a result, they have deepened their mutual understanding about the various home visiting models in the state with regard to how they are similar and how they differ. More recently, MIECHV has created additional reporting goals around which partners can convene.

Some informants offered that to be effective, efforts to streamline reporting have to consider requirements of both program models and funders. As evidence of the models' growing awareness of the national emphasis on evidence-based fidelity, several informants pointed to recent curriculum and implementation changes for PAT; new, soon to be released best practice standards for HFA; and discussions occurring with the BabyTALK curriculum.

Additional respondents shared their perspectives that there has been movement, at least in terms of increased commitment, to streamline the process and reduce the burden for programs while attaining quality data.

By coming together to focus, at least in part, on developing improved strategies for data collection, data reporting, and monitoring, the funding bodies and the Executive Committee embraced a collective impact approach (Kania & Kramer, 2011). Complementing this work is the Strong Foundations Partnership's new scope of work around continuous quality improvement (CQI), which will also address issues of data collection, data reporting, and data utilization.

**Using Data to Inform Programming and Policy**

According to our informants, having quality data and access to data is critical for building and sustaining the home visiting infrastructure and delivery of services to families and communities. In particular, they stressed the need for data on implementation and program quality as well as outcomes. Several informants credited Strong Foundations with increasing stakeholders' understanding of the value of data use, but also of the system problems that interfere with data use. These problems include systems that collect different information and do not have ways to communicate with each other.

Given the desire to use data effectively, state agencies began addressing the number of technical and other barriers to building a more unified data system or integrating more than one data system. For example, ISBE modified its Student Information System (SIS) data system to allow pregnant women to be added to the system, capture prenatal visits, and connect an individual child with one or more caregivers entered into the system. Demographic information can now be used, according to one informant, to "understand who the children are, what risk factors are present, and what potential risk factors are for the family in terms of education level and employment."

Another change during SFY 2013 was a shift from using Social Solutions' Efforts to Outcomes as the MIECHV data system to using Visit Tracker, which has increasingly been used over the past few years by PAT sites in Illinois and by some HFI and CPS programs. There have been preliminary discussions with the Ounce about the possibility of shifting their providers to Visit Tracker. However, IDHS will continue to use Cornerstone as its data system because the data it holds is so comprehensive, even though integrating Cornerstone and the MIECHV system has proved to be more difficult than anticipated.

**Continuous Quality Improvement**

During SFY 2013, the Strong Foundations Partnership began a new major component of its work—creating and implementing a Continuous Quality Improvement (CQI) system, beginning with the MIECHV communities. The Center for Prevention Research and Development (CPRD) was contracted

for the work and receives strategic oversight form OECD, IDHS, and the HVTF Executive Committee. Each MIECHV program received a Memorandum of Understanding (MOU) that detailed what it could expect from the state, from CPRD, and what would be expected of them as part of the CQI process

CQI philosophy holds that most things can be improved and that one learns as much from challenges and failures as from successes. CQI differs from a traditional quality assurance (QA) process in that CQI is "self-directed, self-determined change rather than [change] imposed by an external entity." The goal of CQI is to value data and strive for process improvement for home visiting programs and optimal outcomes for families. Ultimately, the Strong Foundations Partnership wants to institute a statewide CQI system. The state views CQI as a mechanism to inform policy, but also to improve practice by making sure that the programs from which they gather the data also have aggregate data to understand how their local efforts align with changes in home visiting at a state-wide level.

Respondents tended to agree that the EBHV grant afforded the state the opportunity to be in a stronger position in terms of being able to plan for and implement MIECHV's CQI component and think about spreading its reach statewide. At least some state-level stakeholders have concerns that members of the home visiting community were offended by the approach to CQI in the state. While individuals who are more closely involved with the CQI work reported positive reactions and buy-in from the home visiting community at large, other state-level stakeholders felt the communication did not fit the audience.

Other efforts aimed at improving program quality were started during SFY 2013, including, for example, the Home Visiting Quality project, a component of the Illinois State Advisory Council (SAC) grant, which ended in SFY 2013. The Home Visiting Quality project supported program funders and models in their efforts to measure their adherence to the quality standards of their particular model. To that end, ISBE and the PAT, HFI, and BabyTALK programs each conducted a quality implementation project. Quality was also the highlight of the first ever home visiting summit, Innovations in Quality: Home Visiting Summit, held in Illinois during April 2013 The summit was attended by approximately 600 home visiting stakeholders.

### Community Systems Development

As recognized in the Home Visiting State Systems Development Assessment Tool (Home Visiting Task Force, 2009) and in the Strong Foundations Implementation Plan (IDHS, 2009), local and regional collaboration, community planning, and site development are other important aspects of the infrastructure supporting home visiting. These were originally the responsibility of the Community Systems Development Work Group of the HVTF. In 2012, the community systems development work was integrated into the ELC's Systems Integration and Alignment Committee (SIAC) and its Community Systems Development Subcommittee (CSDS).

The objective of the SIAC's CSDS is to serve as an advisory body to community systems work that is being implemented statewide through various grants and projects, including the SAC grant, the Strong Foundations Partnership (EBHV and MIECHV), and the Race to the Top Early Learning Challenge (RTT ELC) grant.

Although the SAC grant ended at the end of state fiscal year 2013 (SFY 2013), the state continues to prioritize the development of local or regional infrastructure that integrates available programs, services, and resources for young children and their families. It is also in the process of forming the Consortium for Community Systems Development (CCSD).

The CSDS also advises the HVTF on its work to enhance community systems, particularly improving coordination between home visiting programs at the state and local level and between home visiting programs and the range of other services for children and their families at the community level. In SFY 2013, much of this work occurred around the significant focus on community systems and collaboration within the MIECHV communities. Viewing MIECHV as a pilot for what could become a statewide, comprehensive infrastructure for all evidence-informed and evidence-based home visiting programs, the OECD and IDHS have worked together to connect the MIECHV communities more closely with AOK Networks, Family Case Management, Early Intervention, local interagency councils, and other existing entities. Recognizing that several of the MIECHV communities have growing Latino populations, MIECHV representatives at the OECD met with the Latino Policy Forum to discuss collaborating to support MIECHV communities as well as English language learners throughout the state.

In addition, as part of community systems development each MIECHV community began implementing a coordinated intake process to match families with appropriate service providers. Although agencies involved in MIECHV understand the value of coordinated intake, several communities have experienced difficulties communicating with and engaging some of the funders and service providers in their communities. To help with this issue and other issues, representatives of OECD and Children's Home and Aid, as well as ISBE and IDHS, have assisted the MIECHV community systems developers with site visits and other technical assistance. Representatives of the MIECHV communities have also shared updates on their collaboration and community systems work on a regular basis during full HVTF meetings and CSDS meetings.

Finally, in SFY 2013 the HVTF focused considerable attention on connecting health systems with home visiting systems. This was done in response to needs in the area of maternal child health. The Health Connections Work Group is charged with improving coordination between health and home visiting systems. The Health Connections Work Group, together with the OECD, has also served in an advisory

capacity to the Illinois Chapter of the American Academy of Pediatrics (ICAAP), which is working under MIECHV to connect home visiting programs and medical homes.

## Training and Professional Development

Strengthening the state's home visiting training and professional development infrastructure has been a focus of Strong Foundations since its beginning. Through Strong Foundations, Illinois offered training in four topics—domestic violence, substance abuse, perinatal depression, and young adults with learning challenges (YALC)—to any home visiting staff member regardless of model, beginning in 2009. (These four topics are often referred to as "the Big 4.") SFY 2013 saw the addition of supervisor learning communities training, designed to provide both content and strategies for providing effective supervision to home visitors contending with the training topic area. For the last 2 years, the Strong Foundations training umbrella has also offered the Happiest Baby on the Block (HBOB) self-study certification program and Strengthening Families trainings on protective factors and on understanding trauma.

The substance abuse training garnered the largest number of attendees. Although each training session had a capacity of 40 people per class, classes were rarely filled to capacity. Home visitors made up the majority of the survey respondents and they primarily represented the PAT and HFI programs.

Analysis of pretest, posttest, and 3-month follow-up surveys showed that training participants were pleased overall with the quality of the training and its applicability to their work with families. They indicated having greater knowledge of the content and more confidence in their knowledge after training than before. Both at posttest and approximately 3 months after the training, knowledge and confidence mean scores were significantly higher than they were at the time of the pretest A majority of respondents also indicated that the training had changed how they handle the topic in their work with families and that they had shared training information with their colleagues.

On all of the satisfaction items in the pretest, posttest and follow-up surveys, the YALC training was consistently rated lower than the other trainings (although ratings were still, overall, positive). However, it also had the highest attendance and follow-up survey response rates. These findings might reflect the fact that the YALC was the most recent addition to the training menu.

### Supervisor Learning Communities

In SFY 2012, Strong Foundations established supervisor learning communities (SLC) around domestic violence and perinatal depression in response to the unique training needs of supervisors. In SFY 2013, SLCs were offered around YALC and the two Strengthening Families trainings–Protective Factors and

Understanding Trauma.[45] The learning communities were designed to review content knowledge and develop supervisory skills in the topic areas to increase supervisors' skills in supporting staff who work with families experiencing depression, domestic violence, substance abuse, and adult learning challenges. One assumption underlying the supervisor learning communities was that increased supervisor would, in turn, alleviate some of the staff discouragement, burn-out, and high turnover rates that home visiting programs face.

Overall, results of the pretest, posttest, and 3-month follow-up surveys were positive. Participants reported increased knowledge and confidence in working with home visitors in the topic area and evaluated the quality of the training favorably. Participants were enthusiastic about recommending the course to others and being able to apply the material from the day's training to their jobs. About three-fourths also reported that the training had increased their awareness and knowledge of referral sources for families.

**Happiest Baby on the Block**

Beginning at the end of SFY 2011, Strong Foundations, in partnership with Prevent Child Abuse Illinois, began to offer home visiting program staff the opportunity to participate in the Happiest Baby on the Block (HBOB) self-study certification process. Strong Foundations also provided HBOB materials for participating programs' lending libraries, as well as parent kits and swaddling blankets for families. HBOB was developed as an approach for calming young children and, in turn, relieving parenting stress and promoting positive child and caregiver relationships.

The HBOB component of Strong Foundations reached only a small number of home visitors and their programs each year. Over a 3-year period, from SFY 2011 through SFY 2013, 36 home visitors from HFI, PAT, and Early Head Start participated in the program. Another 10 home visitors from each of the models and BabyTalk are expected to take part in the program in SFY 2014.

In addition, a supplemental HBOB toolkit was offered in SFY 2013 to expand the number of home visitors who are familiar with this approach. Twenty-seven people participated in the two teleconferences to learn more about the toolkits and to network with their fellow HBOB-certified colleagues about useful hints, challenges, and strategies. Participants were reported to be satisfied with the HBOB technique and appreciated the ability to receive swaddling blankets and other materials for their families. One issue raised in the teleconferences, however, was the new DCFS licensing standards that prohibit swaddling when putting a child to sleep, in conflict with the HBOB approach. It would be beneficial to have higher

[45] Twelve supervisor learning communities were initially scheduled during SFY 2013, but seven were cancelled because of low enrollment. Those canceled include all of the sessions scheduled in the downstate region and one in Springfield. Among the topic areas, the YALC supervisor learning community had the most attendees.

level discussions about the implications of the new standards with DCFS and Strong Foundations stakeholders.

**Future Development of the Training Infrastructure**

The four foundational training topics will not continue to be offered as cross model, in-person trainings into SFY 2014. Rather, these trainings will be converted to an online series entitled, "Home Visiting Challenges." The rollout of the online format will begin with perinatal depression followed by domestic violence and substance abuse, which mirrors how the in-person trainings were rolled out. There are currently no plans to put the YALC training into an online format.

A reason for changing to an online format may have been the steadily declining number of participants in the Big 4 trainings over the past 3 years and the difficulty of providing training to downstate regions and other rural areas of the state. At the same time that the Big 4 trainings are transitioning from a traditional format to having an online presence, MIECHV trainings are offering some overlap and support in some of the Big 4 areas: domestic violence, mental health issues, and substance abuse.

Innovation is needed to ensure that effective, appropriate training opportunities are offered equitably throughout Illinois. GIS mapping of SFY 2012 training locations in relation to home visiting programs in our previous report indicated that sparsely populated areas of the state do not receive many training opportunities (Spielberger et al., 2013). Due to funding constraints, changes to home visiting curricula, and low enrollment, Supervisor Learning Communities trainings in SFY 2014 will not be offered in the same format as they have these past 2 years. Instead of having learning communities across the home visiting models, the new SLCs will be offered to home visitor supervisors using the same model.

Although these are all valid reasons for moving forward with model-based Supervisor Learning Communities, it should be noted that returning to model-based services could reinforce differences among program models rather than similarities. A charge of the Strong Foundations EBHV grant was to build home visiting infrastructure specifically around three evidence-based programs—PAT, HFI, and NFP—but also with an eye towards creating a "big tent" for all home visiting programs in the state. By providing supervisors from different models with the opportunity to meet each other, network, and learn about their commonalities, cross-model SLCs had the potential to increase community collaboration.

In conclusion, training continues to be a highly valued and noted piece of the state infrastructure across the home visiting system in Illinois. Both qualitative and quantitative results reflect how the state of Illinois is creating a culture of training and ongoing learning that is increasingly being integrated into home visiting programs. Our findings indicate that as a result of Strong Foundations, home visiting program staff in Illinois have increased opportunities for training; that these opportunities are considered

to be of high quality and are valued by home visiting staff; and that training is also effective in bringing new knowledge to home visiting staff and increasing their confidence and knowledge in specifically targeted topics.

At the same time, barriers remain to expanding trainings to support regional training needs. This expansion could increase participation in training. Illinois is a large state and funding opportunities to expand training location offerings are limited. Strong Foundations-sponsored trainings helped reduce certain resource limitations by covering the training costs for the participants, as did support for attending state conferences and meetings. However, the Training Institute and state administrators are also taking steps to expand online resources and trainings available throughout the state.

## Financing and Sustainability

Financing and sustaining Illinois's home visiting infrastructure and programming is complex. Since the beginning of the Strong Foundations initiative, Illinois has been experiencing a severe budget crisis. Federal sequestration in 2013 reduced MIECHV funding by 5 percent; state stakeholders worked to minimize the impact of sequestration by changing work plans and not hiring for open staff positions. The state is fortunate to have over two decades of investment in research-based home visiting. In addition, Illinois has, as one informant noted, "a substantial home visiting commitment from both an education funding stream and a social human services funding stream."

Given the state's ongoing fiscal crisis, funding remains a core challenge to sustaining home visiting infrastructure and programs. To address this vital issue, the HVTF's Sustainability Work Group was charged with maximizing sustainable funding opportunities the ELC's Systems Integration and Alignment Committee included collaborating with the HVTF's Sustainability Work Group in its work plan.

Members of the HVTF's Sustainability Work Group met six times in SFY 2013 in order to seek solutions to the funding situation and review their ongoing work.[46] The group considered, but then abandoned, the possibility of using social impact bonds; however, members are continuing to explore different ways to bill Medicaid for some home visiting services. The Sustainability Work Group's goal is to develop recommendations to be presented to the HVTF by December 2013. The ability to leverage federal opportunities, such as President Obama's new Preschool for All initiative, is considered an important support for Illinois's home visiting system. However, some informants expressed concern about relying so heavily on federal funding. A recent federal grant application to organize the trauma-informed practice field for birth to three years old includes creating common language to build more awareness and

[46] See http://www2.illinois.gov/gov/OECD/Pages/HVTF-Sustainability.aspx

integrating that language more into the domains of the early childhood system. The initiative would use the six MIECHV communities as pilots for training and staff capacity building.

Increasing public awareness is also viewed as vital to sustainability efforts. To advance the cause of home visiting, stakeholders and advocates continue to seek the engagement of the business community. As mentioned in previous Strong Foundations reports, a public awareness campaign was part of the initial implementation plan but was sidelined when funding was cut. Some of our informants talked about the need to move forward with such a public awareness campaign.

## Program Implementation

To understand trends in program and family characteristics of the evidence-based models of home visitation programs during the period of Strong Foundations, we analyzed 8 years of data for HFI programs which showed modest changes over time. There are usually between 40 and 48 active programs. The demographic characteristics of families were fairly stable over the period of study: 37 percent of the families were recorded as Hispanic, 29 percent as black, 30 percent as white, and 4 percent as "other." Just over half of the mothers served were teen mothers and just over half were high school graduates. HFI enrollment trends include faster relative increases in the city of Chicago and among Hispanics during this time period. On average, HFI programs successfully engaged mothers prenatally in about one-half of all cases, while 37 percent were initiated after the birth of the child. Although the statewide patterns were fairly stable, there was a clear upward trend in prenatal enrollments in Chicago, which is positive. A comparison of two groups of families—those who entered prenatally and those who had their first visit shortly after the child's birth—suggests program duration was longer and retention was greater for those cases with prenatal enrollment in HFI.

The proportion of expected home visits that were completed is considered to be an important measure of fidelity. For most of the 8 years, it appears that between 80 and 90 percent of the planned home visits took place, with the lower completion levels occurring in programs in Chicago. At the time of the SFY 2010 fiscal crisis (summer 2009), the completion level in Chicago dropped to its lowest level, although it rebounded quickly. By SFY 2013 the rate of completion for Chicago sites were higher than for the other two regions, around 90 percent. In contrast, programs in the other regions of the state showed a smaller relative decrease in home visits completed during the same time. In addition, the number of case closings increased considerably in Chicago and downstate regions during the fourth quarter of SFY 2009. All three regions showed increased recruitment of new cases during the following months (winter 2010). The final result of these changes was small in terms of the reduced number of clients served. However, the fluctuations caused by a short period of unusually high terminations followed by a period of active

enrollment reflect instability in caseloads raised questions about the system's ability to provide stable services to families.

## Concluding Thoughts

In the final year of the initiative, state informants continued to be optimistic about the increasing collaboration among the three main state agencies involved in the development of the home visiting system—IDHS, ISBE, and DCFS. Their confidence reflects progress towards the vision of the original Strong Foundations plan for shared leadership and accountability among organizations in the home visiting system. Our informants also acknowledged the growing integration of Strong Foundations and the MIECHV program as a support for system-building. At the same time, they agreed that there is still work to be done to have all of the evidence-based models and funding agencies fully engaged in the state's system-building effort.

Over time, as Strong Foundations became integrated with the MIECHV program, stakeholders recognized that Strong Foundations provided the initial supports needed to implement many aspects of MIECHV. The EBHV initiative also kept system building as an integral part of and support for program implementation and quality improvements. In the words of one informant, "the additional years of EBHV [Strong Foundations] provided us with the foundation to run with MIECHV and I'm not sure that had we not had EBHV initially that we would be where we're at right now with MIECHV."

During the 5 years of Strong Foundations, the state strengthened the infrastructure for evidence-based home visiting programs in several key areas—leadership and governance, collaboration and partnerships, training and professional development, and community systems development. The state also revised the structure of the ELC, its subcommittees, and work groups. This revision was intended to address remaining challenges in the efforts to strengthen the system of supports for home visiting programs and improve program quality and model fidelity. These challenges included stable funding, common understandings of quality, aligned data collection and monitoring systems, local system building, and communication across the system. Bringing quality services to all communities in a large state—making efficient use of all the available resources and sources of talent, ensuring consistent quality of service, reaching the full range of racial and ethnic groups, and focusing particular attention on the most underserved families and regions—is an enormous strategic, organizational, and logistical task. Although new federal MIECHV funding in 2011 helped to stabilize funding, advocates and policymakers still express concern about the sustainability of the system and the programs it supports. Our analysis of administrative data, which showed some fluctuations in services around the time of the SFY 2009 fiscal crisis showed the importance of continuing to monitor trends in services over time to see whether the system, as it grows stronger, is less likely to experience fluctuations like these.

Despite these challenges, the infrastructure in Illinois continues to show strength and resilience in a number of areas that affect program quality and effectiveness. [47] These include strong advocacy and philanthropic organizations, growing state-level collaborative leadership that includes public entities—such as the OECD and its Strong Foundations Partnership, and state agencies—as well as the ELC, HVTF, Early Childhood Comprehensive Systems Initiative (ECCS), and other early childhood collaborations. Although the newer MIECHV program has mainly focused on a small number of communities, it has provided needed, if short-term, resources to expand home visiting services and served as a pilot for a more comprehensive, statewide system. As noted by several informants, the integration of Strong Foundations and MIECHV has been a positive development that recognizes the importance of system building in any effort to improve service quality, access, and outcomes for families and children.

[47] See last year's Strong Foundations' Year 3 report for a discussion of system resiliency (Spielberger, et al., 2013 and Build Initiative. (2011). 2011 State Build Evaluation Guidance. As adapted from Johnson-Lenz, P. & Johnson-Lenz, T. (2009, Feb 2.) Six Habits of Highly Resilient Organizations. People and Place, 1(3). Retrieved from http://peopleandplace.net/perspectives/2009/2/2/six_habits_of_highly_resilient_organizations). The EBHV grant and the MIECHV grant both fall under the larger Strong Foundations Partnership of the OECD. The interconnectedness of the two grants, for example with regard to leadership and strategic vision, demonstrates resiliency within the home visiting infrastructure.

# Bibliography


Build Initiative. (2011). 2011 State Build Evaluation Guidance. As adapted from Johnson-Lenz, P. & Johnson-Lenz, T. (2009, Feb 2.) Six habits of highly resilient organizations. *People and Place*, *1*(3). Retrieved from http://peopleandplace.net/perspectives/2009/2/2/six_habits_of_highly_resilient_organizations

Center for Prevention Research and Development. (2013a, March 21). Memorandum of Understanding between CPRD, University of Illinois and [MIECHV Program Name].

Center for Prevention Research and Development. (2013b). Illinois MIECHV CQI Plan. Chicago, IL: University of Illinois.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Coyne, I. T. (1997). Sampling in qualitative research: Purposeful and theoretical sampling; merging or clear boundaries? *Journal of Advanced Nursing*, *26*(3), 623–30. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9378886

Daro, D. (2012, Nov. 13). *Creating a Context for Successful Programs to Succeed: Recognizing the Collective Need for Change* [PowerPoint slides]. Retrieved from http://www.familylife.com.au/site-images/Presentations/FRSA%20-%20Creatinga%20%20Context%20for%20Successful%20Programs%20-%20Dr%20Deborah%20Daro.pdf

Futures Without Violence. (2011, April 7). New resources on domestic violence for home visitation programs. *Family Violence Prevention & Health Practice: An e-journal of Futures Without Violence*. Retrieved from: http://www.futureswithoutviolence.org/health/ejournal/2011/04/new-resources-on-domestic-violence-for-home-visitation-programs/

Governor's Office of Early Childhood Development. (2014). About us. Retrieved from http://www2.illinois.gov/gov/oecd/pages/aboutus.aspx

Governor's Office of Early Childhood Development. (2012, Nov 2). Illinois MIECHV Update. Retrieved from http://www2.illinois.gov/gov/OECD/Documents/HVTF_MIECHVP/MIECHVP/MIECHV%20Update%202012-11-02.pdf

Governor's Office of Early Childhood Development. (2013, Mar 7). MIECHV Health Connections Update. Distributed at March 11, 2013 HVTF Health Connections meeting.

Hargreaves, M. (2010). Evaluating system change: A planning guide. A Methods Brief. Cambridge, MA: Mathematica Policy Research.

Home Visiting Task Force. (2009). Home Visiting State Systems Development Assessment Tool.

Home Visiting Task Force. (2013, April 9). Executive Committee meeting notes. Retrieved from http://www2.illinois.gov/gov/OECD/Documents/Early%20Learning%20Council/HVTF/HVTF%20Exec%209Apr2013%20NOTES%20FINAL.pdf

Home Visiting Task Force. (2013, June 3). Home Visiting Task Force ELC Exec Update. Retrieved from http://www2.illinois.gov/gov/OECD/Documents/Early%20Learning%20Council/Council/6.24%20ELC%20Email%20Handouts.pdf.pdf

Home Visiting Task Force Health Connection Workgroup (*sic*). (2012, March 19). Meeting Minutes. Retrieved from http://www2.illinois.gov/gov/OECD/Documents/HVTF_MIECHVP/Health%20Connections/HVTF%20Health-Minutes-03%2019%2012.pdf

Home Visiting Task Force Health Connection Workgroup (*sic*). (2012, Oct 15). Meeting Minutes. Retrieved from http://www2.illinois.gov/gov/OECD/Documents/HVTF_MIECHVP/Health%20Connections/Health%20Connections%20-%20Minutes%20-%2010%2015%2012.pdf

HVTF Sustainability Work Group Meeting Notes. (2013, May 23). Retrieved from: http://www2.illinois.gov/gov/OECD/Documents/Early%20Learning%20Council/HVTF/Sustainability/Sustainability%20WG%20Mtg%20May%2023%202013%20NOTES%20FINAL.pdf

Home Visiting Task Force. (2012). Work Plan. Distributed at 7/19/12 HVTF meeting.

Home Visiting Task Force. (2013). Work Plan, Draft 4. Distributed at 1/29/13 HVTF meeting.

Illinois Department of Human Services. (2009). Implementation Plan for Strong Foundations. Submitted to the Children's Bureau.

Illinois Department of Human Services. (2011). Maternal, Infant, and Early Childhood Home Visiting Program Implementation Plan. Submitted to Health Resources and Services Administration.

Illinois Department of Human Services. (2011, June 1). Memorandum of Concurrence in Support of the Federal Maternal, Infant and Early Childhood Home Visiting Program.

Illinois Department of Human Services. (2012). Division merger announcement. Retrieved from http://www.dhs.state.il.us/page.aspx?item=58522

Illinois Department of Human Services. (2013). *ACF performance progress report*. State Advisory Council Final Report.

Illinois Early Learning Council. (2012). Strategic Plan. Retrieved from: http://www2.illinois.gov/gov/OECD/Documents/Reports/ELC%20Strategic%20Plan%202012.pdf

Kania, J., & Kramer, M. (2011, Winter). Collective impact. *Stanford Social Innovation Review*, 36–41.

Kania, J., & Kramer, M. (2011, Jan 19). Collective impact: Creating large-scale social change [Webinar]. In *SSIR Live! Webinar Series*.

Kania, J., & Kramer, M. (2013, January 21). Embracing emergence: How collective impact addresses complexity [Web log post]. Retrieved from http://www.ssireview.org/blog/entry/embracing_emergence_how_collective_impact_addresses_complexity.

Karp, H. (2002). *Happiest baby on the block: The new way to calm crying and help your newborn baby sleep longer*. New York: Bantam Dell.

Lester, K. (2013, June 10). Despite windfall, Illinois still to lag on bills [Web log post]. Retrieved from http://www.nbcchicago.com/blogs/ward-room/Despite-Windfall-Illinois-Still-to-Lag-on-Bills--210752341.html#ixzz2Z9FtgsfI

Liebman, J. (2011, Feb 9). Social impact bonds: A promising new financing model to accelerate social innovation and improve government performance. Washington, DC: Center for American Progress. Retrieved from: http://www.americanprogress.org/issues/open-government/report/2011/02/09/9050/social-impact-bonds/

Metro, G. (2013, August 7). Child abuse and neglect deaths on the rise in state. *The Southern Illinoisan.* Retrieved from http://thesouthern.com/news/local/child-abuse-and-neglect-deaths-on-the-rise-in-state/article_ff8715a4-ff1c-11e2-bab4-0019bb2963f4.html.

Ounce of Prevention. (2012). "We all need Strong Foundations." Promotional materials for Strong Foundations/Strengthening Families Special Topic Trainings.

Palandijian, T., & Shah, S. (2012, December 12). Social impact bonds in the United Sates: Their promise and future. *SSIR Live!* Retrieved from https://video.webcasts.com/events/pmny001/viewer/index.jsp?eventid=44744

Prevent Child Abuse Illinois. (2013). *Happiest Baby on the Block, Strong Foundations Summary FY13*. Chicago, IL: Prevent Child Abuse Illinois.

Prevent Child Abuse America. (2013, October 1). HFA Best Practice Standards, effective July 1, 2014–December 31, 2016. Chicago, IL: Prevent Child Abuse America.

Roman, J. K. (2013, February 26). Statement on Social Impact Bonds. Retrieved from: http://www.urban.org/UploadedPDF/901558-Social-Impact-Bonds.pdf

Spielberger, J., & Gitlow, E. (2012). *Illinois BUILD 2011 Evaluation report: Resilience in the early childhood development system*. Chicago, IL: Chapin Hall at the University of Chicago.

Spielberger, J., Gitlow, E., Dadisman, K., Winje, C., Harden, A., Banman, A., & O'Reilly Schlecht, C. (2011). *Building a system of support for evidence-based home visitations programs in Illinois: Early findings from the Strong Foundations Evaluation*. Chicago, IL: Chapin Hall at the University of Chicago.

Spielberger, J., Gitlow, E., Dadisman, K., Winje, C., Harden, A., Banman, A., & O'Reilly Schlecht, C. (2012). *Building a system of support for evidence-based home visitation programs in Illinois: Findings from year 2 of the Strong Foundations Evaluation*. Chicago, IL: Chapin Hall at the University of Chicago.

Spielberger, J., Gitlow, E., Winje, C., Harden, A., & Banman, A. (2013). *Building a system of support for evidence-based home visitation programs in Illinois: Findings from year 3 of the Strong Foundations Evaluation*. Chicago, IL: Chapin Hall at the University of Chicago.

System Integration and Alignment Committee. (2012). System Integration and Alignment Committee Work Plan Retrieved from http://www2.illinois.gov/gov/OECD/Documents/Early%20Learning%20Council/Sys%20Align%20a

nd%20Integration/Systems%20Integration%20and%20Alignment%20Committee%20Work%20Plan.pdf

System Integration and Alignment Committee. (2012, June 13). Meeting minutes. Retrieved from http://www2.illinois.gov/gov/OECD/Documents/Early%20Learning%20Council/Sys%20Align%20and%20Integration/SIAC%20-%20minutes%20-%2006%2013%2012.pdf

Topinka, Judy Baar. (2013, July). Bill backlog drops. . .for now. *The Illinois State Comptroller's Quarterly*, 10. Retrieved from: http://www.ioc.state.il.us/index.cfm/resources/comptrollers-quarterly/quarterly-edition-10-july-2013-bill-backlog-dropsfor-now/

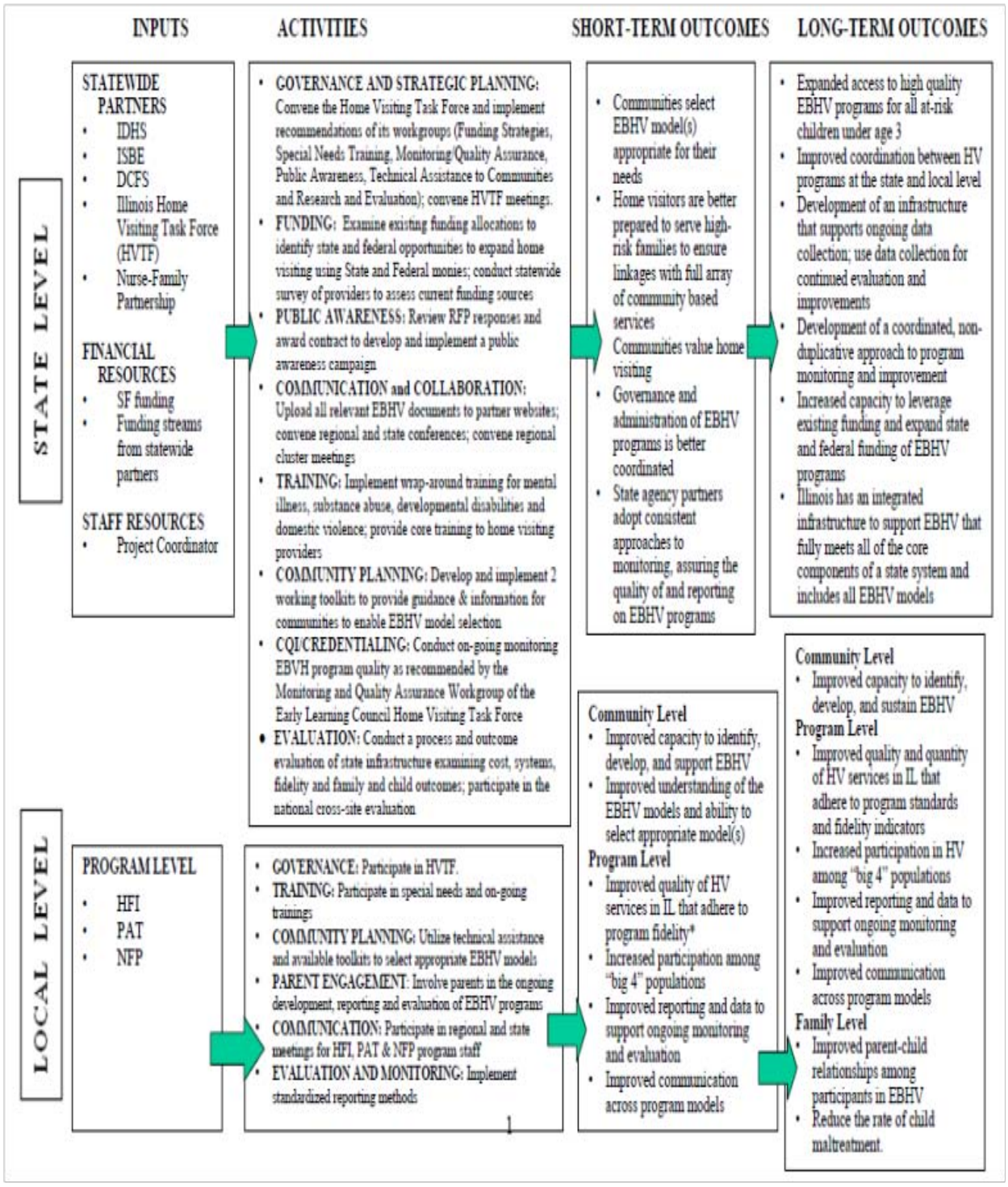
U.S. Department of Health and Human Services. (2011). *State issues and innovation in creating integrated early learning and development systems.* HHS Publication No. (SMA) 11-4661. Rockville, MD: U.S. Department of Health and Human Services.

# Appendix A: Original Strong Foundations Logic Model

As outlined in Figure A-1, Strong Foundations was designed to strengthen a number of infrastructure components. These include funding strategies; training for home visiting staff to strengthen their skills in working with families affected by domestic violence, mental health problems, substance abuse, or developmental disabilities; technical assistance to communities in selecting evidence-based programs that meet the needs of their families and in coordinating services; monitoring and assuring the quality of services; use of data for evaluation and program improvement; and public awareness. During the planning year of the grant, which ran from October 2008 through September 2009, the Home Visiting Task Force (HVTF) established six work groups to develop implementation plans for each of these areas. Over time, as the work of the HVTF and the Early Learning Council (ELC) of which the HVTF is a component grew, some of these work groups were modified to reflect new priorities.

This logic model served as a guide for the evaluation of Strong Foundations, which was designed to assess the home visiting infrastructure in Illinois and the changes in state infrastructure and program quality that have resulted from the implementation of Strong Foundations.

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



# Appendix B: Ratings of Individual Items on Wilder Collaborative Factors Inventory by State Informants[48]

[48] Copies of the Wilder data collection protocols are available from Chapin Hall upon request.

**Table B-1. State Informant Ratings of Items on Wilder Collaborative Factors Inventory (Spring 2013)[a]**

| Factor | Statement | *N* | Mean Level of Agreement | | Strongly Agree/ Agree | Neutral | Strongly Disagree/ Disagree |
|---|---|---|---|---|---|---|---|
| | | | Mean | % | % | *SD* | % |
| *History of collaboration or cooperation in the community* | Agencies in our community have a history of working together. | 12 | 4.0 | 83 | 0 | *1.04* | 17 |
| | Trying to solve problems through collaboration has been common in this community. It's been done a lot before. | 12 | 3.9 | 83 | 0 | *1.00* | 17 |
| *Collaborative group seen as a legitimate leader in the community* | Leaders in this community who are not part of our collaborative group seem hopeful about what we can accomplish. | 12 | 3.6 | 67 | 25 | *0.67* | 8 |
| | Others (in this community) who are not a part of this collaboration would generally agree that the organizations involved in this collaborative project are the "right" organizations to make this work. | 12 | 3.6 | 50 | 42 | *0.90* | 8 |
| *Favorable political and social climate* | The political and social climate seems to be "right" for starting a collaborative project like this one. | 12 | 4.3 | 100 | 0 | *0.45* | 0 |
| | The time is right for this collaborative project. | 12 | 4.4 | 100 | 0 | *0.51* | 0 |
| *Mutual respect, understanding, and trust* | People involved in our collaboration always trust one another. | 12 | 2.9 | 8 | 75 | *0.51* | 17 |
| | I have a lot of respect for the other people involved in this collaboration. | 12 | 4.5 | 100 | 0 | *0.52* | 0 |
| *Appropriate cross section of members* | The people involved in our collaboration represent a cross section of those who have a stake in what we are trying to accomplish. | 12 | 4.1 | 92 | 0 | *0.79* | 8 |
| | All the organizations that we need to be members of this collaborative group have become members of the group. | 12 | 3.3 | 50 | 17 | *1.06* | 33 |
| *Members see collaboration as in their self interest* | My organization will benefit from being involved in this collaboration. | 12 | 4.7 | 100 | 0 | *0.49* | 0 |
| *Ability to compromise* | People involved in our collaboration are willing to compromise on important aspects of our project. | 12 | 3.8 | 75 | 25 | *0.58* | 0 |

| Factor | Statement | *N* | Mean Level of Agreement | | Strongly Agree/ Agree | Neutral | Strongly Disagree/ Disagree |
|---|---|---|---|---|---|---|---|
| | | | Mean | % | % | *SD* | % |
| *Members share a stake in both process and outcome* | The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts. | 12 | 3.8 | 75 | 25 | *0.45* | 0 |
| | Everyone who is a member of our collaborative group wants this project to succeed. | 12 | 4.7 | 100 | 0 | *0.49* | 0 |
| | The level of commitment among the collaboration participants is high. | 12 | 4.2 | 92 | 8 | *0.58* | 0 |
| *Multiple layers of participation* | When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations to confer with colleagues about what the decision should be. | 12 | 3.3 | 33 | 42 | *1.06* | 25 |
| | Each of the people who participate in decisions in this collaborative group can speak for the entire organization they represent, not just a part. | 11 | 2.9 | 27 | 36 | *0.83* | 36 |
| *Flexibility* | There is a lot of flexibility when decisions are made; people are open to discussing different options. | 12 | 3.4 | 67 | 8 | *0.90* | 25 |
| | People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working. | 12 | 3.9 | 83 | 17 | *0.51* | 0 |
| *Development of clear roles and policy guidelines* | People in this collaborative group have a clear sense of their roles and responsibilities. | 12 | 3.4 | 50 | 33 | *0.90* | 17 |
| | There is a clear process for making decisions among the partners in this collaboration. | 12 | 3.8 | 75 | 17 | *0.75* | 8 |
| *Adaptability* | This collaboration is able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or change in leadership. | 12 | 4.0 | 92 | 0 | *0.74* | 8 |
| | This group has the ability to survive even if it had to make major changes in its plans or add some new members in order to reach its goals. | 12 | 4.2 | 100 | 0 | *0.39* | 0 |

| Factor | Statement | *N* | Mean Level of Agreement | | Strongly Agree/ Agree | Neutral | Strongly Disagree/ Disagree |
|---|---|---|---|---|---|---|---|
| | | | Mean | % | % | *SD* | % |
| *Appropriate pace of development* | This collaborative group has tried to take on the right amount of work at the right pace. | 12 | 3.8 | 83 | 0 | *0.87* | 17 |
| | We are currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project. | 12 | 3.8 | 83 | 8 | *0.72* | 8 |
| *Open and frequent communication* | People in this collaboration communicate openly with one another. | 12 | 3.6 | 75 | 8 | *0.79* | 17 |
| | I am informed as often as I should be about what goes on in the collaboration. | 12 | 3.5 | 50 | 33 | *1.00* | 17 |
| | The people who lead this collaborative group communicate well with the members. | 12 | 3.6 | 67 | 17 | *0.90* | 17 |
| *Established informal relationships and communication links* | Communication among the people in this collaborative group happens both at formal meetings and in informal ways. | 12 | 4.3 | 100 | 0 | *0.49* | 0 |
| | I personally have informal conversations about the project with others who are involved in this collaborative group. | 12 | 4.4 | 100 | 0 | *0.51* | 0 |
| *Concrete, attainable goals and objectives* | I have a clear understanding of what our collaboration is trying to accomplish. | 12 | 4.3 | 100 | 0 | *0.49* | 0 |
| | People in our collaborative group know and understand our goals. | 12 | 3.9 | 83 | 8 | *0.79* | 8 |
| | People in our collaborative group have established reasonable goals. | 12 | 3.8 | 83 | 8 | *0.72* | 8 |
| *Shared vision* | The people in this collaborative group are dedicated to the idea that we can make this project work. | 12 | 4.3 | 92 | 0 | *0.87* | 8 |
| | My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others. | 12 | 3.7 | 67 | 17 | *0.98* | 17 |

| Factor | Statement | *N* | Mean Level of Agreement | | Strongly Agree/ Agree | Neutral | Strongly Disagree/ Disagree |
|---|---|---|---|---|---|---|---|
| | | | Mean | % | % | *SD* | % |
| *Unique purpose* | What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself. | 12 | 4.8 | 100 | 0 | *0.45* | 0 |
| | No other organization in the community is trying to do exactly what we are trying to do. | 12 | 4.2 | 83 | 0 | *1.11* | 17 |
| *Sufficient funds, staff, materials, and time* | Our collaborative group had adequate funds to do what it wants to accomplish. | 12 | 3.4 | 67 | 8 | *0.90* | 25 |
| | Our collaborative group has adequate "people power" to do what it wants to accomplish. | 12 | 3.3 | 58 | 17 | *0.89* | 25 |
| *Skilled leadership* | The people in leadership positions for this collaboration have good skills for working with other people and organizations. | 12 | 4.2 | 100 | 0 | *0.39* | 0 |

# Appendix C: Descriptions of Strong Foundations' Big Four & Supervisor Learning CommunitiesTrainings[49]

[49] Source: Ounce of Prevention Training Institute (the Institute).

**Figure C-1. Big Four Training Description**

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

## About Chapin Hall

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

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

1313 East 60th Street
Chicago, IL 60637

T: 773.256.5100
F: 773.753.5940

www.chapinhall.org

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