# Florida Maternal, Infant, & Early Childhood Home Visiting Initiative

## Intimate Partner Violence Learning Collaborative Baseline Report
## August, 2015

### Introduction

One of the components of the Florida Maternal Infant and Early Childhood Home Visiting (MIECHV) Initiative is to offer support to families experiencing intimate partner violence (IPV) or those that are at-risk. This process includes screening and detection of ongoing IPV, creating safety plans and providing ongoing support as well as referrals to appropriate agencies. The Florida MIECHV State Continuous Quality Improvement (CQI) Team determined that a more comprehensive approach to IPV is needed and set up a Learning Collaborative modeled after the Institute for Healthcare Improvement Breakthrough Series to fulfill this need. The purpose of this report is to discuss the baseline knowledge and confidence level of home visitors with regards to IPV screening and supporting families experiencing IPV; and to describe the content of the breakout sessions that took place during the first of three Learning Sessions (LS).

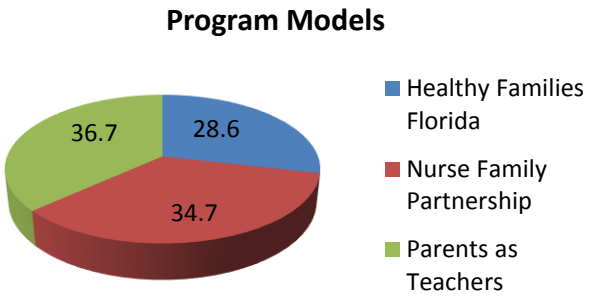
### Methods

To determine the baseline confidence and knowledge of home visitors in offering support for families experiencing IPV, a brief survey was distributed via email link to Qualtrics online survey software platform to all home visitors working in nine of the 11 Florida MIECHV programs (2 were excluded because of their participation in the national Home Visiting Collaborative Improvement and Innovation Network [HV CoIIN]). This very brief survey was developed by the state CQI team and reviewed by an expert panel. The questions collected information on participants' program affiliation, previous training experience, and questions to assess confidence and knowledge pertaining to IPV service delivery.
The Learning Collaborative began with a two-day Learning Session (LS1) for the nine teams.

Specific components that were addressed in LS1 included the definition, prevalence and impact of IPV on survivors and their children. Other components included strategies for improving IPV screening and support services for survivors, measurement through appropriate data collection and reporting, and appropriate referrals. Specific themes that were discussed during LS1 included strategies for interacting with IPV survivors and issues around protecting client information, best practices for IPV screening, identification, safety planning and service coordination. The LS was made up of presentations alternating with group activities to engage participants in active learning. On the second day, discussion groups were held in breakout sessions - one for home visitors and the other for supervisors. These breakout sessions enabled each group to discuss their thoughts about the presentations they had listened to as well as challenges in the field and potential strategies to overcome these challenges.

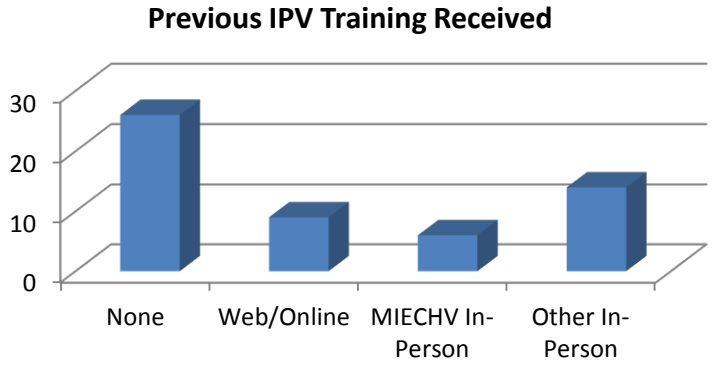
## Baseline Survey Results

A total of 52 home visitors accessed the survey, and 49 completed the survey in its entirety. Participants were almost evenly distributed in terms of the program model they were affiliated with. Among participants, 18 (36.7 %) were in programs that implemented the Parents as Teachers model, 17 (34.7%) were in Nurse-Family Partnership model programs and 14 (28.6%) were in Healthy Families Florida program models.

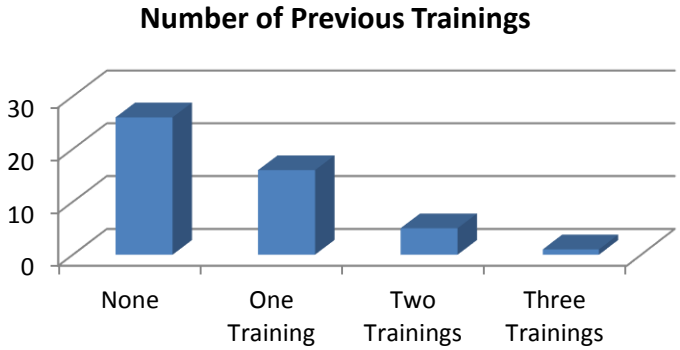



### *Previous Training*

Almost half of the participants, 23 (46.9%), had received prior IPV training at the time the survey was collected. Among participants who had received previous training, nine had received a web/online training, six had received a MICHV in-person training, while 14 had received an in-person training from another provider [Note: Participants could select more than one option for previous training]. Other sources of in-person training included Department of Children and Families (DCF), Florida Coalition Against Domestic Violence (FCADV), Supporting Families Affected by Domestic Violence (two-day MIECHV training), University of Miami Domestic Violence and Sex Trafficking, and a DV and Sexual Abuse program.




The majority of the respondents who had received training (n=16) had participated in one previous training session. Other respondents had been involved in more than one training in the past, with five respondents having participated in two previous training sessions and one respondent having participated in three training sessions in the past.



### *Confidence, Systems Awareness, and Knowledge of Home Visitors in Addressing IPV*

There were varying levels of confidence in IPV service delivery among participants. Overall, more than half of the participants reported high levels of confidence with regards to screening (57.1%), knowing what to say and do following disclosure (55.1%) and identifying red flags (59.2%). Almost half (49%) of participants reported that they feel confident creating safety plans in cases of IPV disclosure, while 42.9% felt they were prepared to serve families affected by IPV (Table 1).

Among participants that demonstrated high levels of confidence, home visitors with prior training made up a higher percentage than those without prior training; however, this difference was not statistically significant ($p>.05$), possibly due to the small number of respondents in the sample. Percentage of respondents reporting high levels of confidence for each item ranged from 55.2 - 71.4% (Table 2).

**Table 1. Confidence Levels of IPV Service Delivery among Home Visitors**

| **Items measuring confidence level** | Agree/Strongly Agree (%) | Disagree /Strongly Disagree/Neutral (%) |
|---|---|---|
| I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship | 29 (59.2) | 20 (40.8) |
| I feel confident screening participants for IPV | 28 (57.1) | 21 (42.9) |
| When a participant tell me he/she has experienced IPV, I feel confident that I know what to say or do | 27 (55.1) | 22 (44.9) |
| I feel confident creating a safety plan with participants that disclose IPV | 24 (49.0) | 25 (51.0) |
| I feel prepared to serve families affected by IPV | 21 (42.9) | 28 (57.1) |

*All p-values were >0.05

**Table 2. Confidence Levels of IPV Service Delivery among HV Stratified by Prior Training**

| **Items measuring confidence level** | High Confidence – Strongly Agree/Agree (%) | | |
|---|---|---|---|
| | Total (N=49) | HV with prior training (N=23) | HV without prior training (N=26) |
| I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship | 29 (59.2) | 16 (55.2) | 13 (44.8) |
| I feel confident screening participants for IPV | 28 (57.1) | 18 (64.3) | 10 (35.7) |
| When a participant tell me he/she has experienced IPV, I feel confident that I know what to say or do | 27 (55.1) | 16 (59.3) | 11 (40.7) |
| I feel confident creating a safety plan with participants that disclose IPV | 24 (49.0) | 16 (66.7) | 8 (33.3) |
| I feel prepared to serve families affected by IPV | 21 (42.9) | 15 (71.4) | 6 (28.6) |

***** All p-values were >0.05

There were varying levels of system awareness among participants with higher system awareness reported with regards to child abuse. Almost three-quarters (73.5%) of participants agreed that they knew when to make a report to the child abuse hotline for IPV. However, lower levels were reported for other items testing system awareness. Among respondents, 38.8% reported that they knew the name of a staff person at the local DV center that they could call for assistance and only 20.4% reported familiarity with criminal and civil legal options for IPV survivors (Table 3).

Among participants that demonstrated high levels of system awareness, home visitors with prior training also made up a higher percentage than those without prior training; this difference was also not statistically significant ($p>.05$), Percentage of respondents reporting high levels of confidence for each item ranged from 52.8 - 80% (Table 4).

**Table 3. Systems Awareness of IPV service Delivery among Home Visitors**

| **Items measuring systems awareness** | Agree/Strongly Agree (%) | Disagree /Strongly Disagree/Neutral (%) |
|---|---|---|
| I know when to make a report to the child abuse hotline for IPV | 36 (73.5) | 13 (26.5) |
| I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant | 19 (38.8) | 30 (61.2) |
| I am familiar with the legal options (both criminal and civil) for survivors of IPV | 10 (20.4) | 39 (79.6) |

**Table 4. Systems Awareness of IPV Service Delivery among HV Stratified by Prior Training**

| **Items measuring systems awareness** | High Confidence – Strongly Agree/Agree (%) | | |
|---|---|---|---|
| | Total (N=49) | HV with prior training (N=23) | HV without prior training (N=26) |
| I know when to make a report to the child abuse hotline for IPV | 36 (73.5) | 19 (52.8) | 17 (47.2) |
| I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant | 19 (38.8) | 11 (57.9) | 8 (42.1) |
| I am familiar with the legal options (both criminal and civil) for survivors of IPV | 10 (20.4) | 8 (80.0) | 2 (20.0) |

Equal percentages of home visitors reported that their agencies had specific protocols about what to do when a participant discloses IPV, with 51% agreeing while 49% were neutral or disagreed.

There were also varying levels of knowledge among participants at baseline. More than half of the participants answered correctly to the knowledge items that assessed knowledge of types of IPV and factors relating to staying or leaving an abusive relationship. Fewer than half of the respondents however answered correctly on knowledge items that addressed causes of IPV and treatment/prevention methods (Table 5). On items testing knowledge of IPV, there was not a marked difference between home visitors with prior training and those without prior training (Table 6). Knowledge items were scored out of a total of 9. None of the participants

scored 100%. Six participants scored at least 80% and 26 participants scored at least 50%. Again, those with prior training did not appear to have higher total items correct compared to those without prior training (Table 7).

**Table 5. Knowledge of IPV Service Delivery among Home Visitors**

| Knowledge items | Correct (%) | Incorrect (%) |
|---|---|---|
| All IPV includes physical violence | 39 (79.6) | 10 (20.4) |
| I don't understand why anyone would stay in an abusive relationship | 38 (77.6) | 11 (22.4) |
| I only refer to the local DV center if the participant wants to leave the relationship | 33 (67.3) | 16 (32.7) |
| If the participant chooses to stay in an abusive relationship, there is nothing I can do | 29 (59.2) | 20 (40.8) |
| The primary cause of most IPV is alcohol or drug abuse | 23 (46.9) | 26 (53.1) |
| If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline | 22 (44.9) | 27 (55.1) |
| A problem with anger is the primary cause of IPV | 19 (38.8) | 30 (61.2) |
| Couples counseling is an effective strategy for stopping IPV in families | 15 (30.6) | 34 (69.4) |
| Anger management programs are effective in preventing the recurrence of IPV | 13 (26.5) | 36 (73.5) |

*All p-values were >0.05

**Table 6. Knowledge of IPV Service Delivery among Home Visitors, Stratified by Prior Training**

| Knowledge items | Correct Responses (%) | | |
|---|---|---|---|
| | Total (N=49) | HV with prior training (N=23) | HV without prior training (N=26) |
| All IPV includes physical violence | 39 (79.6) | 20 (51.3) | 19 (48.7) |
| I don't understand why anyone would stay in an abusive relationship | 38 (77.6) | 18 (47.4) | 20 (52.6) |
| I only refer to the local DV center if the participant wants to leave the relationship | 33 (67.3) | 18 (54.5) | 15 (45.5) |
| If the participant chooses to stay in an abusive relationship, there is nothing I can do | 29 (59.2) | 14 (48.3) | 15 (51.7) |
| The primary cause of most IPV is alcohol or drug abuse | 23 (46.9) | 13 (56.5) | 10 (43.5) |
| If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline | 22 (44.9) | 11 (50.0) | 11 (50.0) |
| A problem with anger is the primary cause of IPV | 19 (38.8) | 11 (57.9) | 8 (42.1) |
| Couples counseling is an effective strategy for stopping IPV in families | 15 (30.6) | 8 (53.3) | 7 (46.7) |
| Anger management programs are effective in preventing the recurrence of IPV | 13 (26.5) | 7 (53.8) | 6 (46.2) |

*All p-values were >0.05

**Table 7. Total Items Correct for Knowledge of IPV Service Delivery among HV, Stratified by Prior Training**

| Total Items Correct (out of 9) | Total HV (N=49) | HV with prior training (N=23) | HV without prior training (N=26) |
|---|---|---|---|
| 0 | 3 (6.1) | 1 (33.3) | 2 (66.7) |
| 1 | 0 (0.0) | 0 (0.0) | 0 (0.0) |
| 2 | 6 (12.2) | 2 (33.3) | 4 (66.7) |
| 3 | 7 (14.3) | 4 (57.1) | 3 (42.9) |
| 4 | 7 (14.3) | 1 (14.3) | 6 (85.7) |
| 5 | 4 (8.2) | 2 (50.0) | 2 (50.0) |
| 6 | 10 (20.4) | 6 (60.0) | 4 (40.0) |
| 7 | 6 (12.2) | 2 (33.3) | 4 (66.7) |
| 8 | 6 (12.2) | 5 (83.3) | 1 (16.7) |
| 9 | 0 (0.0) | 0 (0.0) | 0 (0.0) |

## Learning Session 1: Sarasota, FL – August 2015

### IPV Discussion Breakout Session Summary: MIECHV Supervisors and Administrators

To begin the breakout session the moderator brought up the recurring themes seen on the Post-it notes collected on the previous day of training. "Being successful and working with families who may be in denial or what does that actually mean and how to initiate that trusting relationship" were topics addressed by many attending the training. The staff was then asked what they were doing to take care of themselves which opened up a dialogue on emotional stress. "As nurses, we kind of give ourselves that fixing role and that therapeutic role that you think that you have until something happens that makes you question 'Have I related to them enough? Have I done the right thing?'" said one respondent. "It is important to use all of the resources available to you, such as the family specialist, and maintain your own health first. Taking care of yourself will allow you to support the staff and encouraging them to take care of themselves as well because again, this can be draining." The staff then spent time addressing how to encourage and support their home visitors, understanding how stressful and frustrating it can be when they offer referrals and the participants choose not to use them. "I do always make it a point to make sure that they understand that they can only do what they can do. They can only give the information and then it is up to the participant if they're going to do something."

The role of the supervisor, as then discussed, is to help the home visitor see the big picture and model a positive attitude towards the changes being put in place: "it has to be modeled from the top-down." Support for the supervisor is also needed: "I have to understand it in order for me to explain it to my staff." "We're on a journey and I'm here on the journey" said one respondent. The change will not be instant but will take place over time and will only be accomplished if it is done together. One program even started implementing rapid cycle testing by conducting "really small tests" that have already shown "some really big improvements" which has encouraged the staff to continue in the process. Team building activities to help boost morale were also discussed to help "lessen the pain" of implementing yet another change. Having to help their staff deal with and accept the changes taking place was another area where support is needed. The home visiting staff is already responsible for so much and adding one more responsibility could be another challenge.

Lastly, the definition of success was a topic that needed to be addressed. Success cannot be measured based on how many women use the resources and education given to them. One person described success as "when the

woman or participant or client is feeling comfortable and confident with her decision and her choice." The co-facilitator defined success as the home visitor providing the information and offering services. While it is important to respect the decisions of the participants, they may or may not feel comfortable with their decisions because of what is at stake. Due to the concern for safety, the decisions may change as the circumstances change. The important piece is that the home visitor has provided resources so that the participants can make informed decisions. The role of the supervisor is to help coach their staff in recognizing IPV and supporting survivors. They must help their staff to become aware of their own biases, in an effort to eliminate judgment. "You have to say this is her choice, her life, you have to respect that." "So when we're connecting someone with a referral regardless of how they respond, whether we know they call or not, the success is that we offer that service, that we offer that referral, that we planted that seed, that we talked to them about domestic violence services so they know that's out there in the community."

### *Additional Quotes*

*"For me, it's the supervision and good quality supervision where you're helping them steer through things."*

*"I think there's another concern in that we don't know the history of all of the people on our teams, on our staff. We don't know who is a child from a battered home. We don't know if the individual is a survivor nor should we expect anyone to make that public. But there's still - as a supervisor, I want to know what to do, how to respond, how to support the nurse."*

*Moderator: "Just in general, do you all do things to support each other, do you have that built in already?"*
*Respondent: "Now we're at the point where we're doing well but we recognize that we really need to really celebrate any little thing, when we have an accomplishment because I think so many times, we're just 'Do this, do that. These screens were not completed. We don't have enough clients' and just step back and say we really are moving in a very good direction and we celebrate any accomplishment or when they've done a good job, because they really do great things every day."*

*Moderator: "How are you going to help your staff have a positive attitude about participating in this learning collaborative on top of everything else that you have to do?"*
*Respondent: "I think it has to be modeled attitude, it has to be modeled from the top-down, but I also think that we need to be very transparent with stuff and also have those discussions about 'There's a change coming. Some of you will not be comfortable with this. We can talk through this. Some of you will get anxious about this. Some of you will embrace it' and just recognizing that everybody deals with change differently."*

*"It really starts with us so we have to set the stage. We have to set the tone. We have to be there."*

*"If I'm having difficulty with it, with lots of years of experience in the nursing field, how am I then going to convey that to my staff? I try very hard to be optimistic. I let them know, 'This is a learning curve for me too. I've not done this before. So we will get through this together as a team. If you're struggling with it, don't struggle. Come to me, let's talk about it. Let's sit down. Let's look at it. If I can't help you, I will reach out to those people who really know how this process works and I will get help for us.'"*

*"I think for me, success is when the woman or participant or client is feeling comfortable and confident with her decision and her choice… Because it's not our life. It is her life. So whatever she chooses, it's our role to help her sort through to make the best possible decision for her, whatever that is."*

*"We need to increase the sensitivity of the tools that we use so that we can actually recognize the women who have experienced it first."*

*"So just everybody being more aware and realize even though you only know what they tell you. You're not going to catch everything but that doesn't make you unsuccessful."*

*"I had a really big 'Aha' just listening to the powerful stories from our survivors and I'm not sure that any strengthening of the tool or – they just said this topic is so sensitive to a family, they're not going to share with anyone until they have a defining moment and then they're ready."*

*"So it's not denial. It's their experience. I know an interview from the Caribbean nurse, some Caribbean culture believe that if a man loves you, he's going to hit you. I mean it's actually a saying that he loves you. It's not. So, it's not going to be a denial situation. It's absolutely – it's based on who they are, where they came from, what they saw when they were growing up, their culture, so that denial is this thing about "Okay, they know and they're pretending not."*

### IPV Discussion Breakout Session Summary: MIECHV Home Visitors

During the home visitors' focus group breakout session, participants discussed multiple aspects of the Learning Session that they believed were thought-provoking. Throughout the hour long discussion several aspects of competently serving families experiencing IPV were discussed. One of the main themes discussed was education. Several home visitors stated that education was an important aspect that needed to be implemented for both home visitors and clients. Other points of discussion included use of screening tools as well as helping participants to navigate within the system.

With varying levels of experience and differing educational, as well as occupational, backgrounds, some of the home visitors reported very little understanding of how to appropriately convey the impact violence in the home has on children. A few home visitors expressed an interest in further training to learn more about this.

It was mentioned that many resources are provided to the mother to cope with experiencing IPV, but quite often there is "...nothing in place for the children." It was also addressed in this quote: "Mostly with domestic violence, they focus so much on the mom that they forget that their children have to live with it long term because as they grow into adulthood... The trauma is still in you. It never goes away." Home visitors believed that a main reason mothers stayed in an abusive relationship was they felt it was important for their child to have a father. Home visitors also stated that appropriately educating women on resources, as well as impact of violence on themselves and the children witnessing the violence would lead to women leaving the relationships. One home visitor stated a participant had already "denied" experiencing IPV. Upon hearing information about the negative impact IPV has on a child, she left her partner. Quoting the participant, the home visitor stated, "I ended up *[sic]* the relationship with him right away after I heard you saying how much it affects our children, and I've been in this domestic violence relationship for a long time. I'm sorry I lied to you."

To resolve this issue of lack of knowledge on both the part of some of the home visitors and the participants, a suggestion was made that a curriculum be developed or acquired that appropriately addressed healthy and unhealthy relationships, not just IPV, and appropriate resources to provide to participants and their children. This curriculum would permit the conversation to occur in a less startling manner and afford the home visitor the opportunity address the topic in a sensitive and appropriate manner.

Another point discussed was utilizing screening tools for IPV. Many of the home visitors in the focus group placed heavy emphasis on the screening tools used across the programs. The concern was how these tools may not necessarily be the most successful at gathering the necessary information to decipher whether a family has experienced IPV. Some home visitors felt that the stark and "aggressive" nature of the questions, along with the fact the questions so clearly are trying to assess for violence in the home, make it awkward to address within the first few months of interacting with the family. There was also a feeling that participants are unlikely to disclose such personal information.

Two approaches were discussed that other sites use to lessen the intensity of asking such sensitive questions. The first suggestion was ensuring the rapport was developed between the home visitor and mother. This home visitor stated she was able to establish rapport because she saw her families on a weekly basis for the first few months and assured that these questions were asked of every family. One home visitor agreed that rapport was important, but that waiting longer to complete the measure could be a viable option if frequency of visits was less than once a week. Another suggestion made to help with the issue of the required screeners was incorporating the questions into a conversation as opposed to engaging in an interaction that comes off "robotic" and unnatural. Some home visitors said that they were able to do that because of training they received at their respective sites. Others stated they were fearful of not completing every question if they did try to make the questions flow in a conversation as they had not been granted permission, or been provided the training, to do so by their program. One home visitor eloquently stated, "We need to stop focusing so much on the form and give more, be more human and be more empathetic." In being more human, or "real," the participants would then feel more comfortable in sharing private information.

Though not a primary point of discussion, home visitors expressed concern regarding how they work within multi-layer systems. As many of the MIECHV programs occur in various agencies, different requirements exist in addition to those required by MIECHV and the program that is being implemented (i.e., PAT, NFP, Healthy Families). Many home visitors felt frustrated that the agency in which they were housed required they attend meetings they felt were irrelevant or interrupted time with their families. One session participant stated that her colleague missed out on a whole day of work due to meetings and still had to meet with her 25 families within her remaining 30 hour work week. Another point specific to systems navigation was aiding immigrant and undocumented families because leaving a violent partner would lead to social isolation and with no control of whether the participant could stay in the US after leaving said partner. No suggestions were made on how to deal with this particular concern.

Overall, when asked by the moderator to share their experiences and thoughts following the first day of the Learning Session, the home visitors shared their experiences in personally experiencing IPV and being witness to IPV. They also voiced a desire for more training as it relates to their education and the education of their families, as well as ways to help participants to disclose and seek help. While one home visitor stated training in things like motivational interviewing and other strategies was helpful, the moderator mentioned that training in ACEs would be beneficial and potentially what a lot of the breakout session participants were seeking. In all, the home visitors felt that they were collaborators with the participants. "Planting seeds" and hoping that one day the fruits of their labor would burgeon even if they were not witness to it.

### *Additional Quotes*

*"I go in establishing a relationship with all my families that I'm here to support you and guide you and provide you information. I'm not here to tell you what to do. I'm not here to tell you how to parent. I'm not here to tell you that you have to have a better relationship or whatever subject it is because it's up to them to do with it what they want."*

*"We need curriculum that we can address these issues before that even happens, before... None of our curriculum addressed that. I could simply go back and talk about how does arguing affect your children? What if this happened? If we have some curriculum to go by, to start doing this before we even do the heart because we're already talking about it. That may open them up, disclosing something earlier than we have to wait for six months or close. It may open it up right away and we can get them services right away before the child is dangled over something like that. We don't have curriculums. We have handouts. I mean we have little booklets that we could go in but now I got to figure out how I'm going to get away with this if it was the service plan. We have the service plan. We have that on the service plan, but we really don't have the curriculum at the outside. We've been looking for it, I called and asked for those little booklets, how domestic violence affects families but we have to know how to open that up. If I had an easy curriculum that I could introduce to this family before it gets there, it would make it a lot easier."*

*"Mostly with domestic violence, they focus so much on the mom that they forget that their children have to live with it long term because as they grow into adulthood... The trauma is still in you. It never goes away."*

*"Kids suffer the most. They do suffer long term."*

*"I don't think our parents realize the effect and that's what came to me when my mom was sharing with me what was going on. She needs to know the effects that this is going to have on her children if this does not stop. Because we think if you're just arguing all day, okay they're children they're not paying attention because kids keep going. They keep playing, they keep doing everything they're doing so we think it's not bothering them but I want my parents to know that when you talk to them this way, when you guys argue, what is going on? You got to know that something is happening to your child even though your child may be in the other room because this is what she's said."*

*"So I think the tool is not to get her to disclose. The tool is to give her reasons to rethink what's happening in the violent relationship and plant the seed, right? You plant the seed. It doesn't matter if you ever see it grow. You use the empathy and the kindness and the listening and the caring and you plant the seed and you give the information and, to me, that's the goal of all this and then too bad you don't see the plant but it will be there. We have to have faith that it will be there."*

*"They [moms] can do the groups. They can do the therapies. They can do those things but we have nothing in place for the children."*

*"What I'm just concerned about with listening to one of the presentations yesterday, what we want is to protect the children, what we need is to reassure that mother that these kids are not going into foster care. We are so quick to separate the families and put the children in foster care. Yes, I know some parents don't protect the children. They're afraid they don't have the skills or whatever, but we're so quick to separate the family and put them in foster care, come up with the plan. If this lady said yes then you can reassure them that you've got a plan to take them to live with a grandmother, aunt or somewhere, or you need to go to the shelter. 'Your kids are going to the shelter with you. In that shelter, you're going to receive counseling, both parent and children.' Then, I think, parents will be more apt to say, 'Yes, I'm in a situation. Yes, I need help.' But we need some resources to give them too before we go and throw our weight around and saying this and saying that. Just have something in place with them, too."*

## Next Steps

The Florida MIECHV Program Evaluation Team plans to attend the second and third Learning Sessions in fall 2015 and spring 2016, respectively. Additionally, mid- and post-assessment surveys will be administered in 2016.

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This project is supported by the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative, Florida Association of Healthy Start Coalitions, Inc.