University of South Florida Evaluation Plan for Florida Maternal, Infant, and Early Childhood Home Visiting Competitive Grant (D89MC28265) 2015-2017

Background on the FAHSC Competitive Grant

Strategies included in the FAHSC competitive grant are designed to build on and enhance the strong foundation established during the initial 16 months of the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) implementation by expanding capacity and taking advantage of opportunities to develop coordinated systems in communities that optimize enrollment and engagement of at-risk families. Additionally, as local implementation sites mature, there is a need to be proactive in addressing participant and staff retention—among the most significant challenges to program impact. As described in the FAHSC proposal, competitive funding will be used to increase capacity, enrollment and retention by: Strategy 1) Funding additional high-need communities to implement selected evidenced-based home visiting models (Nurse Family Partnership [NFP], Healthy Families America [HFA], and Parents as Teachers [PAT]); Strategy 2) Working with the state Title V agency to implement a multi-community learning collaborative to develop and test Coordinated Intake & Referral (CI&R) models using the state's universal prenatal and infant risk screens; Strategy 3, Objective 1) Providing support for an overlay of evidence-based mental health services in existing MIECHV-funded sites; Strategy 3, Objective 2) Providing staff training in Mindfulness-Based Stress Reduction (MBSR); and, Strategy 4) Supporting continuous quality improvement (CQI) projects at local sites to address enrollment, retention and selected MIECHV Benchmarks. These strategies address key drivers for successful family engagement and retention identified by the HRSA Home Visiting CoIIN.

Evaluation Plan

The Florida Association of Healthy Start Coalitions, Inc. (FAHSC) is contracted with the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, located within the College of Public Health at the University of South Florida (USF), to conduct an independent evaluation of original D90 funded MIECHV programs and for the strategies outlined in the competitive grant. The D90 and D89 evaluations assess Florida's progress moving toward increased collaboration in communities, system improvement, enhanced capacity, and sustainability of home visiting programs. As data will be collected and reported to the FAHSC and MIECHV program communities at multiple time points during the project period, results will be used for further program planning and implementation. Human subjects' protections are honored in all phases and components of the evaluation.

The USF Evaluation Team has been conducting a comprehensive evaluation of current MIECHV programs for two years (D90 Florida MIECHV evaluation plan) and thus has developed relationships with the 11 MIECHV-funded home visiting programs that facilitate evaluation implementation. While maintaining neutrality, the USF Evaluation Team has incorporated the principles of participatory program evaluation, such as: strong collaboration between the USF Evaluation Team, FAHSC, and the selected communities; focus groups with key informants including home visiting program participants, home visitors and administrators; and dissemination of results to programs for further planning. The evaluation of the components of this proposal, described below by the USF Evaluation Team, will ensure continued independence (neutrality) of the evaluation while also providing consistency in evaluation methods and communication practices and management of staff burden in evaluation research. This consistency will facilitate MIECHV programs' collaborative participation in the evaluation activities and use of results for program improvements.

Figure 1 below displays the 4 strategies utilized in the D89 Florida MIECHV Competitive Grant and their corresponding evaluation activities. Strategies 1 and 4 in the D89 Competitive Grant involve programmatic

components that are conducted statewide, and correspond with evaluation activities being conducted under the D90 grant. Strategies 2 and 3, however, relate to programmatic innovations, and will be evaluated as such according to this proposed plan.

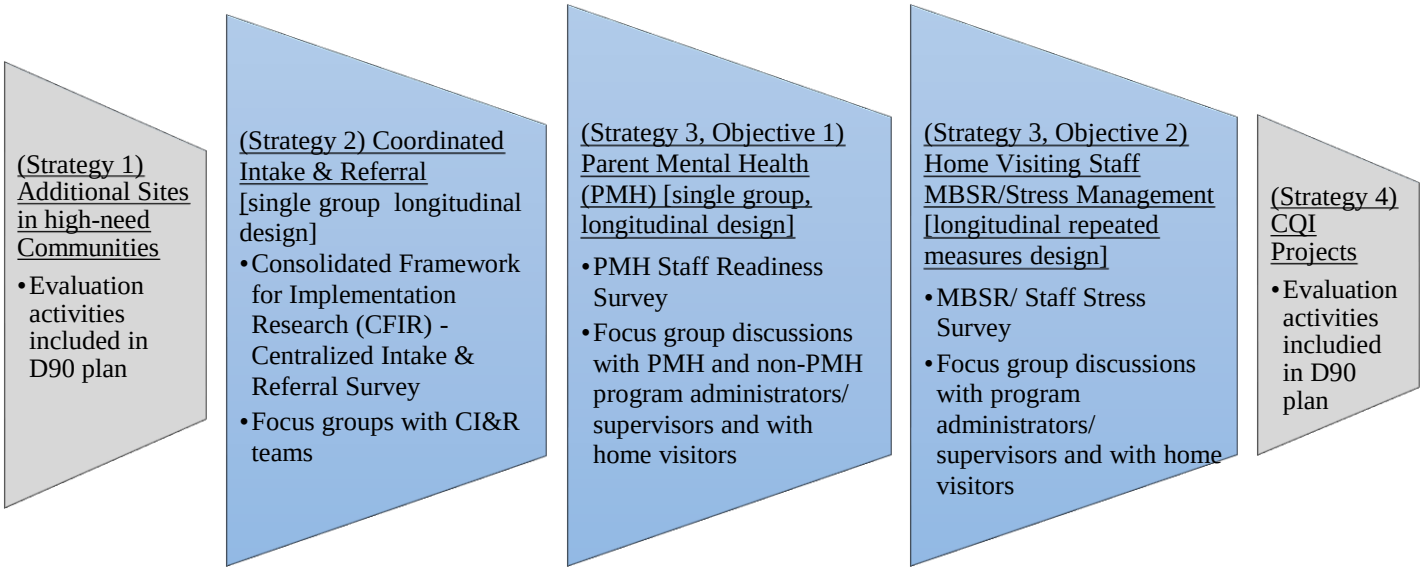

Figure 1: Competitive Grant Innovation Strategies and Evaluation Activities

Because the competitive grant is in its first year, formative evaluation is used for Strategy 2, process evaluation is used to assess the implementation of Strategy 3, Objective 1, and outcome evaluation will be conducted for Strategy 3, Objective 2. Because the strategies within the competitive grant are innovations in home visiting, wisdom gained through process evaluation results can facilitate replication in other sites and states.[1,2,3] Furthermore, while process evaluation examines and documents implementation, it can also monitor and describe the contextual elements affecting implementation and future replication, such as organizational structure, leadership and culture, staff perceptions, and the characteristics of the innovation itself; these contextual elements will be examined in a number of ways throughout the evaluation.[4]

Theory based evaluation: A theory-based process evaluation provides credibility and consistency in the constructs measured through participant surveys and the perceptions and processes explored through qualitative interviews or focus groups. Several practical frameworks and models are available to practitioners to guide the development of a comprehensive evaluation plan, including process evaluation for collaborative community initiatives. The theoretical frameworks utilized in this evaluation to inform survey development and focus group guides include: Consolidated Framework for Implementation Research (Appendix B); Diffusion of Innovation

[1] Gray, L. A., & Price, S. K. (2014). Partnering for Mental Health Promotion: Implementing Evidence Based Mental Health Services within a Maternal and Child Home Health Visiting Program. Clinical Social Work Journal, 42(1), 70-80.
[2] Jarrett, P., & Barlow, J. (2014). Clinical supervision in the provision of intensive home visiting by health visitors. Community Practitioner, 87(2), 32-36.
[3]Moss, E., Dubois-Comtois, K., Cyr, C., Tarabulsy, G. M., St-Laurent, D., & Bernier, A. (2011). Efficacy of a home-visiting intervention aimed at improving maternal sensitivity, child attachment, and behavioral outcomes for maltreated children: A randomized control trial. Development and Psychopathology,23(01), 195-210.
[4] Saunders, R. P., Evans, M. H., & Joshi, P. (2005). Developing a process-evaluation plan for assessing health promotion program implementation: a how-to guide. Health Promotion Practice, 6(2), 134-147.

Theory (Appendix G); and the Transactional Model of Stress and Coping[5] (Figure 3). These theories are described below in subsequent sections.

Participatory evaluation: Annually, the evaluation team will conduct on-site visits with MIECHV programs funded in both the competitive (D89) and formula (D90) grants throughout the state. During these site visits, focus groups and interviews will be conducted (as described below), an overview of the evaluation provided, and at the end of the visit, site-specific evaluation results will be provided to the staff and administrators (in addition to statewide results which are posted on FAHSC MIECHV[6] and USF MIECHV[7] Evaluation websites). The program staff will also be invited to provide feedback on the evaluation (verify or add context to the results, provide input on how to make the evaluation process more helpful and less burdensome), and suggest further evaluation issues. Feedback sessions (at site visits, monthly statewide calls, and through other interactions) provide opportunities for MIECHV sites and for the USF evaluation team to add additional research questions, discuss research methods and measures, and to identify ways to make research findings available to MIECHV families, staff, community partners on an ongoing basis. Therefore, MIECHV programs anticipate a cycle of participant interviews in the spring, site visit reflections and discussions each fall, and smaller reports and presentations on statewide calls and meetings throughout the year, providing ample opportunity to reflect on progress, CQI needs, and contribute additional evaluation questions. As a result, to some extent the USF MIECHV Evaluation is iterative and offers a reliable (though flexible) set of data collection and reporting methods and timeline with continuously developing lines of inquiry based on previous findings, participant feedback during interviews, and program staff input.

Neutrality

Although Florida MIECHV promotes and maintains a culture of collaboration and transparency among all grantee sites, the benefit of using an external/independent evaluation team (rather than FAHSC conducting all evaluation activities) is that program staff and participants can provide feedback in a confidential environment. Individual participants are not identifiable and study results are not linked to individual participants. The USF Evaluation Team follows the American Evaluation Association Guiding Principles for Evaluators[8] including systematic inquiry, competence, integrity/honesty, respect for people, and responsibility for general public welfare. In particular, the principle of integrity/honesty mandates that evaluators: 1) are explicit about their own, their clients', and other stakeholders' interests and values concerning the conduct and outcomes of an evaluation; 2) do not misrepresent their procedures, data or findings, and attempt to prevent or correct misuse of their work by others; and 3) identify and immediately address any concerns in the event that certain procedures or activities appear likely to produce misleading evaluative information or conclusions.

Valid and Reliable Measures:

Where possible, existing standardized and validated measures will be utilized. Measures are selected for content and construct validity, succinctness to reduce burden on participants, reliability, and generalizability for the population of interest. Composite surveys and measures developed by the evaluation team will be piloted prior to dissemination. Survey development and validation processes are described within evaluation component descriptions below.

Contribution of this Evaluation to Home Visiting Knowledge and Practice

[5] Lazarus, R.S. (1966). Psychological Stress and the Coping Process. New York: McGraw-Hill.
[6] FAHSC MIECHV Website: http://flmiechv.com/
[7] USF MIECHV Evaluation Website: http://health.usf.edu/publichealth/chiles/miechv/state-evaluation.htm
[8] American Evaluation Association. (2004). American Evaluation Association guiding principles for evaluators. Available at http://www.eval.org/p/cm/ld/fid=51

Through mixed-methods research, this evaluation will examine characteristics and processes at the individual, organizational, community, and systems levels in order to identify factors promoting successful implementation of the proposed innovations. The findings from the evaluation will be presented locally, regionally, and nationally in order to contribute to home visiting knowledge and also to facilitate translation from research to practice.

First, the USF MIECHV Evaluation will work with the FAHSC Learning Collaborative to increase **state capacity** through our process evaluation of the Coordinated Intake and Referral (CI&R) systems developed throughout the state. The CI&R evaluation identifies organizational-level characteristics, perceptions, and processes based on the Consolidated Framework for Implementation Research (CFIR) that facilitates systems development. This information will be shared with Healthy Start Coalitions and their partners throughout Florida and can provide guidance or 'lessons learned' for future efforts in other communities.

Several components of the competitive expansion grant involve additional **evidence-based** program enhancements (parental mental health [PMH] curricula, MBSR for staff retention) or cross-model program elements (learning collaborative for CI&R). Dissemination and publication of the process and outcome evaluations of these enhancements and elements add to the evidence base for a number of areas in home visiting and family support. For example, the CI&R and collaboration components will identify critical individual, organizational, and community-level characteristics and processes that support systems building, community organizing, and coalition development to support improved perinatal outcomes, family well-being, and early childhood health and development. Additionally, the evaluation of the mental health overlay (Strategy 3) will offer insight into the feasibility and acceptability of implementing parent and staff mental health interventions in family support programs such as MIECHV from the perspective of program staff (administrators, supervisors, and home visitors). The MBSR evaluation will examine staff stress, coping, and mindfulness via a comprehensive quantitative measure (survey) and focus groups. A repeated measures design will be able to examine changes in staffs' perceptions of their stress levels and practices. The PMH evaluation will measure individual and organizational readiness as well as the characteristics that support diffusion of the PMH innovation for institutionalization and sustainability in PMH sites and also implementation into new sites and similar programs.

Finally, the iterative nature of the evaluation (updated as needed in response to emerging issues in home visiting, in communities, and feedback from participating program families, staff and state MIECHV team partners), our emphasis on a collaborative approach to evaluation (i.e., evaluators solicit research questions and feedback on evaluation results from program staff), and the inclusion of process evaluation for newer program components is consistent with empowerment evaluation. **Empowerment evaluation** supports continuous learning and adaptation based on changing conditions and continuous reflection on program data.

Dissemination of Evaluation Results

As many of the strategies employed in the competitive grant are innovations, timely dissemination of evaluation results is helpful; results can provide information to programs implementing the innovations/enhancements to help guide early implementation and adaptations through an iterative process, and results can also identify lessons learned to help guide replication or scale-up of the innovations. Thus, evaluation results will be disseminated via reports to FAHSC which are posted on the Florida MIECHV website (http://flmiechv.com/) and the USF MIECHV Evaluation website (miechv.health.usf.edu, URL: http://health.usf.edu/publichealth/chiles/miechv/). Additionally, evaluation results will be disseminated directly to Florida MIECHV providers, participants, and stakeholders via the monthly newsletter updates developed by FAHSC and short research briefs developed by the USF Evaluation Team. Finally, results will be presented at

local, statewide, and national conferences and disseminated via publication in peer-reviewed journals. These results will reflect the diversity of individual pilot sites and processes and will also provide a picture of the PMH innovation as a whole.

Strategy 2. Development & testing of coordinated intake & referral models using the state's universal prenatal and infant risk screens.

Strategy Overview

Florida MIECHV aims to improve coordination and collaboration among programs serving families with children age 0-3 at the state and local level, leveraging resources and linking parents to services most appropriate to their needs and preferences. Local Healthy Start Coalitions are given unique statutory responsibility for developing local systems of care in their communities. The state's prenatal and infant risk screens provide a foundation for local MCH systems, affording universal access to risk appropriate care and services. Coordinated systems of care reduce duplication of services while optimizing access to care. Effective systems foster collaboration and referrals between programs ensuring families receive the services they need when they need them[9][10][11]. Coordinated intake and referral offers a door through which families enter this system of care.

Florida MIECHV will partner with the state Title V agency to develop and test Coordinated Intake and Referral models with a group of Healthy Start Coalitions using the state's universal prenatal and infant risk screens. This project will be implemented using a Learning Collaborative approach. Participation by at least six diverse communities (rural, mid-size, and urban) will be solicited through an RFP process. Sites will be required to organize local teams comprised of the local Healthy Start Coalition, County Health Department, home visiting programs providing services in the community, and referral agencies. The six communities selected by FAHSC will receive support from Lisa Pelle, a consultant with extensive experience working with Healthy Start at the community level and expertise in quality improvement, planning, systems development and data analysis. The consultant will support the coalitions through regularly scheduled conference calls, webinars and face-to-face meetings (including a kick-off meeting of the Learning Collaborative); will work with Florida Department of Health for using state's universal prenatal and infant risk screens; and will participate in utilizing Plan-Do-Study-Act (PDSA) cycles to test model(s) in each community.

The proposed mixed methods process evaluation will describe the characteristics of the Learning Collaborative using the Consolidated Framework for Implementation Research (CFIR) and will document the success and challenges faced by the Learning Collaborative in integrating CI&R models into local systems of care, particularly in the context of Florida's universal prenatal and infant risk screens.

Evaluation Overview & Rationale

Multi-agency or multi-system coordinated intake systems have been developed for a number of community efforts to improve service delivery in health care systems,[12][13] health care provider knowledge management

[9] Tandon, Darius, et al. "Promotion of service integration among home visiting programs and community coalitions working with low-income, pregnant, and parenting women." *Health Promotion Practice 8.1* (2007): 79-87.

[10] McKnight, M., & Irvine, D. (2014). United Way and Success By 6: Growing Up with Collective Impact. *Collective Impact, 91*.

[11] Ramey, S. L., Schafer, P., DeClerque, J. L., Lanzi, R. G., Hobel, C., Shalowitz, M., ... & Raju, T. N. (2014). The preconception stress and resiliency pathways model: a multi-level framework on maternal, paternal, and child health disparities derived by community-based participatory research. *Maternal and Child Health Journal*, 19(4), 707-719.

[12] Awan, Saima and Loli-Dano, Laura and Zaretsky, Dr. Ari and Sokolov, Dr. Stephen and Ganguli, Dr. Rohan and Martin, Karen, Anxiously Waiting No More: Innovative Approach to Improving Access to Care and Decreasing Wait Times in the Mood Disorders Clinic (June 2012). Available at SSRN: http://ssrn.com/abstract=2263896 orhttp://dx.doi.org/10.2139/ssrn.2263896

systems,[14][15] and for community management of homelessness.[16][17] In the maternal and child health arena, systems development for centralized screening and referral has been underway for decades in newborn screening[18] and more recently for Child Find efforts[19] and through Help Me Grow initiatives.[20][21] Recent research in home visiting implementation has also focused on the processes and outcomes of coordinated intake and referral systems, with an increased focus on methodology,[22][23][24] replication, broad scale implementation and policy development.[25][26] Evaluations of these systems have included formative or process evaluations of the early stages of development and implementation (first 2 years of implementation) which include exploratory, descriptive, and sometimes case study designs and primarily qualitative methods to describe the background leading to the project, planning team members and agencies, and their processes for initiating the work, as well as baseline data collection. Coordinated systems efforts which have been in place over time have been evaluated with more of a focus on patient/client, provider, and system-level outcomes, including decreased wait times, increased satisfaction and service utilization, workflow efficiency, etc. These outcomes studies are able to rely on data collected over time.

FAHSC and Learning Collaborative teams will monitor the contribution of their model on enrollment patterns in their communities using measures such as timeliness of referrals, rate of successful engagement, retention and effect on enrollment and capacity of individual programs. The USF Evaluation Team will provide a context for these data by implementing a descriptive and exploratory systematic evaluation of CI&R Learning Collaborative efforts to develop and test their CI&R models, documenting successes and challenges in the early

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[13] Suter, E., Birney, A., Charland, P., Misfeldt, R., Weiss, S., Howden, J. S., ... & Marshall, D. (2015). Optimizing the interprofessional workforce for centralized intake of patients with osteoarthritis and rheumatoid disease: case study. S*urgery*, *8*, 10.

[14] Vaska, M., Aitken, E., Varney, J., & Stevens, S. (2014). Developing a Provincial Centralized Intake Process for a Knowledge Resource Service Part 1: Literature Search Requests. Journal of the Canadian Health Libraries Association/Journal de l'Association des bibliothèques de la santé du Canada,35(3), 124-127.

[15] Turner, M., & Vaska, M. (2015). Developing a Provincial Centralized Intake Process for a Knowledge Resource Service Part 2: Article Requests. Journal of the Canadian Health Libraries Association/Journal de l'Association des bibliothèques de la santé du Canada, 36(1), 24-26.

[16] Gardner, T. (2010). Centralized intake for helping people experiencing homelessness: Overview, community profiles, and resources. Cloudburst Group for the U.S. Department of Housing and Urban Development (HUD). Available at https://www.hudexchange.info/resources/documents/HPRP_CentralizedIntake.pdf

[17] Durham, C., & Johnson, M. (2014). Homelessness Prevention, Intake, and Shelter for Single Adults and Families. Urban Institute Online Publication. Available at ftp://timecard.urban.org/pubs_prod/2014/pdf/batch1/413060-nyc-homelessness-prevention.pdf

[18] Paul, A. K. (2011). Early identification of hearing loss and centralized newborn hearing screening facility-the Cochin experience. *Indian Pediatrics*, *48*(5), 355-359.

[19] Jackson, B. J., & Needelman, H. (2007). Building a System of Child Find Through a 3-Tiered Model of Follow-Up. *Infants & Young Children*, *20*(3), 255-265.

[20] Bogin, J. (2006). Enhancing developmental services in primary care: the Help Me Grow experience. *Journal of Developmental & Behavioral Pediatrics*, *27*(1), S8-S12.

[21] Dworkin, P. H. (2006). Historical overview: from ChildServ to Help Me Grow.*Journal of Developmental & Behavioral Pediatrics*, *27*(1), S5-S7.

[22] Hargreaves, M., Cole, R., Coffee-Borden, B., Paulsell, D., & Boller, K. (2013). Evaluating infrastructure development in complex home visiting systems.*American Journal of Evaluation*, *34*(2), 147-169.

[23] Mayfield, W. A., Keller, K. J., Zellmer, D. L., & Greever-Rice, T. (2013). Early Childhood Home Visiting Programs in Missouri: A Qualitative Assessment of the State System. Office of Social and economic Data Analysis Online Technical Report. Available at http://dss.mo.gov/cbec/pdf/cbec-home-visiting-assessment-final-report.pdf

[24] McCabe, B. K., Potash, D., Omohundro, E., & Taylor, C. R. (2012). Design and implementation of an integrated, continuous evaluation, and quality improvement system for a State-based home-visiting program. *Maternal and child health journal*, *16*(7), 1385-1400

[25] Duggan et al. (2013). Creating a national home visiting research network. *Pediatrics*, *132*, S82-S89. doi: 10.1542/peds.2013-1021F

[26] Adirim, T., & Supplee, L. (2013). Overview of the federal home visiting program. *Pediatrics*, *132*, S59-S64. doi: 10.1542/peds.2013-1021C

stages of implementation using methods and tools that can be replicated and generalized to other communities, and assist in compiling recommendations to the Florida Department of Health for implementing successful CI&R models statewide. Specifically, the evaluation of Objective 2 aims to describe each community team in the context of their community, and to gather their perceptions of the successes and challenges faced throughout the process of designing, implementing and testing CI&R tools to facilitate the identification and enrollment of high-need families in home visiting programs that best meet their needs and preferences.

A process evaluation will provide useful information applicable for other multi-site learning collaborative projects and for future CI&R implementation efforts. The structure of the process evaluation for the CI&R learning collaborative component is based on CFIR which, as described by the framework developer, "provides a pragmatic structure for approaching complex, interacting, multi-level, and transient states of constructs in the real world by embracing, consolidating, and unifying key constructs from published implementation theories."[27] (p1) This framework is a useful guide for formative evaluation research as it provides an organizational framework for synthesizing and building knowledge about what works in multiple settings.[28] As explained by Kilbourne et al., in describing the usefulness of this model for implementation research, "Adaptive implementation designs consisting of a sequence of decision rules that are tailored based on a site's uptake of an effective program may produce more relevant, rapid, and generalizable results by more quickly validating or rejecting new implementation strategies, thus enhancing the efficiency and sustainability of implementation research and potentially leading to the rollout of more cost-efficient implementation strategies."[29] In their large longitudinal clustered randomized control trial study, Kilbourne et al used CFIR constructs as covariates for implementation outcomes. As proposed in our evaluation, the CFIR framework has also been utilized for smaller community-based health and mental health implementation efforts and is amenable to qualitative, quantitative, or mixed methods.[30,31,32] CFIR has also been used in community settings for formative evaluation of early implementation of new interventions or approaches.[33,34]

Primarily, the formative evaluation will focus on the organizational-level (community teams) collaborative characteristics, perceptions, and processes. Selected constructs from CFIR and also group dynamics for the learning collaborative site teams will be used to guide measures (Appendix B). This evaluation component will

[27] Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implement Sci, 4*(1), 50.

[28] Damschroder, L. J., & Hagedorn, H. J. (2011). A guiding framework and approach for implementation research in substance use disorders treatment. *Psychology of Addictive Behaviors, 25*(2), 194.

[29] Kilbourne, A. M., Abraham, K. M., Goodrich, D. E., Bowersox, N. W., Almirall, D., Lai, Z., & Nord, K. M. (2013). Cluster randomized adaptive implementation trial comparing a standard versus enhanced implementation intervention to improve uptake of an effective re-engagement program for patients with serious mental illness. *Implementation Science, 8*(1), 1-14.

[30]Ament, S. M., Gillissen, F., Maessen, J. M., Dirksen, C. D., van der Weijden, T., & von Meyenfeldt, M. F. (2012). Sustainability of healthcare innovations (SUSHI): long term effects of two implemented surgical care programmes (protocol). BMC health services research, 12(1), 423.

[31] Damschroder, L. J., & Lowery, J. C. (2013). Evaluation of a large-scale weight management program using the consolidated framework for implementation research (CFIR). Implementation Science, 8(1), 51.

[32] Powell, B. J., Proctor, E. K., Glisson, C. A., Kohl, P. L., Raghavan, R., Brownson, R. C., Stoner, B. P., Carpente, C. R. & Palinkas, L. A. (2013). A mixed methods multiple case study of implementation as usual in children's social service organizations: study protocol. *Implementation Science, 8*(1), 92.

[33] English, M., Nzinga, J., Mbindyo, P., Ayieko, P., Irimu, G., & Mbaabu, L. (2011). Explaining the effects of a multifaceted intervention to improve inpatient care in rural Kenyan hospitals--interpretation based on retrospective examination of data from participant observation, quantitative and qualitative studies. Implementation Science, 6(1), 124.

[34] Connell, L. A., McMahon, N. E., Watkins, C. L., & Eng, J. J. (2014). Therapists' Use of the Graded Repetitive Arm Supplementary Program (GRASP) Intervention: A Practice Implementation Survey Study. Physical therapy, 94(5), 632-643.

contribute to the home visiting and family support knowledge base by testing a theoretical model for community change in the context of perinatal/early childhood systems. It is anticipated that identifying organizational and community characteristics and group dynamics related to community organizing and within the learning collaborative teams for generating systems change will inform future efforts for other programs and communities

Evaluation Design & Methods

This study will utilize a mixed-methods single group (nested in 6 communities) longitudinal study design, examining within group characteristics and perspectives at baseline and over time (2015-2017) among the CI&R team members in the participating communities. At least six communities will be selected from the 32 state designated Healthy Start Coalition areas through an RFP process (see Appendix C). At least half of the communities will include MIECHV home visiting projects. Additionally, consideration will be given to the size (number of births) and resources available in communities to ensure resulting recommendations can be brought to scale statewide. The evaluation will utilize a comprehensive CI&R Readiness survey, as well as focus groups conducted with CI&R teams at 3 statewide meetings. Survey items and focus group discussions will be based on CFIR constructs: perceptions of opportunities and challenges of CI&R system change within the context of individual, organizational, community characteristics; characteristics of the intervention; and learning collaborative group dynamics. Analyses will be largely descriptive, and will also examine similarities and differences between CI&R communities. Participants will be recruited from all Healthy Start Coalitions [HSC] CI&R sites, with invitation from all learning collaborative team members to participate. The sampling frame includes all members of the CI&R teams (estimated 5 per team, $n \geq 30$). Methods and measures for answering evaluation research questions are described below. The measures include constructs drawn from CFIR as applied to CI&R systems development in multiple communities using a learning collaborative approach (Appendices B and C). The team also drew guidance from the CFIR resource website developed by the CFIR Research Team at the Center for Clinical Management Research in Michigan, which includes descriptions of CFIR constructs and resources for instrument development (cfir.org). In keeping with the exploratory nature of this formative evaluation, seven broad research questions will be considered for Strategy 2:

- *What are community team members' perceptions, concerns and interactions within their collaborative that reflect group dynamics? Did these group dynamics show positive change over time?*
- *What are MIECHV CI&R community team members' individual characteristics (Agencies and service sectors, organizational roles, knowledge, beliefs, self-efficacy, etc.) that support implementation of CI&R development? Did these individual characteristics show positive change over time?*
- *How do the MIECHV CI&R teams identify and describe characteristics of the inner setting (organization/program) in their communities that serve as barriers or facilitators to organizational adoption of the CI&R models within their programs?*
- *How do the MIECHV CI&R teams identify and describe characteristics of the outer setting (community partners/state programs) in their communities that serve as barriers or facilitators to organizational adoption of the CI&R models within their programs?*
- *How do the MIECHV CI&R community teams identify characteristics of the CI&R models that will predict organizational and community adoption of the model within their programs?*
- *How do the MIECHV CI&R community teams create a timeline for implementation (planning, engaging, executing, reflecting and evaluating)?*
- *How do CI&R teams describe the successes and challenges encountered in the early stages of the CI&R model development process?*

Logic Model

Study Design and Implementation Diagram – Coordinated Intake & Referral

Phase 1

Prepare and pilot test interview questions with MIECHV evaluation team
(Team review, expert panel review, pilot test in paper format and online)

Phase II

Contact participating HS Coalitions via FAHSC with invitation to complete the survey. Survey link and paper copy provided via email (open for approximately 6 weeks with weekly/biweekly reminders to complete)

Participants review consent introduction and voluntarily take the survey

CI&R focus groups (Winter/Spring 2015/6, Fall 2016, Winter/Spring 2017),	**CI&R Survey (Winter/Spring 2015/6, Fall 2016)**
Topics covered: Demographic questionnaire Perceptions of opportunities and challenges of CI&R system change within the context of individual, organizational, community characteristics; intervention characteristics; and learning collaborative group dynamics	• Demographic questionnaire • CFIR Constructs

Phase III

Interview recordings professionally transcribed. Survey closed and data downloaded to SAS

MIECHV evaluation team reviews transcripts and field notes for accuracy. Data checked for accuracy, formatting

Interviews/focus groups are systematically coded and qualitatively analyzed, Demographic data are summarized. Descriptive and inferential analyses of survey results are conducted

Preliminary results reviewed by research team, quantitative and qualitative findings triangulated

Findings summarized and disseminated through reports, presentations, and manuscripts

Qualitative Methods

In the early stages of implementation (February, 2016 project kickoff), focus groups will be conducted with community teams to identify organizational characteristics and barriers to adoption of CI&R and perceptions of community partners/state programs characteristics that involved in the adoption of CI&R models. For example, participants will share their perceptions of the opportunities and challenges of CI&R system change within the context of individual, organizational (Inner Setting), community (Outer Setting) characteristics and characteristics of the intervention itself. Learning collaborative group dynamics will also be discussed. All participants at the kickoff will be invited to participate in discussion groups, and larger groups will be separated into smaller discussion groups of 10-15 participants. Because of the diversity of representation on each team, participants will not be stratified by organizational role; rather the larger group may be separated into smaller groups of 2-3 teams to facilitate all members' participation in discussions. Learning collaborative teams are created by local Healthy Start Coalitions and include, at minimum, representatives from each community's

Healthy Start Coalition, local Department of Health, Federal Healthy Start, MIECHV Program, Healthy Families Florida, Early Head Start, and others.

In Year 2, on-site focus groups at subsequent CI&R statewide meetings (**Fall 2016, Winter/Spring 2017**) will be conducted with community teams (as structured at the kickoff meeting described in the preceding paragraph) to gather members' perceptions of the CI&R models that they have reviewed/developed; including their assessment of the model strength and quality, relative advantage of utilization, adaptability, triability (the degree to which an innovation may be experimented with on a limited basis),[35] complexity, design, and direct and indirect costs. The community team members will also provide feedback on their suggested process and timeline for implementation. A focus group guide developed by the research team includes introduction and informed consent script, and questions and probes related to the above-mentioned constructs (Appendices B and C) (cfir.org). By the end of Year 1, this guide will be reviewed by content experts and pilot-tested with HSC members from non-CI&R sites.

Qualitative focus groups allow the research team to learn from members from each community team program (who have in-depth knowledge of the organization and community context) about organizational characteristics and barriers to adoption of CI&R and perceptions of community partners/state programs characteristics that could affect adoption of CI&R models. In year 2, focus group methods will allow the evaluation team to assess members' perceptions of the CI&R models and to provide feedback on their suggested process and timeline for implementation. Qualitative focus group methodology provides rich, in-depth information on how the individual community team members perceive factors associated with implementation and adoption of CI&R, and also how the collaborative group processes and discusses these issues (group function). The experience of focus group participation will also provide the opportunity for community team members to participate in the evaluation and contribute their unique insight, while facilitating group discussion of the components and issues they face in planning for CI&R.

Groups will consist of community team members, a facilitator, and a co-facilitator. Focus group facilitators consist of MIECHV Evaluation Team PI and Graduate Research Assistants who have been trained and experienced in focus group facilitation and qualitative research methods. Interviews and group discussions will be audio recorded using a digital voice recorder and transcribed.

Measure

Measure	**Description**	**Reference**
Focus Group Guides (Appendix F)	Focus groups conducted with CI&R sites at statewide meetings. Discussions based on CFIR Constructs: perceptions of opportunities and challenges of CI&R system change within the context of individual, organizational, community characteristics; characteristics of the intervention; and learning collaborative group dynamics	Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implement Sci*, *4*(1), 50.

Quantitative Methods

To minimize the burden of the evaluation on staff and to allow for quantitative analysis of factors associated with implementation and changes in these factors over time, an online survey will be used to collect individual

characteristics and perceptions of group dynamics for the CI&R teams. The anticipated sample size is approximately 60 CI&R team members (~10 per each of the 6 teams). Organizational role (Administrator, Supervisor, Home Visitor, Other), agency type, and location will be identified in the survey in order to compare baseline, within- and between-group differences by role and site. The CI&R Readiness Survey will be accessed through a secure web-based link (http://www.qualtrics.com/) prior to the 2016 CI&R kickoff meeting. Follow up surveys will be conducted approximately 9 months later. The survey collects information on individuals' perceptions of the group dynamics for their community team; because the community team approach in itself is innovative, and in order to compare and contrast these dynamics across sites and over time, a survey based on the Schulz, et al.[36] instrument will be utilized (Appendix D). Additionally, the CFIR framework recognizes individual characteristics that affect adoption of new approaches (such as CI&R); therefore the survey includes questions regarding community team members' individual characteristics (knowledge, beliefs, self-efficacy, etc.) related to implementation of CI&R development and how these may change over time. Since the individuals participating in the Learning Collaborative teams are likely to be the innovators and early adopters of a statewide model, understanding their individual characteristics and change over time will document the work of this component and can inform future efforts.

Because an existing validated survey is not available, a survey will be developed by the research team, using resources available at http://cfirguide.org/quant.html and existing literature. Survey development, pilot testing, and validation will take place during Fall/Winter of 2015. To maximize face and construct validity, the survey will be reviewed by an expert panel (researchers who have expertise in CFIR) and the MIECHV state team partners, then the research team will conduct cognitive interviews and pilot testing with a small sample of local community staff (not MIECHV staff) to examine test-retest reliability (using correlation coefficients).

The survey will be disseminated via email to all CI&R Healthy Start Coalition teams prior to the January 2016 Learning Session and will be available in paper at the session for any who did not complete the survey prior. As there is no existing data on the proposed characteristics as measured within CFIR, a research-informed effect size is not available for pre-post change scores; the results are observational and descriptive.

Measure

Measure	Description	Reference
CI&R Readiness Survey (Apppendix B)	Developed by team using Consolidated Framework for Intervention Research (CFIR) constructs http://cfirguide.org/quant.html	Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implement Sci*, *4*(1), 50.

Qualitative & Quantitative Analysis Plan

Qualitative data will be analyzed using qualitative data analysis software, such as Atlas.ti or MAXQDA. Prior to analysis, the evaluation team will develop a flexible *a priori* codebook, which will contain initial codes based on the questions and topics in the focus group guide. Data will be analyzed using a grounded theory approach to identify emergent themes and the constant comparative method through open, selective, and axial coding (using both emergent and *a priori* codes) to develop a theoretical understanding and description of CI&R

[36]Schulz, Amy J., Barbara A. Israel, and Paula Lantz. "Instrument for evaluating dimensions of group dynamics within community-based participatory research partnerships." Evaluation and Program Planning 26.3 (2003): 249-262.

perceptions and processes. At least two coders will code each transcript until an appropriate level of agreement (80% percent agreement or kappa) is reached[37]. Emergent codes will be added to the codebook as appropriate

The analytic plan for quantitative measures will include examination of survey results in the aggregate, stratification and t-test or chi-square to examine comparisons between community team sites in individual, community team group (averaged scores), and organizational characteristics, changes over time for repeated measures, and psychometric analysis of the survey itself (e.g. construct and discriminant validity, reliability). Multilevel/hierarchical models will account for within-group clustering effects as well as within-subject variation over time. Qualtrics data will be downloaded directly into SAS or SPSS analysis software. Survey data will be analyzed with appropriate techniques for each question, based on the chosen operational definitions (including composite variables) and type of comparison group (i.e., cohort-wide or by site). To illustrate this, Cronbach's alpha will be used for construct validity; the intra-class correlation coefficient for test-retest reliability of continuous variables and kappa statistic for test-retest reliability of categorical variables. The analytic methods for each research question are given below.

Analyses for CI&R Learning Collaboratives Process Evaluation

Research Question	Data Source	Analyses
What are community team members' perceptions, concerns and interactions within their collaborative that reflect group dynamics? Did these group dynamics show positive change over time?	Focus group guide CI&R Readiness Survey	Grounded theory/Constant Comparison T-test: Baseline differences in mean scores between CI &R teams Multilevel/hierarchical models to examine changes over time
What are MIECHV CI&R community team members' individual characteristics (Agencies and service sectors, organizational roles, knowledge, beliefs, self-efficacy, etc.) that support implementation of CI&R development? Did these individual characteristics show positive change over time?	Focus group guide CI&R Readiness Survey	Grounded theory/ Constant Comparison Y2 selective coding/constant comparison T-test: Baseline differences in mean scores between CI &R teams Multilevel/hierarchical models to examine changes over time
*How do the MIECHV CI&R teams identify and describe characteristics of the **inner** setting (organization/program) in their communities that serve as barriers or facilitators to organizational adoption of the CI&R models within their programs?*	Focus group guide CI&R Readiness Survey	Grounded theory/ Constant Comparison Descriptive statistics (aggregated averaged scores and stratified by team) and t-test or chi-square to examine comparisons between community teams and predictive models (logistic or linear regression) to examine factors associated with higher levels of readiness or implementation.
*How do the MIECHV CI&R teams identify and describe characteristics of the **outer** setting (community partners/state programs) in their communities that serve*	Focus group guide CI&R Readiness Survey	Grounded theory/ Constant Comparison Descriptive statistics (aggregated averaged scores and stratified by team) and t-test or

[37] McHugh, M. L. (2012). Interrater reliability: the kappa statistic. Biochemia Medica, 22(3), 276-282.

as barriers or facilitators to organizational adoption of the CI&R models within their programs?		chi-square to examine comparisons between community teams and predictive models (logistic or linear regression) to examine factors associated with higher levels of readiness or implementation.
How do the MIECHV CI&R community teams identify characteristics of the CI&R models that will predict organizational and community adoption of the model within their programs?	Focus group guide CI&R Readiness Survey	Grounded theory/ Constant Comparison Descriptive statistics (aggregated averaged scores and stratified by team) and t-test or chi-square to examine comparisons between community teams and predictive models (logistic or linear regression) to examine factors associated with higher levels of readiness or implementation.
How do the MIECHV CI&R community teams create a timeline for implementation (planning, engaging, executing, reflecting and evaluating)?	Focus group guide CI&R Readiness Survey	Grounded theory/ Constant Comparison, Y2 selective coding/constant comparison Descriptive statistics (aggregated averaged scores and stratified by team)
How do CI&R teams describe the successes and challenges encountered in the early stages of the CI&R model development process?	Focus group guide CI&R Readiness Survey	Grounded theory/ Constant Comparison, Y2 selective coding/constant comparison Descriptive statistics (aggregated averaged scores and stratified by team)

Potential Risks, Anticipated Challenges

The major challenges to conducting this subcomponent study relate to 1) analytic limitations that may arise from small sample size, and 2) difficulty in detecting changes over time should baseline measures initially be reported as high. In this case, statistical models based on Bayesian approach may be used since Bayesian inference can give unbiased estimates even in case of small sample size. Additionally, participants will be encouraged to fill out the survey as truthfully and accurately as possible to minimize social desirability response bias which could inflate pre-assessment scores. Examining changes over time is challenging in a single group (cohort) study such as this because the study design does not allow the evaluation team to determine to what extent baseline characteristics or changes over time are unique in CI&R learning collaborative members versus those who are not; nor can changes over time be attributable to the learning collaborative process. There is also an inherent selection bias, as the CI&R pilot sites will likely be those with more positive attitudes, capacity, and community readiness (inner and outer setting) than those not selected as pilots. However, as this is a process evaluation, understanding the individual, organizational, and community-level characteristics in the context of systems change, including participants' interpretation of these factors as barriers or facilitators will be still be informative and useful.

Furthermore, a strength of the mixed methods study design of this component is the use of triangulation of results to strengthen the analysis, by a.) using qualitative results to identify survey items that may need to be added or modified, or clarified; b.) using qualitative results to enrich or explain survey results; c.) using survey findings to examine potential generalizability of qualitative themes; d.) comparing findings from the quantitative and qualitative studies to enhance data interpretation; e.) using the strengths of each method to

answer their corresponding research questions (i.e. using survey to quantify and compare characteristics of individuals and their organizations/systems at baseline and over time, and using focus groups to understand the meaning that participants assign to these characteristics); and finally f.) to allow participants to contribute to the validity and usefulness of the survey analysis by reflecting on results and adding their own interpretive lens through focus group discussions.[38] Specifically, the research team will compile quantitative findings from the pre-assessment survey and identify or clarify points of discussion in the focus groups (e.g. unexpected, contrasting, and general survey results). The focus groups offer an opportunity to enrich the findings from the survey (e.g. add more context) as well as help to explain or clarify results. Additionally, the focus group results will be reviewed in conjunction with pre-assessment survey before the administration of the post-assessment survey, in case items need to be added. Thus, the approach is iterative.

Strategy 3 (Objective 3): Evidence-based parental mental health overlay

Strategy, Evaluation Overview & Rationale

This strategy aims to address depression, stress, substance abuse and/or trauma in high-need families by providing evidence-based mental health and psycho-educational services to at least 300 high-need families enrolled in MIECHV-funded home visiting programs. This cross-model program enhancement of adding evidence based parental mental health (PMH) interventions to existing home visiting programs is an important innovation. This innovation to existing home visiting programs is designed to treat or prevent depression, or provide psycho-educational support to families impacted by substance use and trauma. Depression is considered the most common mental illness with estimated prevalence rates varying from 1.7%[39] to 20.9% [40] in community and clinical samples in a 12-month period. In one sample of over 5,000 parents in the Early Childhood Longitudinal Study, 14% of mothers and 10% of fathers exhibited depressive symptoms based on CES-D results.[41] Florida MIECHV currently serves about 980 families monthly, it is estimated that about one-third of families enrolled would be served by the proposed mental health overlay because of depression, substance-abuse and trauma based on state and national prevalence rates. The current prevalence of depression among FL MIECHV participants based on Edinburgh scores is approximately 25%, and self-reported current or past substance abuse and maltreatment rates among FL MIECHV mothers were 33% and 36%, respectively. Research shows that depression is most common amongst the female population where women are 50% more likely to experience depression than men[42] and pregnant women are found to have increased risk of developing depressive episodes during prenatal, perinatal and postnatal periods. Experiencing these episodes poses major risk for both mother and child during all states of gestation and eventual birth.[43,44]

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[38] Fielding, N. G. (2012). Triangulation and Mixed Methods Designs Data Integration With New Research Technologies. Journal of Mixed Methods Research, 6(2), 124-136.

[39] Weissman MM, Livingston Bruce M, Leaf PJ, Florio LP, Holzer CI. Affective disorders. In: Robins LN, Regier DA, eds. *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study*. New York, NY: The Free Press; 1991:53-80

[40] Zung, W.W., Broadhead, W.E, Roth, M. E. (1993). Prevalence of depressive symptoms in primary care. *The Journal of Family Practice*, *37*(4), 337-344.

[41] Paulson, J.F., Dauber, S., & Leiferman, J.A. (2006). Individual and combined effects of postpartum depression in mothers and fathers on parenting behavior. *Pediatrics*, *118*(2), 659-668.

[42] Kessler, R.C. (2003). Epidemiology of women and depression. *Journal of Affective Disorders*, *74*(1), 5-13. DOI:10.1016/S0165-0327(02)00426-3.

[43] Bennett, H. A., Einarson, A., Taddio, A., Koren, G., & Einarson, T. R. (2004). Prevalence of depression during pregnancy: systematic review. *Obstetrics & Gynecology*, *103*(4), 698-709.

[44] Murray, L., & Cooper, P. J. (1997). Effects of postnatal depression on infant development. *Archives of Disease in Childhood*, *77*(2), 99-101. *DOI:10.1136/adc.77.2.99.*

With the significant prevalence of depression, and the fact that depression is considered one of the leading causes of disease related disability globally[45], attenuation of symptoms has potential to impact many domains. Specific to maternal and child health, decreasing the symptom severity of depression has been demonstrated to positively impact parenting practices and familial relationships[46,47] as well as increased involvement in desired and obligatory activities as the symptom anhedonia, i.e. lack of desire to engage in activities, remits. This remittance could in turn positively impact participant enrollment, engagement and retention.

Similarly, substance abuse in and around pregnancy affects the health of both the mother and baby, and is frequently a marker for underlying trauma. According to national surveys, about 5% of pregnant women age 15-44 admit to using illicit drugs while 9.4% report current alcohol abuse, including 2.3% who admit to binge drinking.[48] Factors that increase a woman's susceptibility to substance abuse problems include life stressors, poor coping skills, limited social support systems, easy access to alcohol and illicit substances, previous traumatic crises, and identity/self-esteem problems.[49] Many substance abusing women experience comorbid conditions, most commonly depression.[50],[51]

Considering the aforementioned impact for mother, child and family, it is imperative to address this major public health issue by assessing the ability of the home visiting site to appropriately intervene in instances of parental mental health problems. FAHSC will have selected evidence-based mental health interventions that can be appropriately implemented as an "overlay" to home visiting models currently implemented in Florida and will implement a RFP process to contract and fund up to nine MIECHV sites. A range of models for integrating mental health services are available and cover the spectrum from prevention to psycho-social education and intensive therapy including Moving Beyond Depression™[52], the Mothers and Babies Course[53], and Seeking Safety[54]. While FAHSC monitors implementation of these models within the mental health overlay and works with new sites to identify sustained funding after the project period, the USF Evaluation Team will conduct a process evaluation to identify factors that support long-term implementation/institutionalization and expansion to other sites (diffusion into other home visiting programs) of parental mental health programs in general. USF

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[45] Murray, C.J.L., & Lopez, A.D. (Eds.), The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020, Harvard University Press, Boston (1996), pp. 325–395.
[46] Eisenberg, N., Fabes, R. A., & Spinrad, T. L. (2006). Prosocial development. In W. Damon, R. M. Lerner, & N. Eisenberg (Eds.), Handbook of child psychology: Vol. 3. Social, emotional, and personality development (6th ed., pp. 646–718). New York, NY: Wiley.
[47] Moreland, A., & Dumas, J. (2007). Evaluating child coping competence: Theory and measurement. Journal of Child and Family Studies, 17(3), 437–454.
[48] Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
[49]Wilson, J, Thorp, Jr., J, Glob. libr. women's med., (ISSN: 1756-2228) 2008; DOI 10.3843/GLOWM.10115 accessed online at: http://www.glowm.com/section_view/heading/Substance%20Abuse%20in%20Pregnancy/item/115.
[50] Connelly, C. D., Hazen, A. L., Baker-Ericzén, M. J., Landsverk, J., & Horwitz, S. M. (2013). Is screening for depression in the perinatal period enough? The co-occurrence of depression, substance abuse, and intimate partner violence in culturally diverse pregnant women. Journal of Women's Health, 22(10), 844-852.
[51] Illangasekare, S., Burke, J., Chander, G., & Gielen, A. (2013). The syndemic effects of intimate partner violence, HIV/AIDS, and substance abuse on depression among low-income urban women. Journal of Urban Health, 90(5), 934-947.
[52] Ammerman, R. T., Putnam, F. W., Teeters, A. R., & Van Ginkel, J. B. (2014). Moving beyond depression: A collaborative approach to treating depressed mothers in home visiting programs. *Addressing Maternal Depression in Home Visiting Programs: Current Issues and Innovative Approaches. RT Ammerman and S. Powers (Eds.), Zero to Three*, *34*, 20-27.
[53] Muñoz, R. F., Le, H. N., Ippen, C. G., Diaz, M. A., Urizar, G. G., Soto, J., Mendelson, T., Delucchi, K., & Lieberman, A. F. (2007). Prevention of postpartum depression in low-income women: Development of the Mamás y Bebés/Mothers and Babies course. *Cognitive and Behavioral Practice*, *14*(1), 70-83.
[54] Najavits, L. M. (2002). Seeking Safety: A treatment manual for PTSD and substance abuse. New York, NY: Guilford.

will also gather qualitative feedback from program staff in those sites on their perceptions of the intervention related to their acceptability, retention, and engagement in their clients (feasibility and acceptability of the mental health overlay from the client perspective as perceived by the MIECHV program staff).

Thus, the process evaluation for the evidence-based parental mental health (PMH) component of the grant utilizes Diffusion of Innovations (DOI) Theory as the overarching framework (Appendix G). DOI is a social science theory that explains how a new idea or program gains support and "diffuses" into a specific community, ultimately leading to the adoption of the new idea or program, otherwise known as an innovation. The key to adoption of an innovation is that the individual or organization must consider the innovation to be new and different in comparison to how the process was done before.[55,56] Adoption of an innovation does not happen at the same rate among all people in the population. There are five established adopter categories used in strategies to promote the adoption of an innovation in the population, which include: Innovators (willing to experience new ideas); Early Adopters (likely to hold leadership positions and are comfortable with adopting new ideas); Early Majority (adopt new ideas before the average person); Late Majority (adopt new ideas after it has already been tried by the majority of the population); and Laggards (skeptics of change).[57,58] The stages by which a person adopts an innovation to achieve diffusion include: knowledge of the existence of the innovation; persuasion to form positive or negative opinions about adopting the innovation; decision to accept or reject the innovation; implementation of the innovation; and confirmation to reinforce or reject the decision made.[59,60]

There are five main factors that influence the adoption of an innovation: relative advantage (why the innovation is superior); compatibility (how the innovation matches needs); complexity (how difficult the innovation is to use); trialability (the ability to experiment and try the innovation); and observability (the ability to observe results.[61,62] Adding evidence-based mental health components to current practices is considered an innovation to the program. By using the DOI Theory, we will be able to conduct a thorough process evaluation, which will allow us to determine how well the evidence-based mental health components were implemented and factors that influenced the adoption of the new components (perceived relative advantage, compatibility, complexity, trialability, and observability) (see Appendices E and F).

A cross-sectional design will compare the initial sites selected for PMH with non-PMH sites at baseline, then a longitudinal repeated measures design will be used to examine changes over time (at three time points) among staff at PMH sites. The results of the cross-sectional component of this study may help to determine whether there are differences in readiness to adopt the innovation between the two groups, perhaps indicating how the PHM and non-PHM sites differ in organizational and individual characteristics. Additionally, differences in change scores among staff over time may help us to measure the influence of training and support provided to PMH sites on individual and organizational readiness and their adoption of the intervention.

[55] Rogers, E.M. (2003). Diffusion of Innovations, 5. New York: Free Press.
[56] Sahin, I. (2006). Detailed review of Rogers' Diffusion of Innovations Theory and educational technology-related studies based on Rogers' theory. The Turkish Online Journal of Educational Technology, 5(2), 14-23.
[57] Rogers, E.M. (2003) op cit.
[58] Sahin, I. (2006) op cit.
[59] Rogers, E.M. (2003) op cit.
[60] Sahin, I. (2006) op cit.
[61] Rogers, E.M. (2003) op cit.
[62] Sahin, I. (2006) op cit.

The process evaluation will examine the adopter category (innovators, early adopters, early majority, late majority, laggards), stage of adoption (knowledge, persuasion, decision, implementation, confirmation), perceptions of the innovation characteristics (e.g. relative advantage, compatibility, complexity, trialability, observability, etc.), and factors/characteristics (e.g. background, knowledge, attitudes, beliefs, self-efficacy, social/professional norms & roles, etc.) influencing adoption among home visitors, supervisors, and administrators at all Florida MIECHV sites. This evaluation component contributes to the home visiting knowledge base by demonstrating how a DOI model can be used to measure implementation of innovations into home visiting programs and communities. DOI provides a framework for a variety of innovations; therefore, as home visiting develops new cross-model components or strategies, or implements program improvements, the DOI framework can be useful.

Research Questions for Parental Mental Health Process Evaluation

1) *At what level of readiness are Florida MIECHV administrators, supervisors, and staff, for institutionalizing PMH interventions into their current practice (among all FL MIECHV sites, as well as PMH pilot sites as compared to those at non-PMH sites)?*
    a. *Did those perceptions for PMH pilot sites change over time?*
2) *What are the individual characteristics (background, knowledge, attitudes, beliefs, self-efficacy, social/professional norms and roles) of administrators, supervisors, staff, and program participants among all FL MIECHV sites, as well as PMH pilot sites as compared to those at non-PMH sites?*
    a. *Did those perceptions for PMH pilot sites change over time?*
3) *What are the Florida MIECHV administrators', supervisors', and staffs' perceptions of MIECHV PMH intervention implementation and institutionalization (relative advantage, compatibility, complexity, trialability, observability) among all FL MIECHV sites, as well as PMH pilot sites as compared to those at non-PMH sites?*
    a. *Did those perceptions for PMH pilot sites change over time?*
4) *What are the perceptions of administrators, supervisors, and staff at MIECHV PMH overlay pilot sites regarding the feasibility and acceptability of implementing/participating in the PMH overlay?*

Methods

The PMH Readiness Survey will be disseminated to all Florida MIECHV staff (both PMH and non-PMH implementation sites) at baseline, and all staff will be encouraged to complete the survey (approximately 80 total staff). Disseminating the survey to all sites will determine the readiness of Florida MIECHV statewide for PMH implementation, including sites that were selected through the RFP process, as well as sites who applied and were not selected, and those who did not respond to the RFP. Data analyses, described below, will compare these groups. The post-assessment and follow-up surveys will be administered only to the PMH sites; a pre-post analysis will examine changes over time in individual and organizational readiness following the first year of implementation. For repeated measures, data will be analyzed using linear mixed effect models.

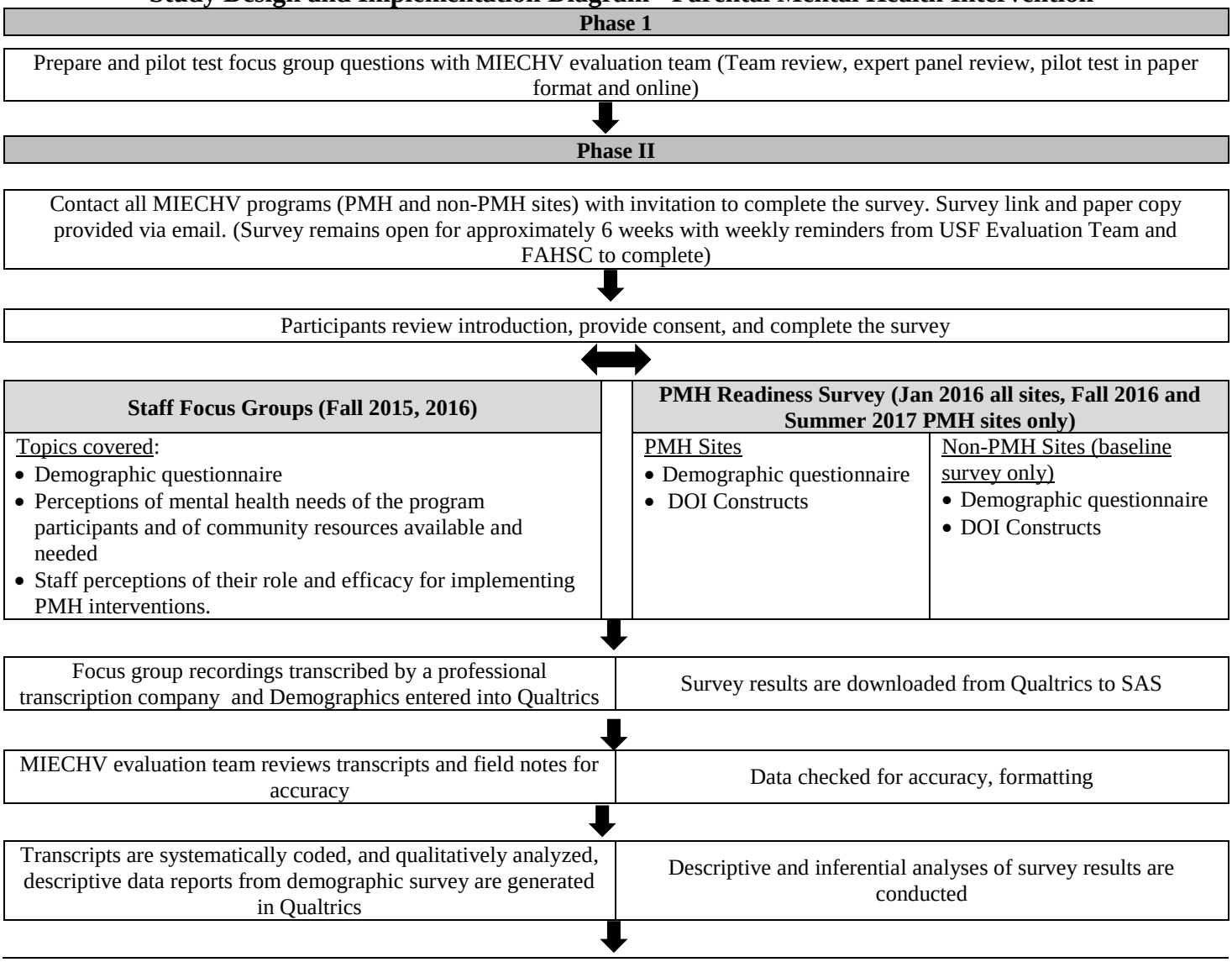
To assess the process (feasibility and acceptability) of implementing the selected PMH intervention (including participant engagement and retention in home visiting), specific questions will be asked of PMH sites during Fall 2016 site visit focus groups conducted with all staff at each site (See Appendix F). Focus groups will be scheduled at each MIECHV site at a time and day convenient for all staff to attend. Administrators and supervisors will participate in one group, and home visitors will participate in a separate group, with questions tailored more closely to their role (Appendix F). Qualitative research relies on a systematic and iterative process throughout data collection and analysis; therefore it is a challenge to determine *a priori* the minimum number of

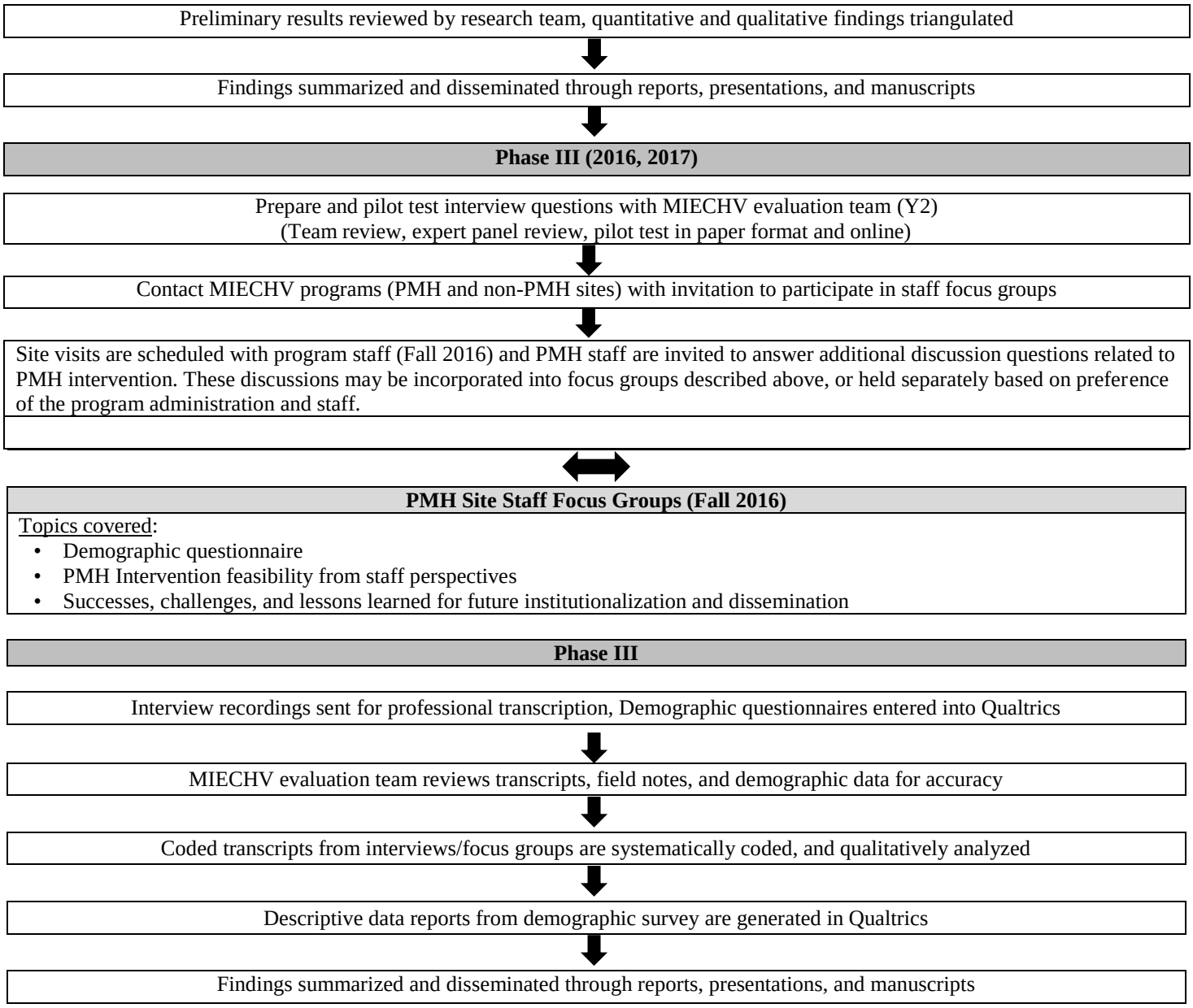
participants needed to reach theoretical saturation; however, in this case all MIECHV staff participate (approximately 30 administrators/supervisors and 50 home visitors) are invited to participate

Focus groups will be conducted by MIECHV Evaluation Team PI and Graduate Research Assistants who have been trained and are experienced in focus group facilitation and qualitative research methods. A focus group guide developed by the research team and content experts includes introduction and informed consent script, and questions and probes related to the above-mentioned constructs (Appendix F). The focus group guide will also be pilot tested with members of the research team before utilization with evaluation participants. Participants have the opportunity to discuss their perceptions of MIECHV participant mental health needs as well as PMH implementation and institutionalization (feasibility and acceptability, and perceptions of the relative advantage, compatibility, complexity, trialability, observability) in the context of implementing the broader set of MIECHV program goals and objectives and the activities specific to each home visiting model (Nurse Family Partnership, Healthy Families Florida, Parents as Teachers).

Logic Model

Study Design and Implementation Diagram - Parental Mental Health Intervention





Measures

The Parental Mental Health Intervention Organizational Readiness Survey (Appendix H) will address PMH intervention adoption among Florida MIECHV home visitors, supervisors, and administrators at pilot and non-pilot sites. This survey was designed by the Lead Evaluator, based on the constructs from Diffusion of Innovation Theory [63][64] including a systematic review which identified 62 structural, organizational, provider, patient, and innovation level measures that have been used for implementation research.[65] The PMH

[63] Rogers, E. M. (2004). A prospective and retrospective look at the diffusion model. *Journal of Health Communication*, *9*(S1), 13-19.

[64] Sahin, I. (2006). Detailed Review of Rogers' Diffusion of Innovations Theory and Educational Technology-Related Studies Based on Rogers' Theory. *Online Submission*, *Turkish Online Journal of Educational Technology*, *5*(2).

[65] Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: systematic review and recommendations. Milbank Quarterly, 82(4), 581-629.

Intervention Organizational Readiness Survey was adapted from a measure used in the Hillsborough County Infant Mental Health Uniting Grant Evaluation (Marshall, not published, see Infant Mental Health section at http://www.ecctampabay.org/).

To minimize the burden of the evaluation on staff and to allow for quantitative analysis of factors influencing implementation and changes in these factors over time, online surveys will be accessed through a secure web-based link (http://www.qualtrics.com/). Survey development, pilot testing, and validation will take place during Fall/Winter of 2015. To maximize face and construct validity, the survey will be reviewed by an expert panel from USF and the MIECHV state team partners, then the research team will conduct cognitive interviews and pilot testing with a small sample of local community staff (not MIECHV staff) to examine test-retest reliability (using Pearson's correlation coefficients). Parental Mental Health Intervention Organizational Readiness Survey will be distributed at approximately 10 months, 20 months, and 26 months post-award (January 2016, November 2016, and May 2017).

Measure	Description	References
PMH Readiness Survey (Appendix H)	Designed by research team – based on Diffusion of Innovation Theory (Rogers, 2003; Sahin, 2006) adapted from measure used in Hillsborough County Infant Mental Health Uniting Grant Evaluation (Marshall, not published)	Rogers, E. M. (2004). A prospective and retrospective look at the diffusion model. *Journal of Health Communication, 9*(S1), 13-19. Sahin, I. (2006). Detailed Review of Rogers' Diffusion of Innovations Theory and Educational Technology-Related Studies Based on Rogers' Theory. *Online Submission, Turkish Online Journal of Educational Technology, 5*(2). Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: systematic review and recommendations. Milbank Quarterly, 82(4), 581-629.
Focus Group Guides (Appendix F)	Discussion of the mental health needs of participating families and the resources available will be built into Fall site visit focus groups.	n/a

Analysis Plan

The analytic plan for quantitative measures will include examination of survey results in the aggregate, comparisons across community team sites in individual, community team group, and organizational characteristics, changes over time for repeated measures, and analysis of the survey itself (e.g. construct and discriminant validity, reliability). Survey data will be analyzed with appropriate techniques for each question, based on the chosen operational definitions, measurement tools, and type of comparison group (i.e., cohort or individual). To illustrate this, Cronbach's alpha will be used for construct validity; the intra-class correlation coefficient for test-retest reliability of continuous variables, and kappa statistic for test-retest reliability of categorical variables. Analysis of Variance (ANOVA) will be used to compare overall means between programs at baseline. Changes over time among will be examined using linear mixed effects models. The Evaluation Team will prepare and provide reports to the PMH sites and FAHSC at regular periodic intervals. Follow up surveys will be conducted 6 months following post-assessment. The analytic method/s for each research question are given below.

Analysis of transcripts will be conducted through a multi-phase process. Prior to analysis, the Evaluation Team will develop a flexible a priori codebook, which will contain initial codes based on the questions and topics in the interview guide. As the research team reviews transcripts for accuracy, the content is reviewed for pre-identified and, consistent with a grounded theory approach, emergent codes or themes and unexpected or

particularly salient quotes. Then, systematic coding is conducted using software, such as Atlas.ti. Data will be analyzed using the constant comparative method within the grounded theory approach, to develop and describe PMH implementation processes and perceptions. At least two coders will code each transcript until an appropriate level of agreement is reached. Emergent codes will be added to the codebook as appropriate. Additionally, coded segments will be examined and compared among the three possible groups to determine if there were overarching differences in the perceptions expressed by 1) PMH sites, 2) non-PMH sites that responded to the RFP, and 3) non-PMH sites that did not respond to the RFP.

Analyses for PMH Process Evaluation

Research Question	Data Source	Analyses
At what level of readiness are Florida MIECHV administrators, supervisors, and staff, for institutionalizing PMH into their current practice (among all FL MIECHV sites, as well as PMH pilot sites as compared to those at non-PMH sites)? *-Did those perceptions for PMH pilot sites change over time?*	PMH Intervention Readiness Survey	T-test/ANOVA: Baseline differences in overall mean scores as well as for each item measuring level of readiness among all sites, as well as comparing PMH sites to non-PMH sites at baseline. Linear mixed effects models to examine changes over time for PMH sites.
What are the individual characteristics (background, knowledge, attitudes, beliefs, self-efficacy, social/professional norms and roles) of administrators, supervisors, staff, and program participants among all FL MIECHV sites, as well as MIECHV PMH overlay pilot sites related to PMH implementation in their current practice as compared to those at non-PMH sites? *-Did those perceptions for PMH pilot sites change over time?*	PMH Intervention Readiness Survey	T-test/ANOVA: Baseline differences in overall mean scores among all sites, as well as comparing PMH sites to non-PMH sites as well as for each individual characteristic . Linear mixed effects models to examine changes over time for PMH sites.
What are the Florida MIECHV administrators', supervisors', and staffs' perceptions of MIECHV PMH implementation and institutionalization (relative advantage, compatibility, complexity, trialability, observability) among all FL MIECHV sites, as well as MIECHV PMH overlay pilot sites as compared to those at non-PMH sites? *-Did those perceptions for PMH pilot sites change over time?*	PMH Intervention Readiness Survey	T-test/ANOVA: Baseline differences in overall mean scores as well as for each item measuring perceptions of MIECHV PMH implementation and institutionalization among all sites, as well as comparing PMH sites to non-PMH sites Linear mixed effects models to examine changes over time for PMH sites.
What are the perceptions of administrators, supervisors, and staff at MIECHV PMH overlay pilot sites regarding the feasibility and acceptability of implementing/participating in the PMH overlay?	Focus Group Guide	Grounded theory

Potential Risks, Anticipated Challenges

One major challenge in this study design is that there is an inherent selection bias due to the RFP process; PMH pilot sites may be those with more positive attitudes, capacity, and community readiness (inner and outer

setting) than those not selected as pilots. However, as this is a process evaluation, those differences in characteristics at baseline will still be informative to the state in determining readiness for future sites. Longitudinal analysis will be examined only for PMH sites as it would be expected that changes over time would be larger for those individuals at implementation sites as their comfort level with PMH increases with training and experience. The PMH and non-PMH sites will also not be compared over time as there is likely to be contamination between PMH and non-PMH sites as information about successes and challenges of the implementation are shared through statewide meetings and calls and also due to the availability of training for all sites.

A general concern is that some level of social desirability response bias is anticipated. Participants may be reluctant to discuss their personal experiences with the mental health component due to their personal stake in the project (e.g. funding, access to services). Specifically, staff may be reluctant to discuss challenges related to implementation if they perceive they could lose program funding, or could be seen by supervisors or /administrators as unwilling employees. Our strategy to maximize the validity of our data is to reassure staff of our positive intentions, assure and reassure confidentiality, and to collect both positive and negative responses. We have had two years of evaluation experience with providers and perceive that trust has been built over that time.

Strategy 3 (Objective 4): Mindfulness training for MIECHV staff

Strategy Overview

This strategy aims to reduce stress among home visiting staff. Depression and stress not only impact families enrolled in home visiting programs, but also affect home visitors themselves.[66] This stress can lead to professional burn-out, contributing to staff attrition. Work in the early childhood education sector points to the potential of Mindfulness-Based Stress Reduction (MBSR) in providing staff with personal resources that will reduce their stress as well as enable them to more effectively engage with children and families.

MBSR has a base in mindfulness. Mindfulness as a construct is considered the ability to engage in the cognitive, present-centered awareness of one's internal and external surroundings in a non-judgmental manner[67,68]. Regular engagement in mindfulness yields an awareness of how behaviors, habitual and automatic in nature, often lead to states of emotional distress (i.e., stress, anxiety, depression, etc.). MBSR then utilizes the principles of mindfulness in a non-religious group format and incorporates practices, specifically meditation and yoga, to enhance one's ability to focus on the present[69]. Upon developing this present-centered focus, practitioners of mindfulness are able to reduce the automatic behaviors and habits related to the occurrence of negative emotionality resulting in the alleviation of said emotional distress and devise more appropriate manners to cope. [70,71] Research indicates that MBSR can aid diverse individuals with emotional distress that is both clinical and non-clinical, as well as provide coping strategies to appropriately deal with varying levels of

[66] Gill, S., Greenberg, M.T., Moon, C., & Margraf, P. (2007). Home visitor competence, burnout, support, and client engagement. *Journal of Human Behavior in the Social Environment, 15(1),* 23-44.
[67] Langer, E. J., & Moldoveanu, M. (2000). The construct of mindfulness. *Journal of Social Issues, 56*(1), 1-9.
[68] Marmorstein, N. R., Malone, S. M., & Iacono, W. G. (2014). Psychiatric disorders among offspring of depressed mothers: associations with paternal psychopathology. American Journal of Psychiatry.
[69] Grossman, Niemann, Schmidt, & Walach, 2003 • Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of Psychosomatic Research, 57*, 35-43.
[70] Linehan, M. M. (1994). Acceptance and change: The central dialectic in psychotherapy. In S. C. Hayes, N. S. Jacobson, V. M. Follette, & M. J. Dougher (Eds.), *Acceptance and change: Content and context in psychotherapy* (pp. 73–86). Reno, NV:Context Press.
[71] Teasdale, J. D. (1999). Metacognition, mindfulness and the modification of mood disorders. Clinical Psychology and Psychotherapy, 6, 146–155.

stress and emotional distress associated with normative life experiences and severe physical or mental illness. [72] MBSR has also been utilized to reduce stress and burnout among health care providers.[73,74,75]

As part of the competitive grant, FAHSC will provide MBSR Training (developed by University of Florida (UF) Health Center for Integrative Medicine) to at least 50 MIECHV home visitors and supervisory staff via one MBSR introductory workshop, followed by an eight week web-based training program, with conference call follow-up as needed. Two cohorts of 25 staff will self-select to participate in the training. Each cohort will attend an introductory in-person workshop. The web-based training will be an adaptation of a web-based training developed by UF for ICU staff. Minor adaptations to the web-based trainings will be made during the Winter of 2015, to reflect the experience of home visiting staff. The training also includes additional support or consultation in their implementation of stress reduction techniques, due to their varying levels of uptake based on skills and maybe even prior exposure to relaxation techniques. The program implemented by UF Health Center for Integrative Medicine has not been adapted for home visitors prior to this project, however the structure of the UF Health Center for Integrative Medicine training is based on similar programs that have had positive results[76,77,78]

Through a sustained process of self-development that includes 30-45 minutes of daily home practice assignments, program participants will receive instructions designed to provide a set of tools for mobilization of their deep inner resources for learning, growing, and healing, and for taking care of themselves and making positive choices regarding their emotional and behavioral responses to stressors. The series is intended to offer systematic training in mindfulness meditation and mindful yoga. Participants will select each week from a menu of daily practice options that vary in length from three to thirty minute audio meditations with guided instruction, and includes videos of mindful eating and yoga.

Methods include the learning and refining of a range of self-regulatory skills aimed at increasing relaxation and awareness. Awareness of mind/body experiences includes their primary physical concerns or complaints, emotions and thoughts and their effects on symptoms, feelings of health and well-being, stress reactivity, coping, and overall sense of self and relationships with others. This strategy is expected to reduce work-related stress and contribute to staff satisfaction and retention.

Evaluation Overview & Rationale

Addressing stress in home visitors, using a training program based on MBSR offers a strategy to reduce staff stress, prevent staff burnout, and improve staff retention. Measuring the process and impact on outcomes will

[72] Teasdale, J.D., Segal, Z.V., Williams, J.M.G., Ridgeway, V.A., Soulsby, J.M., & Lau, M.A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting & Clinical Psychology,68*, 615 – 623.

[73] Shapiro, S. L., Astin, J. A., Bishop, S. R., & Cordova, M. (2005). Mindfulness-based stress reduction for health care professionals: results from a randomized trial. *International Journal of Stress Management*, *12*(2), 164.

[74] Irving, J. A., Dobkin, P. L., & Park, J. (2009). Cultivating mindfulness in health care professionals: A review of empirical studies of mindfulness-based stress reduction (MBSR). *Complementary therapies in clinical practice*, *15*(2), 61-66.

[75] Cohen-Katz, J., Wiley, S. D., Capuano, T., Baker, D. M., & Shapiro, S. (2005). The Effects of Mindfulness-based Stress Reduction on Nurse Stress and Burnout, Part II: A Quantitative and Qualitative Study. *Holistic nursing practice,19*(1), 26-35.

[76] Shapiro, S. L., Astin, J. A., Bishop, S. R., & Cordova, M. (2005). Mindfulness-based stress reduction for health care professionals: results from a randomized trial. *International Journal of Stress Management*, *12*(2), 164.

[77] Irving, J. A., Dobkin, P. L., & Park, J. (2009). Cultivating mindfulness in health care professionals: A review of empirical studies of mindfulness-based stress reduction (MBSR). *Complementary therapies in clinical practice*, *15*(2), 61-66.

[78] Cohen-Katz, J., Wiley, S. D., Capuano, T., Baker, D. M., & Shapiro, S. (2005). The Effects of Mindfulness-based Stress Reduction on Nurse Stress and Burnout, Part II: A Quantitative and Qualitative Study. *Holistic nursing practice,19*(1), 26-35

inform similar and future efforts. Specifically, demonstrating the potential effectiveness of an MBSR training program on reducing staffs perceived stress and increasing mindfulness practice would contribute to the field of home visiting - as well as other family support programs serving high-risk communities – to improve both staff and family outcomes. The evaluation will measure at baseline the levels of stress and burnout among home visiting staff, which helps program supervisors and planners to anticipate the needs of staff and potential factors impacting staff turnover. The evaluation will also investigate whether a self-care MBSR program has the potential to a) significantly reduce various aspects of stress and burnout among home visitors, and b) increase mindfulness among home visitors, which benefits the families served. Data collected during qualitative focus groups will help program administrators and supervisors to identify and sort the sources of work-related stress by their perceived level of impact on stress and burnout as reported by home visitors which will assist in program planning (e.g. staffing, training, budgeting, scheduling, etc.).

Study Design and Methods

This component of the evaluation consists of a repeated measures longitudinal study design with all MIECHV staff invited to receive the intervention, which will be offered in two separate sessions; Group 1 will self-select to receive the first MBSR training, and Group 2 will also participate in the training offered on another date shortly after. Because all MIECHV staff are anticipated to participate in this component of the evaluation, there is no control/comparison group. Because participants may self-select for the first or second wave of training based on a number of factors, scheduling convenience being one of them, our overall analysis will treat participants as one group and measure change over time before (3 baseline measures) and following (3 post-measures) participation in the intervention program.

The survey will be made available via a secure online link (individual link for each staff member so that multiple surveys can be tracked over time at the participant level) to all MIECHV administrators, supervisors, and home visitors in three pre-assessments disseminated at two-month intervals during Fall 2016 prior to the first training, then three post-assessments distributed 1 month following training, and 3 months and 6 months following trainings. After providing consent to participate and verifying that he/she has not completed the survey before, the survey respondent will be asked to indicate whether they have or have not completed the MBSR trainings. The anticipated sample size is at least 25 MIECHV staff in the first MBSR training group and at least 25 staff in the second training group (50 total participants). Organizational role (administrator, supervisor, home visitor, other) and site name will be identified in the survey in order to compare baseline within- and between-group differences by role, site, and training group.

Group 1 (n=≥25)	Pre-test1 Fall 2016	Pre-test2 Fall 2016	Pretest 3 Preceding Fall training	*MBSR Training Fall 2016	Post-assessment 1(1-month) Fall 2016	X	Post-assessment 2 (3-mos.) Spring 2017	X	Post-assessment 3 (6-mos) Spring/Summer 2017
Group 2 (n=≥25)	Pre-test1 Fall 2016	Pre-test2 Fall 2016	X	Pretest 3 Preceding Winter training	*MBSR Training Winter 2016	Post-assessment 1 (1-month) Winter 2016	X	Post-assessment 2 (3-mos.) Spring 2017	Post-assessment 3 (6-mos) Summer 2017

Additionally, all sites participate in annual site visit focus groups. In these focus groups (conducted with administrators/supervisor and home visitors separately), participants will discuss sources of stress; effects of stress on staff recruitment and retention; effects of staff stress and burnout on work with families (including mindfulness/ presence); and workplace supports and coping strategies. During the focus group, a pile sorting

activity will identify staff perceptions of work-related stressors in order of impact. Pile sorting is a qualitative method that uses cards, pictures, or other materials to generate data from participants by studying how they organize the information by priority or category[79]. Through the pile sorting activity, participants will be able to share their perspective on the relative contribution of various work related stressors (e.g. salary, schedule, workplace environment, client factors, neighborhood factors, safety, etc.) to their levels of stress. This information may help the evaluation team to identify and report which stressors (those addressed by the intervention and possibly others that may not be addressed by the intervention) may be most contributing to staff burnout and turnover to support further intervention planning.

Research Questions for MBSR Evaluation

General questions to understand MIECHV staff stress and coping

1) *How do MIECHV staff perceive the types, levels, and contribution of work-related and other stressors to their overall levels of stress?*
    a. *What is the overall level of perceived stress among MIECHV staff?*
    b. *Are MIECHV staff experiencing compassion fatigue and/or burnout?*
    c. *Are MIECHV staff experiencing secondary traumatic stress?*
    d. *Do MIECHV staff experience stress from their own adverse childhood experiences (ACES)?*

2) *How do MIECHV staff currently cope with stress?*
3) *How do MIECHV staff perceive the effect of their stress and coping on their ability to provide mindful presence and practice with the families they serve?*

Intervention-related questions

4) *Did the MIECHV staff participating in MBSR Workshops report higher levels of mindfulness practice 30 days following training and at 3- and 6-months follow up?*
5) *Did the MIECHV staff participating in MBSR Workshops report lower levels of stress 30 days following training and at 3- and 6 months follow up?*
6) *Following MBSR training workshops, to what extent (frequency, intensity, duration) did home visitors utilize the techniques they learned (at 1-, 3- and 6-months follow-up)?*

Measures

Staff outcomes for the MBSR Intervention will be measured with validated tools consistent with key components of the Transactional Model of Stress and Coping[80],[81] including: primary and secondary appraisal evaluation of the stressor; coping efforts (frequency, intensity, and duration of mindfulness practice and use of other coping strategies); dispositional coping styles and outcomes of coping (see Figure 3 below). The survey also incorporates appropriate validated stress and MBSR scales, such as the Perceived Stress Scale,[82] the Professional Quality of Life Scale (ProQol)[8384] or Secondary Traumatic Stress Scale (STSS),[85] the-Adverse Child Experiences (ACEs) Scale (http://acestoohigh.com/got-your-ace-score/), and Toronto Mindfulness

[79] Barton, K. C. (2015). Elicitation Techniques: Getting People to Talk About Ideas They Don't Usually Talk About. *Theory & Research in Social Education*,*43*(2), 179-205.

[80]Lazarus, R.S. (1966). Psychological Stress and the Coping Process. New York: McGraw-Hill.

[81] Glanz, K., Rimer, B.K. & Lewis, F.M. (2002). Health Behavior and Health Education. Theory, Research and Practice. San Francisco: Wiley & Sons.

[82] Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. Journal of health and social behavior, 385-396.

[83] Stamm, B. H. (2008). The ProQOL Test Manual, 2nd Ed. Baltimore: Sidran Press and the ProQOL.org.

[84] Bride, B. E., Robinson, M. M., Yegidis, B. L., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. Research on Social Work Practice, 14(1), 27-35.

[85] Ting, L., Jacobson, J. M., Sanders, S., Bride, B. E., & Harrington, D. (2005). The secondary traumatic stress scale (STSS) confirmatory factor analyses with a national sample of mental health social workers. Journal of Human Behavior in the Social Environment, 11(3-4), 177-194.

Scale[86]. We will also pilot test the MBSR survey with non-MIECHV home visitors during development to ensure that discomfort in answering sensitive questions about stress, trauma, and burnout is minimized to the greatest extent possible. Measures are described below:

Focus Group Guides (Appendix F) are designed to answer the first three research questions: *How do MIECHV staff perceive the types, levels, and contribution of work-related and other stressors to their overall levels of stress?; How do MIECHV staff currently cope with stress?; How do MIECHV staff perceive the effect of their stress and coping on their ability to provide mindful presence and practice with the families they serve?*), and gather staff perceptions of their stressors, coping strategies, organizational supports, and the effects of stress on staff retention and the services they provide to families.

MBSR /Staff Stress Survey (Appendix I) also measures types and levels of staff stress, coping, and mindfulness practices (*Research Questions 2-6).* The pre-post design of the survey will allow the Evaluation Team to examine changes in these variables over time, following the MBSR intervention (research questions 4-6).

Perceived Stress Scale The Perceived Stress Scale (PSS)[25] is designed to measure the extent to which external stressors are appraised (*Research Question 1a).* This tool has been correlated with other stress measures and has been used among nurses and other helping professionals at risk for burnout. The PSS[25] has also been used in other studies measuring the impact of MBSR. The team will use this scale to better understand how home visiting staff perceive the types, levels, and contribution of work-related stressors in their overall levels of stress.

ProQol The Professional Quality of Life Scale (ProQol) measures a combination of compassion satisfaction and compassion fatigue in professionals who assume helper positions (*Research Question 1b).* Compassion satisfaction is one entity while compassion fatigue is broken into two components: burnout and secondary trauma. The research team will use this scale to examine how the home visiting staff's perception of their roles as helpers affects their level of professional satisfaction, physical and emotional burnout, and secondary trauma as a result of the stressors they are exposed to.

Secondary Traumatic Stress Scale The STSS[26] is a validated tool that has been used primarily to measure secondary stress among social workers, nurses, and mental health professionals (*Research Question 1c).*

Adverse Childhood Experiences (ACEs) (Baseline survey only) The version of Adverse Childhood Experiences (ACEs) measure used is based on the ACEs Study performed as a collaboration by the Centers for Disease Control and Prevention (CDC) and Keiser's Permanente's Health Appraisal Clinic in San Diego. The goal of the measure is to assess the relationship between early childhood trauma and health outcomes that occur years later in the child's life (*Research Question 1d).* Effective home visiting may prevent various childhood traumas including, but not limited to: malnutrition, physical abuse, and/or exposure to intimate partner violence. An effective home visitor is one who personally connects with the families they serve, and ideally connects these families to the appropriate resources. Thus the research questions of how MIECHV staff *experience stress from their own adverse childhood experiences (ACES)?*is relevant to assessing how effective the MIECHV staff is in providing services to their families which may prevent childhood trauma. This measure will determine the prevalence of ACEs among home visiting staff. Home visitors' ability to be mindful of their

[86] Lau, M. A., Bishop, S. R., Segal, Z. V., Buis, T., Anderson, N. D., Carlson, L., ... & Devins, G. (2006). The Toronto mindfulness scale: Development and validation. Journal of clinical psychology, 62(12), 1445-1467.

own traumatic experiences while supporting families who have experienced trauma will impact the effectiveness of their work and their levels of work-related stress and secondary traumatic stress.[87,88,89]

Toronto Mindfulness Scale The Toronto Mindfulness Scale measures the level of mindfulness through a series of questions based on two characteristics: curiosity and decentering (*Research Questions 4-6).* Each question is quantified so that a higher curiosity score is associated with someone who embodies a higher level of curiosity. The same applies to the concept of decentering. The Toronto Mindfulness Scale was developed and validated based on a study using participants who practiced mindfulness-based activities.

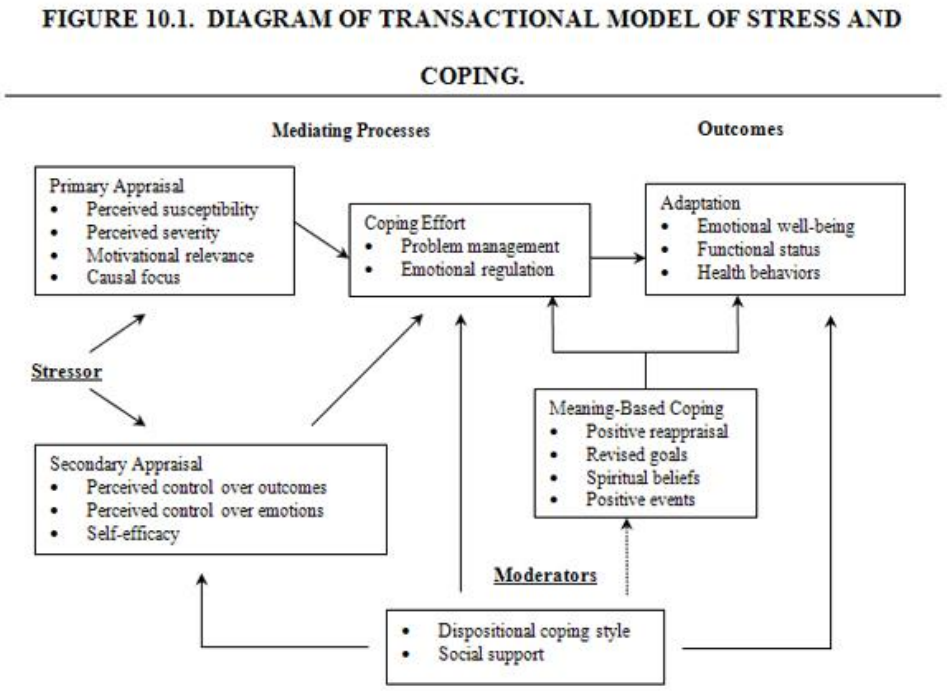


Figure 3: Transactional Model of Stress and Coping[30]

Measures

Measure	Description	Reference
Focus Group Guides (Apppendix D)	Questions related to staff stress: sources, influences on staff recruitment and retention, influences on work with families (including mindfulness/ presence), workplace supports and coping strategies. Pile sorting activity to identify sources and relative contribution of stressors.	n /a
MBSR /Staff Stress Survey (Apppendix G)	Designed by research team to measure participant characteristics, MBSR practices, and stress using measures listed below:	See below
– **Perceived**	Cronbach's alpha ranges from 0.84 to 0.86 and	Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global

[87] Zerubavel, N., & Wright, M. O. D. (2012). The dilemma of the wounded healer.*Psychotherapy*, *49*(4), 482.
[88] Gore, M. T., & Black, P. J. (2009). Bachelor of Social Work (BSW) students' prior sexual abuse victimization. Journal of Teaching in Social Work, 29(4), 449-460.
[89] Nelson-Gardell, D., & Harris, D. (2003). Secondary traumatic stress and child welfareworkers.Child Welfare,82(1), 5–26.

Stress Scale	test-retest reliability=0.85	measure of perceived stress. Journal of health and social behavior, 385-396.
– **ProQol**	Compassion Satisfaction: Cronbach's alpha=0.88 Burnout: Cronbach's alpha= 0.75 Compassion fatigue: Cronbach's alpha=0.81	Available at: http://www.statisticssolutions.com/professional-quality-of-life-scale-proqol/ Stamm, B. H. (2008). The ProQOL Test Manual, 2nd Ed. Baltimore: Sidran Press and the ProQOL.org.
– **Secondary Traumatic tress Scale**	Full scale: Cronbach's alpha=0.93 Intrusion: Cronbach's alpha=0.80; Avoidance: Cronbach's alpha=0.87; and Arousal: Cronbach's alpha=0.83. Convergent validity for extent=0.87, frequency=0.93, depression=0.79, anxiety=0.85	Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on social work practice*, *14*(1), 27-35. Chicago
– **Adverse Childhood Experiences (ACEs)**	Short version based on CDC ACEs Study Measure.	Available at: http://acestoohigh.com/got-your-ace-score/ Related studies: Larkin, H., Felitti, V. J., & Anda, R. F. (2014). Social work and adverse childhood experiences research: Implications for practice and health policy. Social work in public health, 29(1), 1-16. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American journal of preventive medicine, 14(4), 245-258.
– **Toronto Mindfulness Scale**	Bentler's CFI = .94, Bentler & Bonett's Non-normed Index .92. Factor loadings (both statistically significant and moderately large) = .56 to .82. Scale reliability: Item variance = .32 to .67. Proportion of item-level variance to measurement error = Curiosity .57, Decentering .27. Reliability estimates of the composites = .86 and .87.	Lau, M. A., Bishop, S. R., Segal, Z. V., Buis, T., Anderson, N. D., Carlson, L., ... & Devins, G. (2006). The Toronto mindfulness scale: Development and validation. Journal of clinical psychology, 62(12), 1445-1467.

Analysis Plan

The analytic plan for quantitative measures will include examination of survey results in the aggregate, comparisons across community team sites in individual, community team group, and organizational characteristics, changes over time for repeated measures, and psychometric analysis of the survey itself (e.g. construct and discriminant validity, reliability). Qualtrics data will be downloaded directly into SAS or SPSS analysis software. These data will be analyzed using linear mixed effects models to account for repeated measures for each participant. A sample size of 50 has 80% power with an alpha of 0.05 and intra-class correlation coefficient of 0.5 to detect an effect size of 0.60 over six time-points. Covariates include: gender, race, ethnicity, educational status, organizational role, professional work, and years/months in current position

Survey data will be analyzed with appropriate techniques for each research question, based on the chosen operational definitions of each variable and comparison being made. For example, Cronbach's alpha will be used to measure construct validity; the intra-class correlation coefficient for test-retest reliability of continuous variables and kappa statistic for test-retest reliability of categorical variables. The analysis plan for each research question is given in the table below.

As explained in Strategies 1 and 2 above, focus groups will be conducted with program administrators, supervisors, and home visitors (separate groups for home visitors and supervisors/administrators) at each of the 15 sites. These groups will occur in the Fall of each year, so may fall before or between scheduled MBSR

training sessions. Focus group facilitators consist of MIECHV Evaluation Team PI and Graduate Research Assistants who have been trained and are experienced in focus group facilitation and qualitative research methods. Interviews and group discussions will be audio recorded using a digital voice recorder and transcribed. Qualitative data will be analyzed using qualitative data analysis software, such as Atlas.ti or MAXQDA. Prior to analysis, the evaluation team will develop a flexible a priori codebook, which will contain initial codes based on the questions and topics in the focus group guide. Using a grounded theory approach to identify emergent and salient themes, the data will be analyzed using the constant comparative method that employs open, axial, and selective coding (both emergent and *a priori* codes) to generate rich descriptions and a theoretical framework for understanding home visitor stress and coping. At least two coders will code each transcript until an appropriate level of agreement is reached. Emergent codes will be added to the codebook as appropriate.

Research Question	Data Source(s)	Analyses
General questions to understand MIECHV staff stress and coping		
How do MIECHV staff perceive the types, levels, and contribution of work-related and other stressors to their overall levels of stress?	Staff Interview/Focus Group Guide MBSR Staff Stress Survey	Grounded Theory/Constant Comparison Tabulation and thematic analysis of pile sorting activity Baseline mean, median, standard deviation for overall score for each survey
How do MIECHV staff currently cope with stress?	Staff Interview/Focus Group Guide	Grounded Theory/Constant Comparison
How do MIECHV staff perceive the effect of their stress and coping on their ability to provide mindful presence and practice with the families they serve?	MIECHV Staff Interview/Focus Group Guide	Grounded Theory/Constant Comparison
Intervention-related questions		
Did the MIECHV staff participating in MBSR Workshops report higher levels of mindfulness practice 30 days following training and at 1-, 3- and 6-months follow up?	MBSR Staff Stress Survey -Toronto Mindfulness Survey	Linear mixed effects model to calculate change in mindfulness score over time
Did the MIECHV staff participating in MBSR Workshops report lower levels of stress 30 days following training and at 1-, 3- and 6 months follow up?	MBSR Staff Stress Survey -Perceived Stress Scale -Secondary Traumatic Stress Scale -Professional Quality of Life Scale (ProQol)	Linear mixed effects model to calculate change in mindfulness score over time
Following MBSR training workshops, to what extent (frequency, intensity, duration) did home visitors utilize the techniques they learned?	MBSR Staff Stress Survey	Linear mixed effects model to calculate changes in MBSR practices over time

The Evaluation Team will prepare and provide reports to the sites and FAHSC at regular periodic intervals.

Analyses for MBSR Outcome Evaluation

Study Design and Implementation – MBSR/Staff Stress

Phase 1

Prepare and pilot test interview guide and survey questions with MIECHV evaluation team
(Team review, expert panel review, pilot test in paper format and online with non-MIECHV home visiting staff)

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Phase II

Site visits are scheduled with program staff (Fall 2015, 2016). Staff are assigned to Admin/Supervisor group or Home Visitor Group.	Contact all Florida MIECHV programs (MBSR Group 1 and MBSR Group 2 training participants) with invitation to complete the survey prior to first MBSR training. Survey link and paper copy provided via email. The survey link is open for approximately 3 weeks with weekly/biweekly reminders from USF Evaluation Team and FAHSC to complete the survey. The survey is disseminated to each training group prior to training, following training, and 6 months beyond post assessment (timeline permitting)
Overview of evaluation and introductions provided, participants review and provide verbal consent, and participate in the focus group.	Participants review introduction, provide consent, and complete the survey

↔

Focus Groups (Fall 2015, 2016)	**MBSR Staff Stress Survey (Pre-tests Fall 2015, Spring 2016, Fall 2016; Post-tests Fall/Winter 2016, Summer 2016, Spring 2017)**	
	MBSR Participants Group 1	MBSR Participants Group 2
Topics covered: • Demographic questionnaire • Questions related to staff stress, supports, and coping • Pile sorting activity to examine perceptions of work-related stressors in order of impact.	• Demographic questionnaire • Staff stress and coping measures • Pre- (3), Post- (1 month, 3 month), Follow-up (6 months)	• Demographic questionnaire • Staff stress and coping measures • Pre- (3), Post- (1 month, 3 month), Follow-up (6 months)

Phase III

Interview recordings sent to professional transcription company to get transcribed	Survey results downloaded from Qualtrics to SAS 9.3
↓	↓
MIECHV evaluation team reviews transcripts and field notes for accuracy	Data checked for accuracy, formatting
↓	↓
Transcripts are systematically coded, and qualitatively analyzed.	Descriptive and inferential analyses of survey results are conducted

↓

Preliminary results reviewed by research team, findings triangulated

↓

Findings summarized and disseminated through reports, presentations, and manuscripts

Potential Risks, Anticipated Challenges

One challenge in evaluating this component of the evaluation is obtaining valid survey and qualitative data due to social desirability response bias. Participants may be reluctant to discuss their personal experiences with the mental health component due to the sensitive nature of the questions. Our strategy to maximize the validity of our data is to reassure staff of our positive intentions, assure and reassure confidentiality, and to collect data on stressors through a pile sorting method that allows staff to write down their ideas and sort collectively rather than voice them in the group. Also, over two years of prior evaluation experience with these providers trust has been built. We will pilot test the MBSR survey with non-MIECHV home visitors during development to ensure that discomfort in answering sensitive questions about stress, trauma, and burnout is minimized to the greatest extent possible. Additionally, there is a concern that the analysis could be affected by nesting within home visitor programs. Due to the constraints by the number of staff working in the programs, and the large number of programs, a sample size of ~50 is not sufficient for multilevel analysis. Thus, range and variability across programs will be examined, and potential impacts the multivariable analysis is noted as a limitation.

While all MIECHV staff are invited to participate in the MBSR training, it is possible that some may elect not to participate. Furthermore, some participants may not complete all surveys, though every effort will be made to obtain an adequate response rate. There is a great deal of enthusiasm statewide for the intervention, and previous evaluation activities using surveys have demonstrated strong participation among the sites, so the estimated sample size is realistic. However, statistical analysis could be constrained by small sample size. Collecting data at three time points should help strengthen analytic power. Third, while there is possible selection bias, with the first wave of MBSR training participants likely to be those with either higher or lower levels of stress and possibly greater familiarity with mindfulness practice than those who do not participate in the first wave of training, the main analysis is for the effects of the intervention on the cohort as a whole.

Ethical Considerations

Institutional Review Board (IRB) Approval

As shown in Appendix J, the MIECHV Program Evaluation was submitted to the University of South Florida Institutional Review Board (IRB) in 2012 and 2014, and determined to be exempt from IRB review as the project is a program evaluation. Nonetheless, all standard human research protections protocols are adhered to. For example: all evaluation staff have completed and certified through CITI human subjects research ethics training; informed consent protocols are followed; and the privacy and confidentiality of all evaluation participants and linked data sources are protected throughout the evaluation.

The data linkage projects conducted to assist with MIECHV benchmark reporting are under Florida IRB oversight:

- Vital Statistics Data Linkage: Florida Department of Health Institutional Review Board IRB Protocol H13090, Data Use Agreement Study #2013050
- Florida Safe Families Network (FSFN) Data Linkage: Privacy agreement established between Florida Department of Children and Families and Louis de la Parte Florida Mental Health Institute, University of South Florida.

Data Management Plan

All qualitative and quantitative data are stored on USF's secure server which is continually backed up. Access to data is password-protected and limited to specific members of the research team. All data collection, input,

and analysis are checked by multiple members of the research team for accuracy. All research team members have appropriate training for their level of data collection and analyses (qualitative and quantitative) and have current certification in social behavioral research ethics (https://www.citiprogram.org/). Evaluation records are kept in locked offices. To further protect confidentiality, individual identifiers are not collected for qualitative research and surveys.

Staffing and Budgets

- Jennifer Marshall, PhD, MPH, Research Assistant Professor, University of South Florida (USF), College of Public Health, will lead the Florida MIECHV Evaluation Team Provides oversight and guidance for the entire evaluation process (Expansion, CI&R Collaborative, Mental Health Overlay), including design, data collection (non-ETO data), data analysis, and report writing; administrative responsibility and supervision of graduate students; coordination with ETO administrator and communities; product development. Dr. Jennifer Marshall is a Research Assistant Professor in the Department of Community & Family Health in the College of Public Health at the University of South Florida. She holds a BA in psychology and child development from the University of Washington, MPH and PhD in public health from the University of South Florida, and completed her post-doctoral research in special education and early intervention at the School of Education and Human Development at the University of Miami. Dr. Marshall conducts mixed-methods, community-based research in three primary areas: early identification of developmental issues; access to services and supports; and quality in health, education, and community services. Past projects include an examination of developmental screening and referral practices among health care, social services and early education agencies; parental recognition and response to developmental delays in young children (in the US and Malaysia); and enrollment and satisfaction with services following developmental screening.
- Pamela Birriel, Doctoral Candidate, MPH, Evaluation Coordinator has worked with the MIECHV evaluation since 2013. Pam's dissertation topic explores the *Nutritional Needs, Roles, & Expectations of Hispanic/Latina Breast Cancer Survivors after Treatment* using the Stress and Coping Model. Pam has extensive research experience in community & family health and is also fluent in Spanish. Pam will work an additional .10 FTE to oversee expansion sites in conjunction with her position on FL Statewide MIECHV Evaluation.
- Ngozi Agu (RA), is a physician from Nigeria and a doctoral student in Community & Family Health. Ngozi's expertise is in family violence and maternal and child health. Ngozi has considerable experience in conducting qualitative research with sensitive populations, and will work on study design, qualitative research, survey development, data collection, and analysis and reporting/dissemination.
- Stephanie Volpe (RA) is pursuing an MPH in Epidemiology. Stephanie has clinical experience as a medical assistant intern in the U.S. and Poland, and will be primarily focused on survey development, implementation, and analysis.
- Suen Morgan (RA), has a BS in Public Health; her academic areas of focus are global health and infectious disease. Suen has over 5 years of experience working in early childhood care and education and has worked on the larger MIECHV Evaluation for one year on data collection, analysis, and reporting/dissemination; she is also fluent in Spanish.
- Vicky Phares, PhD, Professor, USF Psychology (Co-Investigator) - .01 FTE, beginning summer semester 2015. Provides consultation on all aspects and activities related to parental mental health, including father component. Vicky Phares has two primary lines of research: Developmental psychopathology in the context of the father-child relationship, and clinical assessment. Both of these topics are addressed with regard to racial/ethnic and cultural diversity and clinical implications. My research group has investigated fathers and developmental psychopathology in a number of different content areas, including adolescents of depressed fathers; anger in mothers, fathers, and adolescents; children's and adolescents' perceptions of their father and

mother; therapist's inclusion of fathers in therapy, and the emotional availability of fathers and mothers. Overall, our work has focused on the psychosocial factors that are related to functioning within families. The work is informed by cognitive-behavioral and family systems conceptualizations of developmental psychopathology. Our newest research activities focus on the inclusion of fathers in the treatment of developmental psychopathology.

- Marti Coulter, DrPH, MSW, Professor USF College of Public Health (Co-Investigator) - .01 FTE Provides assistance with collaboration network analysis and mental health component related to home visitor mental health, family violence, and child maltreatment; data interpretation for 4 additional sites. Dr. Coulter serves as Director of the Harrell Center for the Study of Family Violence, and is Professor in the Department of Community and Family Health, College of Public Health at the University of South Florida. Dr. Coulter's various community relationships combined with her national and international academic and professional accomplishments provide strong leadership for The Harrell Center. She is a certified family and dependency mediator and is considered an expert in family violence and its impact on children and families. She has an extensive publication record in the area of family violence, and has taught various courses at the graduate level on violence and maternal and child health at the College of Public Health.
- Alison Salloum, PhD, Professor, USF Social Work (Consultant) - .01 FTE, beginning summer semester 2015. Provides consultation for all mental health components related to trauma-informed care and secondary traumatic stress. Dr. Salloum is an Associate Professor in the USF School of Social Work and has a joint appointment in the Department of Pediatrics. She received her MSW and Doctorate from Tulane University School of Social Work. Dr. Salloum's primary research interest is on the treatment of childhood trauma. She is specifically interested in examining psychosocial interventions for young children, children, adolescents, and their families, who have been exposed to various types of traumatic events such as violence, disasters, and death. Currently, Dr. Salloum is the principal investigator on a three year National Institute of Mental Health R34 grant to develop and test a stepped care trauma-focused intervention that is designed to be accessible, efficient, and cost-effective to improve access to evidence-based treatment. She is partnering with the Crisis Center of Tampa Bay to conduct child trauma treatment studies. Dr. Salloum continues to provide trainings locally, nationally, and internationally on evidence-based trauma and grief focused assessment and treatment for children. Dr. Salloum is a Licensed Clinical Social Worker in Louisiana and Florida. She is a member of the Council on Social Work Education, International Society for Traumatic Stress Studies, National Association of Social Workers and the Society for Social Work Research. Dr. Salloum was selected as an NIMH-funded Child Intervention & Prevention Services Fellow.

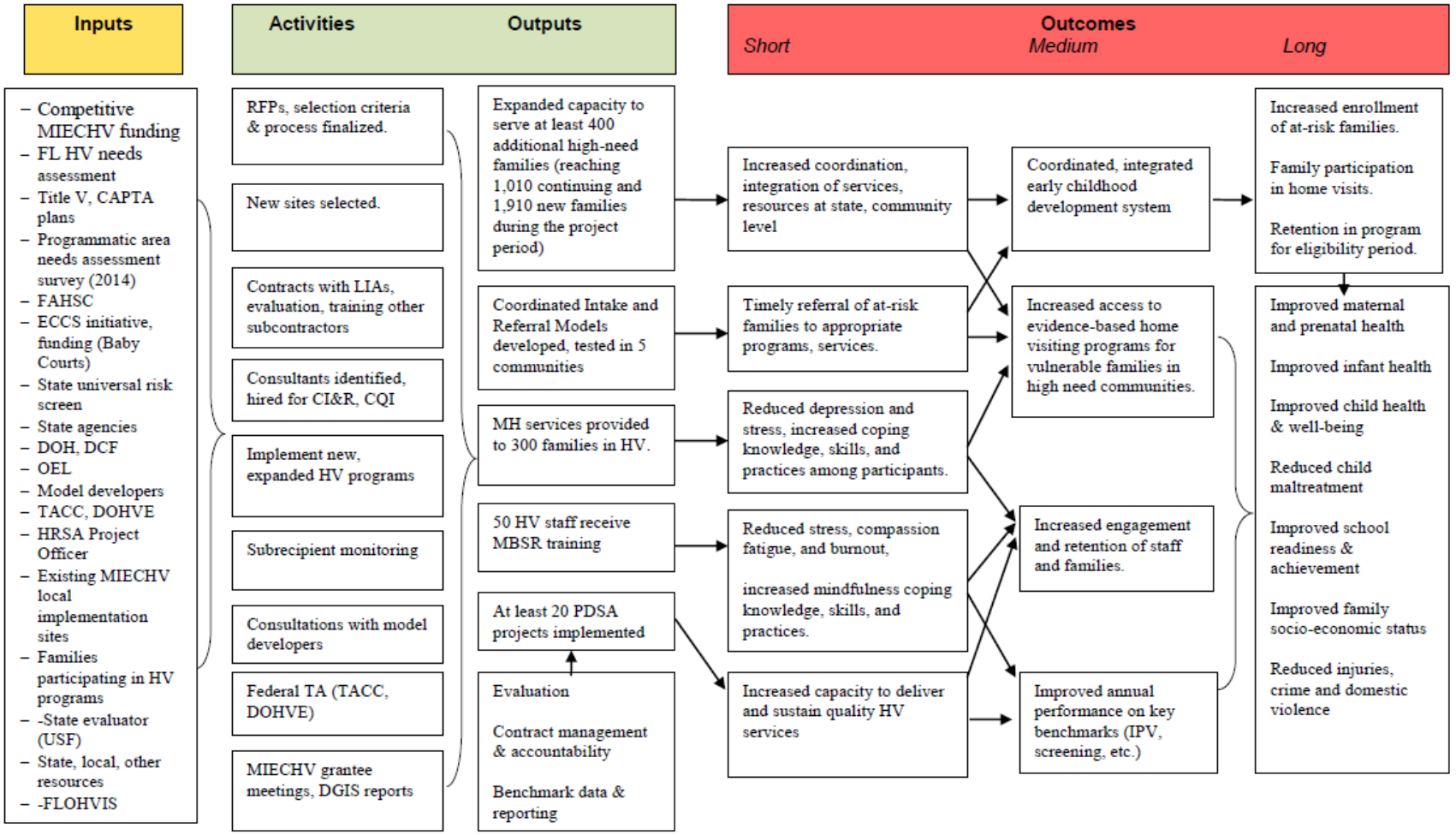
The evaluation will be supported by $210,040 in funding from the competitive grant award over the two year and seven month implementation period (see Budget below and Timeline in Appendix K).

Program Director/Principal Investigator: Marshall, Jennifer				
BUDGET FOR ENTIRE PROPOSED PROJECT PERIOD **DIRECT COSTS ONLY**				
BUDGET CATEGORY TOTALS	INITIAL BUDGET PERIOD	2nd ADDITIONAL YEAR OF SUPPORT REQUESTED	3rd ADDITIONAL YEAR OF SUPPORT REQUESTED	TOTAL
PERSONNEL	58,531	61,947	26,760	
CONSULTANT COSTS Focus Group Transcription	400	7,043	7,043	
EQUIPMENT				
SUPPLIES MaxQDA and Info Gram Software	670	200	200	
TRAVEL Focus groups, site visits and conferences	3,652	7,700	6,000	
OTHER EXPENSES Tuition Remission for GRA	7,758	12,878	9,258	
TOTAL DIRECT COSTS	71,011	89,768	49,261	
TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD				210,040

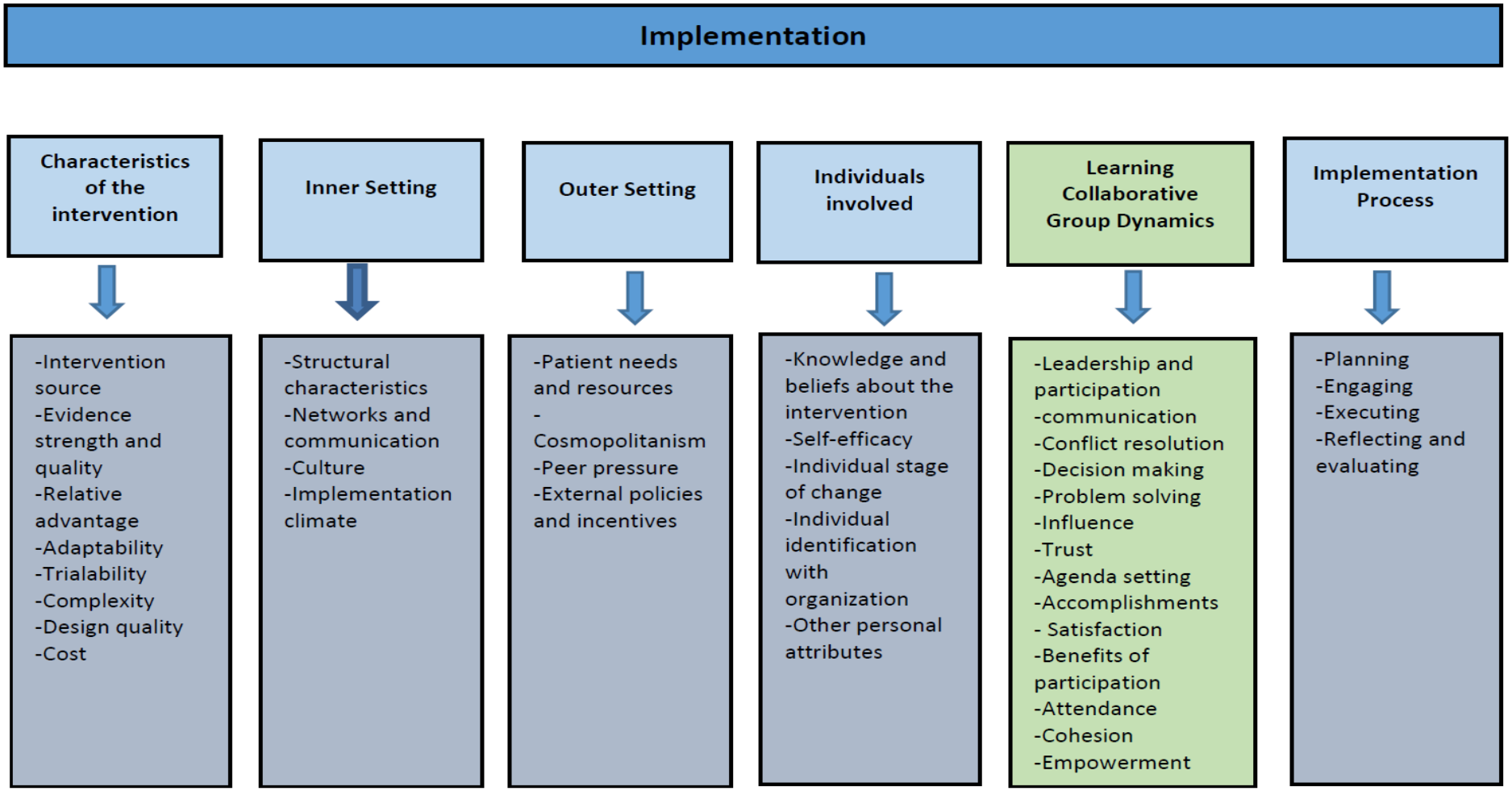
Appendix A: Programmatic Logic Model from FAHSC application

Florida Maternal, Infant and Early Childhood Home Visiting (MIECHV) Competitive Grant Logic Model

Situation: Florida has unmet need for evidence-based home visiting services in 15 of 29 designated high-need communities. Additionally, there is a need to strengthen systems of care, CQI and services at the community and state levels to facilitate recruitment and retention of participants at existing MIECHV-funded sites to optimize program impact and achievement of MIECHV benchmarks.



Appendix B: Consolidated Framework for Implementation Research



Adapted CFIR-Model: Damschroder, et al., 2009, in Ament et al. BMC Health Services Research 2012 12:423. doi:10.1186/1472-6963-12-423. Group dynamics adapted from Schulz, Amy J., Barbara A. Israel, and Paula Lantz. "Instrument for evaluating dimensions of group dynamics within community-based participatory research partnerships." Evaluation and Program Planning 26.3 (2003): 249-262

Appendix C: Coordinated intake and referral learning collaborative selection process.

REQUEST FOR APPLICATION – COORDINATED INTAKE AND REFERRAL (CI&R) ACTION LEARNING COLLABORATIVE PROJECT

Florida MIECHV aims to improve coordination and collaboration among programs serving families with children age 0-5 at the state and local level, leveraging resources and linking parents to services most appropriate to their needs and preferences. Since receiving additional MIECHV funding in April 2013, Florida has made significant progress in implementing high quality home visiting programs as part of a comprehensive early childhood system. We are very excited to provide financial and technical assistance resources over the next two years to support several Healthy Start Coalitions as they develop and test coordinated intake & referral systems in their communities and help make home visiting a "hub" for development of local place-based early childhood systems. Our individual and collective learning will provide us important information needed to develop recommendations for state decision-makers about moving coordinated intake and referral forward as a standard practice in Florida.

Healthy Start Coalitions are given unique statutory responsibility for developing local systems of care in their communities. The state's prenatal and infant risk screens provide a foundation for local MCH systems, affording universal access to risk appropriate care and services. Coordinated systems of care reduce duplication of services while optimizing access to care. Effective systems foster collaboration and referrals between programs ensuring families receive the services they need when they need them. Coordinated intake and referral offers a door through which families enter this system of care.

COORDINATED INTAKE AND REFERRAL (CI&R) SYSTEMS - The MIECHV Technical Assistance Coordinating Center has identified some common tasks in centralized/coordinated intake and referral systems: screening and assessment; determination of fit; and referral to services.

- ***Screening and Assessment***: Centralized intake system staff is responsible for conducting an initial screen to gather enough information that will enable them to make a confident decision regarding referral. Once a family is referred to a service provider, that provider will do a full assessment as part of the intervention. An assessment goes into more depth than the screen and sometimes happens over a number of visits. In all cases, screening and assessment are important early steps in making sure the needs of the family are understood, and that the family is referred to the appropriate intervention.

- ***Determination of Fit***: Using a decision tree or other algorithm typically developed in a collaborative process with the providers in the community, centralized intake workers compare what they know about each family and match that to a decision tree. Age of the child or mother's gestation is often an initial consideration. The decision tree or algorithm is locally determined and regularly updated to accommodate changing needs and resources, thus it is deemed a work in progress. (Samples of decision trees are included with this document.)
- ***Referral to Services***: Centralized intake staff work with the family and the program to ensure continuity of communication when connecting a family to a service. Communication between the centralized intake

worker and the program may continue, however, to ensure that the family is accessing the services and that the fit is indeed an appropriate one. This communication may occur at regular joint meetings of program staff.

MIECHV COORDINATED INTAKE AND REFERRAL (CI&R) ACTION LEARNING COLLABORATIVE PROJECT- Establishing a coordinated intake and referral process for families needing services is a priority activity for the Florida MIECHV Initiative. Coordinated intake is a collaborative process that will use the universal prenatal and infant screen as a single point of entry for various home visiting, care coordination, education and support services. The Healthy Start Coalitions, MIECHV staff and Florida Department of Health are working jointly to streamline the consent process to maximize sharing the screen in compliance with privacy and confidentiality rules. The goal is for families to receive the best services for their needs as well as to minimize duplication of services, ensure effective use of local resources, and collectively track what happens to each family. Successful implementation will require local community collaboration, consensus building, and careful planning and infrastructure development.

The MIECHV State Office is seeking six diverse Healthy Start Coalitions (rural, mid-size, and urban) who are willing to work collaboratively within their community to streamline and coordinate outreach, intake, referral, and feedback across programs at the local level. We are interested in selecting Healthy Start Coalitions that have the capacity to successfully develop and pilot coordinated intake and referral processes. At least half of the participating coalitions will include communities with a MIECHV-funded home visiting program.

Participating sites will organize a local team, including, at a minimum, Healthy Start Coalition, local Health Department responsible for processing screening forms, Healthy Families Florida, Federal Healthy Start, Early Head Start, MIECHV-funded project, Early Steps, additional care coordination, education and support programs, and other key stakeholders. Team members should be diverse and include both program leaders and managers as well as consumers. Each team will use an action learning collaborative (ALC) framework to develop and implement their local work as well as the Plan-Do-Study-Act (PDSA) strategy. The MIECHV State Office will provide financial support (based on number of births in the county) and technical assistance about ALC and PDSA strategies. Additionally, team members will have regular opportunities to participate in cross-site learning activities.

Each community team must be committed to:

- Meet regularly
- Remain honest – discuss concerns and problems as they occur
- Be as open minded as possible
- Keep moving forward
- Focus on bigger picture of how system helps the entire community
- Keep the best interest of the families' needs in mind at all times
- Have support from all levels within partner agencies

It should be noted that over the 21-month project period (January 2016 – September 2017) there will be several work phases. Phase one is to establish a local action learning team and develop CI&R tools and process (map current system, establish decision tree for coordinated system, develop MOUs, obtain input and feedback from

all local home visitation programs, etc.) Phase two is to test tools and processes developed during phase one. Consumer input should be sought and considered during both phases. The MIECHV State Office has engaged the University of South Florida to evaluate the CI&R project. Successes, challenges, and opportunities will be used to develop recommendations for the Florida Department of Health about statewide implementation of coordinated intake and referral.

ACTIVITIES - The following is a brief description of key activities:

(1) Establish and manage a local team to develop and test a local CI&R project. The team must include the Healthy Start Coalition, local Department of Health, all home visitation service providers, consumers, and others. Team members should include those who have authority to influence the local system, those with operational experience about what can realistically be achieved, and those who experience services as participants.

(2) Participate in cross-site activities. Three cross-site meetings will be held: a kick-off in February 2016, a mid-project meeting in October/November 2016, and a wrap-up meeting in summer 2017. A small travel team (3 - 5 people) will attend the cross-site meetings as representatives of their larger local team. Other cross-site learning activities will include regular webinars and monthly update calls. The entire local team should participate in these activities. Groupsite will be used as a collaborative workspace for CI&R projects.

(3) Establish business service agreements that outline responsibilities and linkages to each other allowing for sharing of identifiable demographic and referral information about clients and notify clients in writing that data is shared and used in a limited way with other participating agencies/programs.

(4) Identify a model/approach that works best for the community.

(5) Develop and test a decision tree for the referral process and update it as community capacity or priorities change.

(6) Develop and test a centralized screening log to track each client, key prenatal/infant screen data (score, consent, insurance, and more), referral, enrollment status, and more.

(7) Obtain and use consumer input as CI&R is being planned as well as when the local model is tested.

(8) Participate in a third-party evaluation of the CI&R Action Learning Collaborative by the University of South Florida.

APPLICATION INSTRUCTIONS - In order to assess the readiness and capacity of a Healthy Start Coalition as one of the six pilot projects selected to participate in the CI&R Action Learning Collaborative, the applicant must provide a thorough and comprehensive proposal that describes their vision, current situation,

key participants, partner commitments, budget, and plans to sustain and scale work. The proposal should be no more than 10 single-spaced pages, excluding attachments.

1. ***Vision and Experience*** - Describe in clear terms what the Healthy Start Coalition would like to accomplish locally during the 21-month pilot project period (January 2016 – September 2017). Identify any relevant experience participating in an Action Learning Collaborative or use of Plan – Do – Study – Act process, including focus and achievements. Be specific about the project, participants, challenges, and results.

2. ***Current Situation*** –

    a. Identify target county selected for CI&R and reasons why it was selected, including key descriptive indicators such as annual births, maternal and child health, socio-economic status, etc.

    b. Identify available home visitation programs (ages 0 to 5 years old), including eligibility criteria, number of home visitation staff, service capacity, and other characteristics important for the CI&R project. Specify whether one of the programs is funded by MIECHV.

    c. Explain how families currently access local home visitation and related family support services and describe barriers that they experience.

    d. Describe existing strategies for coordinating local home visitation and related family support services, including MOUs and business agreements (attach copies). Be specific about factors/conditions that make the target county appropriate and ready for testing coordinated intake and referral, including specific conditions that will result in success. (If the Coalition wants to include more than one county it should clearly explain why and how CI&R will work across county lines.)

3. ***CI &R Team*** – List proposed CI&R team members, including their name, title, key job responsibilities, and amount of time they will spend on CI&R activities. The team must include (if present in the community) the Healthy Start Coalition, Department of Health,
Healthy Families, MIECHV-funded project, Federal Healthy Start Program, Early Head Start, Early Steps, other home visitation programs, consumer(s), and other key stakeholders. Identify two co-leads for the team, including reasons for their selection, as well as team members (3 – 5) who will be on the travel team. (It is strongly encouraged that a consumer, if possible, be a member of the travel team.)

4. ***Commitments*** - Specify commitment of each CI&R partner. Attach a letter from each partner clearly outlining their commitment to being an active participant in the action learning collaborative and anticipated contributions to the work.

5. ***Budget*** – Healthy Start Coalitions will be allocated a set amount of funding over the 21month project period (January 2016 – September 2017) based on the size of the target county - $170,000 for urban counties (more than 10,000 births annually), $120,000 for mid-size counties (between 3,500 and 10,000 births), and $90,000 for rural counties (less than 3,500 births). Provide a detailed line item budget (key expenses) and budget narrative, including how proposed line items align to major CI&R activity. If funds are allocated for staff then specify if the position is new or existing and how much time will be allocated to working on CI&R project. Grant funds must be allocated for travel to three required cross-site meetings (each two days). Also identify any in-kind contributions that will be provided by the Coalition or its CI&R partners.

6. ***Scale and Sustainability*** – Discuss plans for scaling and sustaining Coordinated Intake and Referral process beyond the grant period.

REIMBURSEMENT - Coalitions will be reimbursed for achieving key deliverables as outlined in a service agreement executed after their selection for the CI&R project. Key deliverables may include participating in cross-site activities; developing and using decision tree; developing and testing CI&R screening log for specific (agreed upon) number of clients; completing evaluation activities; and others, as appropriate.

USE OF GRANT FUNDS - Allowable and unallowable expenditures are delineated in Office of Management and Budget (OMB) Circulars A-110-General Administrative Requirements, A-133-Federal Single Audit, A-122-Cost Principles for Not-For-Profits, A-21-Cost Principles for Universities, Federal Public Laws, Catalog of Federal Domestic Assistance (CFDA), and Code of Federal Regulations (CFR).

No more than 10 percent of the grant amount may be spent on costs associated with administering the grant (indirect costs).

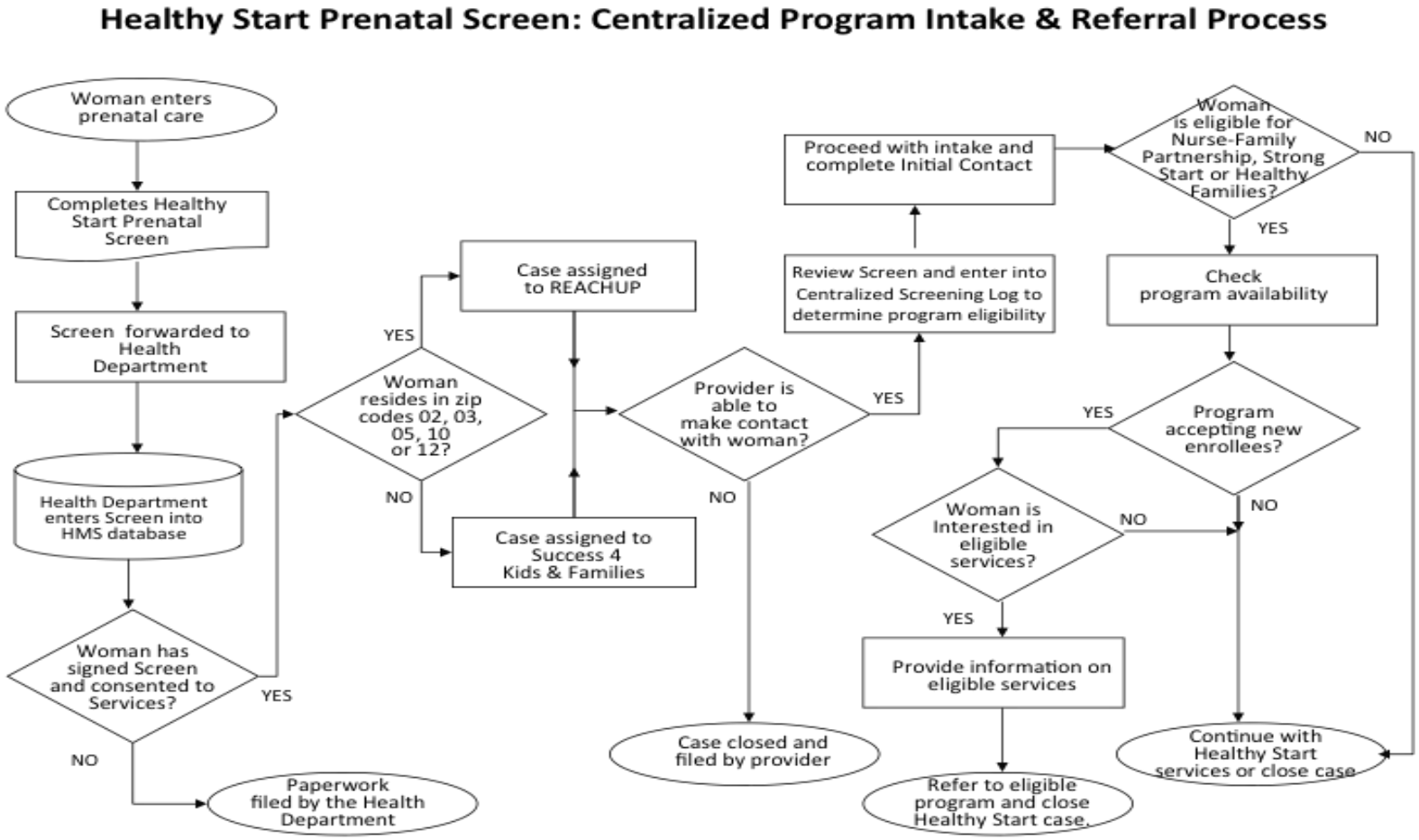
The following lists of allowable and unallowable costs were created solely to be used as a helpful guide for applicants. These lists do not supersede the federal definitions of allowable and unallowable costs. Applicants are urged to review HHS Grants Policy Statement.

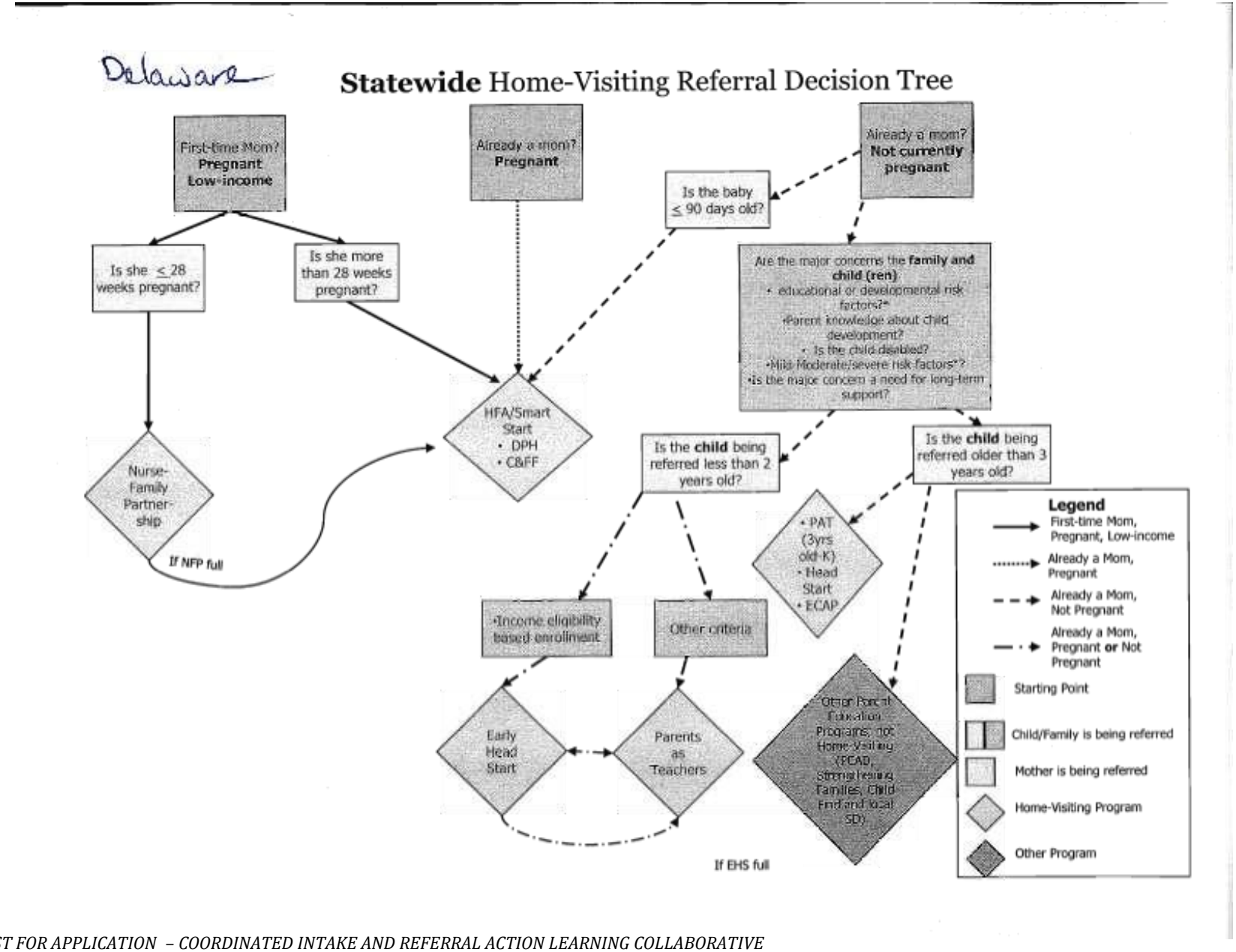
1. **Allowable costs** - must be reasonable and necessary for the provision of home visiting services and may include, but are not limited to the following:
    - Personnel
    - Project related expenses, such as office supplies, postage, and copying
    - Programmatic initiatives related to coordinating home visiting services with other home visiting programs or related services
    - Advisory group/local partner meetings and associated costs
    - Travel, in accordance with FAHSC travel guidelines
    - Data reporting and evaluation participation
    - Computer equipment and supplies needed to fulfill MIECHV reporting requirements

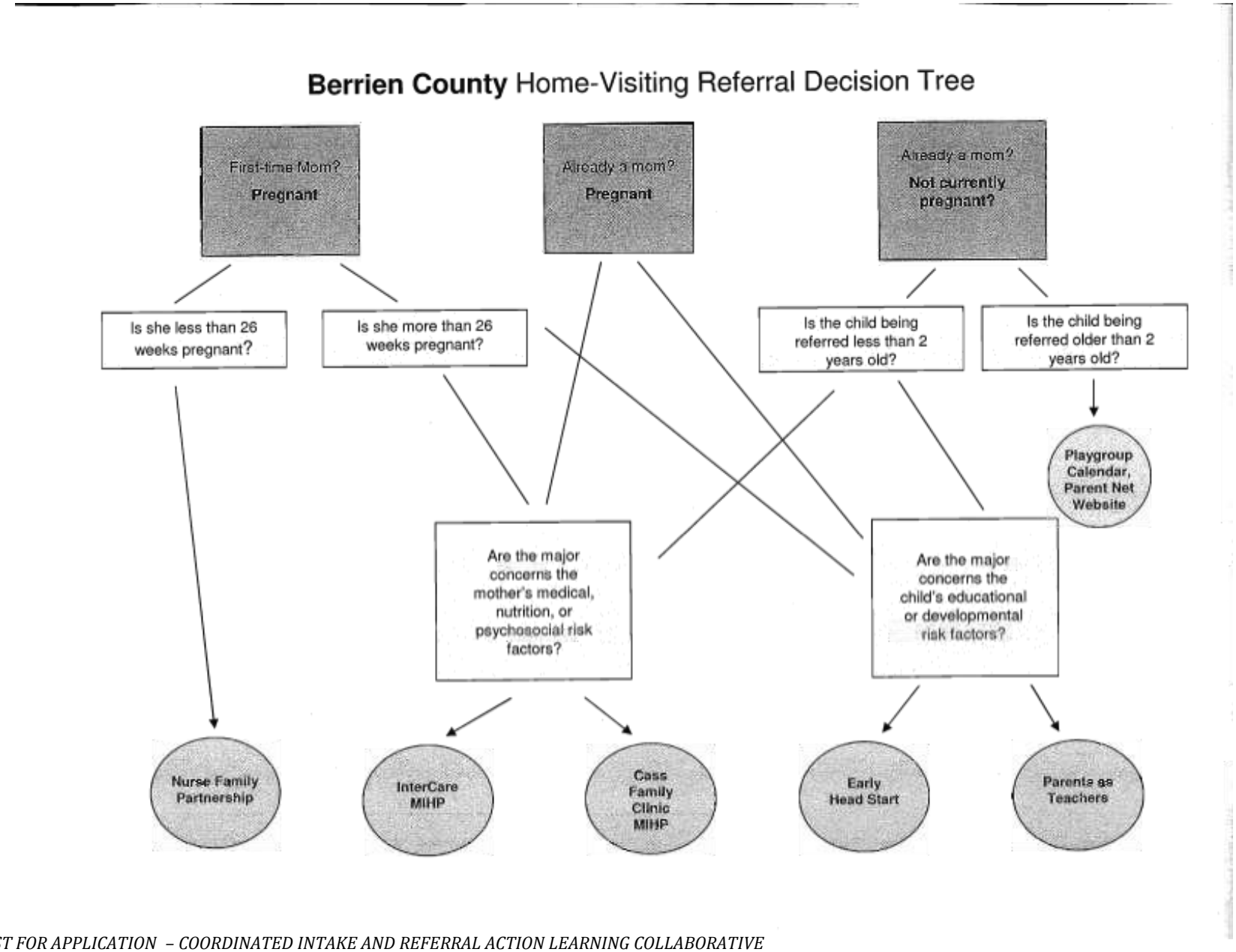
2. **Unallowable costs -** include, but are not limited to the following:
    - Building alterations or renovations
    - Construction
    - Direct services (e.g., hiring grant writers to prepare competitive grant applications, supporting direct patient services such as counseling)
    - Fringe benefits for temporary employees
    - Fund raising activities
    - Lobbying
    - Food or beverages
    - Research
    - Health and social services that are not specified in this RFP

As required by the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, FAHSC must report information for each subaward of $25,000 or more in federal funds, including executive total compensation as outlined in Appendix A to 2 CFR Part 170 (http://www.hrsa.gov/grants/ffata.html).

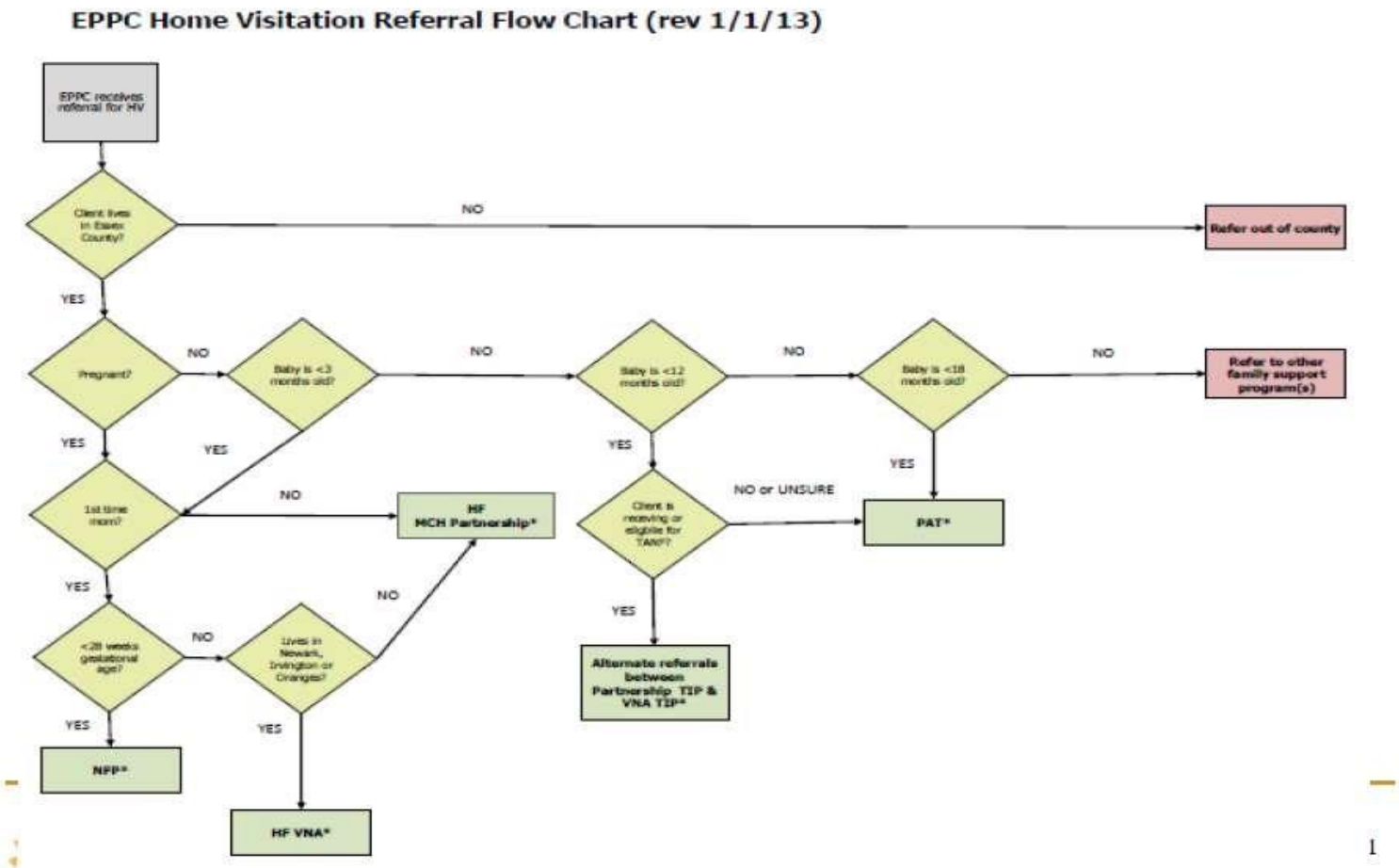
EXAMPLE DECISION TREE: Hillsborough County




Delaware
Statewide Home-Visiting Referral Decision Tree
First-time Mom? Pregnant Low-income
Already a mom? Pregnant
Already a mom? Not currently pregnant
Is the baby ≤ 90 days old?
Is she ≤ 28 weeks pregnant?
Is she more than 28 weeks pregnant?
Are the major concerns the family and child (ren)
• educational or developmental risk factors?*
•Parent knowledge about child development?
• Is the child disabled?
•Mild/Moderate/severe risk factors*?
•Is the major concern a need for long-term support?
HFA/Smart Start • DPH • C&FF
Nurse-Family Partner-ship
If NFP full
Is the child being referred less than 2 years old?
Is the child being referred older than 3 years old?
• PAT (3yrs old-K) • Head Start • ECAP
•Income eligibility based enrollment
Other criteria
Early Head Start
Parents as Teachers
Other Parent Education Programs, not Home Visiting (PCAD, Strengthening Families, Child Find and local SD)
If EHS full
Legend
First-time Mom, Pregnant, Low-income
Already a Mom, Pregnant
Already a Mom, Not Pregnant
Already a Mom, Pregnant or Not Pregnant
Starting Point
Child/Family is being referred
Mother is being referred
Home-Visiting Program
Other Program


Berrien County Home-Visiting Referral Decision Tree
First-time Mom? Pregnant
Already a mom? Pregnant
Already a mom? Not currently pregnant?
Is she less than 26 weeks pregnant?
Is she more than 26 weeks pregnant?
Is the child being referred less than 2 years old?
Is the child being referred older than 2 years old?
Playgroup Calendar, Parent Net Website
Are the major concerns the mother's medical, nutrition, or psychosocial risk factors?
Are the major concerns the child's educational or developmental risk factors?
Nurse Family Partnership
InterCare MIHP
Cass Family Clinic MIHP
Early Head Start
Parents as Teachers

Local Site Example – Decision Tree



CI&R Application Review Tool

Healthy Start Coalition: _____

Target County: _____

Category: **Small** _____ **Medium** _____ **Large** _____

Review Criteria for CI&R Action Learning Collaborative Applications

Criteria	Absent (0)	Minimal (3)	Good (6)	Exceptional (10)	Score
VISION AND EXPERIENCE (Total Possible Points – 20)					
1. Clearly explains vision for Coordinated Intake &Referral (CI&R) project.					
2. Describes prior experience with Action Learning Collaborative (ALC) or Plan-Do-Study-Act (PDSA) cycles, including focus, participants, challenges and results.					
CURRENT SITUATION (Total Possible Points – 80)					
3. Clearly describes target county – annual births, maternal and child health statistics, socio-economic status, and other indicators.					
4. Identifies available home visitation and related family support programs in target county, including specific information about eligibility criteria, staffing, service capacity, etc.					
5. Explains how families currently access local home visitation and related family support services.					
6. Describes barriers in local system.					
7. Describes existing strategies for coordinating local home visitation and related family support services.					
8. Describes factors/conditions that make target county appropriate and ready for testing CI&R strategies.					
9. Identifies specific conditions that will help project result in success.					
10. Has attached existing MOUs.					

CI&R TEAM (Total Possible Points – 20)					
11. Lists proposed CI&R team members, including name, title, key responsibilities and amount of time on CI&R - Healthy Start Coalition - Department of Health - Healthy Families - MIECHV-funded project - Federal Healthy Start Program - Early Head Start - Early Steps - Consumer - Others					
12. Identifies co-leads for team, including reasons for selection.					
COMMITMENTS (Total Possible Points – 20)					
13. Specifies commitments for each CI&R partner.					
14. Includes letters of commitment that identify anticipated contributions to work.					
BUDGET (Total Possible Points – 10)					
15. Provides a detailed line item budget and includes travel funds for ALC meetings.					
SCALE AND SUSTAINABILITY (Total Possible Points – 10)					
16. Includes plan for scaling and sustaining CI&R process beyond grant period.					
SCORE (Total Possible Points – 160)					
5 BONUS POINTS for MIECHV Project in Target County					
TOTAL SCORE					

Review Completed by: _____

Appendix D: DRAFT CI&R Readiness Survey

USF Centralized Intake & Referral Learning Collaborative - Readiness Scale

Thank you for participating in this survey to reflect on your personal perspectives and experiences as a professional related to centralized intake & referral (CI&R) systems change!

This questionnaire will ask about:

- **Your individual perceptions**
- **organizational and community context**
- **learning collaborative group dynamics**
- **perceptions of CI&R systems change**

Completion of the questionnaire takes approximately 15 minutes. Only the research team, including the Principal Investigator and research staff, will be able to see information about individual participants; however when the results of the survey are presented, all personal identifiers will be removed.

The Principal Investigator in charge of this research study is Dr. Jennifer Marshall at the USF College of Public Health, Department of Community and Family Health. If you have any questions, concerns or complaints about this study, contact Dr. Marshall at (813) 396-2672 or jmarshal@health.usf.edu

This survey may be forwarded to
Mail: Dr. Jennifer Marshall University of South Florida, College of Public Health
Department of Community and Family Health, 13201 Bruce B Downs Boulevard, MDC 56
Tampa, Florida 33612-3805
Fax: (813) 905-9998
Email: jmarshal@health.usf.edu

To begin, please verify that you have not completed this survey before.

☐ I have not completed this survey before

Do you work in one of the CI&R system sites?

☐ I participate in one of the centralized intake learning Collaborative teams

First, please tell us a little about you:

What Healthy Start Coalition's do you work with?

_____

What county/counties do you work in?

_____

What is your role at your organization?

- ☐ Administrator/Director
- ☐ Supervisor
- ☐ Home Visitor
- ☐ Other

What service sector best describes your organization?

- ☐ **Home Visiting**
- ☐ **Health Care**
- ☐ **Early Childhood Care or Education**
- ☐ **Other (please specify)** _____

How many years have you worked in your professional field?

_____

What is your ethnicity?

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

What is your race? (Select all that Apply)

- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Pacific Islander
- ☐ Other

What is your highest level of education?

- ☐ Some High School
- ☐ High School Diploma or equivalent (GED)
- ☐ Trade/Technical/Vocational Training
- ☐ Some college (no degree)
- ☐ Associates Degree
- ☐ Bachelor's degree
- ☐ Professional degree/Graduate Degree
- ☐ Other

Directions: Please select the option that best describes you.

My Current Practices:

The statement that best describes my current centralized intake & referral (CI&R) practices:

- ☐ I have been using CI&R strategies for a while (more than 1 year)
- ☐ I recently started using CI&R strategies

- ☐ I plan to begin using CI&R strategies
- ☐ I think it would be a good idea to begin using CI&R strategies
- ☐ I have no plans to begin using CI&R strategies

The following statements relate to your centralized intake & referral system characteristics. Please select the option that best describes your program.

Please rate the strength of the evidence in your opinion, on a scale of 1 to 5 where 1 is very weak evidence and 5 is very strong evidence

	1	2	3	4	5
Please rate the strength of the evidence for CI & R system changes in your opinion.					
Please rate how you think respected officials in your organization feel about the strength of the evidence for CI & R system changes.					

The following statements relate to the "inner setting" (your organization or planning team) of your centralized intake & referral system. Please select the option that best describes your program.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
CI & R system changes take into consideration the needs and preferences of its recipients.					
Management and leadership of CI & R system changes clearly define areas of responsibility and authority for staff.					
Management and leadership of CI & R system changes promote team building to solve problems.					
Management and leadership of CI & R system changes promote communication among community partners.					
Communication will be maintained through regular project meetings with program management and staff to facilitate CI & R system changes.					
Communication will be maintained through involvement of quality management staff in project planning and implementation.					
Staff members are receptive to CI & R system changes regarding the system.					
The current CI & R system is intolerable or needs to be changed.					

The following statements relate to the "outer setting" (your community partners) of your centralized intake & referral system. Please select the option that best describes your program.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Our CI & R system changes take into consideration the needs and preferences of its recipients/participants (e.g. families). takes into consideration the needs and preferences of its recipients/participants (e.g. families).					
Our CI & R system changes take into consideration the needs and preferences of its recipients/participants (e.g. community partners, other agencies).					
The following are available to make the CI & R system changes work: patient awareness/need.					
Those within the CI & R system changes are networked with other external organizations.					
There was peer pressure indicating a need to implement CI & R system changes.					
Implementation for CI & R system changes was influenced by external policy and incentives.					

The following statements relate to the individuals involved in your centralized intake & referral system changes. Please select the option that best describes your program.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
My attitude towards and value placed on the CI & R system changes are positive.					
I am familiar with the facts, truths and principles related to CI & R system changes.					
I believe in my own capabilities to execute courses of action to achieve implementation goals for CI & R system changes.					
I am actively planning to implement CI & R system changes.					
I am already working on CI & R system changes.					
My degree of commitment to CI & R system changes and relationship is positive.					

The following statements relate to the centralized intake & referral system learning collaborative <u>group dynamics</u>. Please select the option that best describes your program.

	Excellent	Good	Average	Poor	Very Poor
Leadership and participation among community partners.					

Communication among community partners.					
Conflict resolution among community partners.					
Decision making capabilities among community partners.					
Problem solving skills among community partners.					
Level of influence on CI & R system changes.					
Trust among community partners.					
Agenda making capabilities among community partners.					
Accomplishments of community partners.					
Satisfaction among community partners.					
Benefits of participation with community partners.					
Community members are consistent with attendance at planning members.					
Cohesion between community partners.					
Perceived empowerment among community partners.					

The following statements relate to the centralized intake & referral system <u>implementation process</u>. Please select the option that best describes your program.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The implementation plan for CI & R system changes identifies specific roles and responsibilities.					
Plans for evaluation and improvement of CI & R system changes include staff participation/ satisfaction survey.					
Plans for evaluation and improvement of CI & R system changes include dissemination plan for performance measures.					
The implementation team members for CI & R system changes share responsibility for the success of this project.					
The implementation team members for CI & R system changes have clearly defined roles and responsibilities.					

The following are available to make the selected CI & R system changes work: system team.					
The following are available to make the selected CI & R system changes work: provider buy-in.					
The CI & R system changes will be implemented according to plan.					
Progress of the CI & R system changes will be measured by collecting feedback from staff regarding proposed/implemented changes.					
Progress of the CI & R system changes will be measured by collecting feedback from program recipients regarding proposed/implemented changes.					

Do you have any additional comments about your personal/professional centralized intake & referral knowledge or practices?

Do you have any additional comments about your organization's centralized intake & referral knowledge or practices?

Thank you for completing this survey!

Appendix E: Coordinated Intake & Referral Focus Group Guide

Coordinated Intake & Referral Team Interview/Focus Group Guide

Hi! My name is _____[insert name], and I am a _____[insert role] at the University of South Florida. Right now, we are asking members of each coordinated intake & referral team to tell us more about their experiences, and I thank you for taking the time to talk to us today. If it is all right with you, I would like to record our conversation today. Please know that all the information you provide will be kept confidential. I just want to record the conversation to make sure I do not miss out on anything you say. Is this okay with you?

Know that you can also skip any question you do not want to answer or stop the interview by letting me know at any time that that is what you would like to do. Also, know that I will never use your name or any identifying information when discussing this interview, so no one will ever know your responses. Do you have any questions before we begin? Okay then, let's get started. First I would like to ask you a few general questions about….

Possible CFIR questions from the Center for Clinical Management Research, to include selected:

1. Questions about the inner setting (current system and participants)
2. Questions about perceptions of the intervention (systems changes)
3. Questions about readiness for implementation
4. Questions about the outer setting
5. Questions about the process

]Questions will be selected for Spring 2016, Fall 2016, and Spring 2017 Focus groups to move to greater depth and complexity as the learning collaborative coalesces and further develops its work in local communities. Questions will also be selected based on results of the survey and questions that arise from survey analysis.]

Questions about the Inner Setting

Structural Characteristics

1. How will the infrastructure of your organization (social architecture, age, maturity, size, or physical layout) affect the implementation of the intervention? How will the infrastructure facilitate/hinder implementation of the intervention? How will you work around structural challenges?
2. What kinds of infrastructure changes will be needed to accommodate the intervention? Changes in scope of practice? Changes in formal policies? Changes in information systems or electronic records systems? Other? What kind of approvals will be needed? Who will need to be involved? Can you describe the process that will be needed to make these changes?

Networks & Communications

1. Can you describe your working relationships with your colleagues? With colleagues in your unit? With colleagues in other units? Can you tell me a story about a time you needed to work with others to solve a problem? Or to implement an intervention in the past or this intervention?
2. To what extent do you get together with colleagues outside of work? To talk about work? Just to have fun together?
3. Do you meet (formally or informally) with a team of people? What is the team membership? How often do you meet? Formally? Informally?
4. Can you describe your working relationship with leaders? Your supervisor? Supervisors of other colleagues?
5. Can you describe your working relationship with influential stakeholders?
6. Are meetings, such as staff meetings, held regularly? Do you typically attend? Who typically attends?

What proportion of staff typically attend? How often are the meetings held? What is a typical agenda? How helpful are these meetings?

7. How do you typically find out about new information, such as new initiatives, accomplishments, issues, new staff, staff departures?

8. When you need to get something done or to solve a problem, who are your "go to" people? Can you describe a recent example?

Culture

1. How would you describe the culture of your organization? Of your own setting or unit? Do you feel like the culture of your own unit is different from the overall organization? In what ways?

2. How do you think your organization's culture (general beliefs, values, assumptions that people embrace) will affect the implementation of the intervention? Can you describe an example that highlights this?

3. To what extent are new ideas embraced and used to make improvements in your organization? Can you describe a recent example?

4. *This question can be open-ended or elicit percentages so that they add up to 100%. e.g., my culture is 50% Team, 40% entrepreneurial, 10% hierarchical.* Some people characterize culture in terms of four general types. To what extent would you characterize your culture as: Team (Clan) Culture (Flexible, Internal Focus): A friendly workplace where leaders act like mentors, facilitators, and team-builders. There is value placed on long term development and doing things together. Hierarchical (Hierarchy) Culture (Control, Internal Focus): A structured and formalized workplace where leaders act like coordinators, monitors, and organizers. There is value placed on incremental change and doing things right. Entrepreneurial (Adhocracy) Culture (Flexible, External Focus): A dynamic workplace with leaders that stimulate intervention. There is value placed on breakthroughs and doing things first. Rational (Market) Culture (Control, External Focus): A competitive workplace with leaders like hard drivers, producers, or competitors. There is value placed on short term performance and doing things fast.

Implementation Climate

1. *This question is likely to uncover topics to explore more within other subconstructs, but be attentive to other themes that may not be included in your assessment.* What is the general level of receptivity in your organization to implementing the intervention? Why?

Tension for Change

1. Is there a strong need for this intervention? Why or why not? Do others see a need for the intervention?

2. How essential is this intervention to meet the needs of the individuals served by your organization or other organizational goals and objectives?

3. How do people feel about current programs/practices/process that are available related to the intervention? To what extent do current programs fail to meet existing needs? Will the intervention meet these needs? How will the intervention fill current gaps?

Compatibility

In a healthcare setting, values related to interacting with patients may include patient centered care, whereas in an education setting, values may include placing special education students in inclusion classrooms.

1. How well does the intervention fit with your values and norms and the values and norms within the organization? Values relating to interacting with individuals served by your organization, e.g. Shared decision making vs. being more directive? Values related to referring to outside vendor-based programs vs. providing services by in-house staff?

2. How well does the intervention fit with existing work processes and practices in your setting? What are likely issues or complications that may arise?

3. Can you describe how the intervention will be integrated into current processes? How will it interact or conflict with current programs or processes?

4. Will the intervention replace or compliment a current program or process? In what ways?

Relative Priority

1. What kinds of high-priority initiatives or activities are already happening in your setting? What is the priority of getting the intervention implemented relative to other initiatives that are happening now? Will the implementation conflict with these priorities? Will the implementation help achieve (or relieve pressure related to) these priorities?
2. Describe activities or initiatives that (appear to) have highest priority for you (for the organization)? What kind of pressure are you feeling to accomplish this? Where is it coming from? Why?
3. To what extent might the implementation take a backseat to other high-priority initiatives going on now? How important do you think it is to implement the intervention compared to the other priorities? How important is it to others, such as your coworkers or leaders, to implement the intervention compared to the other priorities?
4. How will you juggle competing priorities in your own work? How will your colleagues juggle these priorities? What are the other priorities? How does the priority of implementing the intervention compare to other priorities in your organization? For your own work?

Organizational Incentives & Rewards

1. What kinds of incentives are there to help ensure that the implementation of the intervention is successful? What is your motivation for wanting to help ensure the implementation is successful?
2. To what extent do you think your supervisor will consider your role in this implementation in your (next) evaluation? In his/her regard for your work or role?
3. Are there any special recognitions or rewards planned that are related to implementing the intervention? Can you describe them? Will these be targeted to groups/teams/units or individuals?

Goals & Feedback

1. Have you/your unit/your organization set goals related to the implementation of the intervention? [If yes] What are the goals?
2. To what extent does your organization/unit set goals for current programs/initiatives? How are goals communicated in the organization? To whom are they communicated? Can you give an example of a goal? How and to whom is it communicated? Are changes made based on how things are going? Can you give an example?
3. To what extent are organizational goals monitored for progress? Can you give an example of monitoring in terms of the type of information, who is informed, and how?
4. Do you get any feedback reports about your work? What do they look like? Content, mode, form? How helpful are those reports? How can they be improved? How often do you get them? Where do they come from? Who designed them?
5. How does implementation of the intervention align with other organizational goals?

Learning Climate

Questions regarding the implementation of previous interventions may provide insight into many potential constructs to follow-up on later, e.g., exploring the extent to which the same facilitators/barriers may be in play for the new implementation of interest.

1. Can you describe a recent quality improvement initiative or an implementation of a new program? Can you describe the new initiative/program and the motivation to improve/implement it? Can you tell me the major milestones or key accomplishments along the way? What factors helped make it successful/fail? Who were the key "players"? What was your involvement? Were people happy with the outcome/initiative? Can you tell me about how leaders were involved? Who? Their roles? How they helped/hindered?
2. If you saw a problem in your own setting, what would you do? Can you tell a story about a recent problem you resolved or initiative you participated in?
3. To what extent do you feel like you can try new things to improve your work processes? Do you feel like you have the time and energy to think about ways to improve things? Did you feel valued/respected by your supervisor for the role you played? What role did your supervisor (or other leaders) play? What actions did they take?

Questions about the Intervention (CI&R system changes)

Intervention Source

1. Who developed the intervention? What is your opinion of this group/individual?
2. Why is the intervention being implemented in your setting? Who decided to implement the intervention? How was the decision made to implement the intervention?

Evidence Strength & Quality

1. What kind of information or evidence are you aware of that shows whether or not the intervention will work in your setting? What evidence have you heard about from your own research? Practice guidelines? Published literature? Coworkers? Other settings? How does this knowledge affect your perception of the intervention?
2. What do influential stakeholders think of the intervention? What do administrative or other leaders think of the intervention?
3. What kind of supporting evidence or proof is needed about the effectiveness of the intervention to get staff on board? Coworkers? Administrative leaders?

Relative Advantage

1. How does the intervention compare to other similar existing programs in your setting? What advantages does the intervention have compared to existing programs? What disadvantages does the intervention have compared to existing programs?
2. How does the intervention compare to other alternatives that may have been considered or that you know about? What advantages does the intervention have compared to these other programs? What disadvantages does the intervention have compared to these other programs?
3. Is there another intervention that people would rather implement? Can you describe that intervention? Why would people prefer the alternative?

Adaptability

1. What kinds of changes or alterations do you think you will need to make to the intervention so it will work effectively in your setting? Do you think you will be able to make these changes? Why or why not?
2. Who will decide (or what is the process for deciding) whether changes are needed to the intervention so that it works well in your setting? How will you know if it is appropriate to make any changes?
3. Are there components that should not be altered? Which ones should not be altered?

Trialability

1. Will the intervention be piloted prior to full scale implementation? [If Yes] Can you describe what your plans are for piloting the intervention? [If Yes] What will the pilot look like?
2. Do you think it would be possible to pilot the intervention before making it available to everyone? Why or why not? Would this be helpful?

Complexity

1. How complicated is the intervention? Please consider the following aspects of the intervention: duration, scope, intricacy and number of steps involved and whether the intervention reflects a clear departure from previous practices.

Design Quality & Packaging

1. What is your perception of the quality of the supporting materials, packaging, and bundling of the intervention for implementation? Why?
2. What supports, such as online resources, marketing materials, or a toolkit, are available to help you implement and use the intervention? How do you access these materials?
3. How will available materials affect implementation in your setting?

Cost

1. What costs will be incurred to implement the intervention?
2. What cost were considered when deciding to implement the intervention?

Questions about Readiness for Implementation

Leadership Engagement

1. What level of endorsement or support have you seen or heard from leaders? Who are these leaders and how has this affected things so far? Going forward?
2. What level of involvement has leadership at your organization had so far with the intervention? Do they know about the intention to implement the intervention? Who are these leaders? How do attitudes of different leaders vary? What kind of support have they given you? Can you provide specific examples?
3. What kind of support or actions can you expect from leaders in your organization to help make implementation successful? Who are these leaders? How do attitudes of different leaders vary? Do they know about the intention to implement the intervention? What kind of support can you expect going forward? Can you provide specific examples? What types of barriers might they create?

Available Resources

1. Do you expect to have sufficient resources to implement and administer the intervention? [If Yes] What resources are you counting on? Are there any other resources that you received, or would have liked to receive? What resources will be easy to procure? [If no] What resources will not be available?
2. How do you expect to procure necessary resources? Who will be involved in helping you get what is needed? What challenges do you expect to encounter?

Access to Knowledge & Information

1. What kind of training is planned for you? For colleagues? Do you feel the training will prepare you to carry out the roles and responsibilities expected of you? Can you explain? What are the positive aspects of planned training? What is missing? What kind of continued training is planned?
2. What kinds of information and materials about the intervention have already been made available to you? Copies of materials? Personal contact? Internal information sharing; e.g., staff meetings? Has it been timely? Relevant? Sufficient?
3. Who do you ask if you have questions about the intervention or its implementation? How available are these individuals?
4. *This question may also be relevant to Engaging: Key Stakeholders.* What kinds of information and materials about the intervention are planned for individuals in your setting? Copies of materials? Personal contact? Internal information sharing; e.g., staff meetings? Will it be timely? Relevant? Sufficient?

Characteristics of Individuals

Knowledge & Beliefs about the Intervention

1. What do you know about the intervention or its implementation?
2. Do you think the intervention will be effective in your setting? Why or why not?
3. How do you feel about the intervention being used in your setting? How do you feel about the plan to implement the intervention in your setting? Do you have any feelings of anticipation? Stress? Enthusiasm?
4. At what stage of implementation is the intervention at in your organization? How do you think the program is going?

Self-efficacy

1. How confident are you that you will be able to successfully implement the intervention? What gives you that level of confidence (or lack of confidence)?
2. How confident are you that you will be able to use the intervention? What gives you that level of confidence (or lack of confidence)?

3. How confident do you think your colleagues feel about implementing the intervention? What gives them that level of confidence (or lack of confidence)?
4. How confident do you think your colleagues feel about using the intervention? What gives them that level of confidence (or lack of confidence)?

Individual Stage of Change

1. *Explore which level the individual is at using Rogers' (or Porchaska's Stages of Change) as a guide:*
How prepared are you to use the intervention? Knowledge stage (Precontemplation) knowledge of key aspects of the intervention Persuasion stage (Contemplation) likes the intervention, discusses it with others, buys into it, has a positive view Decision stage (Preparation) intends to seek additional information and try it Implementation stage (Action) acquires additional information, uses intervention regularly, and has continued use Confirmation stage (Maintenance) recognizes benefits, has integrated the intervention into routines, promotes use to others Individual Identification with Organization

Questions about the Outer Setting

Patient Needs & Resources

1. To what extent is staff aware of the needs and preferences of the individuals being served by your organization? How "in touch" are staff and leadership with the individuals served by your organization?
2. To what extent were the needs and preferences of the individuals served by your organization considered when deciding to implement the intervention? Can you describe specific examples? Will the intervention be altered to meet their needs and preferences?
3. How well do you think the intervention will meet the needs of the individuals served by your organization? In what ways will the intervention meet their needs? e.g. improved access to services? Reduced wait times? Help with self-management? Reduced travel time and expense?
4. How do you think the individuals served by your organization will respond to the intervention?
5. What barriers will the individuals served by your organization face to participating in the intervention?
6. Have you elicited information from participants regarding their experiences with the intervention? What are their perceptions of the intervention? Can you describe what kind of specific information you have heard?
7. Have you heard stories about the experiences of participants with the intervention? Can you describe a specific story?

Cosmopolitanism

These are individual level questions, but responses should be aggregated to characterize more generally the extent to which the organization encourages individuals to take the initiative to bring ideas in from outside.
These are individual level questions, but responses should be aggregated to characterize more generally the extent to which the organization encourages individuals to take the initiative to bring ideas in from outside.
1. To what extent do you network with colleagues or people in similar professions/positions outside your setting? What are the venues?
2. What kind of information exchange do you have with others outside your setting, either related to the intervention, or more generally about your profession? What professional networking do you engage in? Listservs? Local or national conferences? Trainings?
3. To what extent does your organization encourage you to network with colleagues outside your own setting? Are you able to attend local/national conferences? Other venues?

Peer Pressure

1. Can you tell me what you know about any other organizations that have implemented the intervention or other similar programs? How has this information influenced the decision to implement the intervention?

2. To what extent are other organizations implementing the intervention? How does this affect support for implementing the intervention in your setting?
3. To what extent are other units within your organization implementing the intervention? How does that affect support for implementing the intervention in your own setting?
4. To what extent would implementing the intervention provide an advantage for your organization compared to other organizations in your area? Is there a competitive advantage? Is there something about the intervention that would bring more individuals into your organization, instead of another one in your area?

External Policies & Incentives

In a healthcare setting, external policies and incentives may include clinical performance measures and pay for performance, where as in an education setting, this may include standardized testing performance measures and funding allocation.

1. What kind of local, state, or national performance measures, policies, regulations, or guidelines influenced the decision to implement the intervention? How will the intervention affect your organization's ability to meet these measures, policies, regulations, or guidelines?
2. What kind of financial or other incentives influenced the decision to implement the intervention? How will the intervention affect your organization's ability to receive these incentives? How will the new intervention affect payment or revenue for your organization?

Questions about the Process

Planning

1. What have you done (or what do you plan to do) to get a plan in place to implement the intervention?
2. Can you describe the plan for implementing the intervention? How detailed is the plan? Who knows about it? Is the plan overly complex? Understandable? Realistic and feasible? What is your role in the planning process?
Who is involved in the planning process? What are their roles? Are the appropriate people involved in the planning process? How engaged are they? Do you plan to track the progress of implementation based on your plan? What if you have to modify or revise your plan due to barrier, errors, or mistakes?
3. What role has your plan for implementation played during implementation? Was it used to guide implementation of the intervention? Was it used to compare planned with actual progress? Were there revisions or refinements to the plan? Was the plan shared/reviewed with other stakeholders? How regularly?

Engaging

- Opinion Leaders

1. Who are the key influential individuals to get on board with this implementation?
2. What are influential individuals saying about the intervention? Who are these influential individuals?
To what extent will they influence others' use of the intervention? The success of the implementation?

Formally Appointed Internal Implementation

1. How did your organization become involved in implementing the intervention? How was the decision made to participate in the intervention? Who participated in the decision making process? Were you involved in this process?
2. Who will lead implementation of the intervention? How did/will this person come into this role? Appointed? Volunteered? Voluntold? What attributes or qualities does this person have that makes them an effective leader of this implementation? What attributes or qualities does this person lack? Does this person have sufficient authority to do what is necessary to implement the intervention?
3. Who else is involved with leading the implementation?

- Champions

1. Other than the formal implementation leader, are there people in your organization who are likely to champion (go above and beyond what might be expected) the intervention? Were they formally appointed in this position, or was it an informal role? What position do these champions have in your organization?

How do you think they will help with implementation? Getting people to use the intervention?

2. Can you describe people's perception of this champion/individual? To what extent do you respect the opinions and actions of the champion?

3. What kinds of behaviors or actions do you think this individual/champion will exhibit? For example, helping get senior leaders on board, helping solve problems? Or a small role?

- External Change Agents

1. Will someone (or a team) outside your organization be helping you with implementing the intervention? Can you describe this person/group? How did they get involved? What is their role? What kind of activities will they be doing? How helpful do you think he/she/they will be? In what ways?

- Key Stakeholders

1. What steps have been taken to encourage individuals to commit to using the intervention? Which individuals will you target? How will you approach them? What information will you give them? How frequently and how will you communicate with them?

2. What is your communication or education strategy (not including training, see Access to Knowledge and Information) for getting the word out about the intervention? What materials/modes/venues do you plan to use? For example e-bulletin boards, emails, brochures? What process do you plan to use to communicate? For example, going to staff meetings, talking to people informally?

3. Who are the key individuals to get on board with the intervention? To encourage individuals to use the intervention? To help with implementation?

- Intervention Participants

In a healthcare setting, intervention participants may include patients, whereas in an education setting, this may include students. These questions assume that the intervention is a program for individuals to use.

1. How will you or your colleagues communicate to the individuals that are served by your organization about the intervention? How will they participate in the intervention? How will they access the intervention?

Executing

1. Has the intervention been implemented according to the implementation plan? [If Yes] Can you describe this? [If No] Why not?

Reflecting & Evaluating

1. What kind of information do you plan to collect as you implement the intervention? Which measures will you track? How will you track them? How will this information be used?

2. Will you receive feedback reports about the implementation or the intervention itself? What will they look like? Content, mode, form? How helpful do you think they will be? How could they be improved? How often will you get them? Where will they come from? Who is designing them?

3. How will you assess progress towards implementation or intervention goals? How will results of the evaluation be distributed to stakeholders?

4. Will feedback be elicited from staff? From the individuals served by your organization? [If yes] What kind of feedback?

5. To what extent has your organization/unit set goals for implementing the intervention? How will goals be communicated in the organization? To whom will they be communicated? What are the goals? How and to whom will they be communicated?

Thank you for your participation!

Appendix F: Draft MIECHV Staff Interview/Focus Group Guides

MIECHV Interview Guide

Questions for Home Visiting Administrators and Supervisors

Hi! My name is _____[insert name], and I am a _____[insert role] at the University of South Florida. Right now, we are asking administrators and supervisors of the home visiting programs to tell us more about their experiences, and I thank you for taking the time to talk to us today.

If it is all right with you, I would like to record our conversation today. Please know that all the information you provide will be kept confidential. I just want to record the conversation to make sure I do not miss out on anything you say. Is this okay with you?

Know that you can also skip any question you do not want to answer or stop the interview by letting me know at any time that that is what you would like to do. Also, know that I will never use your name or any identifying information when discussing this interview, so no one will ever know your responses.

Do you have any questions before we begin?

Okay then, let's get started. First I would like to ask you a few general questions about the program.

1. What do you like best about your job?

2. Today we are going to start with a focus on health and mental health needs. Tell me about the health concerns among the families you serve.
    a. Do you see any mental health concerns with the families (such as depression, stress, psychiatric diagnoses, etc.)?
    b. Are there any issues of substance abuse (such as use of alcohol, illegal drugs, or misuse of medications)?

3. In addition to the health concerns, do you see any issues regarding domestic/family violence?

4. Tell me about the formal or informal social supports for the families you serve. Who seem to be the biggest sources of support for them?

Now that I better understand the concerns of your families, I would like to ask you more about how your program meets those needs and your collaboration with other organizations.

5. How would you say that your program contributes to collaboration and systems development at the state and community levels? [Systems development means your program and partners have an agreed upon way of responding to and meeting the needs of families.]
6. What does the collaboration/relationship among agencies look like? Are those collaborations facilitating your program's work?
7. How is the MIECHV program being implemented? What kinds of services are being provided to address those health and mental health needs?
8. What services are currently unavailable for your program recipients (including mental health services)?

9. How do you address those gaps?

Thank you. So far, we have talked about the families you serve and the community partners who serve those families. Now, I would like to redirect our discussion and talk about the home visitors.

10. What are some of the main sources of stress among home visitors? Write down these sources (one on each card, just list your top 3 for now). Please be candid, your individual and site-specific responses will not be identifiable in our reports. Now let's do a pile sorting activity. Let's place these cards in order of most to least in terms of the effect of these factors on home visitor stress and burnout.
    a. How do you think this affects staff recruitment and retention?
    b. How do you think this affects work with families (probe specifically for mindfulness/ presence, with families)?

11. We understand that home visiting with high-need families can be a very stressful job. How do you find that this work impacts your home visitors emotionally or otherwise?

12. What supports are available to home visitors in this program? What other coping/support strategies do home visitors use to deal with work-related stress?

Thank you for sharing that. Please know that the information you have provide today has been very helpful. I would like to wrap up our conversation today by asking a few questions that will help guide us in our evaluation. As we discussed earlier in the presentation that preceded this discussion, our next steps in the evaluation will be to look closer at the outcomes of the home visiting program. However, the data can only tell us so much. I would like to ask:

13. In your opinion, what are the best ways you can promote and address general health and mental health outcomes with the families?
    a. Can you think of any general health and mental health outcomes of the program that would be hard to measure?

14. **PMH Sites [2016 Visits]**: How has the PMH intervention impacted participants' mental health and parenting?
    a. To what extent do you think the PMH intervention impacted participant engagement, participation, and retention in the MIECHV home visiting program?
        i. Do participants in the PMH intervention seem to find the PMH intervention acceptable (e.g. comfort level, participation, engagement, etc.)
        ii. Do participants in the PMH intervention seem more engaged in the MIECHV home visits once their mental health needs are being addressed?
        iii. Do participants in the PMH intervention seem to be participating more in the MIECHV home visits once their mental health needs are being addressed (e.g. fewer cancellations, no shows, etc.)?
        iv. Do you find that participants in the PMH intervention are able to stay in the program longer rather than dropping out once their mental health needs are being addressed?

We would also like to know the best way we can support you in your work.

15. Tell me, how can we make this evaluation most useful to you?
    a. What information would you like to know?

b. How would you like the results communicated? (i.e., report, PowerPoint, video presentation)
c. Do you have any questions or concerns about the evaluation?

16. In the past, we have usually identified a single contact in your community (maybe it is you) and emailed with that person back and forth. Is this the best way to communicate with your program?
    a. Would you prefer an email over a phone call?

17. Is there additional information you need from us that would make this evaluation process go more smoothly?

18. Is there anything else you would like to discuss regarding your program or the evaluation itself?

MIECHV Interview Guide

Questions for Home Visiting Staff

Hi! My name is _____[insert name], and I am a _____[insert role] at the University of South Florida. Right now, we are asking home visitors to tell us more about their experiences, and I thank you for taking the time to talk to us today.

If it is all right with you, we would like to record the discussion. Please know that all the information you provide us will be kept confidential. We just want to record the conversation to make sure we do not forget or miss out on anything you say. Is that okay with everyone?

Also, know that you do not have to respond to a question if you do not want to and that you can leave the discussion at any time. We will never use your name or any identifying information when we report our findings, nor will we ever let anyone know your individual remarks.

Are there any questions before we begin?

Great. Lastly, I would like to note that we have a lot of questions to get through in a short time, so if I move us forward when it still seems like we are having a really good discussion, please do not take it personally. I just want to make sure we have a chance to touch on a number of topics today.

Okay then, let's get started. First I would like to ask you a few general questions about the program.

1. What do you like best about your job?

2. Today we are going to start with a focus on health and mental health needs. Tell me about the health concerns among the families you serve.
    a. Do you see any mental health concerns with the families (such as depression, stress, psychiatric diagnoses, etc.)?
    b. Are there any issues of substance abuse (such as use of alcohol, illegal drugs, or misuse of medications)?

3. In addition to the health concerns, do you see any issues regarding domestic/family violence?

   a. How do you perceive or how would you describe your role with the families you serve in terms of mental health support?

4. Tell me about the formal or informal social supports for the families you serve. Who seem to be the biggest sources of support for them?

We understand that, as part of the home visiting program, you help identify needs of families and do your best to meet those needs. Let's talk more generally now about all of the various needs you encounter in the families you work with.

5. How do you identify those needs?
   a. How comfortable are you in assessing the needs of your families?

6. How do the needs of families relate to retention in your program?
   a. Do the types/amount of referrals needed affect retention? If so, how?

7. What types of referrals do you give to your families?
   a. If you identify services a family needs from another agency, how do you connect the family to the agency?
   b. Which referrals do you give most often?

8. To your knowledge, do families have difficulty accessing any services? If so, why?
   a. What do you do in that situation?

9. Are there services that families seem to need but never ask for?

10. Is there a particular population of families that need more health or other services than others?

11. **PMH Sites [2016 Visits]**: How has the PMH intervention impacted participants' mental health and parenting?
   a. To what extent do you think the PMH intervention impacted participant engagement, participation, and retention in the MIECHV home visiting program?
   b. How do you feel about the MPH intervention?

Obviously, you play a very important role in the lives of your clients. In addition to helping them get the services they need, you also form meaningful relationships with them. To conclude, I would like to ask you a few questions about how your job affects you directly. I understand that you engage in very intense work with families who face a lot of challenges and have many needs.

12. What are some of the main sources of stress among home visitors? Write down these sources (one on each card, just list your top 3 for now). Please be candid, your individual and site-specific responses will not be identifiable in our reports. Now let's do a pile sorting activity. Let's place these cards in order of most to least in terms of the effect of these factors on stress and burnout [facilitator numbers the final list]. Aside from those listed, can you think of any other sources of stress among home visitors?
   a. How do you think this affects staff recruitment and retention?
   b. How do you think this affects work with families (probe specifically for mindfulness/ presence, with families)?

13. What supports are available to home visitors in this program? What other coping/support strategies do home visitors use to deal with work-related stress?

Thank you for sharing that. Please know that the information you have provide us today has been very helpful. As we discussed earlier in the presentation that preceded this discussion, our next steps in the evaluation will be to look closer at the outcomes of the home visiting program. However, the data can only tell us so much. For my last question, I would like to ask:

14. Is there anything else that you think we should discuss, either about the program or your role specifically, that will help us with our evaluation?

Excellent. Thank you for your feedback!

Appendix G: A Model of Five Stages in the Innovation-Decision Process

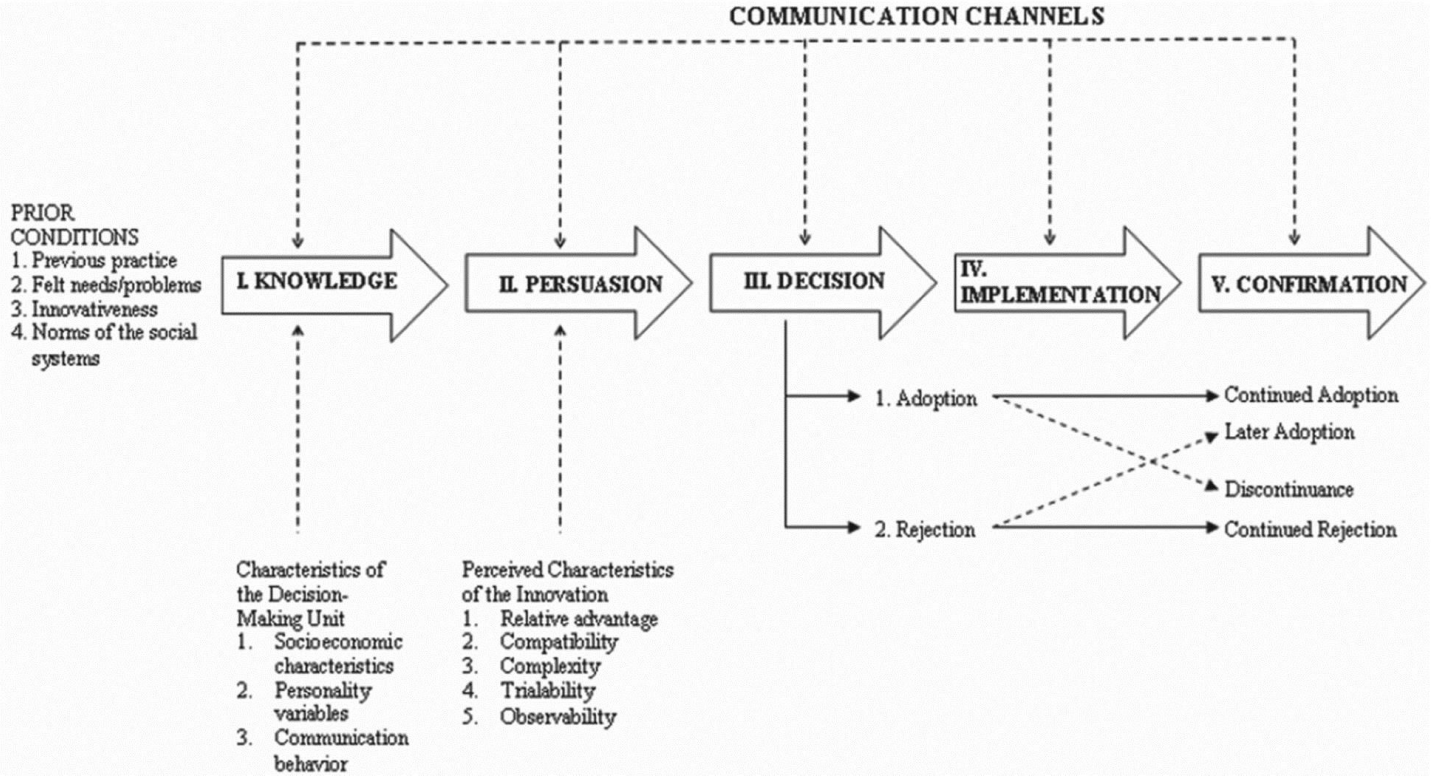


Figure 2.1. Source: *Diffusion of Innovations, Fifth Edition* by Everett M. Rogers. Copyright (c) 2003 by The Free Press) (in Sahin, 2006)

Appendix H: DRAFT Parent Mental Health Intervention Readiness Survey

Parental Mental Health (PMH) Intervention Organizational Readiness Scale

Thank you for participating in this survey to regarding your personal perspectives and experiences as a professional related to implementing interventions to support Parental Mental Health (PMH). The mental and socio-emotional well-being of mother, father, or other primary caregiver strongly impacts on children's physical and emotional development. Completion of the questionnaire takes approximately 15 minutes.

Completing this survey is voluntary. You may choose not to take the survey and are allowed to stop taking the survey at any time. Your participation in this survey is confidential so please answer questions accurately as possible. After the surveys are collected, via paper and electronic copies, the information collected will be entered into a database. Only the research team, including the Principal Investigator and research staff, will be able to see information about individual participants. Since no personally identifying information will have been collected, no data will be linked to you.

Completion of this survey means you have been provided with the above information and have volunteered to take the survey.

The Principal Investigator in charge of this research study is Dr. Jennifer Marshall at the USF College of Public Health, Department of Community and Family Health. If you have any questions or concerns about this study, contact Dr. Marshall at (813) 396-2672 or jmarshal@health.usf.edu

This survey may be forwarded to
Mail: Dr. Jennifer Marshall University of South Florida, College of Public Health
Department of Community and Family Health, 13201 Bruce B Downs Boulevard, MDC 56
Tampa, Florida 33612-3805
Fax: (813) 905-9998
Email: jmarshal@health.usf.edu

To begin, please verify that you have not completed this survey before.

- ☐ I have not completed this survey before

First, please tell us a little about you:

Do you work in one of the Parental Mental Health (PMH) intervention sites?

- ☐ I work in one of the PMH intervention sites
- ☐ I do not work in one of the PMH intervention sites

What is your age?

_____

What is your gender?

- ☐ Male
- ☐ Female

What is your ethnicity?

- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino

What is your race? (Select all that Apply)

- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Pacific Islander
- ☐ Other

What is your <u>highest</u> level of education?

- ☐ Some High School or less
- ☐ High School graduate, diploma or equivalent (GED)
- ☐ Some college
- ☐ Trade/technical/vocational training
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Master's/Doctoral/Professional degree

What is your role at your organization?

- ☐ Administrator/Director
- ☐ Supervisor
- ☐ Home Visitor

How many years have you worked in your professional field?

_____

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Sure
I am familiar with the term Parental Mental Health.						

Following the World Health Organization definition, parental mental health can be described as "a state of well-being in which the child's parent realizes his/her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/her community." Parental Mental Health (PMH) practices include providing skills and tools to support healthy social and emotional functioning; supporting families' strengths and cultural values and beliefs; identifying early signs of emotional and psychological concerns; and promoting successful partnerships among families and community support systems.

Directions: Please select the option that best describes you.

<u>My Current Practices:</u>

The statement that best describes my current Parental Mental Health (PMH) practices:

- ☐ I have been using PMH strategies for a while (more than 1 year)
- ☐ I recently started using PMH strategies
- ☐ I plan to begin using PMH strategies

- ☐ I think it would be a good idea to begin using PMH strategies
- ☐ I have no plans to begin using PMH strategies
- ☐ I have not considered using PMH strategies

The following statements relate to *your* current practices. Please select the option that best describes you.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Sure
Incorporating PMH into my current practices would improve the services I currently provide.						
Incorporating PMH into my current practices would be compatible with the services I currently provide.						
Incorporating PMH into my current practices would be too complicated.						
Incorporating PMH into my current practices would be something I could try out before fully committing.						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Sure
I have seen how incorporating PMH improves practices for others in my field.						
PMH is an important issue for the families with whom I work.						
It is important for someone in my position to engage in PMH practices.						
Someone in my position should be an advocate for PMH.						
It is important for me to partner with others in the community who are interested in promoting PMH programs/services.						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Sure
It is easy for me to find current local, state and national resources on PMH.						
I would know what to do if a parent needed mental health services.						
I have the skills to assess PMH and connect those at risk to appropriate services.						
I feel confident in my ability to implement PMH practices.						
I feel that my current PMH practices are effective.						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Sure
My position permits me enough time to devote to PMH practices.						
I am motivated to implement PMH programs/services.						

I think that I play an important role in improving my community's ability to address PMH by promoting PMH programs/services.						
It is important to involve the whole family in PMH programs/services.						

Do you have any additional comments about your personal/professional Parental Mental Health knowledge or practices?

My Organization's Current Practices:

The statement that best describes my organization's current Parental Mental Health (PMH) practices:

- ☐ Staff in my organization have been using PMH strategies for a while (more than 1 year)
- ☐ Staff in my organization have recently started using PMH strategies (within 1 year)
- ☐ Staff in my organization plan to begin using PMH strategies
- ☐ Staff in my organization think it would be a good idea to begin using PMH strategies
- ☐ Staff in my organization have no plans to begin using PMH strategies
- ☐ Staff in my organization have not considered using PMH strategies

The following statements relate to your *organization's* current practices. Please select the option that best describes your organization.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Sure
Incorporating PMH into the current practices of staff in my organization would improve the services we currently provide.						
Incorporating PMH into the current practices of staff in my organization would be compatible with the services we currently provide.						
Incorporating PMH into the current practices of staff in my organization would be too complicated.						
Incorporating PMH into the current practices of staff in my organization would be something we could try out before fully committing.						
Incorporating PMH into the current practices of staff in my organization would be something we could learn from watching others.						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Sure
My organization is familiar with the term Parental Mental Health.						
PMH is an important issue for the families served in my organization.						
Staff in my organization should be trained to assess PMH and connect those at risk to appropriate services.						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Sure
Most members in my organization know where to go to find resources or information regarding PMH.						
Organizations in my community share information with each other in regards to PMH.						
Most members of my organization have the skills to assess PMH and connect those at risk to the appropriate services.						
Others in my organization have the skills to implement PMH practices.						
My organization promotes PMH effectively.						
My organization partners with community members to promote PMH effectively.						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Sure
My organization places importance on promoting or providing PMH programs/services in the community.						
My organization has adequate funding to implement PMH programs/services.						
My organization has sufficient staff to implement PMH practices.						
Key leaders in my organization are actively involved in PMH practices.						
My organization receives adequate technical assistance and support to educate staff in PMH practices.						
Organizations in my community participate in joint planning and decision-making PMH.						
It is important to continue training home visitors as first responders in identifying PMH challenges.						
Organizations in my community participate in joint meetings to address PMH.						
Community agencies and organizations work together to address PMH problems.						
Organizations in my community share money or personnel to implement PMH interventions.						

Do you have any additional comments about your organization's Parental Mental Health knowledge or practices?

We would greatly appreciate if you would please provide your email so we can follow up with you in an effort to continually assess the professional and organizational needs and concerns addressing Parental Mental Health. Your email will be held confidential and will not be linked to your responses.

_____

Thank you for taking the time to complete this survey! Your responses to the questions above will help us to better understand the individual and organizational needs as it relates to professional concerns addressing Parental Mental Health!

Appendix I: DRAFT MBSR Staff Stress Survey

DRAFT

Mindfulness Based Stress Reduction Survey

Thank you for participating in this survey regarding your practices and experiences as a health professional. You are being asked to complete this survey because of your participation in the Mindfulness Based Stress Reduction (MBSR) Seminar conducted to equip home visitors, administrators and supervisors with tools for stress management skills that can be applied in both personal and professional domains. MBSR is a program created to allow groups of individuals the ability to focus on becoming more aware and in the moment. Through the use of such techniques as meditation, progressive breathing and body postures, participants are able to become engaged in the moment, thus, become more mindful.

The purpose of this survey is to examine the benefits of mindfulness based training on the mitigation of stress and stress related symptoms. This particular study also aims to assess the extent of benefits that such training has both on personal and professional aspects of life. The present survey includes question regarding current stress management practices, mindfulness practices, perceptions of your quality of life and exposure to stress and traumatic life events. Completion of the questionnaire takes approximately 15 minutes and it is required that you are at least 18 years of age.

Some of the questions in this survey packet are of a sensitive nature and may in turn lead to varying levels of discomfort. If these feelings of discomfort do arise, please contact either the Principal Investigator, whose contact information is on the bottom of the page, or the Florida 211 resource by dialing 211 on your phone for potential referrals in your community.

Please be aware that completing this survey is voluntary. You may choose not to take the survey and are allowed to stop taking the survey at any time. Your participation is this survey is confidential so please answer questions honestly. After the surveys are collected, via paper and electronic copies, the information collected will be entered into a database. Only the research team, including the Principal Investigator and research staff, will be able to see information about individual participants. Since no personally identifying information will have been collected, no data will be linked to you.

Completion of this survey means you have been provided with the above information and have volunteered to take the survey.

The Principal Investigator in charge of this evaluation study is Dr. Jennifer Marshall at the USF College of Public Health, Department of Community and Family Health. If you have any questions, concerns or complaints about this study, contact Dr. Marshall at (813) 396-2672 or jmarshal@health.usf.edu

This survey can be forwarded to:

Mail: Dr. Jennifer Marshall
University of South Florida, College of Public Health
Department of Community and Family Health,
13201 Bruce B Downs Boulevard, MDC 56
Tampa, Florida 33612-3805
Fax: (813) 905-9998
Email: jmarshal@health.usf.edu

Before you begin:

Please verify that you have not completed this survey before.

- ☐ I have not completed this survey before

Please verify that you are at least 18 years of age.

- ☐ I am at least 18 years of age.

Are you registered to participate in the MBSR training?

- ☐ I am registered to participate in the MBSR training
- ☐ I am not registered to participate in the MBSR training

[Post-Test] **Please indicate which MBSR trainings you have participated in (select all that apply):**

- ☐ MBSR Workshop ___
- ☐ MBSR 8-week Web-Based Trainings
  - How many web-based trainings did you complete? _____
- ☐ MBSR follow-up conference calls
- ☐ Other trainings
  - (please describe) _____

First, please tell us a little about you:

What is your age? _____

What is your gender?

- ☐ Male
- ☐ Female

What is your ethnicity?

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

What is your race? (Select all that Apply)

- ☐ White
- ☐ Black/African American (Includes individuals from Africa, Haiti, Jamaica, etc.)
- ☐ Asian (Includes individuals from China, Japan, Philippines, India, etc.)
- ☐ American Indian/Alaskan Native
- ☐ Pacific Islander (Includes individuals from Hawaii, Guam, Samoa, etc.)
- ☐ Other: Please Specify:_____

What is your highest level of education?

- ☐ Some High School
- ☐ High School graduate, diploma or equivalent (GED)
- ☐ Some college
- ☐ Trade/technical/vocational training
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Masters/Doctoral/Professional degree

What is your role at your organization?

- ☐ Administrator/Director
- ☐ Supervisor
- ☐ Home Visitor
- ☐ Other: Please Specify:_____

How many years have you worked in your professional field? _____

How long have you worked in your current position? (years, months)_____

Stress and Coping Practices

Mindfulness Based Stress Reduction (MBSR) programs were created to allow groups of individuals the ability to focus on becoming more aware and in the moment. Through the use of such techniques as meditation, progressive breathing and body postures participants are able to become engaged in the moment, thus, become more mindful.

The questions that follow will be asking questions regarding your stress management practices as well as your knowledge of stress management techniques. Please provide answers that best fit your stress management practices and knowledge of stress management techniques **before** you participated in the MBSR seminar.

Prior to this survey/seminar, had you heard of Mindfulness Based Stress Reduction?

- ☐ Yes
- ☐ No

If yes, how would you rate your knowledge of Mindfulness Based Stress Reduction?

- ☐ No knowledge of MBSR
- ☐ Very little knowledge of MBSR
- ☐ Some Knowledge of MBSR
- ☐ A lot of knowledge of MBSR

Of the following stress management techniques, please select what you currently use.

- ☐ Exercise: Please specify: _____
- ☐ Meditation
- ☐ Positive Imagery
- ☐ Deep breathing
- ☐ Progressive muscle relaxation
- ☐ Mindfulness
- ☐ Counseling: Please specify: _____
- ☐ Talk to a loved one/friend
- ☐ Talk to co-worker/supervisor
- ☐ None
- ☐ Other: Please specify: _____

Please rank the stress management techniques you use **where 1 is used most frequently**. Please be sure to rank the selections from the previous question.

_____ Exercise
_____ Meditation
_____ Positive Imagery
_____ Deep breathing
_____ Progressive muscle relaxation
_____ Mindfulness
_____ Counseling: Please specify: _____
_____ Talk to a loved one/friend
_____ Talk to co-worker/supervisor
_____ None
_____ Other: Please specify: _____

Of the following stress management techniques, please select all that you currently use.

_____ Thought stopping (forcing one's self to stop thinking about a stressful topic)
_____ Distraction
_____ Procrastination
_____ Alcohol consumption
_____ Substance use
_____ Smoking
_____ Prescription medication
_____ Other
- Please specify: _____

Of the following practices, which do you believe are most commonly used by other home visitor staff?

- ☐ Exercise
- ☐ Meditation
- ☐ Positive Imagery
- ☐ Deep breathing
- ☐ Progressive muscle relaxation
- ☐ Mindfulness
- ☐ Counseling
- ☐ Talk to a loved one/friend
- ☐ Talk to co-worker/supervisor
- ☐ None
- ☐ Other

Of the following practices, which do you believe are commonly used by other home visitor staff?

_____ Thought stopping (forcing one's self to stop thinking about a stressful topic)
_____ Distraction
_____ Procrastination
_____ Alcohol consumption
_____ Substance use
_____ Smoking
_____ Prescription medication
_____ Other
- Please specify: _____

How often do you engage in Mindfulness Meditation?

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Never/Rarely
  - Please specify: _____

Toronto Mindfulness Scale

The questions that follow assess the extent to which you experience varying levels of mindfulness. Please read each statement and select how true each statement is of your experiences based on the following scale: **"not at all," "a little," "moderately," "quite a bit," and "very much."**

Instructions: Please indicate the extent to which you agree with each statement. In other words, how well does the statement describe what you just experienced, just now?

	Not at all	A little	Moderately	Quite a bit	Very much
I experienced myself as separate from my changing thoughts and feelings.	0	1	2	3	4
I was more concerned with being open to my experiences than controlling or changing them.	0	1	2	3	4
I was curious about what I might learn about myself by taking notice of how I react to certain thoughts, feelings or sensations.	0	1	2	3	4
I experienced my thoughts more as events in my mind than as a necessarily accurate reflection of the way things 'really' are.	0	1	2	3	4
I was curious to see what my mind was up to from moment to moment.	0	1	2	3	4
I was curious about each of the thoughts and feelings that I was having.	0	1	2	3	4
I was receptive to observing unpleasant thoughts and feelings without interfering with them.	0	1	2	3	4
I approached each experience by trying to accept it, no matter whether it was pleasant or unpleasant.	0	1	2	3	4
I remained curious about the nature of each experience as it arose.	0	1	2	3	4
I was aware of my thoughts and feelings without over identifying with them.	0	1	2	3	4
I was curious about my reactions to things.	0	1	2	3	4
I was curious about what I might learn about myself by just taking notice of what my attention gets drawn to.	0	1	2	3	4

Professional Quality of Life Scale (ProQOL)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation.

Directions: Select the number that honestly reflects how frequently you experienced these things in the **last 30 days.**

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help].*
_____ 7. I find it difficult to separate my personal life from my life as a *[helper].*
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help].*
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help].*
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*. I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper].*
_____ 13. I feel depressed because of the traumatic experience of the people I *[help].*
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped].*
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feeling about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case (work) load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [*help].*
_____ 24. I am proud of what I can do to [*help*].
_____ 25. As a result of my [*helping*], I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a [*helper*].
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

The next two scales comprise of questions about your current experiences and their impact on your stress.

Secondary Traumatic Stress Scale

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in **the past seven (7) days** by circling the corresponding number next to the statement.

NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.

Directions: Please select the option that best describes you

	Never	Rarely	Occasionally	Often	Very Often
I felt emotionally numb.	1	2	3	4	5
My heart started pounding when I thought about my work with clients.	1	2	3	4	5
It seemed as if I was reliving the trauma(s) experienced by my client(s).	1	2	3	4	5
I had trouble sleeping.	1	2	3	4	5
I felt discouraged about the future.	1	2	3	4	5
Reminders of my work with clients upset me.	1	2	3	4	5
I had little interest in being around others.	1	2	3	4	5
I felt jumpy.	1	2	3	4	5
I was less active than usual.	1	2	3	4	5
I thought about my work with clients when I didn't intend to.	1	2	3	4	5
I had trouble concentrating.	1	2	3	4	5
I avoided people, places, or things that reminded me of my work with clients.	1	2	3	4	5
I had disturbing dreams about my work with clients.	1	2	3	4	5
I wanted to avoid working with some clients.	1	2	3	4	5
I was easily annoyed.	1	2	3	4	5
I expected something bad to happen.	1	2	3	4	5
I noticed gaps in my memory about client sessions.	1	2	3	4	5

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts **during the last month.** In each case, you will be asked to indicate by circling **how often you felt or thought** a certain way**.**

Directions: Please select the option that best describes you.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
In the last month, how often have you felt nervous and "stressed"?	0	1	2	3	4
In the last month, how often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
In the last month, how often have you felt that things were going your way?	0	1	2	3	4
In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4

The questions in the following survey pertain to sensitive experiences some people have as a child. Please answer these questions as open and honestly as possible as of your responses are held confidential.

Adverse Child Experiences [Baseline survey only]

Directions: Please select the option that best describes you **prior to your 18th birthday**.

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?

No___ If Yes, enter 1 __

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?

No___ If Yes, enter 1 __

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? Or Attempt or actually have oral, anal, or vaginal intercourse with you?

No___ If Yes, enter 1 __

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?

No___ If Yes, enter 1 __

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

No___ If Yes, enter 1 __

6. Was a biological parent ever lost to you through divorce, abandonment, or other reason?

No___ If Yes, enter 1 ___

7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her? Or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

No___ If Yes, enter 1 ___

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

No___ If Yes, enter 1 ___

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

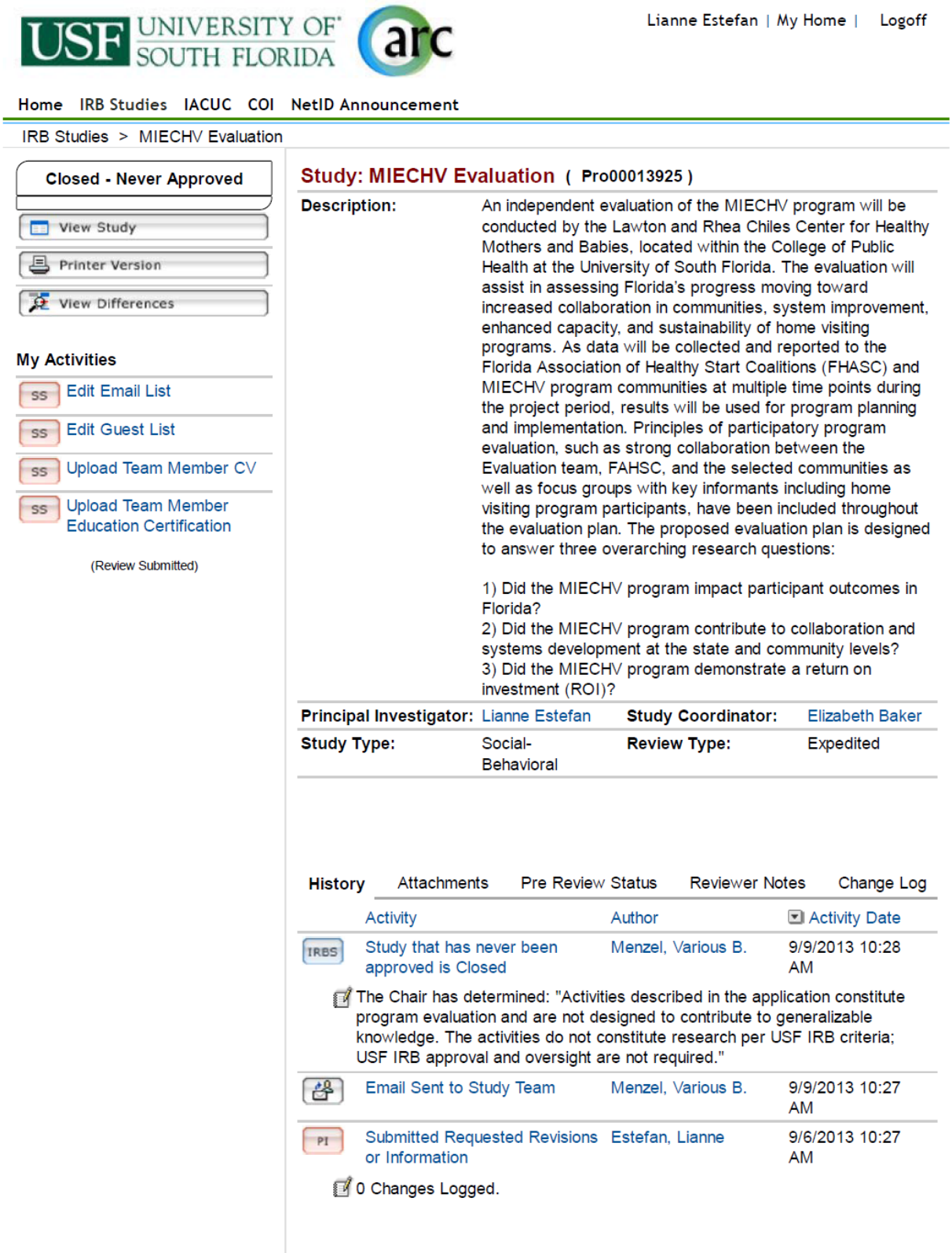
No___ If Yes, enter 1 ___

10. Did a household member go to prison?

No___ If Yes, enter 1 ___

Thank you so much for your participation!

Appendix J: IRB Exemption Letters



USF UNIVERSITY OF SOUTH FLORIDA arc

Lianne Estefan | My Home | Logoff

Home IRB Studies IACUC COI NetID Announcement

IRB Studies > MIECHV Evaluation

Closed - Never Approved

View Study

Printer Version

View Differences

My Activities

Edit Email List

Edit Guest List

Upload Team Member CV

Upload Team Member Education Certification

(Review Submitted)

Study: MIECHV Evaluation (Pro00013925)

Description: An independent evaluation of the MIECHV program will be conducted by the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, located within the College of Public Health at the University of South Florida. The evaluation will assist in assessing Florida's progress moving toward increased collaboration in communities, system improvement, enhanced capacity, and sustainability of home visiting programs. As data will be collected and reported to the Florida Association of Healthy Start Coalitions (FHASC) and MIECHV program communities at multiple time points during the project period, results will be used for program planning and implementation. Principles of participatory program evaluation, such as strong collaboration between the Evaluation team, FAHSC, and the selected communities as well as focus groups with key informants including home visiting program participants, have been included throughout the evaluation plan. The proposed evaluation plan is designed to answer three overarching research questions:

1) Did the MIECHV program impact participant outcomes in Florida?
2) Did the MIECHV program contribute to collaboration and systems development at the state and community levels?
3) Did the MIECHV program demonstrate a return on investment (ROI)?

Principal Investigator:	Lianne Estefan	**Study Coordinator:**	Elizabeth Baker
Study Type:	Social-Behavioral	**Review Type:**	Expedited

History | Attachments | Pre Review Status | Reviewer Notes | Change Log

Activity	Author	Activity Date
IRBS Study that has never been approved is Closed	Menzel, Various B.	9/9/2013 10:28 AM
The Chair has determined: "Activities described in the application constitute program evaluation and are not designed to contribute to generalizable knowledge. The activities do not constitute research per USF IRB criteria; USF IRB approval and oversight are not required."		
Email Sent to Study Team	Menzel, Various B.	9/9/2013 10:27 AM
PI Submitted Requested Revisions or Information	Estefan, Lianne	9/6/2013 10:27 AM
0 Changes Logged.		

Marshall, Jennifer

From: Menzel, Various
Sent: Wednesday, March 11, 2015 3:30 PM
To: Marshall, Jennifer
Cc: Detman, Linda; Guevara-Carrasquero, Pamela
Subject: RE: IRB - MIECHV

Hello Jennifer:

Are you doing the same things, if yes, then you are still doing a program evaluation and you would not need to re-apply.

Best,

Various B. Menzel, CCRP
Sr. Research Compliance Administrator - *Social & Behavioral Studies*
University of South Florida
Phone: (813) 974-6433
E-mail: vmenzel@usf.edu

From: Marshall, Jennifer [mailto:jmarshal@health.usf.edu]
Sent: Wednesday, March 11, 2015 3:24 PM
To: Menzel, Various
Cc: Detman, Linda; Guevara, Pamela
Subject: IRB - MIECHV

Good afternoon Various,
I am the new PI on the MIECHV Evaluation, which was found IRB exempt when it began. This month, we received expansion for the MIECHV evaluation to include:

- 4 new MIECHV sites of same evaluation activities described in the attached IRB
- Evaluation of mental health intervention at 5 MIECHV sites
- Evaluation of learning collaborative activities at 5 MIECHV sites

Would we need to re-apply to IRB for the expansion, or does it remain exempt as a program evaluation?

Thanks for the guidance,

Jennifer Marshall, PhD, MPH
Research Assistant Professor
University of South Florida College of Public Health
Department of Community & Family Health
(813) 396-2672

Appendix K
Timeline/Workplan

FL MIECHV Expansion - Proposed Evaluation Timeline

FL MIECHV Expansion - Proposed Evaluation Timeline

University of South Florida, Chiles Center for Healthy Mothers and Babies

Year 1: Milestones and Timelines

Year 1												
Milestones and Timelines	**Mar 2015**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan 2016**	**Feb**
Program Organization and Management												
Project Start Date (contract finalized May 1, 2015)			X									
Obtain of IRB Approval	X											
Hire Research Assistants			X									
Finalize evaluation plan in collaboration with FAHSC, including selection of measures for CI&R Community teams and Mental Health Components			X	X	X							
Hold regular weekly or biweekly meetings with Research Assistants			X	X	X	X	X	X	X	X	X	X
Hold bimonthly evaluation team meetings (or as needed)			X		X		X	X	X		X	X
Notes:												
Milestones and Timelines	**Mar 2015**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan 2016**	**Feb**
Strategy 2: Implementing a multi-site community team to develop and test Coordinated Intake and Referral (CI&R) models												
Program Organization and Management												
Select and finalize measures (existing, modified, or developed)	X	X	X	X	X							
Pilot test measures developed by evaluation team						X	X	X	X			
Q1: What are community team members' perceptions, concerns and interactions within their collaborative that reflect group dynamics? Did these group dynamics show positive change over time?												
Q2: What are MIECHV CI&R community team members' individual characteristics (Agencies and service sectors, organizational roles, knowledge, beliefs, self-efficacy, etc.) that support implementation of CI&R development? Did these individual characteristics show positive change over time?												
Conduct baseline survey of community team members' individual characteristics and perceptions of group dynamics.											X	X
Analyze results												

Report results to partners and FAHSC												
Q3: How do the MIECHV CI&R teams identify and describe characteristics of the inner setting (organization/program) in their communities that serve as barriers or facilitators to organizational adoption of the CI&R models within their programs?												
Q4: Did the MIECHV CI&R community teams identify characteristics of the outer setting (community partners/state programs) that impact the organizational adoption of the CI&R models within their programs?												
Conduct focus groups with community team members to gather their perceptions of the CI&R models. Y1 SEPT/OCT										X		
Analyze results NOV/DEC											X	
Report results to partners and FAHSC JAN/FEB												X
Q5: How do the MIECHV CI&R community teams identify characteristics of the CI&R models that will predict organizational and community adoption of the model within their programs?												
Q6: How do the MIECHV CI&R community teams create a timeline for implementation (planning, engaging, executing, reflecting and evaluating)?												
Q7: How do CI&R teams describe the successes and challenges encountered in the early stages of the CI&R model development process?												
Prepare materials/interview guide for focus groups year 2											X	X
Conduct literature reviews on adoption of CI&R			X	X	X	X	X	X	X	X	X	X
Milestones and Timelines	**Mar 2015**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan 2016**	**Feb**
Strategy 3: Evidence-Based Mental Health												
3a: Parental Mental Health – Process Evaluation												
Q1. At what level of readiness are Florida MIECHV administrators, supervisors, and staff, and program participants at MIECHV PMH overlay pilot sites for institutionalizing PMH into their current practice (including PMH pilot sites as compared to those at non-PMH sites)? a. Did those perceptions for PMH pilot sites change over time?												
Q2. What are the individual characteristics (background, knowledge, attitudes, beliefs, self-efficacy, social/professional norms and roles) of administrators, supervisors, staff, and program participants at MIECHV PMH overlay pilot sites related to PMH implementation in their current practice as compared to those at non-PMH sites? a. Did those perceptions for PMH pilot sites change over time?												
Q3. What are the Florida MIECHV administrators', supervisors', and staffs' perceptions of MIECHV PMH implementation and institutionalization (relative advantage, compatibility, complexity, trialability, observability) at MIECHV PMH overlay pilot sites? a. Did those perceptions for PMH pilot sites change over time?												
Q4. What are the perceptions of administrators, supervisors, and staff at MIECHV PMH overlay pilot sites regarding the feasibility and acceptability of implementing/participating in the PMH overlay? (Year 2)												
Conduct focus groups with home visitors, supervisors and administrators to discuss parental mental health needs and practices in their programs and communities							X	X				
Send audio files for transcription and review for accuracy and overarching themes/open codes								X	X	X		
Conduct coding and analysis on focus group data											X	X
Finalize PMH Intervention Organizational Readiness Survey			X	X								

Finalize PMH Intervention Organizational Readiness Survey				X	X							
Pilot test PMH Intervention Organizational Readiness Survey						X	X	X				
Distribute PMH Intervention Organizational Readiness Baseline Survey to all staff											X	X
Analyze survey results												
Prepare baseline report												
Milestones and Timelines	**Mar 2015**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan 2016**	**Feb**
3b: Mindfulness-Based Stress Reduction (MBSR) for Home Visitors – Outcome Evaluation												
Q1. Did the MIECHV staff participating in MBSR Workshops report higher levels of mindfulness practice 30 days following training and 6 months follow up?												
Q2. Did the MIECHV staff participating in MBSR Workshops report lower levels of stress 30 days following training and 6 months follow up?												
Obtain validated measures			X	X								
Finalize online survey incorporating measures (PSS, STSS, ProQol, ACEs, Mindfulness Practice, etc.)				X	X	X	X	X				
Administer online survey – Pretest 1									X	X	X	X
3b: Mindfulness-Based Stress Reduction (MBSR) for Home Visitors – Process Evaluation												
Q4. At what level of readiness are MIECHV administrators, supervisors, staff for institutionalizing MBSR into their current practice?												
Q5. What are the characteristics (background, knowledge, attitudes, beliefs, self-efficacy, social/professional norms & roles) of administrators, supervisors, staff, and program participants for institutionalizing MBSR into their current practice?												
Q5a. Did those perceptions change over time?												
Q6. What are the administrators, supervisor and staff perceptions of MBSR (relative advantage, compatibility, complexity, trialability, observability) of MBSR?												
Q6a. Did those perceptions change over time?												
Q7. Following MBSR training workshops, to what extent (frequency, intensity, duration) did home visitors utilize the techniques they learned												
Conduct focus groups with home visitors, supervisors and administrators to discuss sources of staff stress and burnout, as well as coping and support strategies							X	X				
Send audio files for transcription and review for accuracy and overarching themes/open codes								X	X	X		
Conduct coding and analysis on focus group data											X	X
Finalize Maternal MBSR Intervention Organizational Readiness Survey			X	X								
Pilot test MBSR Intervention Organizational Readiness Survey					X	X	X	X				

Year 2: Milestones and Timelines

Year 2												
Milestones and Timelines	**Mar 2016**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan 2017**	**Feb**
Program Organization and Management												
Hold regular weekly or biweekly meetings with Research Assistants	X	X	X	X	X	X	X	X	X	X	X	X
Hold bimonthly evaluation team meetings (or as needed)	X		X		X		X		X		X	
Milestones and Timelines	**Mar 2016**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan 2017**	**Feb**
Strategy 2: Implementing a multi-site community team to develop and test Coordinated Intake and Referral (CI&R) models												
Q1: What are community team members' perceptions, concerns and interactions within their collaborative that reflect group dynamics? Did these group dynamics show positive change over time?												
Q2: What are MIECHV CI&R community team members' individual characteristics (knowledge, beliefs, self-efficacy, etc.) that support implementation of CI&R development? Did these individual characteristics show positive change over time?												
Conduct follow-up survey of community team members' perceptions of group dynamics and their individual characteristics.								X	X			
Analyze results	X	X							X	X		
Report results to partners and FAHSC			X								X	X
Q3: How do the MIECHV CI&R teams identify and describe characteristics of the inner setting (organization/program) in their communities that serve as barriers or facilitators to organizational adoption of the CI&R models within their programs?												
Q4: Did the MIECHV CI&R community teams identify characteristics of the outer setting (community partners/state programs) that impact the organizational adoption of the CI&R models within their programs?												
Conduct focus groups with community team members to gather their perceptions of the CI&R models. *(Year 1 Activity)*	X	X					X	X				
Analyze/ Modify results and update based on new information as needed Year 2			X						X			
Q5: How do the MIECHV CI&R community teams identify characteristics of the CI&R models that will predict organizational and community adoption of the model within their programs?												
Q6: How do the MIECHV CI&R community teams create a timeline for implementation (planning, engaging, executing, reflecting and evaluating)?												
Q7: How do CI&R teams describe the successes and challenges encountered in the early stages of the CI&R model development process?												
Conduct focus groups with community teams to identify organizational characteristics and barriers to adoption of CI&R and perceptions of community partners/state programs characteristics that impact adoption of CI&R models.	X	X					X	X				
Analyze results			X						X			

Report results to learning collaborative teams/members, partners and to FAHSC				X						X	X	X
Conduct literature reviews on adoption of CI&R	X	X	X	X	X	X	X	X	X	X	X	X
Prepare and submit manuscript(s) for publication, presentation	X	X	X	X	X	X	X	X	X	X	X	X
Milestones and Timelines	**Mar 2016**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan 2017**	**Feb**
Strategy 3: Evidence-Based Mental Health												
3a: Parental Mental Health – Process Evaluation												
Q1. At what level of readiness are Florida MIECHV administrators, supervisors, and staff, and program participants at MIECHV PMH overlay pilot sites for institutionalizing PMH into their current practice (including PMH pilot sites as compared to those at non-PMH sites)? a. Did those perceptions for PMH pilot sites change over time?												
Q2. What are the individual characteristics (background, knowledge, attitudes, beliefs, self-efficacy, social/professional norms and roles) of administrators, supervisors, staff, and program participants at MIECHV PMH overlay pilot sites related to PMH implementation in their current practice as compared to those at non-PMH sites? a. Did those perceptions for PMH pilot sites change over time?												
Q3. What are the Florida MIECHV administrators', supervisors', and staffs' perceptions of MIECHV PMH implementation and institutionalization (relative advantage, compatibility, complexity, trialability, observability) at MIECHV PMH overlay pilot sites? a. Did those perceptions for PMH pilot sites change over time?												
Q4. What are the perceptions of administrators, supervisors, and staff at MIECHV PMH overlay pilot sites regarding the feasibility and acceptability of implementing/participating in the PMH overlay? (Year 2)												
Distribute online Parental Mental Health Intervention Organizational Readiness Survey Follow-up								X	X			
Analyze survey results Baseline, Follow-up	X	X								X	X	
Prepare final report Baseline, Follow-up			X	X							X	X
Conduct literature reviews on mental health overlay innovation	X	X	X	X	X	X	X	X	X	X	X	X
Prepare and submit manuscript(s) for publication, presentation	X	X	X	X	X	X	X	X	X	X	X	X
Conduct focus groups with home visitors, supervisors and administrators at PMH sites to discuss implementation							X	X				
Send audio files for transcription and review for accuracy and overarching themes/open codes								X	X			
Conduct coding and analysis on focus group data									X	X	X	X
Notes: MBSR Organizational Readiness Survey												
Milestones and Timelines	**Mar 2016**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan 2017**	**Feb**
3b: Mindfulness-Based Stress Reduction (MBSR) for Home Visitors – Outcome Evaluation												
Q1. Did the MIECHV staff participating in MBSR Workshops report higher levels of mindfulness practice 30 days following training and 6 months follow up?												

Q2. Did the MIECHV staff participating in MBSR Workshops report lower levels of stress 30 days following training and 6 months follow up?												
Distribute online MBSR Intervention Organizational Readiness Survey - Pretest 1					X	X	X					
Administer online survey – Pretest 2						X	X	X				
Administer online survey – Pretest 3								X	X	X		
Attend MBSR Training								X	X	X	X	
Administer online survey – Post-test 1										X	X	X
3b: Mindfulness-Based Stress Reduction (MBSR) for Home Visitors – Process Evaluation												
Q4. At what level of readiness are MIECHV administrators, supervisors, and staff for institutionalizing MBSR into their current practice?												
Q5. What are the characteristics (background, knowledge, attitudes, beliefs, self-efficacy, social/professional norms & roles) of administrators, supervisors, staff, and program participants for institutionalizing MBSR into their current practice?												
Q5a. Did those perceptions change over time?												
Q6. What are the administrators, supervisor and staff perceptions of MBSR (relative advantage, compatibility, complexity, trialability, observability) of MBSR?												
Q6a. Did those perceptions change over time?												
Q7. Following MBSR training workshops, to what extent (frequency, intensity, duration) did home visitors utilize the techniques they learned												
Conduct focus groups with home visitors, supervisors and administrators to discuss sources of staff stress and burnout, as well as coping and support strategies							X	X				
Send audio files for transcription and review for accuracy and overarching themes/open codes								X	X			
Conduct coding and analysis on focus group data									X	X	X	X
Administer online surveys (see above)	X	X	X	X	X	X	X	X	X	X		

Year 3: Milestones and Timelines

Year 3												
Milestones and Timelines	**Mar 2017**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**			
Program Organization and Management												
Hold regular weekly or biweekly meetings with Research Assistants	X	X	X	X	X	X	X	X	X			
Hold bimonthly evaluation team meetings (or as needed)	X		X		X		X		X			
Milestones and Timelines	**Mar 2017**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**			
Strategy 2: Implementing a multi-site community team to develop and test Coordinated Intake and Referral (CI&R) models												
Q1: What are community team members' perceptions, concerns and interactions within their collaborative that reflect group dynamics? Did these group dynamics show positive change over time?												

Q2: What are MIECHV CI&R community team members' individual characteristics (knowledge, beliefs, self-efficacy, etc.) that support implementation of CI&R development? Did these individual characteristics show positive change over time?												
Conduct follow-up survey of community team members' perceptions of group dynamics and their individual characteristics.								X	X			
Analyze results									X			
Report results to partners and FAHSC												
Q3: How do the MIECHV CI&R teams identify and describe characteristics of the inner setting (organization/program) in their communities that serve as barriers or facilitators to organizational adoption of the CI&R models within their programs?												
Q4: Did the MIECHV CI&R community teams identify characteristics of the outer setting (community partners/state programs) that impact the organizational adoption of the CI&R models within their programs?												
Conduct focus groups with community team members to gather their perceptions of the CI&R models. *(Year 1 Activity)*	X	X					X	X				
Analyze/ Modify results and update based on new information as needed Year 2			X						X			
Q5: How do the MIECHV CI&R community teams identify characteristics of the CI&R models that will predict organizational and community adoption of the model within their programs?												
Q6: How do the MIECHV CI&R community teams create a timeline for implementation (planning, engaging, executing, reflecting and evaluating)?												
Q7: How do CI&R teams describe the successes and challenges encountered in the early stages of the CI&R model development process?												
Conduct focus groups with community teams to identify organizational characteristics and barriers to adoption of CI&R and perceptions of community partners/state programs characteristics that impact adoption of CI&R models.	X	X					X	X				
Analyze results			X						X			
Report results to learning collaborative teams/members, partners and to FAHSC				X								
Conduct literature reviews on adoption of CI&R	X	X	X	X	X	X	X	X	X			
Prepare and submit manuscript(s) for publication, presentation	X	X	X	X	X	X	X	X	X			
Milestones and Timelines	**Mar 2017**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**			
Strategy 3: Evidence-Based Mental Health												
3a: Parental Mental Health – Process Evaluation												
Q1. At what level of readiness are Florida MIECHV administrators, supervisors, and staff, and program participants at MIECHV PMH overlay pilot sites for institutionalizing PMH into their current practice (including PMH pilot sites as compared to those at non-PMH sites)? a. Did those perceptions for PMH pilot sites change over time?												
Q2. What are the individual characteristics (background, knowledge, attitudes, beliefs, self-efficacy, social/professional norms and roles) of administrators, supervisors, staff, and program participants at MIECHV PMH overlay pilot sites related to PMH implementation in their current practice as compared to												

those at non-PMH sites? a. Did those perceptions for PMH pilot sites change over time?												
Q3. What are the Florida MIECHV administrators', supervisors', and staffs' perceptions of MIECHV PMH implementation and institutionalization (relative advantage, compatibility, complexity, trialability, observability) at MIECHV PMH overlay pilot sites? a. Did those perceptions for PMH pilot sites change over time?												
Q4. What are the perceptions of administrators, supervisors, and staff at MIECHV PMH overlay pilot sites regarding the feasibility and acceptability of implementing/participating in the PMH overlay? (Year 2)												
Distribute online Parental Mental Health Intervention Organizational Readiness Follow up Survey 2			X	X								
Analyze survey results Follow-up 2					X	X						
Prepare final report Follow-up Survey and Focus Groups							X	X	X			
Report results to sites								X	X			
Conduct literature reviews on mental health overlay innovation	X	X	X	X	X	X	X	X	X			
Prepare and submit manuscript(s) for publication, presentation	X	X	X	X	X	X	X	X	X			
Notes: MBSR Organizational Readiness Survey												
Milestones and Timelines	**Mar 2017**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**			
3b: Mindfulness-Based Stress Reduction (MBSR) for Home Visitors – Outcome Evaluation												
Q1. Did the MIECHV staff participating in MBSR Workshops report higher levels of mindfulness practice 30 days following training and 6 months follow up?												
Q2. Did the MIECHV staff participating in MBSR Workshops report lower levels of stress 30 days following training and 6 months follow up?												
Administer online survey – Posttest 2	X	X	X	X								
Administer online survey – Posttest 3		X	X	X	X							
Analyze survey results Year 3					X	X	X					
Prepare final report on MBSR Year 3							X	X	X			
3b: Mindfulness-Based Stress Reduction (MBSR) for Home Visitors – Process Evaluation												
Q4. At what level of readiness are MIECHV administrators, supervisors, and staff for institutionalizing MBSR into their current practice?												
Q5. What are the characteristics (background, knowledge, attitudes, beliefs, self-efficacy, social/professional norms & roles) of administrators, supervisors, staff, and program participants for institutionalizing MBSR into their current practice?												
Q5a. Did those perceptions change over time?												
Q6. What are the administrators, supervisor and staff perceptions of MBSR (relative advantage, compatibility, complexity, trialability, observability) of MBSR?												
Q6a. Did those perceptions change over time?												
Q7. Following MBSR training workshops, to what extent (frequency, intensity, duration) did home visitors utilize the techniques they learned												
Send audio files for transcription and review for accuracy and overarching themes/open codes												
Conduct coding and analysis on focus group data	X											
Prepare final report on MBSR focus groups		X	X									

Administer online surveys (see above)	X	X	X	X	X	X	X	X	X			
Report results to sites								X	X			