MIECHV BRIEF STUDY REPORT – 2015 COMMUNITY SITE VISITS AND FOCUS GROUPS

August 2015

Center for Prevention Research and Development
University of Illinois

Illinois Maternal, Infant, and Early Childhood Home Visiting
Community Site Visits and Focus Groups
August 2015

As part of its MIECHV evaluation plan, staff at the Center for Prevention Research and Development (CPRD) at the University of Illinois conduct annual site visits to the six MIECHV communities to ask about the successes and challenges that sites may encounter during home visiting, Continuous Quality Improvement processes and the field data collection procedures. Focus group style structured group interviews were completed with home visiting program site supervisors and home visitors. CPRD staff (Peter Mulhall, Stacey McKeever, Mary Anne Wilson and the Field Data Collector working with the site) have met with the MIECHV community sites located in Elgin, Cicero, Englewood, Rockford, Macon County, and Vermilion County on a rotating basis over the past 3 years, and have now completed visits with almost all of the MIECHV home visiting programs. This year's visits were completed between May 20, 2015 and June 26, 2015, in each of the six MIECHV communities. The focus groups were digitally recorded, after acquiring participant assent, and were transcribed by an external vendor. Participants were assured anonymity for their participation.

The specific interview questions/topics and the range of responses were categorized by questions, thematic groups, commonalities and convergent and divergent constructs. The results for this round of site visits and focus groups are presented and described in the tables below:

2015 CPRD Site Visits: Cicero, Elgin, Englewood, Macon, Rockford, Vermilion	
Field data collection • How has the collection of field data been going?	• Good in general, working through any problems as they arise • Can be confusing to be working with MIECHV, MIHOPE, and Mothers and Babies at same time • "we've gotten used to doing things one way and so now we have to shift to doing things another way – but I think the fact that we have some flexibility in when we have to schedule the visits helps." • "I think it's going really well…. "Being able to explain the questions to the participant beforehand helps: "I don't just want to show up and tell the girls well somebody's gonna come but I don't I know what they're gonna ask, you know. It helps me explain to them what to expect." • Our FDC is very friendly and easy to be around • In general a very interesting and positive experience: "…things that I can learn and continue to learn from it." • Our FDC has evoked a very positive response: "I have two families that the FDC came to see when they were pregnant, and they asked me, "Well, when's that lady coming back?"" • During the video assessment "… I'm sitting there and I'm like I'm not supposed to say anything, I'm not supposed to do anything. … I wanted to shout out, talk!"
• How has coordinating scheduling been? With Field Data Collector (FDC)	• "For the most part I think it's been fine." • Have been able to keep to regular schedule, FDC has adapted to that • FDC does a good job of working around our schedule. • Scheduling issues more difficult during transition time after FDC left. • Never any problems getting our FDC into a visit • Schedule visits by phone (or text), use shared Google calendar afterwards
With families	• We always text to confirm • If texts don't work, call or stop by • There are some last-minute cancellations, tend to be more over the summer • Whatever problems we have are usually due to baby's schedule (sleeping, dr. appts., etc.) • Have integrated data collection process into the HV system • It's been harder recently because of HV schedule; but neither FDC nor client has presented scheduling issues • Use e-mail & text with families

	• Gift card incentive makes it easy
• Do families seem to mind the data collection?	• "They don't mind the surveys. What they most of the time mind is the video." "Stage fright," nervous about being videotaped. • None have refused videotaping • With the video assessment "…it helps to tell them it's kind of like the same thing that we do in our visits. It's just somebody else is doing it and you're not gonna get a copy of it. But it's pretty much the same thing." • Had one client that was excited for the year 3 data collection visit • Families persuaded by need to maintain funding and by gift card incentive: "that really does help to get her in every time…" • Going through the handouts with participants: "I think if you can just get the FDC in the door, then the FDC can explain the project and go through the details…" • Our FDC is thorough and easy-going • With some questions, participants may not understand the purpose of the question: "… they just want to know why they're being asked certain questions. I think it can be overwhelming with other projects along with this one, but I don't see a particular problem with the surveys." • Need to introduce the issue of data collection from the start, as a requirement for MIECHV, in order to encourage participation • Only one family did not want to participate in data collection • Some have trepidation regarding video aspect of data collection; mostly for reasons unknown; in one case may have had to do with superficial reasons: "… just really not comfortable being recorded right now, right here. Maybe another day and time the participant would have." • Using a FDC pamphlet and trying to do a better job of explaining the purpose of the video and make it seem less intimidating in terms of what's actually involved. • "Our FDC has said you can refuse to answer any questions, you can change your mind in the middle, so it's just will you let her come and ask you some questions? … I haven't had a family yet say no, she can't come." • "…One day we were meeting and then she was like, the FDC came and, you know, I felt like this mom is going to respond the way that she always responds, but she was kind of like a fridge." • Stress that data collection is only once a year, with a gift card reward • Limited experience so far: "I always tell them, you know if there's a question that's just too personal and you don't want to answer it, skip it, and they do."

Feedback on new ACEs survey?	• No feedback from participants on the ACE survey • In one case, the ACE survey provided an opportunity for the home visitor to learn something about the mother/child that she might not have otherwise been told. • "I think she took it as an opportunity to share something with me she hadn't before." • "pretty easy" • No feedback from ACE survey – have done a few • Generally no problems so far • "I don't think it's a problem. Because you just introduce it. But it's not a problem. It's just another questionnaire, but they usually agree." • "They've never mentioned - like the following visit, they never brought it up." • Haven't done many ACEs surveys, but with any survey, it may touch on something that was not addressed previously; need to be cautious in terms of developing relationships; consent form warns participant regarding "graphic" and "sensitive" questions.
• Do you believe that field data collection has had any positive or negative effects on staff turnover?	• Paperwork, tracking: "I think it's difficult to track how many people are involved. You know you get information from so many different avenues and so you kind of have to try and say oh, okay, that's MIECHV. You know, kind of associate the names with MIECHV. But you have at any given time received you know six, seven different emails from different people all associated with MIECHV. And so I know that's been a challenge." • "I think it did in the past. Well, for our program, we're new. Well, we've been here a year." • "I think it's a perspective maybe in how you train your workers when they come in. We have more than one home visiting program at our site and we've participated in lots of different research studies." • "Well, it definitely got easier with more experience. But as far as MIECHV and dealing with like the study, it's the same to me. It feels the same." • "The MIHOPE thing. Probably both at one time was a lot compared to what people were used to." • No, but extra individuals on home visits may cause participants to draw back: "so it makes our work harder because we have to work twice as hard to build that relationship with that family because we bring in extra people in the home." • Turnover that occurred was not data-related. In fact, staff feel appreciation of the "thoroughness" of the MIECHV approach to data collection.
How is other data collection going? EPDS, ASQ's, 4-P's, DV screening	• "…all these things that I see that are happening – they don't get counted because it's not the right kid or because the benchmark for the ASQ:SE is 10 to 14 months instead of 9 to 14 months." • "I like when things reflect what I know is happening, so there's always a frustration when it doesn't. But,

	you know, that's when we have to get creative on trying to help them do what we know they do." • "It's actually been a little challenging since I took over for another home visitor, so I kind of caught up -- I had to go back and see where she left off." • So what I find a bit challenging is that when they're a certain age and the ASQ has like a frame – an age range from like 23 months, 0 days, what is it, to 24 months and something – I mean of course it's easier just to do it when they turn 24 months and do the 24 months, 'cause the ASQ is every three and the ASQ-SE is every six, if I'm not mistaken." • Streamlining Visit Tracker has helped: "We had our own form to fill out for our own agency. And now we put everything together in one place." • "And lucky Visit Tracker came along with the home visit record and trying to get it where so everything's streamlined too. Because you also have to be credentialed. You're credentialed as a program." • "I think some of the questions we kind of like integrate them in play and interaction, so we kind of already know the answer, but we still ask them. One of my main issues with the ASQ is when it comes to communication. When I have not heard that child say more than three words and the mom says, "Oh yeah, she talks." Wow, that's really – I don't know. I have to take the mom's word for it." • ASQ: "I have about three families that I'm a little bit concerned about because to the parents it doesn't seem like a major concern, but to me it is and I'm new to it and I'm already seeing something – that something's wrong or something that needs to be done. So that's what's challenging for me." • Situational difficulty regarding Domestic Violence screening: "That one sometimes is a little harder for our – a lot of – especially if any of them are due this summer because – over the summer when there are older children at home, because they read. So it's not just that you don't want to say something that maybe the child hears, but if they're really close to mom, they're looking, like what's that you're doing, and so sometimes it gets a little bit more challenging to figure out how to present that when there are other people in the home." • 4P's: "they haven't gotten easy but they have gotten easier the longer I've done it. The one that was the hardest for me to get comfortable with using I think was – is the 4P's." • 4P's: "you're supposed to read it word for word, but you're not supposed to read it like a checklist, so getting comfortable enough with it that I can glance at it, remember what it says and ask it embedded in a bunch of other health questions. So like – figuring out how to do that, and it's not one I do as often because we haven't had a ton of pregnant moms. It's not the bulk of our moms so – I think that one took the longest for me to get sort of a flow in doing it 'cause I have the least practice and it's one of the more challenging." • "We have a pretty good system … or at least I do. I put them in my agenda as to when it's due to like six months or whatever it is." • Domestic Violence screening has not been a challenge • "In the beginning since we're required to do it pretty early … they might not answer as honestly. But once you start building that relationship, things come out here and there."

	• With depression screening: "I think they're more desensitized to it 'cause they do it so often in their doctor's appointments … So I feel it comes out in conversation more than the screen itself." • Participants already used to the ASQ • Depression screening done at beginning, therefore not problems with that • Depression screening too geared towards pre and post-natal, needs to be modified to be administered to mother with toddler • Depression can be "circumstantial"; Edinburgh is used, but may not be appropriate tool • Going fine so far—will be attending Futures Without Violence training • There have been some complaints regarding the intrusiveness of questions related to domestic violence and alcohol/drug use
Has the "weekly visits for 1st 8 weeks after child is born" mandate impacted your program?	• We do weekly visits "Until six months or where they reach six months and we feel like they might not be ready, you know, crisis or domestic violence. Then we'll keep 'em on. We'll keep seeing them weekly until we feel like they're ready to move on." • Use Partners curriculum with Healthy Families • In summer it's more challenging to get visits in, lots of rescheduling • Already doing weekly visits, so nothing new, didn't need to make any changes • No changes have had to be made for that: "it's important to have a weekly visit." • "We start seeing them before the doula does. So whenever she gets the referral, then we'll go ahead and start. And when they get closer to their due date, about six or seven months, they'll go ahead and get a doula. And after the doula's done, I will just continue the visits." • We see better retention with regular frequent visits • No change, because already do weekly visits year round for our model
Statewide, why did some benchmarks not see improvement? • ER visits	• Doctors are telling parents to use the ER: "So that's sort of – I feel like it's a little bit of a battle that we can't win on our own. Because I can say, well you don't need to take them to the emergency – but if the doctor says take them to the emergency room, I mean they gotta listen to their doctor." • Doctors are telling parents to go to the ER after hours • No urgent care available in our community, so families use the ER • "I haven't had many moms take their babies to the emergency room. I can only think of a couple. But not out of the ordinary." • "It would be just because the temperature wasn't going down and it was after like you know the weekend and then she was worried 'cause the baby wasn't eating that good. So then she would. But not like a continuous pattern." • Not the case in our area that doctors advise to go to ER • Lots of federally qualified clinics in the community with evening/weekend hours

	• "I think when they do use the ER they might not know right away or they're scared. You know it's in the evening, you don't know with the baby. That kind of situation. Yeah. But then if they do, then we talk about it … you know next time this is when you should use a doctor, you know, that kind of thing." • Over past year, children's visits to the ER have increased while mothers' visits stayed the same: "just the quickest way to see the doctor vs. trying to get an appointment." • Difficult to get an appointment in current system sooner than one week or so • Even doctors may recommend to go to ER • "For example, at our Urgent Care pediatric clinic, you have to be there between 7:00 and let's say 9:00 in the morning. So what if they have other children they have to take to school at those hours? You can't take the baby to the Urgent Care clinic because you can't be there during those hours, so what's your next best option? So I think that's what's going on with the emergency room visits." • It's the time/convenience factor that provokes use of ER, or "habit" • Our community data show childhood injuries have gone down in the past year, in spite of what state data may show; our community data is collected every quarter • "And there's been some serious collaboration within our area because with the local clinics in the last two years they've increased convenient care hours. So we have found that the visits to the emergency room were – I don't know how much it decreased by, but I knew it was reported that it did decrease because of additional convenient care times." • "So you can take your child up to 8:00 to convenient care, and that is something that was just absolutely not available in the past." • Nevertheless, convenient care can refuse to see a child that it has not seen before • May be an issue regarding our local clinic not accepting certain types of insurance coverage • There are appropriate reasons to go to ER, in one case a car accident • Other reason to use ER is when doctor offices are closed • "Actually it was something we had to address. And you sent me great information that I was able to give out to the girls and talk to them about when would be the right time to him and when not to. And when to just take him to, you know, their regular doctor. And I think that did actually help a lot." • An "education issue." "Some of those girls you know your parents are very quick to say well just take him the emergency room. I think it has a lot to do with our culture. You know something's wrong, they don't want to wait. Just take him right away. So I think giving them this information and some of them have actually learned it from experience. That they go to the emergency room and they're there for two hours. They go and they don't even get a medicine or anything. So they've actually learned that it's just better to see their doctor." • Walk-in clinics easily available; evening hours, back-up doctors

• Breastfeeding	• "– I have a number of moms that have breastfed, but yeah, I mean three months – I have one –everything seemed to be going fine, I didn't think she was having any problems, and then I just went at the last visit, baby is almost four months, just turned four months old. And I asked how breastfeeding was going, she goes, "Oh I stopped. I'm just doing the bottle now." Oh. Okay. So what happened? She goes, "Eh, it was just – I'm just not doing that anymore."" • "Yeah, a teenager that continues three months I think is a huge victory that she lasted even three months." • Getting teen moms to breastfeed is difficult • "… but with the second one (child) she is trying and she said, "I didn't know why I didn't try to – you know, I didn't know why I quit, with the first one. … I don't have to wash a bottle, it's so great."" • "I had another mom who tried and her milk production just wasn't enough. She felt like the baby was eating all day and she just couldn't – she's got – this is baby number four; four-year-old, three-year-old, five-month-old." • Note conflict and difficulty of entering employment and maintaining breastfeeding: "… if the employer is not sensitive to that issue I would see that as a number one deterrent just based on the amount of moms that are entering employment. Now, data-wise, I don't think we've asked the question…" • Some mothers "…feel like it's time consuming. They'd rather just bottle feed and be done with it." • One mother didn't start breastfeeding because of pain medication administered after a C-section. • Six months not "realistic" • Difficult for younger moms, "just like, no." • "So you always have information on it, but if they decided that that's something they don't want to do, then there's nothing they're gonna do." • May try in hospital, but not after returning home; moreover, difficult when going back to work, issue of "convenience." • A lot of moms "just go straight to formula…" • Suggest benchmark changed for initiation rate--by two months might be more realistic goal for this population • "I'm trying to think if we had that many that just flat out say no. They usually all want to breastfeed." • "They're very receptive to at least learning about it. Like they never saw it at the home. They've always been very receptive to that information." • Support from our local hospital with lactation curriculum • Also have doulas now: "So some of our cases have doulas who their goal is breastfeeding and get extensive training in that. We do send like if they want their Certified Lactation Counselor training, the lactation specialists, we send them to the training as part of our program." • "Establishing their breastfeeding supply is always kind of the hardest. But some of them actually continue

	to try. Yeah, there's some who decide not to. But for the most part, most of my moms are breastfeeding." • Culture in our community is generally amenable towards breastfeeding, but not universally: "I know in our area, we have both. We have some cultures that all you should do is breast feed and then others, like what do you mean - you've got to give 'em the formula." • Some going 10 months: "I think they do a really good job about, you know, education with breastfeeding. And they're very supportive too and available to their clients. So I think the clients feel supported that way." • At 6 month mark, parents may go to school or work; common in our community • Most continue till six months; some much longer; lactation consultant will go to house if needed; doulas also help
• Others issues locally?	• Difficulty in tracking prenatal visits related to paperwork burden; sometimes difficult to get the dates correct: "And the way they do the benchmark is really difficult." • May miss visits if visiting Mexico • Doctors may also be out • Undocumented mothers don't have insurance; no way to meet that benchmark • Difficult to track income and show improvement; if they're stable, it's not counted as improvement: "…if they don't have a job, we work on getting a job as part of our goals. And if they don't have WIC, we help them get WIC. If they don't have the LINK card, we help them get. That's just a natural part of the program." • Health insurance—can't do anything about it: "It keeps coming up, but since so many of our parents are undocumented, we can't impact that. I mean unless we can get them jobs that pay a whole lot – offer insurance, which they're undocumented so they can't get – you know, I mean it's just this vicious cycle of – but we are trying to encourage some of them to become part of Access to Care, which isn't insurance but does encourage them to have a relationship with a medical home and provides – for a small fee – then provides lower cost visits and services and things so that they get regular – it encourages them to keep regular medical visits and get what they need done, done, without feeling like they're gonna have this $5,000 bill that they, you know, have no hope for paying for." • Question if household income benchmark can be met, given circumstances beyond clients' control
• What additional supports would be helpful?	• Offer incentive to avoid unnecessary ER visits

Impact of MIECHV requirements • Has MIECHV put any undo load or stress on you or your staff? Impact on workload	• "It can get a little overwhelming. Well, especially in the beginning. We have a lot of paperwork to do just for our agency, plus the MIECHV put together. I think we overwhelm the parents. And we're overwhelming ourselves. And then we have to be out in the community driving around and sometimes we don't get the time in between to write everything up. And then we're kind of backed up." • "And the parent survey, calling on the weekends, too, which I never understood that. You know it should be business days. Not necessarily count the weekend for like the benchmark of the 30 or 35 days." • Paperwork burden with new clients when priority should be on getting to know them: "It's hard to establish the relationship when I'm like oh, how you doing. And they're like writing down like okay, well, let me get this done with the screen or whatever thing we have to do that." • With MIHOPE, parents may be confused with duplicate questions, don't understand it's a separate entity. • More work, but not particularly stressful • Our supervisor keeps us updated on "where we are or where we stand and what we need to work on."
• Feedback on Visit Tracker – computer connection and use	• "ETO was – from what I remember, it was like – it wasn't as simple as Visit Tracker, and Visit Tracker has changed since we first started using Visit Tracker. So I mean some of the changes, okay, you just flow with it, but some of them are like, okay, well why did they take that part out? I liked that part. So and then there's talk of a new system, right?" • "Well I started with Visit Tracker. It seems pretty cool to me." • Visit Tracker is a great improvement on Cornerstone • Have personnel to address technical problems well • Visit Tracker takes more time, but now that it's implemented is efficient and can run reports • Auto-save has helped improve efficiency of data entry • Need to be careful to go to bottom of Visit Tracker page and save entire page • Can be time consuming to go back and forth between mid-page and bottom of page to save after each entry • Staff has own computers, no need to share • Data must be entered two days after visit, as required; do it "right away"
Staff turnover • Could you tell us more about staff turnover?	• "As far as the staff, we haven't really had a high turnover. They can speak better about the clients, but one of our home visitors has been here since the beginning of when we received MIECHV, so the staff turnover hasn't really been that high for us." • We have a "happy group" with decent pay • Can be a lot to learn at the beginning: "But like I said, maybe first three months once I went through the core training that's when I'm like oh, I'm painting the picture finally. So the first like three months I felt like I was able to kind of grasp more."

• What could help to reduce staff turnover?	• May leave due to moving or other employment opportunity • One HV left due to move out of state, otherwise would not have left • HV turnover can be an obstacle to retention of participants, but transition can be successful: "One of our home visitors who left prepared her families because she knew she was leaving. They knew why she was leaving that it wasn't anything adverse, where I feel like we lost more of our other home visitor's families because her leaving was abrupt. It was a supervisor calling and saying your worker is no longer here. There was no transition period." • Have had a lot of stability at our site • Time off during summer & holiday season: "And I think you are able to rejuvenate and come back after a few days off and still have some holidays off and I mean it's great so we love it." • Good hiring decisions: "none of the three of these guys really had early childhood experience but they had case management experience. They knew how to be organized and to do that side of it and my theory is I can teach you child development. I can't teach you how to be responsible. I can't teach you how to be organized. I can't teach you how to write, you know the writing style part of it. So I guess you know from that aspect that's what I look for is people who have those maybe little bit different qualities and if they have early childhood it's a bonus but we can do that. I think they've all been grade A." • "I think the thing that helps a lot is that we work as a team. We support each other. And we only have one family support worker for the MIECHV program. But we work together with the other family support worker, lots of trainings. Sharing issues, staffing, we are one thing. So she receives support from the coworkers and she gives support to them. We share information and we help each other. And I think that's what is being successful." • "I think if she was left alone it'd be different." • Good retention with participants as well because "work as a team." • Weekly supervisions allow opportunity to voice concerns • "I think we are supported from you guys. I always feel like I'm putting my weight on you now – in supervision. So I feel like I'm able to process everything. And we have our staff meetings where we're able to share as a whole. We can talk about our cases or I usually ask questions when I have an issue. And since they're more experienced they have different ideas and so we bounce ideas off of each other."
Safety Concerns • Do you have concerns about your safety as it relates to your home visiting work?	• Not really, last violent incident occurred three years ago. • Agency policy to not visit late in the afternoon, especially in winter when it's dark. • HVs generally feel safe, although one violent incident is described • Pit bull issues described, are common: "I always thought I was very dog friendly until I started working here." • We make visits early in the day

	• "If they feel unsafe to go in an area or a home, we always try to see a plan or see how it is first. I mean and then to evaluate if we can see that family. … And I always tell them to use your gut. If they don't feel safe, don't go in. My concern is them, you know, over any other situation. So we talk about it." • Going into new buildings or new areas, need to "watch your surroundings." • Take care in parking car and not leaving things on the seats • "Well yesterday at 10:00 in the morning they were shooting outside. So then you come concerned like, okay, what happened yesterday and is they gonna be doing the same thing today, and you sit in the home or you might hear some stuff, some commotion outside, and you don't know what's going on and you have to leave and go get in your car." • "So Visit Tracker has a calendar where you can put on there what visit you're going to and they know the address of where you're going. So when I leave the building I let my supervisor and my managers know when I'm leaving. If they're not available for some reason, our home visiting staff, we tell each other. Listen, I'm going on such and such street and I'll be back in two hours. And so they know if you're not back in two hours, okay, well where is she, let me hit her on the cell phone, text her, what's going on." • Dogs kept in yard • Concerns about multiple dogs or other animals (ducks, chickens), and unsanitary conditions • Some of the big dogs can be very scary • Concerns with smokers • Concerns with bedbugs • Encountering extended families during home visits can be unsettling at first, but no real threat is posed • Neighborhood issues that may involve drugs; one HV has chosen to meet (pregnant) participant at park in nice weather • Neighborhood safety issues diminish with increased experience with family • HV's need to have IDs in case of encounter with law enforcement, and cellphones • Day visits preferable • May take a while to get used to dogs, but they are friendly once they get to know you; some families may lock up dogs during visits • Concern with beg bugs, take precautions • "There's some places where you know I'm still kind of keeping an eye, but it's fine. But there are other places where I do kind of look around first before I get out of the car because yes, it is a concern." • "…we review that with them pretty often. You know I mean I'm from the school of safety first." • "And you know our crime rate is pretty high. And so I do, I worry about them out there all the time." • Concern with dogs (pit bulls) • Don't visit after dark or in evening, unless unavoidable

Referral Issues • How is the Coordinated Intake System working for your site/community?	• CI and CSD close by – home visitors are in the building frequently • Referrals flagged through Visit Tracker, then bring forms over • New CI, still a learning process, shortage of referrals; feels like lack of referrals is tied to staff turnover (CI) • "As soon as you have a turnover, if you don't have the right orientation in place, you don't have the right person in that place, then it breaks down everybody's referrals." • "But when it's up and running great – it's great." • "So, yeah, it was working good. And now that she's gone, it seems like we get less and less referrals." • New CI employee may not be getting the helps she needs • No problems, enough referrals; they don't have to get referrals themselves, but they can also recruit when possible: "I think we like the fact to kind of get the relationship going our self." • "We've established a relationship, you know, we go do what we're supposed to do. We submit everything that we're supposed to, but when it comes back to us then we've already established the relationship." • Also get referrals from Family Case Management and WIC • Since CI is associated with HFI, referrals for HV can tend to be steered toward HFI • Situation has improved with new CI person; can now usually get referrals when there are openings • Do need to make sure she gets emails or phone calls in order to ensure that referrals are passed along to MIECHV • MIECHV limited at our site by not being able to take participants from outside the school district • CI issue: "really our only limitation is they have to be within the school district and we've got like five referrals in a like two-week period that weren't in the school district and she said it wasn't her job to check to see if they were in the school district." • Re referrals and assignments: "I don't know how she does and maybe it's something that we just need to find out how she does it." • Use both paper referrals and Visit Tracker • Complaints resulted in more referrals through Central Intake • One thing that turned around is that our CI worker is full-time now for intake. Where before, she was kind of split in different departments and things. So I'm certain that had something to do with it." • The CI worker also went to observe home visits -because from the beginning they didn't have a very clear idea of what we do. And the families say, no, I don't need that or it was just different. But now it's better. I can see the difference now." • "And we do a good amount of outreach too, community outreach. In some way, shape or form, we're always pounding on somebody's door, letting them know that this program is here. If it's not us, somebody from the agency, you know, does radio spots, and some TV spots. We're in the schools. A lot of times there's referrals from other programs within our agency. What else? Any kind of health fair or

	neighborhood fair, things like that, somebody's always there giving out information." • Also we get referrals from other participants • We do have a keeper system. It's kind of like where you could keep them. But it's just so weird." … "And I think too it's like sometimes you have some they don't really understand referrals. It's that whole training piece of it takes 10 referrals to get one or two to answer and to go through." • "You know a teen. Some of them don't even tell their parents. And so they see that you have all these pending. But they think well, you have all these. And it's like well, no, these are all almost considered like well, we tried three or four times already. We're still gonna be trying, but they might have moved already. You know they might be gone." • "We have a whole procedure on how many times you keep 'em and hold 'em. And obviously changes 'cause of the MIECHV with that all. You know and so for every one referral you get one, could be randomized out too." • Potential clients concerned about immigration issues • Some referrals request MIECHV because they already have friends and family in the program: "I said, "Well I can give you a number to call, but if you'd like to give me your name and number, I can pass it right on to them," and so then those are gonna come back to us." • "And an issue we were having is we weren't getting enough referrals and then we hit like a spot in MIHOPE where everybody was getting randomized out." • "Now they changed there to two and two 'cause I said you can't go four or four either way when these programs are so small with staff. They're like oh, yeah." • "See it's not the CI person in our county. It's the outreach people. We leave it up to the program.… I think they're confused to be honest. Very confused. Even with talking to them, they're like wait, what. You know so now MIHOPE's gonna call me. And then by the time they get out there they're still confused. You know like who are you? Where are you from? And some just don't care to ask, so they are just letting random people show up at their house, you know." • We meet with a youth taskforce—collaborative early childhood committee, CI slots for preschool: "What's this point system that you use? Does it have to be so secretive? Can we get a little bit more information? And through our participation it's getting a little bit more open so we're getting more information that, you know, can funnel down to us on that. It's still somewhat frustrating, the school district, to be honest. I think school districts in general are frustrating, but there are some things I don't think our community is fully embraced to the benefit of everyone." • Only 20-23% of referrals end up enrolling • Still only at 80% enrollment • CI worker educates referrals regarding home visiting program options, refers those best suited for our model • Information regarding referral/enrollment has been documented and submitted in quarterly reports

	• "… a child from the MIECHV program, when they turn 30 months, just like the Early Head Start model, would begin the transition, start to do center visits, and once a center opening is available they can enter any time during the year, you know, during a nine-month school year if we have openings in Head Start. So it's a great opportunity to get your kids easily into Head Start centers, especially that are six hours, you know, four days a week. That's free childcare… because our home visitors would serve every child under the age of three in that family."
• What are the challenges with attracting new clients?	• Depends on the time of year • If we relied solely on CI, we would not be full • There is a competing program in our community that also offers home visiting and is very incentive-based; they recruit at the hospitals. They send their most challenging families to us as referrals. • Challenge of maintaining home visiting when mother finds employment • A lot of children not MIHOPE eligible because need to be six months or younger or pregnant; a lot of referrals tend to be families with older children.
• What could help to improve these challenges?	• Home Visit "parties" have attracted new participants • Internal recruitment • Parent educators for Pre-K who have siblings for referral • When low in Jan-Feb, sent flyers to elementary kids in school district • Better understanding of the CI process, choices • Suggest presentation explaining CI process • Interact with Community Systems Development (CSD) • "So finally I feel like now when the CI sends a referral and … she'll usually have a little paragraph written up now, like spoke to this mom here and give us a whole story now and so that was a whole thing on how she is talking to people about our program … and the recruits ever since we had that conversation they – we had a lot better outcomes from that so that's been really good." • Perhaps incentive at 8-week mark; but there have been incentive funding cutbacks • MIECHV does give a book once a month • "We had an incentive program, but we just heard about the funding and everything and so I don't know how that's gonna play out if we can keep that, 'cause we had baby bucks, it was called. And so every quarter– we have a little catalog and they get to pick from it and they get so many based on you know if they kept a visit, if their kid had a birthday, if they showed up for an event, so that's what we were doing and the other MIECHV home visitor and I were on that committee and we really revamped everything and I thought this was probably the best one we've had 'cause they were able to get so much that we changed prizes. We added new products and now to hear that about the funding, we're not supposed to be spending money now, I guess next year, on incentives is what I heard and that may not be MIECHV."

	• Suggest connection with fraternities, sororities, civic groups for funding of incentives • Do work with local agencies for incentives to help families such as Thanksgiving baskets • Need bi-lingual worker at Health Department, but hasn't impacted referrals yet • "Saturated" campaign to increase awareness of home visiting services availability • "Put up billboards in rural areas and in local areas. • Increase number of MOU's • Outreach and partnership with medical providers – those providing prenatal and infant care to educate them on the types of home visiting available in our area • Emphasis on identifying iGrow with home visiting • "So we're able to kind of market through CSD the value of home visiting. One of the CSD personnel is a home visitor that can speak directly about the benefits on what she does for her families in home visiting. So as far as progress, I think we're moving on very well." • Good collaborative relationships with other agencies in the community • "… We have our monthly collaboration meeting and the collaboration members are always asked to give their input as to what CSD events they think would be helpful and, you know, stirring up more referrals. And I think we all get along fine."
• What kinds of supports and services do families need that they are not getting in their community?	• Transportation issue central, to appointments and work, school, library, etc. • Housing: "always the biggest issue." • Job readiness trainings and referrals • Mental health is biggest challenge: "If somebody wants counseling it's hard to get them in – there are a lot of hurdles, waiting lists. It seems to be the hardest thing to get to happen in a timely fashion while they're still interested. They often get turned off in the process or give up or whatever." • MIHOPE: "…it's sad not to be able to service some of these families that really needed it, so we're watching those deadlines." • MIHOPE: "And they're almost gonna have to go MIECHV, I mean if they can – if they have some characteristics to go MIECHV, but because the kids are gonna be 2, so all those kids will be 2 at least and it's like to throw 'em in PI for a year, or not even a full year, doesn't make sense." • Networking with thrift stores to assist our participants with winter coats, etc. • MELD program addresses whatever need for shelter might arise • Need for bi-lingual mental health services

Caseload Capacity • Are you currently at capacity?	• Yes – at capacity • Yes • No problem keeping caseloads full • Waiting list at eight families • Yes, with caseload of 20 for two part-time home visitors. • We have a home visitor who is brand new in the program, again, we decide to give her families little by little because the eight fundamental visits need to be on a weekly basis. So now with the four or five new families, right, they still need their eight fundamental visits - completing them probably in around one month.… So the agency has been very supportive in not overloading us caseload-wise. • "…the flexibility and taking our lives into consideration as well, not overwhelming us. You know, the fact that we have …young children at home and so it's a big plus and I really appreciate them and am grateful for that." • MIECHV at or near capacity, but still have open PI slots
• What are the challenges with keeping the current clients?	• MIHOPE randomization is main reason why caseload is not full "Our last seven pregnant moms were randomized out in a row." • "MIHOPE is not helping" regarding randomization: question how "controlled" randomization really was: "But something has gone wrong recently. And it's the first time that we've seen them go beyond five. Yes, it's the first because I get all the letters that says whether they're randomized in or randomized out. This is the first time." • Follow EHS model, serve multiple children in single family, and end up below percentage because in MIECHV they count only one child per family. We're now serving one child per family • "So we had to make a change, transfer families from the MIECHV Program into the Early Head Start Program and limit the MIECHV home based teacher to serve only one child per family, and that was our first hit. So in the process of converting from multiple children within the household to just one child our numbers decreased. With the randomization out, we have not been able to get up to where we need to be and it has taken longer than we anticipated." • "I mean these things have to be sort of reinforced with the state what the issue is." • "Now we did get children that were eligible for the research, but majority of the children were not. And then just by luck [laughs] many were randomized out. So it slowed up the process for us." • Need 33 more families for MIHOPE study (about halfway there) • Not lately: "I think some challenges are like if they go back to work and they don't find time for visits. So that's sometimes where we're okay, they might be making progress when they can go to every other week or monthly. Some just feel like they don't need it anymore. I'm trying to think some of the ones that closed

	out. But mainly it's the time." • Big challenges due to change in rules regarding siblings for Early Head Start • Employment and housing issues related to client attrition • "I have some clients that I've been working with since 2012, and I have a good relationship with them." • "So I think overall though we keep our clients for a pretty long average." (3-year program) • Just generally difficult to keep MIECHV clients engaged • Parent educators have issues with participants understanding their role • The intake process – lots of paperwork, • Home visiting services not explained well by intake worker– some families think we're coming to play with their children or clean their house • Had difficulties with retention, lost half of caseload at one point, affected by staff turnover, "just didn't want to start over." • Now maintain full caseload, and will be able to have HVs go fulltime with more HVs • Some mothers think they can deal with issues through computer applications rather than having a Home Visitor • Not a challenge to keep full caseload, especially with WIC available • When graduate from high school and go to work, think no longer need home visitor: "So sometimes that is when we switch them to maybe monthly or every other week, just so we can continue providing them with services."
• What could help to improve these challenges?	• Flexibility for visits later in day or in evening (flextime) • Incentives help with engagement
Feedback on survey information from CPRD • How useful do you find the data that we shared with agency during December and March CQI calls? • Did you use it? (KIDI questions, PICCOLO Teaching items?)	• "So I like getting – I mean I like those reports and seeing the areas of growth is really exciting. Getting that second year and being like, oh look, we went up there and oh yay." • "I think it's good for us (home visitors) to truly understand, you know, why this person, this third party is there, so that we can communicate this to the families and say they're not coming here to see your house or what – you know, or look at how you're living." • I like this information because it validates what we do and we've seen improvements • "It – well it's always helpful. You know, it lets us stay abreast of what's going on and then keeps us on track. So I think it's helpful." • "… I know more of a higher percentage of our parents have to be doing things like talking – are talking about naming colors and numbers and whatever. Why aren't our percentages up? Why aren't they doing it on the video? Why aren't they showing that when it counts? What can we do to make that happen more?

	And that sort of ended up in part of the CQI." • "The thing that we're working on now is embedding – trying to do some videoing so that maybe they're less self-conscious and they're more doing the things that we see them doing all the time and we can praise them for doing those things so that maybe they'll do them when the data collector comes out and then they can get counted."
CQI • What talk has there been around CQI since our last year's meeting?	• "Well, everything's good. And like I say, you're very on top of things. So it really helps. So it helps to have someone who's really good at it too." • "I think at first it was confusing and kind of viewed as oh, no, another thing to do. But I don't know if it's just we got used to it or saw that we could actually learn something from the outcomes or it was Stacey coming on. But it all kind of jelled at the same time. And so now I think it's pretty useful. And I know sometimes I have trouble coordinating the phone calls, but now I think we understand better why and what we need to do and things like that." • "But it has turned out to not be that bad and I appreciate that – and I have her to look over the data and point out things to me that I've missed, that any of us have missed and say, hey, you know, you need to take a look at this and Visit Tracker or look at that, and actually it's really – it is really very helpful." • The feedback we get about what we need to document and what we missed is very helpful. • "nothing hard" about it, either in terms of the plan or meeting the plan • Easy to talk to Stacey on the phone • "You know, as the time goes by. It's kind of self-explanatory, but what we don't understand, Stacey is always willing to help us, so she's our go-to person." • "I think a monthly check-in is an appropriate amount of time." • "The length of our calls has been long enough where we can address whatever needs to be talked about. It doesn't seem – it hasn't been tedious so far." • Gives us something to shoot for to improve on • New representative on CQI team, has gained a better understanding of what it's about, feels didn't do well on ER visits • "Your emails are very helpful. Like the follow-up emails are very good." • "The plans are good. I mean a lot of the plans and the benchmarks are things that are in our credentialing anyway." • "…we talk about things and we do in supervision. So it helps to focus on those things. I think it helps to bring understanding on why we're doing the benchmarks."
• What did you accomplish?	• Big accomplishment with breastfeeding, IFSP (Individual Family Support Plan) goals • "They are actually opening up a new lending library here in the facility, so we'll get that up and going and communicating that to the families. … We've got a bunch of books now to go with that."

• What are the challenges of CQI?	• "developed center parenting topic" • Helped with referral process in terms of documentation and follow-up • Ensure not missing ASQ's • Use GOLD (teaching strategy) • "So it's just very helpful to know that Stacy – I'm sorry – that CQI and the governor's office will contact me if they see a benchmark that we're low in, and then they help us come up with ideas to improve, so it's helped us – it's helped me to learn the benchmarks better." • Sometimes have trouble coordinating the phone calls • Lost Internet service for three days (first time this has happened). "And then when you're down for this long and you're doing everything on paper, when you start up again, you have to then go back." • "… sometimes you know trying to navigate, trying to find where you put stuff in that Visit Tracker system is half the battle. You know because we're trying to be out in the homes … have it happen in real life. … trying to translate that into the Visit Tracker. You know sometimes you're like oh, I'm supposed to there or you check this … I mean like you said, sometimes computer people don't realize. 'Cause hopefully the bulk of our time is trying to get those changes in the home. And so when you point out those little things it's very helpful. 'Cause you know sometimes we don't have as much time to look in those computer systems and see where we're supposed to, or look back in the 30 page packet of where you're supposed to enter something. Like, oh, yeah. Like the domestic violence plan." • "You know the Ounce, the doula ones wanted initiation, with breastfeeding. But MIECHV wants it the six month one. So yeah, it's a little bit different in how you approach and what you're doing, you know when we have that little bit of a change. We don't have of course the immunization ones, the well babies, the ASQs. All of those are like similar but how you, where you measure them are different. You know then DHS is different than the MIECHV. The MIECHV one is a little bit more comprehensive. So that's why we keep this system a little separate." • Director of QI at agency: "And she does all of it. You know she has a whole plan for the whole agency on everything and Healthy Families is part of that.… And we report. We have a board that reports quarterly from outside people that come in and look at that for the agency wide and how we're doing that and everything. Yeah, we're on top. They like their QI process here. I don't get as much feedback like you. So it's good to have that." • "I think we're pretty a reflective sort of team. We're always kind of talking about issues and challenges and throwing out ideas for what to do in a very informal way. I tried over the last year and a half or so kind of trying to formalize things a little, and it just doesn't really work so well to kind of – so things work better when it's just sort of that informal …" • "… for our team, we've kind of embedded a lot of CQI just in the way that we interact and discuss things. I still hold out hope that we can get it to move to other parts of the agency, but I don't think there's been a

• How do you see CQI process next year? What would be helpful?	lot of receptiveness about that." • Focus on increasing caseload • Also use CQI for postpartum contraception • "Keep on doing a great job." • Would like to work more on family engagement next year
Training and technical assistance • How does your IMH consultant work with your agency?	• Meet with consultant once a month. • "She comes twice a month to our meetings and asks us if we have anything we want to talk about. She'll help give suggestions for how to look at things differently if someone's struggling." • "She comes once a month. And she always brings information and some kind of workshop or training on different topics.… That's a very valuable resource." • Monthly visits from IMH specialist • "We reviewed cases and then like a few months back we kind of asked for ideas from the group. And what kind of topics she would want to bring, so that she could bring a little bit of information and then talk about it. And then we chose a couple of ongoing cases that were really tough, but they talked about it." • "This is actually my first time really working with her. I had a chat with her last week. She's going to come to our next staff meeting and do some updates with the staff on the moms and babies, the 4 P's and all of that. So, so far it's going okay." • Can also rely on "in-house" people. • "So it's, you know, self-care, but also sometimes we'll have case discussions, you know, what – about a family. How do you work with this situation or sometimes there's trainings like how do you do an ASQ? How do you score it? What does it mean? What is the intent of this question? … What are you supposed to be doing with that? She also has done presentations, you know, had us watch videos about particular things. She had a – she showed us Graham's Story, which is a documentary about a child with sensory processing who was labeled autistic but wasn't actually autistic." • She referred to the movie Let's Talk About Kevin, about school violence and issues of infant-parent attachment • "She's (IMH Consultant) also available for individual consultations. You know, I've spoken with her about specific families. Okay, this is what's going on and I don't know what – like what – you know, how to work through something, how to handle my own reaction to it and brainstorming how to help the family and what maybe is really going on, as an additional resource beyond supervision. She's only with us part time. She's got her own families and her own thing, and so she's not always physically available to sit and talk. • Our MIECHV site not chosen for "full on" IMH Services; participation in monthly reflective supervision groups (collaboration supervisors, includes non-MIECHV home visitors)

• Have you found the training you received helpful?	• Supervisor: "… we do our weekly staff meetings too. From a program manager part, I try to create like a structure. Like we have a lead. So that you can feel like you can move up the ladder and you can do things, you know, that way hopefully to promote people to stay." • Supervisor: "I always try to give the big picture of things … see how you fit into the big picture, not just what you're doing day to day." • Home Visitor: "I really like the fact that we're learning lots of new information based off studies, the newest things. That really keeps me interested in this job. And obviously since we like kids, you know we want to be working here. Learning all that stuff is very interesting." • Lots of questions and good, open communications between staff and supervisor: "So I like to take feedback. Like when you gave us this report from Field Data Collection. We give that back. They see the monthly report cards. You know so they can see the feedback and how it reacts to what they're doing day by day. I'm trying to give you as much as I can think of." • MIECHV Feedback, report card "helps us keep on track and see what we need to improve." • PAT training: ". It was a bit overwhelming. I went in knowing zero, so but it was good." • "With our new staff person, we're trying to think of everything we can, but it's a lot at once. And some of these things we had come on to us piecemeal, so we started doing this and then we started – added this, and then we added that, and she's (new home visitor) getting it all in one package." • "…one of my main concerns was I need to have all the forms that I need. … Do I have all the forms that I need in the binders? You know, and then when I heard audit, I was like, oh my gosh." • Yes; reflective supervision • Meeting with our community area partners: "… we all bounce ideas off of each other and if there's anything that like this agency is struggling with, I can bring it there and discuss it with them. So it's good." • Have been highly involved with training from the Ounce • Go to a lot of Ounce trainings, very helpful. • "Our infant mental health consultant helped me out a lot. I had a lot of issues when I came in as a parent educator, and moved up to lead so I had a lot of things I needed to talk to her about and you know so she's been able to provide a lot of – like I feel like I've gone to her more probably a counseling session than – [laughs] which is good. I mean I know that's what she's here for, too. But yeah, I think she showed me a different way. One of the things that I love and I always give her the credit for saying is that I was told whenever I'd go on home visits that it was hard to engage the parent and I was like I don't understand. You know the kid will – I'll give the activity and she's like well do you give the activity to the kid or the parent and I said oh, well usually the kid will take it out of my back and I'm like let's play or whatever. So it came down to the point where now I give it to the parent. I said this is what you're doing with your kid today – and that made a huge difference in my visits. I come over and I say this is the activity you guys are doing today and it's not about me at all. I just had a family the other day who sat down, she like made

• What additional training would be interested in?	space for me to come sit down so I could be by the activity but she cleared off a chair for me to sit down because she knew she was gonna be on the floor with the child doing the activity and that was huge 'cause this parent has been a whew, it's been a challenge. But - I think she's great when she can give advice and especially advice that we can use in the field." • "And any time there's a problem our parent educators will come talk so I feel like it's always reflective 'cause they're always coming to talk." • We attend quarterly meetings with our IMH consultant: "It is beneficial to a point where just those of us that are in the program or those of us home visitors, we can – because of the closeness, we know more so about each other's family through socialization or things like that. So that personal closeness is good to be able to just talk to, and try to work things out just among the group.… There have been some points that have been brought out for me to help me better do a visit, suggestions that I was given that I tried, and it did work out." • "So with the HIV (MATEC, University of Chicago) training, I mean it was a lot of good information. I was unaware that the hospitals don't require them to do testing twice throughout the pregnancy, so that's something to share with the client. You know, make sure if you're still sexually active, make sure you request to know your status, doing it the last trimester. So that was some good information to share with the clients." • "Stories for children" also good training • MIECHV required trainings often in Chicago; difficult to attend • Attending trainings has been a big challenge • Need for better understanding of community services and resources: "Well we've been having trainings …, but I think we still need more. We just need to learn – I think the home visitors and myself all need to learn more about agencies like the housing authority and how it works and how things with the Social Security office works and how things with the unemployment office works and what we can do to help our families when they need help with those agencies." • Professional development for serving families with mental health issues: "So if they're able to identify and be able to do more connections and helping the families with mental health issues, I think that that would be a great strength, because in poverty, we have so many undiagnosed mental health issues by themselves. So you've got this behavior, and from what I hear from the home based teachers, one thing that I've heard from them, they're glad to be able to speak to someone to kind of relieve stress." • "Activities to help with child development. Because a lot of the parents, they want to know things they can do to help the child develop. And we have activities, but I think I need more information about that." • Partners for Healthy Babies program is not activity focused – we need help coming up with activities. • I wish we could have another training on Learning Through Music. I really enjoyed Learning Through Music training/program" "They talk about child development with the fine motor skills and gross motor

	and everything through the music. And they teach parents how to do that with their kids. It was awesome." (offered through the school district) • Trainings on child development through play – learning by playing together. • Update regarding lactation consultant; training is difficult for that • Nothing right now, but HIV/perinatal training was "really interesting." • Need PAT Foundational 2 in Springfield: "I think the training's been the biggest thing. If we can't go out of state and go to St. Louis to get trained that's been a huge thing, 'cause I think Foundational 2 has been offered in St. Louis and we haven't been able to go." • Our team can't do anything about 3-5 age group with PAT because we haven't been to the Foundational 2 training to use the curriculum for older children. • Looking into more training from Ounce • Have taken advantage of online training • Lack of convenient training - time, availability and location - a huge issue • Address issues regarding parents with developmental delays • Transitioning families from home visiting to center based/preschool services • "Conscious discipline" (training program): "… we do have the PAT curriculum, but it just seems like additional help is needed, especially when we transition. That year before we transition into preschool, how do we prepare the family, especially when we talk about – the home base teachers, at least the feedback I got, conscious discipline, a training that we did about behavioral – teaching children to regulate their behavior, you know, and the things that the teachers did, but it would be wonderful to have conscious discipline applicable to the home."