Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Evaluation

Time 1 and Time 2 results for the Coordinated Intake and Referral Initiative, 2016

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Florida Maternal, Infant & Early Childhood Home Visiting Initiative

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Introduction

The Coordinated Intake and Referral Learning Collaborative

The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program is an evidence-based home visiting program that aims to improve health and developmental outcomes for families living in at-risk communities. The Florida MIECHV, in partnership with the state Title V agency developed coordinated intake and referral (CI&R) models with a group of Healthy Start Coalitions in the spring of 2016. The CI&R system is a community-based and a collaborative process which utilizes the statewide prenatal and infant risk screens to help connect at-risk families to services that best meet their needs and preferences through better utilization of community resources, reduction in duplication of services, and appropriate follow up of families' involvement and referrals. This was intended to be achieved through utilization of the state's prenatal and infant screen as a single point of entry for various home visiting, care coordination, education, and support services.

In August 2015, a request for application for a CI&R action learning collaborative project was sent to the 32 Healthy Start Coalitions in Florida, out of which eight elected to participate. Application requirements included the inclusion of particular organizations on teams, such as: Healthy Start Coalitions, Healthy Families Florida, Early Head Start, Early Steps, Federal Healthy Start, local Health Department responsible for processing screening forms, MIECHV funded projects, education and support programs, additional care coordination, and other relevant stakeholders. This 21 - month project (January 2016 – September 2017) is supported financially and technically by the MIECHV initiative. Based on the annual births of the counties/ participating coalitions, the Florida MIECHV initiative provided $90,000 to $170,000 grant support to the participating coalitions. This was to enable them to design, implement, and test CI&R system changes as part of the learning collaborative. The MIECHV evaluation team was tasked to evaluate the participating coalitions at different stages of implementation, from no knowledge to some knowledge, while documenting the challenges and successes faced by the participating coalitions in their implementation of CI&R system changes.

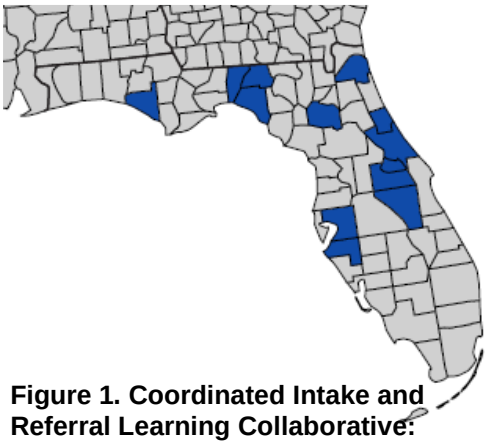

Figure 1. Coordinated Intake and Referral Learning Collaborative: Participating Healthy Start

Table 1: Healthy Start Coalitions that Participated in the Coordinated Intake and Referral Learning Collaborative

Participating Healthy Start Coalition (HSC) Teams	County/Counties	Annual Number of Births: 2014	Annual Number of Births: 2015
HSC of North Central Florida	Alachua	2,916	2,885
Bay, Franklin, Gulf HSC	Bay	2,328	2,396
Northeast Florida HSC	Duval	12,514	13,041
HSC of Flagler & Volusia Counties	Flagler, Volusia	5,600	5,736
HSC of Hillsborough	Hillsborough	16,846	17,570
HSC of Jefferson, Madison & Taylor	Jefferson, Madison, Taylor	535	583
HSC of Manatee	Manatee	3,545	3469
HSC of Orange, Osceola & Seminole	Orange, Osceola, Seminole	24,931	25,455
Total	**13 Counties**	**69,215**	**71,135**

Source: Florida Charts (http://www.flhealthcharts.com/charts/default.aspx)

Evaluation Framework

The Consolidated Framework for Implementation Research (CFIR) framework was utilized by the University of South Florida (USF) MIECHV evaluation team to describe the characteristics of the learning collaborative focusing on the coalitions' perceptions and processes with regards to implementing the CI&R system changes.

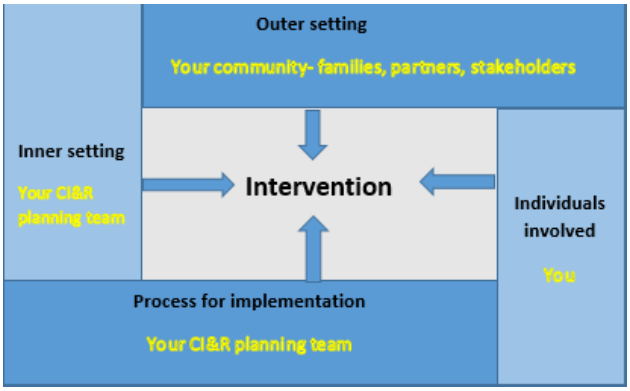

Figure 2. Adapted CFIR showing interacting domains in implementation research (Henao-Martínez, Colborn, & Parra-Henao, 2016).

The CFIR framework, developed by Damschroder et al. (2009, 2011), consists of 25 constructs across five major domains influencing implementation and implementation effectiveness. CFIR serves as a useful guide in formative evaluation research. This framework is beneficial in various diverse and multiple settings, as it aids in analyzing and organizing findings from implementation research. It also increases knowledge on the effectiveness of the various strategies used in the implementation process. A sixth domain, "Learning Collaborative Group Dynamics", consists of 14 constructs adapted from Schulz, Israel, and Lantz (2003) (Figure 3). This domain can be considered as a subset of the inner setting domain of the CFIR framework.

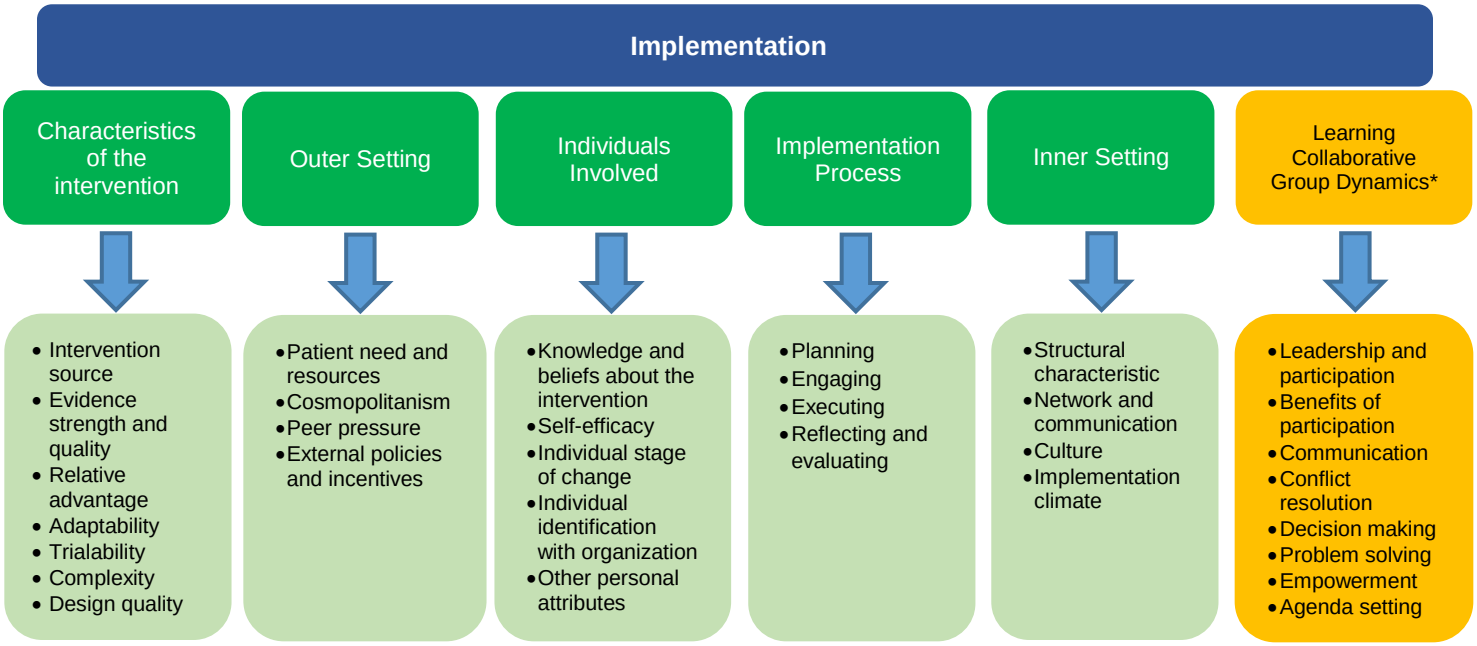

Figure 3. Domains and constructs of the Consolidated Framework for Implementation Research and Group Dynamics (Adapted from Damschroder et al., 2009 and *Schulz, Israel, & Lantz, 2003)

The MIECHV team used this modified framework to evaluate characteristics of teams, coalitions, and system changes, methods of incorporating the CI&R framework into their various sectional systems of care, and accomplishments and barriers encountered during their various implementation processes.

CI&R Learning Sessions

Two face-to-face learning sessions of this collaborative have occurred to date. The baseline learning session took place March 10-11, 2016, in Jacksonville, and the second one occurred at the Children's Board of Hillsborough County in Tampa September 29-30, 2016. Both sessions were similar in structure and format, consisting of a two-day event with various activities such as lectures from guest speakers, poster presentations, and breakout sessions with representatives from each of the ten participating Healthy Start Coalitions comprising eight teams (Table 1, Figure 1). The purpose of these activities was to promote networking and knowledge sharing among the participating Healthy Start Coalition teams with regards to their local CI&R systems and implementation processes.

Prior to convening at each two-day collaborative learning session, the evaluation team distributed a comprehensive CI&R readiness survey electronically to all the learning collaborative participants. The surveys included multiple choice and open-ended questions assessing: 1) participants' individual, professional and organizations' CI&R knowledge; 2) their personal involvement in their community's CI&R system changes; 3) inner setting and group dynamics of their CI&R teams; 4) the outer settings of their organizations; 5) their impressions of the CI&R implementation process in their community; and 6) their respective community's CI&R system characteristics and perceptions of system changes.

On the second day of each learning session, focus groups were conducted with all attendees divided into three smaller discussion groups. These discussions were based on the CFIR constructs and group dynamics. All of the focus group discussions were audio recorded and professionally transcribed verbatim. Each focus group transcript was then reviewed with accompanying audio recordings by the MIECHV evaluation team members to ensure accuracy.

This report documents the process evaluation, participant and organization characteristics and perspectives at baseline (LS1) and at a follow-up period about six months later (LS2). It also describes changes in various CFIR domains and selected constructs from LS1 to LS2. The detailed description of Learning Session 1 and the baseline collaborative survey including participant demographics and organizational-level collaborative characteristics, perceptions, and processes can be found at the evaluation website (http://miechv.health.usf.edu).

Demographic Characteristics of Participants at Learning Session 2

Out of the 53 respondents who completed the CI&R readiness survey prior to the meeting, 38 attended the session at the Children's Board of Hillsborough County. Most of the survey respondents identified their role in their organization as administrator/director (40%), supervisor (21%), or program manager (8%), and the rest were divided among other roles. Most respondents described their service sector as home visiting (53%), early childhood or education (12%), or both (6%); 8% as health care; and the remainder as other service sectors. Respondents had worked for an average of 15 years in their professional field. Half (49%) had a professional/graduate degree, 48% Bachelor's or Associate degree, and 4% some college education. Nearly all (98%) identified as non-Hispanic; 60% identified as White, 31% Black/African American, 4% Asian, and the remaining 5% as other racial groups.

Integrating CI&R Models into Local Systems of Care

Intervention Characteristics

The various CI&R teams described system changes being planned, namely implementing a system to link families with the best services for their needs, improving community-wide system of care, while

minimizing duplication of services. However, activities through which the common goal is being achieved varied by team.

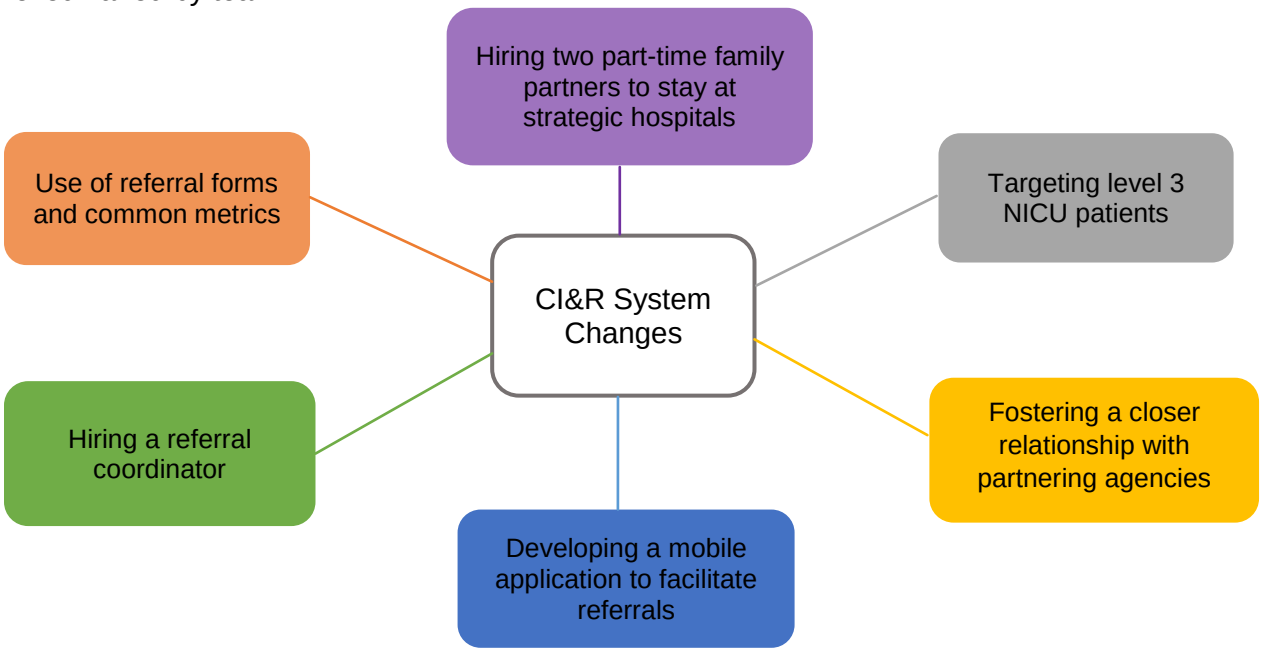

Figure 4: CI&R system change activities by different teams.

Participants indicated that these interventions generally fit in with existing processes and practices within their organizations, such that they were mainly expanding and refining similar existing systems, adding more partners and agencies to their referral system, while making them more formal and beneficial to clients and community partners. In addition, having preexisting connections and communications with certain organizations made it easier to implement the system changes.

"We already have our own systems and need to figure out how to reach out to each other. Find a way to bridge that area and have systems talk to each other."

"Same with our Healthy Start Program in [our county]. We're already doing that, but this will make it maybe more formalized, and hopefully, more beneficial to the patient and to our community partners."

"I think that [our county] is kind of the same thing. We've done a lot of sharing internally because we have several home visiting programs under the same agencies, so we've always shared referrals, but now we're just moving out to the other agencies."

"I think it fits pretty well with ours. At least in our Healthy Start Program part, we have a similar process of evaluating families and trying to meet their needs. So, I think this is just sort of broadening that out and including our community partners."

As teams compared the existing system with ideas for system improvements, they identified several advantages and disadvantages. The advantages of the change/intervention were that: 1) it was population-based; 2) it gave the ability to coordinate with different agencies thereby preventing counties from hoarding knowledge; and 3) receipt of appropriate feedback enabled them to reassess and make relevant changes. One team reported that the proposed change would be the first in their community as it will integrate a lot of services, provide help to families by connecting them to organizations that meet

their needs, educate counties on choices of different programs available to families, understand the curriculum of other programs, and leverage community resources to build better programs. The teams felt that this process increased interconnectedness between organizations through relationship-building and sharing of resources that would benefit communities. They hoped to increase awareness about how their programs work together and sustain the involvement of all agencies already involved so as to have greater reach for better outcomes regarding the health of their communities.

However, lack of follow up of referrals was cited among many as a disadvantage due to programs tending to stay within their niche. They also reported the need to understand why some families who needed a program were rejecting those programs.

"What program they want to, and also how to change the program because they're going to get the family's input on, what they wanted from out of this program. Everything is done to meet each family's need."

"That's really the main purpose of why this work is important to us, it's because we want to get the client where each family is getting served individually what they need or co-served what they need."

"We hope to be able to link them to support and services. We've created a little getting-to-know-your-family forum, kind of another intake, so that we can make sure that we're referring them to the right services and support."

"I think less confusion for the community in general, because if we have a unified message and a unified referral form or whatever, it's not going to be – somebody in the community is thinking, "Where do I need to refer those families?"

Despite these disadvantages, most participants in both LS1 and LS2 perceived that there was strong evidence that strategies to improve CI&R systems will meaningfully impact family outcomes, as shown in Figure 5. Most also agreed that respected officials within their organization would rate the strength of evidence as strong. In addition, there was an increase in participant perceptions over time, with little change in perceptions related to respected officials.

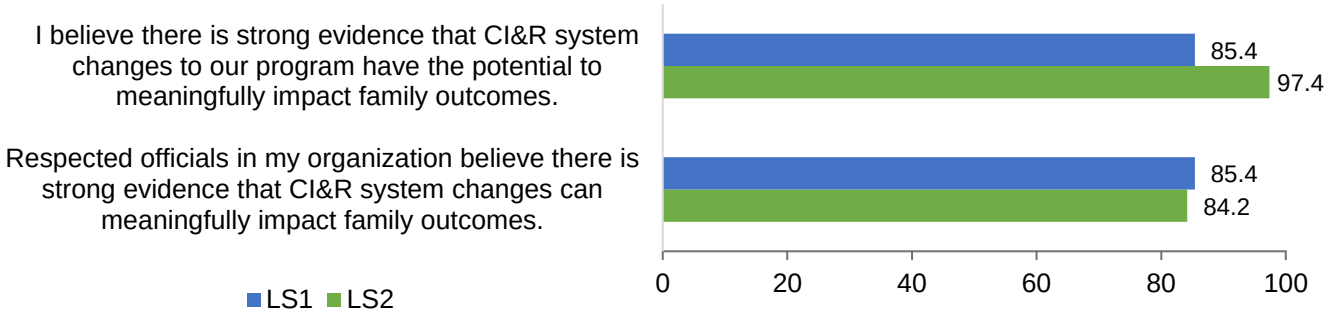

Figure 5: Perceptions on strength of evidence.

Characteristics of Individuals

Individual characteristics that the evaluation explored were related to each team member's perceived self-efficacy, knowledge and beliefs about the intervention, and their stages of change, as shown in Figure 7. Between the two learning sessions, there was great

⬆ Individual Characteristics
- Working on system changes (+11.2%)
- Actively planning to implement changes (+6.3%)
- Self-efficacy (+4.8%)
- Familiarity with facts & principles of system changes (+14.8%)
- Positive system change (+6.1%)

⬇ Individual Characteristics
- Commitment to system changes (-2.8%)

Figure 6: Individual Characteristics' Changes Time 1-Time 2

improvement in indicators related to individual participants' involvement in system changes (Figures 6 & 7). By the second learning session, most participants: 1) believed system changes would be positive; 2) were familiar with facts, truths, and principles related to CI&R system changes; 3) believed in their own capabilities to execute courses of action to achieve implementation goals; and 4) were committed to and actively planning to make system changes. The greatest increase was for the perception that the participants were familiar with the facts and principles related to CI&R system changes (Figures 6 & 7). However, one fifth of participants had not started working on system changes by the second meeting. There was also a slight (2.8%) decline in commitment to making system changes.

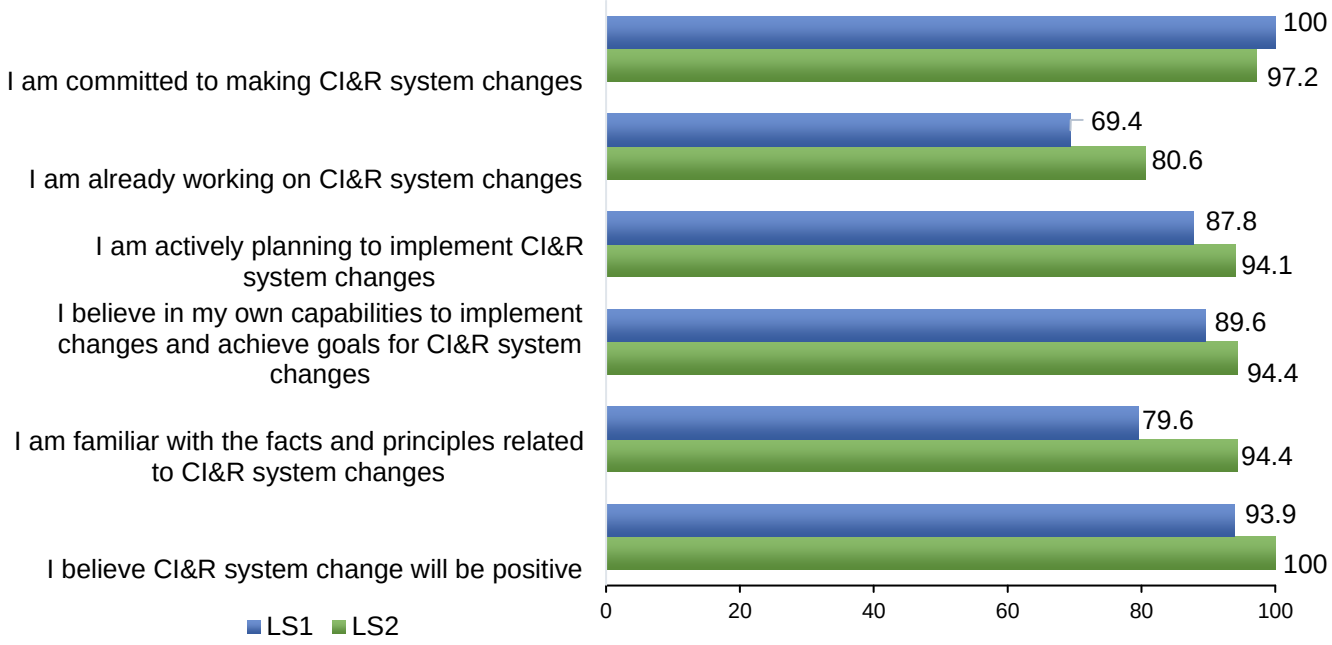

Figure 7: Individual characteristics

Inner Setting (CI&R Team)

Most of the inner setting perceptions increased over time. For example, most participants continued to agree that regular project meetings were held, that leadership promotes team building to solve problems, system changes take into account needs and preferences of families, and that leadership have clearly defined areas of responsibility to implement changes (Figures 8 & 9).

Between the two sessions, the largest increase was in the perception that the current system was intolerable or needed to be changed (9.3 percentage points), indicating a larger proportion (about one third) of participants expressing motivation to make these changes (Figures 8 & 9). By LS2, participants also increased in their reporting that there is a need for the system to take into account needs and preferences of families, and that within their team there are regular project meetings, team-building activities, clearly defined areas of responsibility and authority for staff. However, there was a reduction in the percentage of individuals who

⬆ Inner Setting Perception
- Current system intolerable/needs to be changed (+9.3%)
- Regular management and staff meetings (+0.6%)
- Team-building promotional activities (+3.2%)
- Clear definition of responsibility & authority (+2.8%)
- Needs & preferences of families considered (+3.8%)

⬇ Inner Setting Perception
- Receptiveness to system change (-8.6%)
- Quality management in planning & implementation (-5.1%)
- Effective communication (-4.5%)

Figure 8: Inner Setting Changes Time - Time 2

believed that staff members were receptive to system change, quality management staff were involved in planning and implementation, and individuals in the system communicate effectively (Figures 8 & 9).

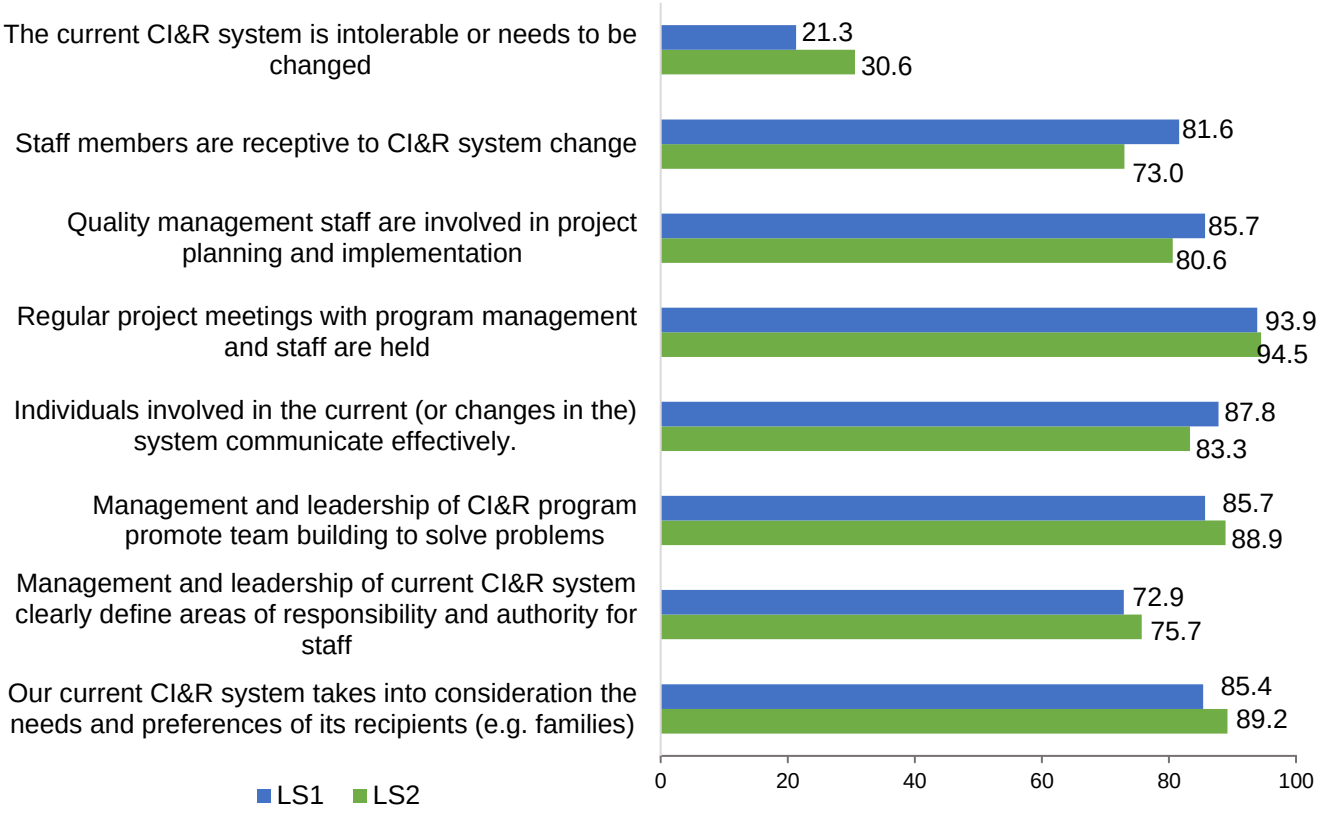

Figure 9: Perceptions of inner setting (CI&R Team).

In the focus groups, the teams identified several barriers to compatibility of these system changes with their current/past approach, such as: finding the right people for the job and retaining them; inadequate communication and inconsistency of information shared between agencies; discomfort with the amount of data shared with other agencies in light of HIPAA regulations; and time constraints. Some teams, however, planned to address these issues based on their assessment after implementation.

Outer Setting (Broader Community)

The change in outer setting perceptions over time was ambivalent (Figures 10 & 11). The majority of participants agreed that system changes take into consideration needs and preferences of recipients (e.g., families), and participants (e.g., community partners, other agencies). This perception increased slightly between LS1 and LS2. Smaller proportions of participants in LS2 compared with LS1 agreed that patient/family awareness/need was available to make changes work, and that the CI&R system was networked with other external organizations that could help or provide resources for making changes. Additionally, the perception that there was peer pressure or external incentives in the community to implement CI&R changes remained quite low.

⬆ Outer Setting Perception
- Implementation influenced by external incentives (+4.1%)
- Preferences of community partners taken into account (+3.0%)
- Needs & preferences of families considered (+4.3%)

⬇ Outer Setting Perception
- Peer pressure to implement system change (-3.6%)
- Networking with external organizations for resources (-4.6%)
- Patient awareness/need available (-3.8%)

Figure 10: Outer Setting Changes Time 1 - Time 2

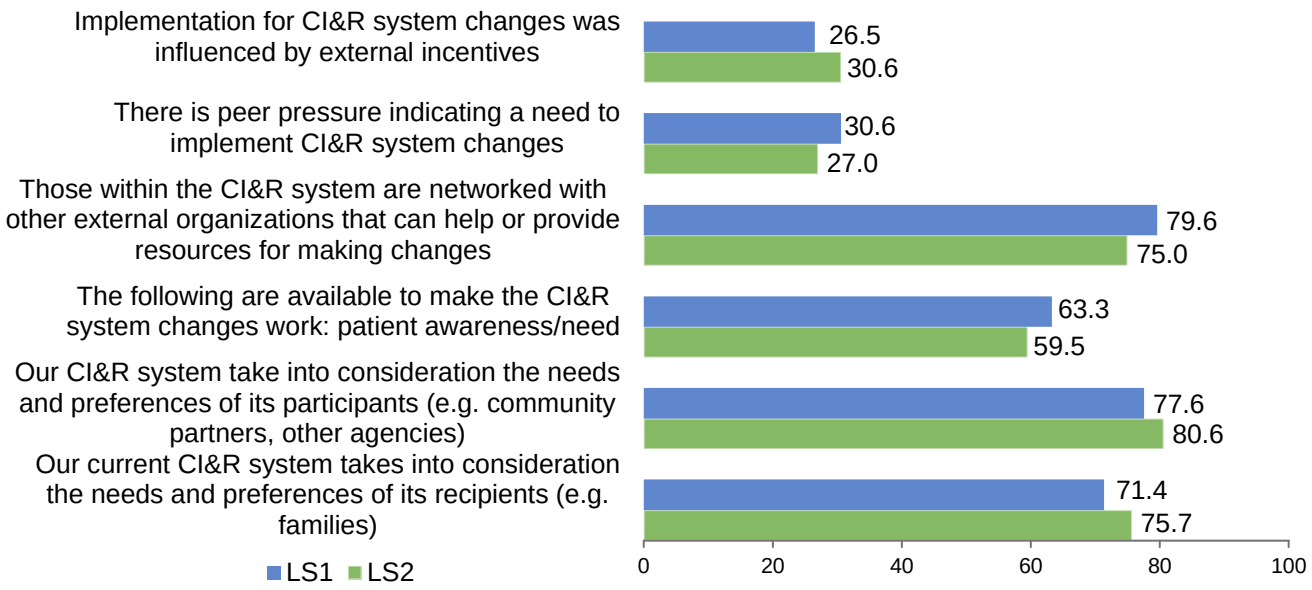

Figure 11: Outer setting

In focus groups, CI&R teams mentioned communicating with stakeholders about the initiatives and system changes through various avenues such as joint meetings involving all partners or representatives of the different agencies involved. During these meetings, they held discussions on progress, impact, and goals though use of tools such as power point, handouts, and sometimes problem-solving exercises. They also communicated via use of progress reports, monthly newsletters, and distribution of fliers to relevant agencies.

"Little nuggets until we get ready to really solidify and implement… but we want them to be hearing about it monthly to know that this is coming down the pipeline."

"So our Tri-County Partnership, we have a lot of conflict goals to go over. A lot of the information that we're working on and then the face-to-face we share through PowerPoint, through handouts. Also, sometimes we do exercise solving."

Additionally, in focus group discussions, most CI&R team members were confident they could successfully implement the intervention due to high stakeholder buy-in once stakeholders heard about the concept, and were confident that the system changes would be sustainable. Other teams were, however, concerned about sustainability, and noted the importance of listening to other people's concerns, avoiding internalization, getting agencies to be engaged and trust in the program, and acknowledging, where present, lack of fit with client needs and sending them to appropriate agencies more appropriate for those needs.

Implementation Process

Most measures of implementation process increased between LS1 and LS2 (Figures 12 & 13), although the level of agreement within teams was generally lower than in the other domains. By the second meeting, 80% and 74%, respectively, indicated that progress in system changes would be measured by collecting feedback from program recipients and from agency staff regarding proposed/implemented changes. Most agreed that the changes would be implemented according to plan, with a majority indicating that there was a clearly defined team in place to make system changes. However, 64% of participants agreed that there was provider buy-in. About four out every five participants agreed that team members shared responsibility for project success, while 60% agreed

that the implementation plan identified specific roles and responsibilities. Less than half of participants (46%) indicated the presence of a plan for providing feedback using performance measures to evaluate the program and about 20% were given a satisfaction survey to evaluate the current program.

Focus group discussions revealed that team members believed active involvement and positive commitment of those involved were essential for successful implementation. They expected stakeholders to be clear in the goals of their respective programs for easy referrals, provide relevant information, fully buy-in and adequately utilize the changes. They mentioned that trainings of the staff undertaken by the involved organizations will be beneficial as it will help to improve services and retention.

⬆ Implementation Perception
- Progress measured by program recipients' feedback (+12.7%)
- Progress measured by agency staff feedback (+7.0%)
- Implemented according to plan (11.5%)
- Provider buy-in available (+6.8%)
- Clearly defined team available (+13.3%)
- Clearly defined roles and responsibilities for members (+23.2%)
- Shared responsibility (+13.3%)
- Specific roles and responsibilities identified (+6.9%)

⬇ Implementation Perception
- Clear plan for feedback (-1.4%)
- Satisfaction survey provided for program evaluation (-30.4%)

Figure 12: Implementation Process Changes Time 1- Time 2

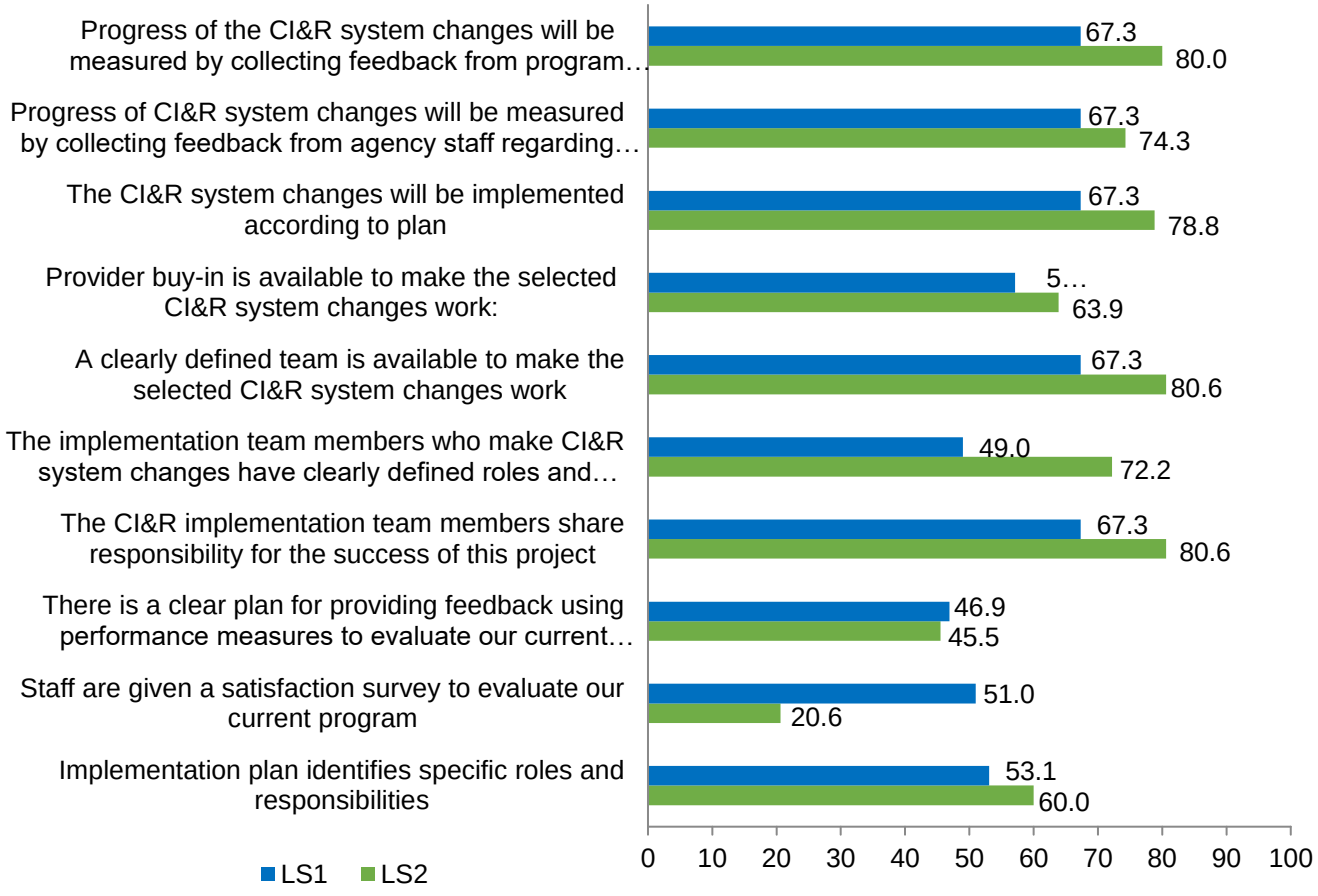

Figure 13: Implementation

"Also to be able to explain what their program is all about, and what they do, and how they would want to receive a referral, and how they will serve them."

"I think the trainings from the different organizations will help our staff and of us, that would be an opportunity… If we have augmented support, compassion, and training for our home visitors – that kind of will complete the circle."

"I think that they just support when they come across a woman that is in need, and that's our target population."

"Using that and then not going through our process then – all our stakeholders fully buying in, all of it contingent upon all of our staff really buying in and wholeheartedly doing the process."

Barriers to implementation of system changes identified through focus group discussions include: 1) unwillingness of some organizations to partner with others; 2) change of leadership in the organization of any of the partners; 3) ineffective communication to stakeholders on what CI&R is; 4) lack of support and resources; 5) double data entry for some of the partnering agencies which requires more time, energy and money as a result of a new database system in place; 6) issues with regulations that govern interagency information sharing; and 7)problems with communication between systems. They also mentioned other barriers such as poor progress in implementation of programs due to different organizations involved, increase in the volume of work without a corresponding increase in the staff due to inadequate funding, and stakeholders who are focused on personal interests.

"Helping them see the buy in and the benefit because nobody wants to go to another meeting or do – add one more item to their plate on a daily basis."

"Some of the root causes will be ineffective communication of what really our mission and our vision is, or the CI&R. Just making sure that we effectively communicate to the stakeholders or any of the entities that we are engaging with."

"I also think one of our challenges is to see how we can support. We're putting all this on our Intake Unit that has not increased in size."

"To see that as our goal, you must do duplication data entry. It's just a big barrier, for sure. We need to figure out a way to handle that around and have our systems talk to each other."

"Some that we're seeing already, and I'm sure we'll continue to see is, that it's going to require double data entry for some of the aid partnering agencies. We all have our own Well Family system or whatever each one is using, and now we have this additional system that's going to require more time and energy and money because time is money, and I think that's a barrier."

CI&R staff reported that they assessed progress towards their goals by use of tools such as: surveys; timelines which enable them to accomplish things at certain points as it ensures they meet the deadlines; group meetings where progress updates are given and followed up; participation in webinars and group sites; and the use of reports and HMIS data system. Some also stated that they have received positive feedback from centers that have agreed to have their family partners there and reported progress with certain administrative processes such as HIPAA clearance as regards to confidentiality and access to patient information.

Conclusion

The findings from the first and second learning CI&R collaborative sessions indicate that there has been a general improvement in positive feedback from participants between the two sessions. In the second session, the most positive feedback was in the domains of individual characteristics of participants, inner setting within the CI&R team, and implementation measures. These findings indicate increased participant awareness of the CI&R intervention and the facilitators and barriers of implementation measures. However, work needs to be done to improve networking with external community organizations to leverage resources for implementing CI&R. In addition, some areas of concern identified included need for follow-up referrals, identification of families' needs to increase their participation, sustainability, ineffective communication to stakeholders, and low staff: work ratio due to inadequate funding. However, perception of greater buy-in by stakeholders and increased interconnectedness between organizations through relationship building and sharing of resources are encouraging factors for successful implementation of CI&R within the eight Healthy Start Coalitions.

The barriers and facilitators identified in these domains will help to provide feedback to participants, which can be discussed within and across teams to enable improvement of the implementation of CI&R system changes. Learning Session 3 will take place in June 2017. Prior to that session, participants will complete the Readiness Survey for the final time, including perceptions of the inner and outer settings; individual, organizational, and community characteristics; and learning collaborative team dynamics such as leadership, participation, communication, conflict resolution, leadership, decision-making capabilities, problem-solving skills, trust, agenda-making capabilities, accomplishments, satisfaction, benefits of participation, cohesion, perceived empowerment, consistency with attendance at meetings, and perceived level of influence on CI&R system changes.

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