

***U.S. Department of Health and Human Services
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**Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program
Technical Assistance Coordinating Center's**

Webinar
"Family Engagement and Retention: Part II"
September 24, 2013
3:00pm Eastern

Presentations by:

*Dr. Karen McCurdy, University of Rhode Island
David A Jones, Office of Head Start
Shannon Self-Brown, SafeCare
Pauline McKenzie-Day, SafeCare
Molly O'Fallon, Nurse-Family Partnership*

Operator: Good day everyone welcome to today's MIECHV TACC Webinar on Family Engagement and Retention: Part II.

Today's conference is being recorded. And at this time I like to turn the conference over to Ms. Christy Stanton. Please go ahead ma'am.

Christy Stanton: Thank you. Hello everybody and welcome to Family Engagement Retention: Part II.

Today's Webinar is brought to you by the Maternal Infant and Early Childhood Home Visiting Technical Assistance Coordinating Committee or Center the MIECHV TACC.

The TACC is funded by HRSA and is staffed by ZERO TO THREE and subcontractor partners Chapin Hall, the Association of Maternal and Child Health Programs and Walter R. McDonald & Associates.

The TACC provides different levels of support to MIECHV grantees using ZERO TO THREE and partner staff along with numerous expert consultants and in coordination with other TA providers.

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My name is Christy Stanton and I'm a TACC TA Specialist with ZERO TO THREE. I will be introducing this Webinar today. Cathy Bodkin, Senior TA Specialist and Maria Gehl, the Assistant Director of the TACC will be staffing the Chat Box.

Lena Cunningham and Tracey Harding with the TACC will be providing behind-the-scenes support with our Webinar technology.

We're so glad you're with us today and know that you will find this a fascinating Webinar.

We're very pleased that Kathleen Kilbane is with us today to offer you words of welcome from HRSA. Kathleen?

Hello Kathleen?

Kathleen Kilbane: It is my pleasure to be with all of you on this Webinar today. On behalf of Health Resources and Services Administration, Maternal Child Health Bureau and the Administration for Children and Families I would like to say welcome to all of you to the second part of the Family Engagement and Retention Webinar series. Thank you for your participation today.

Family Engagement and Retention is one of the major keys to the success of the Maternal Infant and Early Childhood Home Visiting Program and really to evidence-based home visiting programs in general.

Our MIECHV goal of implementing high-quality evidence-based programs as part of a comprehensive early child system can only be realized if families are engaged and retained in programs and referred to all of the health and social services that they would need. It is all about relationships at every level.

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Family engagement and retention is no easy task. We recognize this. It is also an area of great interest to our division of Home Visiting and Early Childhood System as well as to the Maternal and Child Health Bureau and HRSA Leadership.

The first year of data reporting demonstrates that grantees are hard at work in this area, have experienced some challenges in some cases and where the opportunity exists are eager to continue to improve in this area.

We are eager to share best practices across programs in this area to face this challenge in order to better serve the at-risk populations.

To this end HRSA and ACF are excited about today's Webinar and grateful to all of the presenters that will be sharing their expertise today.

Once again thank you very much for your participation in this Webinar today, your commitment to this program and for your dedication to improving the lives of the many children and families you touch not only through the MIECHV program but the myriad of other programs and services you provide. Thank you all.

Christy Stanton: Thank you so much Kathleen. Now let me share a bit more detail about our Webinar program today. We'll begin with a presentation by Dr. Karen McCurdy and we'll continue with retention strategies with guests from Early Head Start, SafeCare and Nurse-Family Partnership.

We will then proceed to an open discussion with question and answer with the presenters and will welcome your input through the chat box.

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The Webinar objectives are as follows. We believe that as a result of participating on this Webinar you will increase your understanding of the differences between enrollment, engagement, and retention in home visiting programs.

You will understand how individual, family and community considerations can affect participation in home visiting programs and consider how different approaches to enrollment, engagement and retention might influence outcome measures.

Before we jump into our agenda I have a few items to share with you. First your phone lines will stay muted throughout the duration of the Webinar.

For optimal sound quality we encourage you to call in via the phone line versus listening in on your computer speakers.

You will also have the opportunity to participate in two polls today. We invite you to share your thoughts and questions via chat throughout the Webinar.

Feel free also to respond to one another's comments in the chat box.

The chat box is located in the lower left corner of the Webinar window just to the left of the PowerPoint slide. To post your comments in the chat box you will type your post into the text field at the bottom of the chat area and click the arrow.

Only public chat is available for this Webinar.

So before we move on to the presentations we'd first like to hear from you. Think about this question. How much concern do you feel about your program's family retention rates? A - none,

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very few families leave our program early, B - a little concern, C - some concern, D - a lot of concern.

You can share your answer with us by selecting the letter that best represents your answer in the feedback window to the left of the PowerPoint slide.

If you're not seeing the letter options click the little arrow to the left of the word Feedback to open that window. As soon as the circle in front of your selected letter has turned blue with a little black dot inside you've submitted your answer.

If you'd like to offer additional thoughts please feel free to type them into the chat box. So I'll give you a little bit more time to answer the question and we'll show the results as they come in.

Okay it looks like people are typing in their answer. I'll give this another couple of seconds. So far it looks like the majority; almost three quarters, of you feel some or a lot of concern about your family's retention rates.

So certainly in line with what Kathleen was sharing, this is an issue that many of us are thinking about a great deal in the field of home visiting to get the outcomes that we're also interested in for families and children.

So let's look at the next question. Do you know or notice that families are most likely to leave your program at specific times? A - yes before three months of service have passed, B - between three and six months of service, C- between six and nine months or D - after nine months?

There is also an option to indicate you're not sure. So please take a moment to enter what you believe to be the case in your program and we'll look at those together.

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Okay all right answers are still coming in. I'll give you another couple of seconds. Well this is more of a mixed bag. It looks like the largest response is for C between six and nine months may be followed by after nine months.

So perhaps initially engaging is less of a challenge than keeping a family retained over a multi-month program. So this will be something we talk about in our presentations today. Thank you very much for your input on those questions.

If you are registered for this Webinar you received a packet yesterday that included detailed biographies for each of our presenters today.

And I hope that you take the time to get to know them through reading through that packet. But now it is my pleasure to introduce Dr. Karen McCurdy who will begin our discussion today on Family Engagement and Retention Part II. Thank you for being with us Karen and I'll turn things over to you.

Karen McCurdy: All right. Well I want to thank you for inviting me to speak today about the challenges of retaining families in home visiting and prevention focused programs.

For today's talk I want to cover four major areas. So first I want to revisit some of the key themes and ideas that were talked about in the last Webinar by Deborah Daro so that we all kind of have a common base of knowledge.

And then I want to consider some different ways you could define retention especially including those that are commonly used in the research, things like duration, dosage and intensity of visits but also briefly talking about some less common definitions that may be of interest to programs.

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Then I'm going to use a multilevel model to discuss characteristics of the parent, the home visitor, the program and the neighborhood that influence retention but I'm going to focus particularly on the provider program factors as these can be influenced by the program more readily.

And then finally I want to spend some time discussing what these findings mean for retaining families in voluntary home visiting programs.

So first I want to recap a little bit about what (Deborah Darrell) described in the last Webinar about the engagement and retention process.

So this is a multi-step process and it has many decision points along the way. So this is kind of a simplified version of it.

So the first step is getting parents to actually intend to enroll. So here we're interested in what factors make parents say I want home visiting.

The next step is actual enrollment which many people define as receiving the first visit. So here we're interested in factors that make the parents say I'll try it.

Then the next step which is actually a series of steps that I just grouped together is keeping the family enroll and retained in the program.

And so today's talk is going to focus on this third step and we're going to investigate why parents choose to stick with it.

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So why are we interested in retention? Well one of the main reasons is that there are substantial dropout rates across many different types of home visitation programs especially once programs decide to go to scale.

So programs might have done a great job engaging families when they were smaller but as they grow and try to attract more families attrition becomes a bigger issue.

Often we see rates of 50% attrition in the first year of services. Now obviously this is more true for longer-term programs, programs that are serving families for six months or so but retention can be an issue for any home visiting program.

The second reason we're interested in retention is because across every kind of home visiting program studies show the programs typically deliver only half of the intended visit.

So this means if you have a service plan to deliver weekly visits it's quite likely that your families are only getting visits every other week or if your service model is to deliver visits on a monthly basis it's quite likely that your families are only getting visits every other month.

Now perhaps the most important reason we're interested in retention has to do with the fact that more visits and longer time in service actually lead to better outcomes for both the parents and the children.

So study suggests that retention leads to improved parenting attitudes, a reduction in repeat births and even higher vocabulary among young children.

So clearly we need to be more effective in the ways that we keep families in service.

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Let's talk a little bit about how retention can be defined. I'm going to focus first on definitions that are typically used in the research.

So dosage, this is a term that is borrowed from medical models and it usually means a number of visits received by the family.

Now I would argue that this is the most consistently measured indicator of retention. And because of that it's going to be the focus of today's presentation.

So most of the studies I'll be talking about looked at the number of visits received during the first year of services. But we could also define retention as duration which means the number of weeks a family is enrolled in a program.

The problem with this definition is that it can vary due to program procedures. So for example if programs use creative outreach with additional efforts to reengage families they are going to look better on this indicator than programs who terminate more quickly.

Intensity is another way we could define retention and this typically means visits per week of enrollment. But this has similar drawbacks as the duration variable.

So in this case programs who use creative outreach will actually look worse on this indicator because they keep families on their list for longer than programs that terminate more quickly.

So find a way that research has often defined retention is completion. And by this I mean a family has completed all the visits or some high percentage, let's say 75%.

Now this is less commonly used in research but potentially it's an important indicator of retention.

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Now clearly there's other ways we could talk about engagement and these are probably some of the ones that programs are more interested in.

The problem is they are generally unexamined in the research base. So for example retention of the father or partner, that must be key to family engagement but few studies have looked at that.

We often wonder how actively the family participates in visits. Is the parent listening to what the home visitor's saying, are they participating in activities or is the visitor spending more time interacting with the child?

We often are concerned about whether families are consistently open to visits. This has been linked to intensity. And by this I mean are they there at the time that you scheduled a visit?

Now Wagner and her colleagues have come up with two innovative ways to think about engagement.

The first is what they call do the homework engagement. And here we wonder do families actually practice the strategies that they have learned in home visiting in-between visits?

And then there's also look for more engagement. And here we mean do families go beyond what the home visitor has told them to actually access more services or to find more information about ways to support childrearing.

The final wave that has - we could define engagement is something called goal completion. So people who are invested in this area define it as has the family completed any or all of the program goals?

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And I'm going to be talking later about one study that has been done that has looked at this outcome.

Future research needs to include all these definitions of retention. But today I'm going to focus primarily on dosage as the key indicator of engagement in a program.

So Deborah Daro and I proposed a multilevel model of retention that considers four key domains. First, parent factors that relate to retention.

Here we distinguish between objective program experiences so things like can the family enroll prenatally or do they have to wait until after the birth of the child?

And we also thought subjective program experiences or the actual perception of the family would play a key role in retention.

So by subjective program experience I could mean things like does the family see some benefit from these services?

But we also thought that provider factors are going to play a key role in retention. And we identified four areas we thought would be of critical impact. The first is the provider's cultural competence.

Then there's their service delivery style. Are they more focused on the family or achieving program goals? Caseload will obviously play a role as will training.

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But providers do not operate in a vacuum. Indeed their ability to engage families may be supported or inhibited by the program in which they're working.

So we also identified four program factors that we believe are of critical importance. These include stable funding of the program, the amount of supervision that can be provided to each home visitor.

Does the program offer participant incentives? Can they give diapers or books to families and is there a low level of staff turnover?

And then finally programs also don't operate in a vacuum. They must deliver services in the neighborhood that they're operating in.

So we identified a couple of neighborhood factors we thought might be key to retention. So we talked about things like social cohesion, how chaotic or distressed is a neighborhood? And we thought that more highly distressed neighborhoods might be less conducive to home visiting.

And then there's also the question of concrete resources for the family, what is available in that neighborhood? Are there parks? Are there libraries? Are there open spaces for children to play in?

So today I'm going to briefly talk about the left side of this graph so the parents and neighborhood factors. But more of my talk will be focused on what research has to say about the right side of this graph, the program factors and the provider factors that are related to retention.

So what neighborhood factors contribute to more visits? Well unfortunately not much is known but I'll talk about two things we have learned.

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Contrary to our expectations about distressed communities studies suggest that parents who live in distressed communities actually engage in more visits than those who live in less distressed communities?

So what do I mean by distressed? It could be high rates of poverty or indicators of instability such as a high percentage of rental households.

But there's a note of caution, McGuigan and his colleagues found that a high level of community violence actually impeded visits so they lead to fewer visits. So this is a particular challenge because parents in violent communities may be the most stressed and the most in need of service.

What parent factors contribute to more visits? Well early studies focused largely on demographic characteristics of the parent and the home visitor and they seem to suggest that demographic match on things like ethnicity and race, age, or parenting status were critical to keep families in program - programs.

But now we find that studies that look beyond demographic characteristics find that demographic match is not as important as initially thought. However we do know the retention rates vary by race ethnicities. And most studies suggest Hispanics are more likely to remain in programs.

And many studies suggest that whites or Caucasians are less likely to remain in programs so we don't clearly know the reasons why.

We do know that the subjective experiences of the parent matter. So in terms of cost if a parent already has a large support network they tend to receive fewer visits.

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In fact one study found that parents who have partners received eight fewer visits than single parents.

So this suggests that if you have a large support network the intrusion of a home visitor into that network might be viewed as a cost by the parent.

But the parents' view of benefits also influences visits. So if a parent perceives an infant or the parent themselves as in need of some kind of help they are more likely to participate in visits.

Now here want to remind everyone that it's really the parent's perception of infant need or parental need, not the providers.

More recent research has identified that the parent's perception of the strength of their relationship with the visitor is actually key toward engagement.

So studies of both Healthy Families America and Nurse-Family Partnership find that when parents say they have a strong relationship with the visitor they engage in more visits.

Now what home factors - what home visitor factors contribute to more visits? Well interestingly when we assessed both sides of the parent home visitor relationship we found that it was actually the provider's perception of that relationship that had stronger effects on visits than the parent.

So when providers had a positive view of the parent visitor relationship parents were more likely to engage in visits.

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Now we often hear from programs that lowercase loads are associated with more visits. And studies in fact back that up.

It seems that when home visitors have more time and can work with fewer families they're more successful at engagement.

However we don't know yet what is the ideal caseload. And in fact these caseloads might vary depending on the type of home visitation program one is in.

Now lastly a recent study suggests that motivational interviewing may enhance service completion. And here by service completion I mean actual completion of program goals.

So a study of SafeCare found that when providers were trained in motivational interviewing and they used it to actually encourage families to seek professional care for potential mental health issues this increased the number of visits that the family had in the program and I think it allowed the home visitors to actually focus more on parenting issues while the mental health issues were addressed elsewhere.

So let's turn to the program and talk about what program factors can contribute to more visits. Well first low staff turnover.

Now most of us know that when a home visitor leaves midstream often the families are likely to leave.

But this study looked at staff turnover or these studies looked at staff turnover at the program level. And there they found that when a program had low staff turnover families were likely to engage in visits.

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Now flexibility in the service delivery model is another important component that has recently come to light.

So Nurse-Family Partnership train their home visitors to give parents a choice as to how often they wanted to receive home visits so they could receive more or less or service as usual.

They also train these home visitors to kind of spend more time actually talking to parents about the goals that the parents had.

So when they compared programs that had trained nurses on these areas to programs that had not based on that giving flexibility in the service delivery model led to parents receiving more visits.

Now you might think well wait a minute, aren't all the parents going to opt to have fewer visits if they're given that choice? But only 7% of parents opted for fewer visits.

So to me this seems to suggest that the key here is that you gave the parent a choice or some control over service delivery.

Now you'll be happy to know that this study is going to be discussed in more detail later along with other surprising findings by Molly O'Fallon of the Nurse-Family Partnership.

So the final program factor I want to talk about is direct supervision of the home visitor. (McGuigan) and his colleagues found that when home visitors received more hours of direct supervision families were more likely to stay in service. And what's really important about this finding is that this was the most significant factor related to retention in a study that also looked at

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all visitor credentials and levels of community violence. So this suggests that the supervisor and supervision is critical to family engagement rates.

All right so let's briefly recap what I've covered so far, some of the key findings.

First demographic match between parent and home visitor is not as important as we thought.

Now this isn't to say the programs shouldn't hire a diverse number of home visitors or shouldn't try to see that the home visitors match their client population.

But it really says that it's the relationship between the home visitor and the parent that matters and that's what the program should attend to.

I think there's good news here because it suggests that the home visitor's perception of that relationship actually has stronger impacts than the parent's view so that means the home visitor has more control really over retention issues.

Then finally program and home visitor characteristics matter and they're probably related in ways that influence the relationship.

So for example not only do low caseloads allow for greater engagement of the family but low caseloads most likely reduce staff turnover.

We also have seen that supervision is connected to family engagement. And this may be because close supervision really helps foster that positive view of the family that is critical for a home visitor to have.

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All right so I've talked a lot about the parent visitor relationship but what do I mean by that? What does a strong relationship look like?

Well when research addresses this two components come out as being key. First is this interpersonal connection. Do the family and the home visitor have mutual respect especially around cultural differences or family traditions?

Is - has a level of trust been established? Is the home visitor sensitive to the needs and pressures on the family?

Then the second component of this relationship is how collaborative is it? When families are seen as partners in the service planning process so they're involved in identifying the initial goals and they're involved in actually assessing their own progress throughout services this leads to a strong relationship.

So we asked parents from their point of view what promotes a strong relationship and they told us two things. First they said that when they thought the home visitor had done more than expected what I'm calling home visitor extra effort that this made them rate the relationship more highly.

So home visitors who go the extra mile, they make that extra call, they provide more visits in times of crisis, they help find resources, they show a perseverance that helps build trust, those are visitors who are making that home visitor effort.

The second response from parents had to do with a family centered service delivery style. So when home visitors engaged in this family centered style that was less directive and showed a willingness or an ability to adapt the program to family's needs parents rated the relationship

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more highly than if a visitor was using a program centered service delivery style where the focus was really adhering to the program model.

So what can we do to promote retention? Well clearly the first thing we want to do is promote that parent-provider relationship.

So I'm going to talk about four ways that might be of interest. But there are experts from home visiting models who are going to be elaborating on many of these areas.

First we want to explicitly train visitors on ways to better involve parents and service decisions. We want to make it collaborative.

So some ways might be we're going to give more choices to how many visits the families receive or how long they want to be in services.

But we also need to focus on what participants say they want so we need to train visitors on how to be flexible but without losing sight of program goals.

Just as critical we need to train supervisors so that they can effectively support the home visitor. They need to know how to evaluate how the home visitor feels about the family, how to identify positives of the family and reframe any negatives so that the home visitor has positive perceptions of each family because when visitors think families can be engaged effectively families are engaged.

So supervisors also need to be trained on ways to promote cultural awareness and sensitivity of the home visitor as these may be critical to the home visitor having a positive view.

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And David Jones from Early Head Start will be talking about ways to do that next in the seminar.

We also need to promote methods that indicate effort by the visitor to actually engage with the family.

So we need to train visitors on things like how to engage in active listening, how to do motivational interviewing, how to use innovative technology to stay in touch with families.

Shannon Brown will be talking about some of those technologies later on in the Webinar.

And then finally to create a strong relationship we need to reduce caseloads to allow visitors more time and energy to actually engage with their families.

But beyond the provider visitor relationship what else can we do to promote retention? Well we need to reduce the costs and increase the benefits of program involvement for parents.

Now remember cost and benefits are perceptions on the part of the parents so they are open to change. So two ways to do this might be first involved as many of the parents network as possible in services especially authority figures because they often function as gatekeepers.

So if you don't have the maternal grandmother on board for the visitor coming into the home you are likely to run into problems down the road.

Next we need to train visitors on ways to actually facilitate discussion with the parent about whether the program's meeting parent or infant needs.

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So Healthy Families America in North Carolina spent time training their home visitors on how to give rationales of the cost and benefits of staying enrolled in the program each time they visited with a family.

And they actually think that by doing this they achieve their success in reducing second births.

We also need to continue to serve distressed communities. Your program may be a lifeline for these families, in fact it may be the only game in town.

So we need to work with other community organizations to assess community violence and develop strategies for safe service delivery.

So we want to connect with community watch groups and maybe neighborhood block organizations to talk about ways we can deliver services safely.

This presentation has emphasized what research said about why parents stay in home visiting services. But as we all know research has its limitations and clearly it cannot answer all the critical questions.

So we need to listen to the experience of people actually in the field because they are the ones trying innovative strategies to engage families.

I'm now going to turn to the three home visiting programs who have volunteered to talk about the strategies they are using to enhance retention and we're going to begin with David Jones from Early Head Start. David?

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David Jones: Thank you Karen for getting this off to a great start about this really important topic. So one of the things that we believe firmly with Early Head Start the connects with some of what you already said was low staff turnover is the goal and good quality supervision contributes to the development of what we would call individual practitioners, people who are trained well enough to go out and do the job.

So staff members require a variety of training and professional development experiences to better understand social and emotional development in the needs of infants, toddlers, preschoolers.

When this is done they will grow and find meaning in the work and develop capacities to support families in a number of ways.

With this slide what you can see is that the Head Start Act and the Head Start performance standards outline the parameters for service provision.

The three components -- family and community partnerships, early childhood development and health and program design and management contributes to comprehensive services. And the fact that anyone enrolled in our model requires a weekly 90 minute home visit for a minimum of 48 per year and also bimonthly group socialization ensures that families are not isolated and are benefiting from everything that we have to offer.

Model fidelity is ensuring that programs implemented in our home visiting model understand that creating an alliance with families is the foundation.

Respectfully explain the program setting parameters, contracting and ensuring that parents understand the components of service provisions is important.

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The ongoing professional development provided to staff motivates and encourages them to take on new challenges, embrace risk, and tackle complex family situations.

Supervision, staff training, professional development and mentor coaching are investments of time, energy, and thoughtful preparation.

The return on that investment is staff that are competent, staff who identify as professionals who understand the importance of and the maintenance of boundaries and staff who understand the work and the levels of complexity associated with doing the work well.

But most importantly we are talking about staff that remain cognizant of the fact that they are working within the context of a team.

The Early Head Start model consists of ensuring that many programs develop what we call an annual training calendar. And it's mandated for all of our grantees and programs.

So what happens is there's a comprehensive set of workshops and trainings that all staff go through. There is participation in service, in service and external professional conferences.

Each employee receives a personalized professional development plan. There is frequent individual reflective supervision, mentor coaching and peer learning experiences.

Staff are actually trained on the operating guidelines or our performing standards. And then there's really a lot of conversation around the development of the shared philosophical approach and shared responsibility for service delivery which means that they're going to develop, deliver services from a relationship based perspective with the commitment to serving children and families.

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And when that's done well you can see on this slide this framework really illustrates the ways in which the foundations in the program impact areas contribute to outcomes for families as well as the children.

And this is just another slide that kind of emphasizes the same point. What's important about this slide is again parent involvement increases with careful matching, clear explanation of services, and can provide provisional comprehensive services.

Participation, consistent home visits, socialization and community meetings, engagement increases for families and is sustained when as Karen said earlier trusting relationships are grounded in professional boundaries are built with families.

And again well-trained staff understand how to keep home visits engaging maintaining a focus on child development individualized to specific needs of their families that might be at risk for dropping out of the program and communicating with them honestly about their progress.

Finally this slide on knowledge and practice professional boundaries it's really again important to be thinking about culturally responsive reflective practice, the importance of the reflective supervision that the staff will receive, enables them to do the work in the way that we would like to see it done.

Optimal distance, we ask a lot of home visitation staff to go in and really move deeply to build a relationship with families. And then they have to also know when to step back and give parents and families room to grow.

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So it's a balancing of all the relationships. It's multiple relationships, the supervisor to the family service work or the home visitor. There's the peer to peer relationships that need to be negotiate that contributes to staff retention and family retention, the staff to parents and finally the staff to the external customers.

And with that I will turn it over to Pauline.

Pauline McKenzie-Day: Thank you David. I appreciate that. I'm going to talk briefly about the SafeCare Home Visiting Program and how a few components in that training program really address the area of family retention.

One of the components and the first thing we do when we're training our home visitors or providers is we talk about communication.

This is an important piece which really encourages our home visitors to demonstrate empathy to the families.

We help them to understand the importance of using open-ended questions, their positive body language using reflective and summarizing statements to really show their concern for the family and for the children.

Another component of our training program, the SafeCare program as a whole, is that we provide coaching once our training program is over for all our home visitors.

I love the fact that Karen talked about the relationship between the home visitor in the family and how important that is.

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What our coaching does is we support the home visitor. We really help them to feel effective as practitioners. We also support them in how they're implementing the program.

So they are implementing it with also with confidence but then quality. So they're not feeling like they're out there alone.

And we really feel that that greatly impacts the family retention because it is speaking to the relationship between the home visitor and the family.

Another area that we talk about in our training program is we have a problem solving worksheet. And I'm going - to this is what's up on the slides right now just to talk about that.

It's really a key component in helping to provide the parent and promote empowerment of the parent. It really helps, this process helps the parent think through their own issues, what some of their own crises might be and help them come up with viable solutions.

So when a parent feels fully empowered it really helps to foster their attention in the program. And as you can see the problem solving worksheet is very simple. It's not complicated. And really we're looking for the parent to come up with what the problem is themselves and then several different solutions to that problem and talk about why that problem may be a good idea or not such a good idea. And then we have the parent rate the solution that they have come up with.

And then also of course we want things that are really evidence. We want them to put them into practice. And so we have what is the best option and then what will they do to then do that best option, so several steps to make sure that they're done.

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And usually the home visitor will follow-up with the parents to make sure that they're able to follow through and take care whatever the issue was.

And I love this because it really does empower the parents. So our home visitors love it also.

So that was my brief talk about how our home visiting training really helps to promote family engagement. And now I'm going to turn it over to my colleague Shannon: who is going to talk about some technology.

Shannon Self-Brown: Hi everyone. So I am very interested in research and looking into ways that we can be innovative and thinking about engagement.

And so I'm going to present to you today a couple of projects that we - where we have used technology to assist us in engaging and retaining parents.

This is not part of our standard practice at this point in time but I hope that it'll just get you thinking outside the box a bit on how we might want to move forward.

Just to give you some information about the level of folks that we serve who have technology at this time if you go to the next slide for me.

Oh I'm sorry, I'm in control, never mind. If you take a look at this graph you'll see that in the age range of parents that at least our model is serving the majority of time is between the ages of 18 and 34. About 95% of 18 to 34-year-olds are estimated to have cell phone technology.

And in that same age range about 82% of that population is predicted to go online wirelessly so meaning they're not, you know, going to libraries and sitting down at computers to get on the

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Internet. They have access to wireless technology where they can get online and communicate online.

To look at this data a little more closely you can see that also about 83% of this millennial generation is using social networking sites.

And the most common form of communication you see at about 95% is text messaging. And if you look at how this drills down this shocks me because I'm a little bit outside of this millennial age group and I don't text nearly this often.

But on average adults in the 18 to 29 year age range are having about 88 text messages daily. So it really has become a primary way that adults in this age group communicate.

And so I think as home visitors we have to consider how to stay relevant with the parents that we're serving.

And especially as these generations that have been raised with technology and with Internet access become adults it's important for us to consider how to teach them in the most appropriate manner.

Do we need to be using technology to, you know, as a partner with us in human service delivery to really convey important messages and engage parents and seem relevant?

And so the first study I would like to talk with you about is a study that was conducted by Judy Carta. And in this study which was funded by the Centers for Disease Control and Prevention Dr. Carta was able to recruit 330 parents from Early Head Start.

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And she randomly assigned them to one of three groups -- SafeCare as usual, SafeCare with a cell phone enhancement in which the parents were provided cell phones.

This study started back in 2006 at a time when there was a significant digital divide and a lot of the parents they were working with did not have cell phones.

So I think if the study were to be conducted now perhaps we wouldn't even need to give out the technology as part of the research project.

But regardless the parents in the cell phone condition received cell phones and had iterative communication with their home visitor through this device while they participated in the program.

And the outcomes of the family who participated in these two SafeCare conditions were compared to a weightless control group that were involved in community services but no standardized services.

Just to give you an example of how the text messaging was used in this study one way that the home visitors use text messaging was to simply use it as a prompt.

So we teach PAT skills or Planned Activities Training as part of one of our modules in SafeCare. And so the home visitors would use text messaging to remind the parents to use some of the skills that we had taught in session that week.

So helping, you know, generalize those things that we teach in one session to their everyday behavior.

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We also use the prompts to communicate messages about fun activities going on in the community or just to be friendly and check in with the parent to see how they were doing on a job interview or in a course they were taking.

The parents really reported liking receiving information on these free and low-cost community events. That was very important to them. It gave them a sense of ways they can get more involved in the community and do things for in a cost effective way that would be positive for their family.

And we also sent out text message questions through the cell phones. And this allowed us to collect data basically on different things that the parents were doing in the time that, you know, in-between sessions.

You know, were they using the skills we taught them in mealtime for instance and even asking more general questions hey did you remember to have fun with your child today?

So parents were asked these questions but they were not expected to respond just we asked them to respond when they could but it wasn't required. But it was still a way to just enhance the communication between the home visitors and the parents on a daily or weekly basis.

So the findings for this study have been really important. We have found that both SafeCare groups exhibit significant positive parent and child outcomes as compared to the weightless control.

So both groups of parents that went through the program, you know, were doing better on average as compared to the control group.

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However there were significant differences that emerged in terms of engagement and retention.

And they both were in favor of the cell phone group.

So parents in the cell phone group reported being significantly more engaged than did the SafeCare group that did not have the cell phone communications.

And also there was greater completion of the program for the parents that participated in the cell phone conditions. So just by having this way of enhancing the communications and, you know, just sending out a text or having a way to check in by phone once a week really seemed to make a significant difference in terms of the engagement and retention of the parents.

I'm just starting a research project now where I'm looking at using a computer as a partner in the home visiting relationship between the therapist and the client.

This is a grant funded by the National Institute of Minority Health and Health Disparities. And it's going to be a project that focuses on fathers.

My idea was that perhaps we would be able to engage dads in the program a bit more if we used some technology that can make the program delivery a bit more exciting.

So how the technology is used in this project is that a therapist will go into the home with a tablet essentially. The dad will sit down with the tablet and will go through components of the home visiting session on the tablet.

In SafeCare we have explained model, practice and feedback components of our training sessions. They'll be able to receive the explanation or the psycho-education as well as the modeling on the computer software.

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And then they will actually practice the new skills with the home visitor who's live there in session. I certainly am not an advocate or forever taking the home visitor out of this work completely but just thinking about ways to increase engagement and use the technology to improve what we do or at least make the parents more excited about what we do.

And we were - we just finished piloting this project and we're moving into a randomized controlled trial. And the dads are really reporting liking the videos where they get to see other dads using the skills we teach with their children.

So it seems that using technology in this way and having video modeling in this way can be a very powerful teaching tool as compared to us as home visitors, you know, trying to model it ourselves and then think well you're the expert. How am I ever going to learn to do this seeing other people who look like them and talk like them be able to deliver the skills that can really be an effective teaching tool.

So we will be running a randomized controlled trial over the next two years to study this program with 120 dads. And we'll ultimately be able to tell if there are differences for dad participants in the Dad2K program and engagement and parenting behavior and father child interaction as well as risk factors for maltreatment.

And so hopefully in a couple of years I can get back on a Webinar like this and report how effective the program was.

And now I'll turn it over to Molly O'Fallon from Nurse-Family Partnership.

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Molly O'Fallon: Thank you very much. I'm happy to be here today to talk about some innovations around retention that are occurring at the NFP program.

I'd like to start out by saying that NFP continues to use our data to evaluate and identify strategies for improving retention.

As we identify areas of concern we work closely with the Prevention Research Center at the University of Colorado to determine best methods for quality improvement.

At this time we've identified some areas of retention that I would like to speak to. The first one is identification of client risks. The second is flexibility of the home visitor. And third is supports for the home visitor.

I'll begin by elaborating the article about the article that Karen mentioned by Erin Ingoldsby and then providing some implications for this research.

This article was published in July 2013 in Prevention Science and describes a pilot study conducted in 2004 specifically for client retention.

This ten month retention intervention study was designed to increase client engagement by tailoring the visit schedule to meet participants' needs.

The study involved 1100 clients. The intervention and control groups were very similar in size, urban settings, clients and staff characteristics.

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The outcomes found significant increase in participant retention in the intervention group and an increase in the number of completed home visits in those agencies that were part of the intervention group.

The primary strategy was that the nurse home visitor talks of newly enrolled families about adjusting the normal NFP visit frequency and duration to meet the client need.

Specifically clients were asked at enrollment and then again when the child was four weeks and six months if she preferred to be visited according to the typical visit schedule at a reduced frequency to temporarily leave the program or to stop involvement with the program completely.

The researcher supported the nurse supervisor and the nurse home visitor in this intervention group to increase their comfort in discussing the alternate visit schedule.

This included providing written materials, team conference calls to support this change as well as education on motivational interviewing.

The purpose of this intense intervention was to deepen the nurse home visitor skill in listening and adapting the program to meet the family's needs while adhering to the program goals.

The visits were flexible but the core content of the program was still delivered.

For those clients involved in an intervention group 91% requested a traditional schedule, 7% requested an alternative schedule and less than 1% requested a leave or left the program.

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As described earlier the results were that clients in the intervention group that more home visits and were at a lower risk for dropping out for addressable reasons such as missed visits, the inability to locate the client or the client to client further participation.

This study has had several implications for home visiting and has had applications in the NFP program specifically in nursing education and consultation.

In nursing education motivational interview has been - motivational interviewing has been added to our core education and has a discussion about providing clients with an alternative visit schedule.

We also now collect data in our data collection system on alternate visits and we can compare that with outcomes.

In nurse consultation additional support has been added around client engagement and retention particularly related to risk identification, supporting the nurse's flexibility and supporting the nurse home visitor through supervision.

In regards to client risk identification the nurse home visitor is encouraged to have in-depth discussions with the clients early in the relationship to identify any risks and to discuss client choices around an alternative visit schedule.

Some of the risks that have been identified include things such as mental health issues, homelessness and family and community support.

We continue to do ongoing research about common areas of risks in our client population.

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Around supporting nurse's flexibility this research as well as other work that we have done has found that nurses maintain better engagement and retention when they were encouraged to have flexible scheduling.

This may have include - this may include items such as late afternoon visits, visits on the weekends, visits at school and changes in the duration or the frequency of visits either increasing them or decreasing them depending on the client's needs.

Another area that was identified around flexibility is the opportunity to have pre-visits to start engaging the client and encouraging them to have the intent to enroll.

The second area that we found around supporting nurse's flexibility is increasing nurse's competency. Nurses with more experience have greater retention.

So we have several methods that we work with the nurse to identify her competency level in the Nurse-Family Partnership model and then to support her gaining in her expertise.

Lastly barriers to reduce to - excuse me. Barriers have been identified that impact flexibility.

The two that we found primarily are attitudes of the nurse around the alternative visit schedule and secondly the organizational structure of the agency itself.

The agency's structure is important because the agency structure really impacts whether or not the nurse is able to conduct the flexible visits and whether or not the nurse may be involved in other activities outside of nurse home visiting.

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The third area is support of the nurse home visitors through supervision case conferences and team meetings. Specifically spending time increasing the nurse's interest and understanding of an alternate visit schedule by discussion of pros and cons and barriers and enhancers to conducting alternate visit schedules and then having in-depth conversations with the clients about the risks early on in the visits as well as throughout the early periods of the home visitation program.

The second area is discussing organizational flexibility with an agency before implementation. This enables supervisors to develop procedures that will serve families in a manner that is consistent with the home visiting program and allow for flexibility.

The third area around support of the nurse home visitor is working with the team or one-on-one, a supervision to review caseload, visit schedule, and retention and the impacts of alternative visits on retention.

And then lastly updating and enhancing motivational interviewing skills for all home visitors.

So this summarizes NFP's recent application of some of the research on retention. And now I'd like to turn this back over to Karen.

Karen McCurdy: Thank you. I want to thank all the program representatives for sharing these great ideas on how to engage families.

And it's wonderful to hear that the research is being reflective in your innovative strategies around supervision, increasing flexibility and being more collaborative.

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So now we want to be able to open up the discussion for the questions from our listeners. And we have one question that came in prior to the Webinar that we're going to start with.

So David I want to direct this question to you. What might be some back to work challenges or what does going back to work and school enrollment mean for engaging and retaining families? How do you address those kinds of issues?

David Jones: Well Karen it's like, you know, with anything else you start from a very respectful place. All of our work really entails again that alliance that I talked about that we create with families.

So really what you want to do is if there is a schedule change you sit down with the family, you look at some sort of alternative plan about when you might be able to meet with them or visit with them.

You know, sometimes programs have flexibility in their schedules where they do late evening visits. Sometimes there's weekend visits that can happen.

So it's really about sitting down with the family and accommodating what's going to be in their best interest.

Because again if you try to be too prescriptive or restrictive then that would contribute to families maybe making a decision to disengage rather than engage.

Karen McCurdy: Thank you David. Does any other program want to share their experiences?

So Cathy what else has come in in the chat box?

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Cathy Bodkin: Well we have a couple of questions Karen. One is one is have any of these programs performed research related to the difference in retention and outcomes for Hispanic families?

Karen McCurdy: That's a great question because we've already identified that Hispanics are more likely to stay in programs but that suggests that there are some ethnic differences in retention rates. Would anyone care to respond?

Shannon Self-Brown: Hi. This is Shannon Self-Brown. I'll speak for SafeCare. The study that Karen mentioned by Damasek, et al 2011 was conducted in rural - I'm sorry in an urban area in Oklahoma and did include a significant portion of Hispanic and Latino families.

And, you know, the results of that project indicated that as compared to the services as usual that were offered in the community that families were more likely to enroll and complete SafeCare.

However, we have not had any studies where we have kind of separated our data based on race or ethnicity and looked at completers so that could be a great next step.

Karen McCurdy: This is Karen. And I'd also like to join in. We actually looked at ethnic differences among families and their retention rates. But at the time we didn't have any measures of the home visitor- parent relationship.

So that early study suggested that Hispanic families were more likely to stay if there home visitor was also a parent.

But that might just really reflect a comfort level with the home visitor from having the same experiences as the family.

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So again we need to do more studies to really get a better handle on what some of these differences may be for different ethnic and racial groups.

Cathy Bodkin: Karen we have a couple other questions. One is in those cases when families choose up front to reduce the number of contacts how does that flexibility impact fidelity to the program? And are there any tensions then with the nurses who may be making fewer home visits for instance?

Karen McCurdy: That's a great question. I'm sure that's of concern to several programs because they want to be faithful to the program model. So Molly if you could respond that would be great.

Molly O'Fallon: I'd be happy to. I didn't hear the second half of that question so I may have to have you repeat that Cathy.

But I can just say that with regards to model fidelity what we're finding in our initial review of the data is that it really is not impacting outcomes and it's not impacting model fidelity.

We're still able to carry on the program as it's designed with the facilitators and with the work that is planned for each one of the phases.

Generally what we're finding is that when the client is provided the opportunity to have a change in their visit they usually don't change it very much.

If they change it it may be by reducing one or two visits but then perhaps increasing it soon after the baby is born so that they have more visits. So what we're finding over time is that there's really not much of a difference in the frequency of the visits.

And then the second part Cathy could you say that one more time?

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Cathy Bodkin: Does the changing of the number of visits create any tensions between the different staff members where one staff member may be providing fewer home visits and another staff member may be sticking to the rigid schedule?

Molly O'Fallon: You know, I really haven't heard of that yet. The research article that I alluded to talked about the fact that nurses had been in practice for a longer time had somewhat more difficulty with changing to the alternative visit as compared with newer employed nurse home visitors.

So I think over time if we've rolled this out over time the nurses have found that this is just another tool in the toolkit to be able to meet the family's needs.

Karen McCurdy: Great. Thanks.

Cathy Bodkin: And Karen we have another question. The best - are there best ways or better strategies to keep families who have severe mental health issues engaged in the program or families that have had a high degree of trauma in their lives?

Karen McCurdy: Thanks. This is a pressing issue as more and more families seem to have these issues facing them and home visitors have to serve a broad array of families.

I know in the SafeCare study what they found is that encouraging families through motivational interviewing to actually seek help outside of the program resources for mental health issues was effective. But I would be interested to hear what the other programs have done in this area.

Molly O'Fallon: This is Molly. I feel that the use of motivational interviewing is absolutely a very important key to working with families with mental illness.

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The other thing many agencies have found is to bring on a mental health coordinator or a mental health worker to assist the nurses in working with these clients and to discuss these clients during case conferences and team meetings to be able to learn about working with different populations.

David Jones: Yes. I would add see that within the Early Head Start model and the provision of comprehensive services there's a full scale team approach.

There's thoughtful planning around all interventions for families where parents are actually involved in the process.

I think the quality supervision allows staff to be able to sort of identify when the issue is a little more complex than what they're capable of dealing with so then bring it back into the team which would entail, you know, levels, multiple levels of supervision, a mental health consultant.

Every Head Start program has a mental health consultant that provides, you know, consultation services around challenging family situations. And so that's sort of the comprehensive approach that Early Head Start uses to address those types of situations.

Karen McCurdy: Great. Those are some wonderful strategies.

Cathy Bodkin: Karen we're having some activity in the chat box particularly about the use of technology and the impact having texting, using cell phones have had on improving contact with home visiting and then also some questions related to HIPAA and confidentiality.

So perhaps there might be some comments from the presenters and from yourself about the use of technology?

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Karen McCurdy: Yes. I think that's a great area to investigate. As a parent of teens I can tell you that texting is a great way to get a hold of a teen.

So but let me turn it first to Shannon: because she has spent some time actually investigating this from a research perspective.

Shannon Self-Brown: And so could you tell me a little bit more about the question? I was trying to find it in the box if it's - let's see, oh any thoughts about using Twitter as opposed to texting for communicating with parents?

Yes...

Cathy Bodkin: And a comment about how having cell phones has certainly increased their ability to contact clients and follow-up with clients not having missed visits.

Then there was a question earlier about HIPAA and confidentiality and just how that might be affected.

So just perhaps policies your programs have or experiences you've had about the impact of technology and...

Shannon Self-Brown: Yes certainly cell phones are becoming, you know, more and more available and can help with maintaining engagement.

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I mean the trouble that we're still finding a lot in our program which I'm sure many of the home visitors can relate to is when you're relying on contacting the parents with their personal cell phones is that, you know, they're often using phones that they just add minutes to.

And so sometimes they're working and other times they've hit their max on minutes. And then there'll be a few days that you're out of touch. So it's still not a perfect solution but something that is certainly helpful.

And texting does seem to be the primary mode that parents that we've asked about how they want to be communicated with, you know, how they do want to be communicated with.

In terms of HIPAA, you know, that is not something that has come up in consideration before. And, you know, in thinking about the texts that were sent out in the - in a research project they were not identifiable in any way that I know of.

And it wasn't they never ask questions although they might try to tailor the text to say, you know, how was your exam this week or how was your interview -- something that was a little bit more personable?

It wasn't ever divulging any information that the parent would want to keep confidential in case, you know, somebody else was to have the phone in their hands at that time.

So I would say, you know, to obviously be careful about those high risk situations especially when it would come to circumstances where you might expect domestic violence in the home or, you know, other risk factors where communications could cause more harm than good.

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We I also saw the question about Twitter and social networking. Again, you know, we're constantly trying to explore these things within the research context first before, you know, really incorporating it into our standard practice.

And one of my colleagues here at SafeCare, (Ann Edwards) has submitted a couple of grants really trying to consider Facebook as a way to form a community of SafeCare parents, you know, just a small group where they could exchange ideas and talk about parenting issues and talk about ways that they view Save Care in their lives.

She's done a little bit of piloting. Unfortunately none of the larger grants have gotten funded yet so it's an idea still in progress.

But that is definitely where we start to get concerned more about those kinds of ethical issues and making sure the parents are going to be okay being connected with other parents and a program and what all that could entail for them.

Karen McCurdy: Have any of the other programs experimented with forms of technology to enhance retention or engagement?

David Jones: Not really. Not with Early Head Start. I think it varies across programs so there's nothing that's happening consistently across the board.

Karen McCurdy: And for Nurse-Family Partnership?

Molly O'Fallon: Ours would be the same as Early Head Start. I know some agencies do use texting to remind clients and to verify appointments. But as far as the using it as a standard intervention it has not occurred yet.

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Karen McCurdy: Okay great. So these are good ideas for other programs to think about?

Cathy Bodkin: Another question that's come in is when serving families living in distressed communities but also experience above average episodes of violence do any of these programs have good examples of safety protocols home visitors can utilize that allow them to maintain high visit rates?

David Jones: This is David...

Karen McCurdy: It's a very good question.

David Jones: ...at Early Head Start. You know, I think, you know, one of the realities of home visiting is that we go where the families live.

And a lot of those communities have challenges around safety and violence. And what you do is you have policies and procedures and protocols that sort of dictate how a staff ought to respond to potentially dangerous situations.

Some of the strategies at different programs use is teaming where home visitors will go out together, you know, making sure that when staff are out visiting families they check in with the office periodically throughout the day but also trusting their instincts.

I mean they're trained to trust their instincts. If they're going to visit a family they inherently feel that the community, if something is happening in the community that is unsafe they're to, you know contact the office and potentially cancel or reschedule a visit.

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So it's challenging true but I think again training staff, having protocols and safety measures in place really enables them to kind of make those visits when they can.

And one of the things that as a former director of a Head Start Program our home visitors would actually call their families prior to the visit so they would be sort of looking and waiting for the home visitor when they arrived.

And getting to know people in the community also helps people to know that you're coming there for a positive reason and not anything potentially challenging to what might be happening in the community?

Karen McCurdy: Any other program responses?

Molly O'Fallon: This is Molly and I agree with everything that was just said. I think that having policies and procedures and knowing what those are is going to help in many situations.

Karen McCurdy: And I just want to talk a little bit -- this is Karen -- about the study I mentioned earlier that found that violence in the community was detrimental to visits.

That same study found that supervision by the supervisor's supervision was critical in helping home visitors go out to those families but also they thought that if they had families themselves get involved with community block organizations or neighborhood watch groups that that increase level of safety that the family felt and that enabled the family to engage in more visits with the home visitor.

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So that would be like a second level of strategies beyond program procedures but ways to kind of encourage families to feel safer in their communities and then they might participate more in their home visits.

Cathy Bodkin: Karen we've got a follow-up on the services for father's engagement of fathers. We've heard about the Dad2K as one approach. But are there other ways to consider engagements and retention to increase father involvement?

Karen McCurdy: That's a great question. And I think the programs are doing various innovative things. So the research says not too much about it so I'm going to turn to the programs.

David weren't you talking about an initiative to involve fathers earlier?

David Jones: Yes. Within Early Head Start we've always again part of the comprehensive services we work with all family members.

And one of the key components of being successful at engaging fathers, communicating with fathers, and really sustaining their involvement in programs begins with staff training.

I think it's really important that staff sort of understand the philosophical approach that's going to be used when reaching out to fathers.

Sometimes there's a self-assessment that is necessary. They have to be honest about their histories with men which could preclude or prevent them from being as effective communicating with fathers as they are when they communicate with mothers.

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But the reality is fathers of parents who also love their children they are equally concerned about all aspects of their child's development.

So what I would always encourage staff to do is be respectful in your communications with fathers just like you are with mothers, make sure that your environments are welcoming to dad that void of the dads, void of judgments because they're very, very sensitive when they're walking into your environment for the first time.

And just doing, treating them the same that you would treat a mother that loves their child.

Karen McCurdy: Thank you, great suggestions. Is SafeCare doing anything along those lines of ways to enhance father involvement?

Shannon Self-Brown: Pauline do you want to speak about anything - any discussions you're having in training or in your support of home visitors at the ((inaudible)) level?

Pauline McKenzie-Day: We're - well sometimes and not all the time there are two parent families so we always of course want to involve the fathers.

But I like what David said about, you know, really understanding and having respect for the father and knowing that they are just as invested and involved in their children too.

So yes we do talk about how can the home visitor really if the father is there in the home and even if he isn't and he visits how can they involve him also in the process and not just the mom.

So yes we do have conversations about that.

Karen McCurdy: Great thanks. Cathy is anything else come in on the chat box?

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Cathy Bodkin: Yes. We've had a couple other questions talking about the importance of the home visitor's perception of the family and how that relates to the number of home visits.

Is there - are there any tools that would measure the home visitor's view of the family and are there strategies that might be used by the supervisor particularly or the home visitor to mitigate these perceptions if they're standing in the way of the service?

Karen McCurdy: Let me answer that first part. So one of the tools that we've used to study the parent provider relationship is something called the Helping Relationship Inventory. And it's been used by, you know, a number of groups including Jon Korfmacher with Nurse-Family Partnership.

And that inventory allows both parents and the provider to rate the strength of the relationship. So that would be one tool that you could use to get a sense of how the provider views the actual relationship with the family.

Then in terms of actually improving the provider's perception of the family I'm going to turn this back to the programs because it sounds like many of them work on communication strategies in other ways that an effective supervision and reflective supervision that get to some of these issues.

So programs, I know you all have something. Should I direct it to someone? I will start with Molly since we haven't heard from her recently.

Molly O'Fallon: Well, I agree with you on the scale that you talked about and also the reflective supervision, team meetings, case conferences to discuss some of the characteristics of nurse

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home visitors as well as clients that will impact the nurse home visitor's perception or the home visitor perception of the client interaction as well as the client's perception.

The other thing that we have developed most recently is we actually have a client survey that we're implementing with our agencies and with our clients when the client is at 36 weeks in pregnancy as well as when the infant is at 1 year of age.

And we're using the competencies of the nurse home visiting model to ask the client about the nurse and the visit with the nurse and to see how they feel that's going.

It's not a client satisfaction tool. It's more of a survey around the competencies of the model.

We just started that in July so we don't have any results yet. But our goal is to be able to use that information to enhance our education and our consultation around improving the nurse perception of the client interaction as well as the client's perception of the home visiting model.

Karen McCurdy: Great. Any other thoughts on this issue how to improve the perception of the family by the home visitor?

Cathy Bodkin: We have another research question directed to you Karen.

Karen McCurdy: Okay.

Cathy Bodkin: Is there - in the research on engagement and retention has anyone asked for feedback from the families who've dropped out?

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Karen McCurdy: Yes. In our larger study that I did with Deborah Daro we followed families for up to a year. And we tried to re-interview families whether they were still in the program or not.

So we actually included families who said no to visits. So we got some information on why they never even enrolled in the first place.

And then we got information at three months from families who were still in the program, families who had left. And then we also tried to follow families for 12 months.

But what we found is that many of the families who dropped out of services between that three to 12 month point also no longer wanted to be involved in our study.

So many of the findings actually that I talked about today talk about the family's perception of the home visitor at three months regardless of whether they stayed in or dropped out later.

And then it ties that to the number of visits that they have. So we had information from families who dropped out later.

And when you looked at both of those it was still that quality of the parent provider relationship that was the strongest predictor along with also the parent's perception of cost and benefits.

Cathy Bodkin: Another kind of follow-up question to that has been the discussion about do incentives really keep families in programs? Do incentives help the - them stay in the program?

Karen McCurdy: That is something that Deborah Daro and I thought would be important and so that's why we include it as a potential program factor.

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When we tested that in terms of retention we didn't see that it had a very strong impact. But for engaging a family initially it might be of more importance.

But I'd like to turn to the programs and see what their actual experiences have been in that area?

Would anyone care to comment on the use of incentives?

Shannon Self-Brown: This is Shannon.. In the state of Georgia when we did our first implementation in a region here they did incentivize the parents for completing each module.

And we actually did not see - and I think it was a Target gift card for \$20 or so. And we did - we haven't seen a program completion differences, you know, once we've implemented more statewide where we haven't been able to provide the incentives.

So I'm not sure that, you know, again it might be something that helps in the enrollment phase but in terms of retaining to me it seems more the other stressors the families are experiencing.

And, you know, when it gets down to a 20 or so dollar incentive it's just not enough to keep them in if their life is too stressful to maintain, you know, in the program.

Molly O'Fallon: Well...

David Jones: Yes I would tend to agree with that. Of course Early Head Start I think it's really more about addressing those concrete services partnering with families in reaching those outcomes that begin to stabilize a family in a particular way that contributes to retention as opposed to incentives.

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So it looks like there's time for one more question for the chat box. So Cathy I'll turn it back to you.

Cathy Bodkin: Okay. There was a question about any kind of strategies that would be different working with teams as opposed to adult women especially around the time when teens are going back to school or adult women might be returning to work.

But are - is there anything that keeps teens in the program once they're going through that process of going back to school?

Karen McCurdy: Well let me first direct this question to Molly because of Nurse-Family Partnership's focus on teen parents. Molly?

Molly O'Fallon: Thank you. I think the main thing to take into consideration here is to start discussing that with the client as we talk about their maternal goals and their goals, their life course goals and how they want to move forward in their life and their life progression.

And so that would be part of what the nurse would include in their early conversations with them or relative early during the course of the involvement with that family.

And then as the time got closer for the team to go back to school it may be that an alternative schedule might be more appropriate.

It might be that the nurse home visitor would want a visitor later in the day. It may be that periodically visit schools -- things such as that in order to make the visit successful for both the client and for the nurse so that the goals are met.

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Cathy Bodkin: And just a comment, that would seem to show the effort that the home visitor's making to adapt to the...

Molly O'Fallon: Yes.

Cathy Bodkin: ...other team.

Molly O'Fallon: Yes. That does connect to that. Absolutely.

Karen McCurdy: Any other thoughts on engaging teens?

All right well at this point I want to thank all the programs for all their great insights into the strategies that they're using and for the thoughtful questions from our listeners.

And let me turn it back over to Christy.

Christy Stanton: Thank you so much Karen for facilitating that discussion and thank you for your wonderful presentation today.

And I'd like to thank the other presenters, the representatives from the models who shared with us as well, David Jones from Early Head Start, Pauline McKenzie-Day from SafeCare, Dr. Shannon Self-Brown from SafeCare and Molly O'Fallon from Nurse-Family Partnership.

Additionally thanks to Kathleen Kilbane for sharing HRSA's perspective and welcome with us today.

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It was great to see so much chat box activity from all of you who are participating on the Webinar and we thank you for that as well.

Please stay tuned for more information on family retention in the upcoming October MIECHV TACC newsletter. We will be providing some follow-up that was requested in the chat box as well as some additional resources.

And we'd like to remind you that for more information an archived copy of this Webinar please visit the MIECHV TACC Web site.

It often does take a couple of weeks for archived copies to become available but we will put it up on the Web site as soon as possible once it's been processed to meet 508 compliance quality assurance standards.

Thank you for - to all of you for attending and we wish you a good rest of your day.

Operator: Ladies and gentlemen again that does conclude today's conference. Thank you all for joining.

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