West Virginia Home Visitation Program
Office of Maternal, Child and Family Health

U.S. Department of Health and Human Services
Maternal, Infant, and Early Childhood Home Visiting Development Grant No. D89MC23160-02-02 from United States Affordable Care Act

Preliminary Evaluation Report
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Introduction

Early childhood home visitation is a no-cost service provided to families that choose to participate. Home visiting is typically offered to families in the prenatal stage or to those who have children age five or under. In 2010, with funds authorized by the Affordable Care Act, the Maternal Infant Early Childhood Home Visitation Program (MIECHV) awarded Development Grants to states seeking to enhance the infrastructure of statewide home visitation programs. The MIECHV program provides the means for collaboration at the federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

To be eligible, states were required first to participate in a formal statewide needs assessment\(^1\) to determine where services were lacking and where populations were at highest risk for poor health and child development outcomes. Once the needs assessments were completed and approved, states were required to identify their communities with highest need as well as the capacity for home visitation to address federally-identified priorities by either a) selecting one or more home visiting programs from a list of approved evidence-based models that were already in place or could be developed, or b) identifying a proposed model that could be considered an innovative or promising approach. While all states following these guidelines received a set amount of funding, those that wanted to improve or expand their programs were invited to apply for either Development Grants or Expansion Grants.

\(^1\) The full Statewide Needs Assessment completed September, 2010 is accessible through DHHR’s website at [http://www.wvdhhr.org/wvhomevisitation/needs.asp](http://www.wvdhhr.org/wvhomevisitation/needs.asp).
The West Virginia Department of Health and Human Resources (DHHR), Office of Maternal, Child and Family Health (OMCFH) is the designated lead agency for home visitation programs and elected to apply for a Development Grant which it subsequently received. The focus is to expand the role of professional development and community collaboration strategies to develop and improve the program statewide.

There are seven home visitation models in West Virginia; at the time of this report, the models are: Early Head Start, Healthy Families America, Healthy Start/HAPI, Maternal Infant Health Outreach Workers, Parents as Teachers, Right From the Start and Save the Children. and every county has at least one program in place. However, only three of those were included on the approved list of evidence-based programs. OMCFH has identified the models that are eligible for MIECHV support:

- Early Head Start (EHS)
- Healthy Families America (HFA)
- Parents as Teachers (PAT)

In addition, the Maternal Infant Health Outreach Workers (MIHOW) program is West Virginia’s proposed promising practice model and is currently involved in a randomized control trial in effort to be recognized as evidence-based. Consequently the federal Development Grant supports all four of these models.

Following the MIECHV program objectives, West Virginia’s main goal is to improve the quality of its home visiting services to high-risk populations through professional development opportunities, ongoing technical assistance, and program monitoring within a cohesive early care and education system. By strengthening the state’s early care and education infrastructure, West Virginia hopes to improve services and positively influence child and family outcomes primarily by increasing the professional capacity of staff working directly in the homes. For the first year of the project, the state’s efforts are intended to:

- Improve and monitor the quality of trainings,
- Increase access to trainings,
- Develop cross-training opportunities with partners,
- Introduce specialized training series, and
- Improve staff supervision.

As a result of these efforts, West Virginia’s OMCFH expects that direct service staff at contracted agencies will use knowledge gained through trainings in their day-to-day work, stay in their positions longer and report greater satisfaction with their work and supervision.
The state plan also prioritizes collaborative efforts with the notion that increased knowledge of available services, cross-program referrals and cross-program trainings will enhance collaboration and contribute to improving child and family outcomes. The West Virginia Home Visitation Program (WVHVP) is working to:

- Encourage active collaboration and shared learning among multiple models through state and local continuous quality improvement (CQI) activities;
- Coordinate trainings for all staff across home visiting models for maternal depression screening, injury prevention, preconception care, child abuse prevention and domestic violence; and
- Increase capacity to integrate home visitation services into an early childhood system.

Community collaboration is viewed as a critical component since West Virginia is a largely rural state without an abundance of service resources. Programs and providers serving families during the prenatal, infancy or early childhood stages attempt to collaborate and conserve resources and reduce duplication of efforts. This approach has also been shown to be more effective and family-friendly.²

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Purpose of This Report

The purpose of this report is to present the preliminary findings of the evaluation of professional development and community collaboration activities from a mid-year vantage point. It is issued by OMCFH’s evaluator, Hornby Zeller Associates, Inc. (HZA). To do this, HZA will first provide an overview of the evaluation design and methods used for both parts of the study of 1) professional development, and 2) collaboration. All activities described here were conducted during the first phase, from November 2012 through May 2013, although some activities will be ongoing throughout the next two phases of the project, which is to conclude in May 2014.

These preliminary findings include significant emerging themes and trends identified in the data collected, as well as recommendations for program improvement and possible refinements to the data collection plan. HZA will highlight those findings that may be helpful for the state to consider as it approaches the next phase of the Development Grant and explores the possibility for expansion of home visitation.

This report discusses the results of the evaluation in relation to both the professional development and community collaboration initiatives covering the first phase of the project.

“The State has given more attention to home visiting. We are more focused on training and thinking about what happens next.”
Evaluation Design and Methodology

The statewide evaluation of home visitation services examines West Virginia’s two inter-related areas of focus: professional development and community collaboration.

The professional development component analyzes whether the variables found in the research literature to correlate with job satisfaction, staff turnover, burnout and retention in prior studies hold true in West Virginia. The research questions as stated in the State’s Evaluation Plan are as follows, however at the time of this report not all questions have concrete results. Nonetheless, the evaluation continues and findings will be shared as the project unfolds.

1. How does participation in West Virginia’s professional development and reflective supervision efforts correlate with the following?
   a. Job satisfaction
   b. Burnout
   c. Intent to leave
   d. Sense of job mastery

2. Which of the following variables are positively associated with greater job satisfaction, less burnout, reduced intent to leave, and positive sense of job mastery?
   a. Demographic characteristics
   b. Education and experience
   c. Caseload
   d. Home visitation model
   e. Work environment

3. What additional efforts can produce greater job satisfaction, less burnout, reduced intent to leave and positive sense of job mastery?

The community collaboration component looks at how state-level efforts influence local provider’s work. Examples are coordinated cross-model trainings, development of cross-program practice standards, and implementation of the Zero to Three Home Visiting Community Planning Tool.
**Methodology for Professional Development**

To answer the research questions related to professional development, the evaluation uses three data collection processes: in-person interviews with direct service and supervisory staff; staff surveys for all levels including an exit survey for those who have left their positions; site visits; and a review of documentation relevant to professional development efforts.

Together, the data collected measure:

1. the number of training hours home visiting staff complete,
2. the types of training they attend,
3. the number and types of conferences or professional meetings staff attend,
4. home visiting staff participation in work-related planning committees or similar workgroups,
5. the extent and quality of the supervision they receive and
6. home visiting staff satisfaction with their job.

The first five of these will show the extent to which the activities undertaken by DHHR have resulted in actual staff development activities at this stage of the project. The last question then sets the stage for measuring the impact of participation in staff development activities on job satisfaction, including analysis of whether that impact is different for home visiting staff in different situations.

**Staff Survey**

HZA researched and considered many instruments currently used in similar workplace environments. Because no single instrument was specific to home visitation, nor ideal for gathering the breadth of information needed for this study, a new instrument was developed for West Virginia. The survey contains targeted sets of questions that were developed after thorough review of other known and tested instruments. For instance, to measure job satisfaction, the research team drew from Paul Spector’s Job Satisfaction Survey (JSS) from 1994. While the full set of questions was not included, the Staff Survey contains 23 of the original 36 questions. A similar process was used in developing the sections addressing burnout, intent to leave and job mastery.

The final instrument has eight sections and 85 items covering topics such as supervision and support, training needs and opportunities, and workplace climate, to name a few. (A full description of the survey can be found in the Home Visitation Evaluation Plan). The survey was administered online between December 2012 and early January 2013 through an email link provided to all 105 home visiting staff; 69 valid surveys were returned (66%) from 21 programs.
covering 31 counties, and the survey reportedly took an average of about fifteen minutes to complete.

For this report, descriptive and inferential statistical techniques were used to identify important relationships among the factors tested. Correlation analysis was used to test the relationship of the interventions to job satisfaction, burnout, intent to leave, and job mastery, factoring in the roles of environmental variables such as the education and experience level of the home visitor. For example, the analysis explored whether the amount and type of training received by a home visitor related to their sense of job mastery. To accomplish this, six different scales were created which scored and averaged the responses to all the survey questions related to a single indicator. The scales covered the topics of job satisfaction, intent to leave, burnout, job mastery, supervision type and supervision quality.

**Interviews**

A 40 percent sample of home visitors and supervisors or managers (N=42) was interviewed during the first phase in November 2012. Participants were randomly selected from a group of all current staff to assure objectivity, though participation was voluntary. Topics discussed included: training quantity and quality; type and relevance of training or other professional development activities; sense of competence or mastery; and reflective supervision and support. For those programs in high-risk counties, participants were also asked to discuss their work with other agencies or organizations as an additional topic. Interview responses were summarized by topic and coded on a three-point scale. (See criteria displayed in Table 1.)
### Table 1: Interview Response Criteria

<table>
<thead>
<tr>
<th>Interview Topic</th>
<th>Criteria for Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Training</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td>Offered: Quantity</td>
<td>Sufficient opportunities; attended training</td>
</tr>
<tr>
<td><strong>Training Offered: Quality</strong></td>
<td>High or good quality; helpful</td>
</tr>
<tr>
<td>Activities or Efforts Specific to High-Risk Population</td>
<td>Aware of efforts in most topics related to risk factors</td>
</tr>
<tr>
<td>Job Mastery</td>
<td>Training has helped achieve competence</td>
</tr>
<tr>
<td>Reflective Supervision: Practice</td>
<td>Most or all elements of reflective supervision always used</td>
</tr>
<tr>
<td>Reflective Supervision: Quality</td>
<td>Supervision is supportive and helpful to staff</td>
</tr>
<tr>
<td>Collaboration in High-Risk Areas</td>
<td>Affirmed working well w/partners; works with other state programs</td>
</tr>
</tbody>
</table>
Methodology for Community Collaboration

The results and progress of this part of the project informs West Virginia of the extent to which collaborative efforts are effective in promoting partnerships and scaffolding the prenatal to age five continuum of services. The research questions are as follows.

1. How have state-level coordination efforts improved program management, efficiencies, service continuum and climate across early childhood programs?
2. How have cross-agency trainings (e.g., domestic violence, maternal depression screening, injury prevention, preconception counseling, child abuse prevention, and SIDS/SUID) been used to foster collaboration?
3. How have the roles and perceptions of partner agencies changed towards home visitation?
4. How do the high-risk counties differ in their collaboration efforts and what factors might account for differences?

At the state level, the evaluation examines how agencies relate to one another both formally and informally, and the resulting impact on outcomes. For this factor, we are looking at West Virginia’s process for establishment or enhancement of: policies and practice guidance; climate and culture; community links; personnel and human resources; information-sharing; and quality improvement in the service continuum for families prenatal to five years old.

At the community level, the evaluation examines how the activities and services provided across the agencies have changed. This includes the home visiting agencies along with the collaborative partners, and is intended to determine outcomes of activities similarly studied at the state level as described above: formal and informal partnerships; gaps in services for families in the prenatal to five year stage; effectiveness of services to high-risk areas; and how collaborative efforts have reduced duplication of effort or otherwise saved resources.

This component employs a variety of tools, some of which will allow quantification of results and comparisons in at least two points in time. Both descriptive statistics and qualitative techniques are used for data analysis and to identify important relationships among the factors related to collaboration.

Within the ten high-risk counties, each home visiting agency is included for interviews and participation in the Staff Survey. Other data collection efforts described below will include: the Community Partner Survey, analysis of point-of-contact data, a Group Functioning Scale for the Stakeholders Team meetings, and key informant interviews.
Community Partner Survey

For the Community Partner Survey, agencies were asked to provide contact information for collaborative partners who would then be sent an electronic link to the survey. The research team then cross-referenced those with data from the DHHR-developed Points of Contact Forms, completed a simple internet search for each county, and consulted with members of the leadership team who have knowledge of the typical partners across the state. About 180 names were gathered in total; all of these individuals were sent standard email requests and follow-up reminders to complete the Community Partner Survey. The return rate was 19 percent.

Document Review

To supplement the information gathered from staff and stakeholders, the evaluation includes a review of Points of Contact Forms, relevant meeting minutes, agency reports and publications, work plans, committee reports and similar materials. These materials provide a basis for capturing the collaborative process and understanding the context in which decisions were made. Over 1100 Points of Contact entries were analyzed.

Group Functioning Scale for Stakeholders

To test how well a group is functioning and whether the members believe the group is working collaboratively toward similar or differing objectives, the evaluation team has selected the Diagnostic Tool for Evaluating Group Functioning developed by Iowa State University’s Extension (2000). This checklist was reformatted for this evaluation project to fit on one double-sided page, and was renamed to suit the Stakeholders Group. This worksheet is concise and designed to prompt discussion about: understanding each other’s perspective; elements of successful collaboration and healthy work environments; and discovering areas of commonality and difference from which to work.
The Group Functioning Scale was intended to be used at the state-level quarterly stakeholder and ECAC team meetings. For the next phase of data collection, the evaluation team will work to collect and analyze those that might have been completed but not yet submitted by the time of this report.

**Key Informant and Staff Interviews**

At least half of the West Virginia Home Visitation Stakeholders Workgroup and the Early Childhood Advisory Council will be interviewed, equaling about 15 people selected at random. Researchers will use a structured, open-ended interview protocol to explore the topics associated with state- and community-level change that are fully defined in the evaluation plan. The interviews will be conducted over the phone in the summer of 2013; results will then be reviewed and coded by evaluators for inclusion in the next report.

Directors and program managers of the home visiting agencies in all of the high-risk counties are also considered “key informants” for this study. These individuals were interviewed in person (along with the other staff) during the first round of site visits and interviews completed November 2012. Staff working in the high-risk communities that were not selected for the first round interviews will be included in the second, July–August 2013.
Phase I Findings

The evaluation plan was approved by HRSA November 1, 2012; this marks the official start of the first phase data collection effort. From November 2012 through May 2013 the evaluation activities that have been completed include: in-person site visits and staff interviews; administration, data collection and analysis of the Home Visiting Staff Survey; orientation and distribution of the Group Functioning Scale; collection of meeting minutes and notes kept during Partners in Community Outreach (PiCO)\(^3\) meetings; review of points of contact forms collected by state epidemiologist; administration of the Community Partner Survey; and participation in quarterly Stakeholder Meetings. The information presented in this report will be based on all of the activities above with the exception of the Community Partner Survey and the Group Functioning Scale since there were too few submitted to conduct meaningful analysis.

Demographics of Home Visiting Staff

As referenced above, the staff survey yielded 69 responses from 21 programs covering 31 counties. At the time of this report, no exit surveys had been received, though about five people have indeed left or retired from home visiting.

The 42 randomly-selected interviews completed in November 2012 were conducted in-person at each program’s office location by a team of four HZA research staff. A semi-structured interview allowed program staff to expand on their responses as they thought further about themes related to their community collaboration or professional development.

\(^3\) Partners in Community Outreach (PiCO) funded by the Claude Worthington Benedum Foundation with in-kind support from OMCFH, is a program of TEAM for WV Children, Inc. and the coalition of HFA, MIHOW and PAT programs in West Virginia. PiCO provides technical support, training and collaboration opportunities for home visiting staff.
The number of questions varied according to the relevance to the home visiting staff’s position. That is, supervisors could be asked more questions about their management system, decision-making process for hiring and how formal agreements are made, for example, questions that may not be relevant to home visitors.

Table 2 shows which program models the study participants identified with. Most people responding to the surveys and participating in interviews identified with the Parents as Teachers model.

### Table 2: Program Models

<table>
<thead>
<tr>
<th>Participating Programs</th>
<th>Interview</th>
<th>Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents as Teachers (PAT)</td>
<td>57%</td>
<td>59%</td>
</tr>
<tr>
<td>Healthy Families America (HFA)</td>
<td>14%</td>
<td>20%</td>
</tr>
<tr>
<td>Maternal Infant Health Outreach Workers (MIHOW)</td>
<td>29%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Table 3 shows the demographics of people responding to the survey. The vast majority were women (which is representative of the home visitation staff across the state) with a wide range of years of experience in the field of early education, home visitation or similar.

Table 3: Participant Demographics

<table>
<thead>
<tr>
<th>Demographics of Survey Participants</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>98.5%</td>
</tr>
<tr>
<td>Male</td>
<td>1.5%</td>
</tr>
<tr>
<td>Relationship Status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>13.0%</td>
</tr>
<tr>
<td>Divorced</td>
<td>5.8%</td>
</tr>
<tr>
<td>Married or Partnering</td>
<td>76.8%</td>
</tr>
<tr>
<td>Widowed</td>
<td>4.3%</td>
</tr>
<tr>
<td>Have Children?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>94.2%</td>
</tr>
<tr>
<td>No</td>
<td>5.8%</td>
</tr>
<tr>
<td>Age Group</td>
<td></td>
</tr>
<tr>
<td>&lt;30 Years Old</td>
<td>5.9%</td>
</tr>
<tr>
<td>30–40 Years Old</td>
<td>42.6%</td>
</tr>
<tr>
<td>41–50 Years Old</td>
<td>29.4%</td>
</tr>
<tr>
<td>51+ Years Old</td>
<td>22.1%</td>
</tr>
</tbody>
</table>
When examining their experience in the field, it became clear both from the survey data and the interview results that there is a significant number of new home visiting staff across the state, although most have reported having some kind of relevant experience.

The figure below shows that more survey participants had been in their current position for one year or less (47%) than any other category. This makes sense given that programs have prioritized hiring new staff this past year with development grant funding. On the other hand, over a third of the workforce, thirty-five percent, had been in their position for five years or more.

**Figure 1: Length of Time in Position**

<table>
<thead>
<tr>
<th>Number of Years in Position</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 year or less</td>
<td>47%</td>
</tr>
<tr>
<td>2-4 years</td>
<td>18%</td>
</tr>
<tr>
<td>5-7 years</td>
<td>17%</td>
</tr>
<tr>
<td>8-10 years</td>
<td>6%</td>
</tr>
<tr>
<td>Over 10 years</td>
<td>12%</td>
</tr>
</tbody>
</table>

For many people home visiting is not a full-time job. In fact, approximately half of the survey respondents said they worked for home visiting less than full time.

It appears that all the home visiting models had fairly solid representation among direct service staff, those that have both caseload and management duties and those who are exclusively supervisors. This was consistent across the interviews and the surveys. However, there was some variation by curriculum model (or program type). As demonstrated in Figure 2., Healthy Families was the most highly represented model among home visitors and supervisors. Note that no supervisors with caseloads were represented in the Healthy Families model.
When examining the education of home visiting staff, as shown in Figure 3, almost twice as many staff had some type of Bachelor’s Degree than those with a high school degree. About a fifth have a related BA, while another fifth had an unrelated degree. According to the survey participants, 13 percent of all staff had a Master’s Degree as the highest level of education. The survey results were very similar to the interview results in this regard.
Staff Development Opportunities and Technical Support

West Virginia DHHR arranged for numerous training opportunities covering a range of topics important to In-Home Family Education. Topics included: domestic violence, child abuse and neglect, early literacy, social-emotional development, postpartum depression, data collection and documentation, non-profit management, and home visitor safety. All survey participants said they attended at least one statewide training in the past year. The overwhelming majority (95%) of interviewees also attended trainings that were open to other programs and/or home visiting models beyond those funded by the development grant. This reflects West Virginia’s efforts to promote community collaboration and resource-sharing, as well as the importance of increasing staff capacity to work with high-risk groups, regardless of the location or agency for which staff work.

Home visitors and supervisors alike felt that both the training topics and the number of opportunities for new staff to attend were a good start. During interviews, many people stated that the site visits and direct technical support provided by OMCFH on documentation and federal reporting requirements was extremely helpful. However, many of these comments were followed by the staff person acknowledging that they were overwhelmed by the additional paperwork requirements under the new MIECHV grant.

Likewise, one open-ended question on the survey asks, “What is most challenging thing about your job?” There were 40 written responses to this question, 17 (or 43%) of which reported that the new or additional paperwork was the most challenging part of their job.

“The amount of documentation our parent educators have to do [is a challenge]. Assessments are important, but the frequency is affecting the quality of the program and their relationships with parents.

So in the end, documentation becomes sloppy or unreliable because they just want to get it done for the deadline.”
Many of those interviewed indicated that there is still a great need for intermediate or more advanced trainings (as shown in Figure 4). One staff person stated, “The training for new staff has been great... From a supervisory perspective, I think there is still ample need for the state to provide more advanced training to promote the professionalism of the field.” Home visitors want professional development activities that go beyond basic training or review of previously covered material, although interviewees stated that refreshers are typically a good thing. Staff members at both the direct service and supervisory levels were most interested in opportunities that provide them with useful skills as well as information.

Staff development opportunities were not only provided as in-person trainings, but also in alternative formats such as webinars or online courses. Webinars provided a means to overcome the obstacle of scheduling difficulties and extensive travel time and cost. As demonstrated below, the majority of interviewees (64%) participated in at least one webinar in the past year. However, nearly a quarter were unaware of trainings offered in alternative formats.
While many home visitors appreciated the opportunity to attend training sessions remotely, opinions of the quality of the training experience were mixed. Staff also stated that trainers must make an extra effort to ensure that webinars are interactive. However, these results are too varied to make any generalization about the effectiveness of training provided using alternative formats.

One series of trainings, sponsored by the state, warrants special focus. Originally designed for center-based early childhood educators, the Center for Early Literacy Learning (CELL) developed a training series in collaboration with the Technical Assistance Center for Social Emotional Intervention (TACSEI) and In-Home Family Education (IHFE) staff. The training was provided to home visiting staff to increase knowledge and improve quality of attention to a) children’s social and emotional development (TACSEI), and b) early literacy with families of young children (CELL). Four IHFE programs piloted the training series during the past year, though all staff were asked about their experience with both training series to determine the level of knowledge and interest in the topics.

Participants did not always recognize that TACSEI and CELL were offered in partnership as part of the State’s effort to address a previously identified training need. As shown in Figure 6, less than half of those interviewed attended the training, and many were not aware of either CELL or TACSEI, with more than half stating that they didn’t know about TACSEI.
According to the interviews and surveys, most participants felt the TACSEI and CELL training series was fairly basic and even a bit general. When discussing the details of the training with home visitors, it was clear that those who had been in their position for more than one or two years felt the material covered in the series was already part of their program’s philosophy and curriculum, and they were very experienced with appropriate ways to engage families in early literacy activities.

A few staff also reported that they had a great deal of familiarity with promoting positive social emotional connections between young children and their families and were more interested in working with complex family dynamics such as those struggling with serious depression or other mental illness or substance abuse in the household.
Training Effectiveness and Unmet Needs

Another focus of the evaluation is to determine whether or not the professional development efforts help staff to meet job requirements. Thus far, the survey results show modest correlations, although the vast majority of interview participants expressed their recognition that ongoing training is important, useful, and sometimes affirming.

During first-round interviews, staff rarely stated overtly negative feelings about training; rather, they described the challenges with logistics such as: notice of and timing of training; length of training (a few reported difficulty in getting away for the required 1-2 days); required distances to travel to sessions; and disappointment when the description did not “match” the content covered. It was somewhat common to hear seasoned staff express frustration when presentations were redundant or repetitive.

However, survey results showed strong correlations between those who had a positive rating of training (i.e., the degree to which they felt the training “prepared” them to work with high-risk groups) and job satisfaction. Those who said the training they received was effective also reported high job satisfaction. Figure 8 on the following page shows how helpful training was perceived to be based on the staff person’s length of time in her position. There was no real pattern correlating length of employment and training effectiveness.
When interviewed in person, home visitors and supervisors who had been in their positions longer thought trainings were repetitive and were often a waste of time. They stated the need for more training opportunities related to the troubling and complex issues they are seeing the families experience. Numerous staff members expressed the desire to learn more about what to do when presented with situations related to substance use (particularly prescription drug abuse), mental illness, and complex family dynamics (such as with multigenerational households). Home visitors are interested in gaining a better understanding of these topics, beyond reviewing the basic information about a subject area.

“Trainings really need to provide a skill, not just information. It needs to be hands-on. We want the opportunity to practice skills.”

“I think we all need to work on reassuring and reinforcing what we are doing as a result of the learning.”
The overwhelming majority of new home visitors found any and all trainings to be helpful. They often stated things like “You always learn something new,” and “Refreshers are always good.” In summary, while numerous opportunities for professional development are being offered and/or paid for by the state, they are perceived as good opportunities for new staff and will need to be adjusted to address the more advanced and complex needs of more seasoned professionals.

**Reflective Supervision Practices**

To understand the context of the responses to questions pertaining to reflective supervision and support provided to staff, we will first review the basic philosophical concepts of reflective supervision. The goals of reflection are grounded in a relationship-based approach to supporting staff rather than the once typical top-down or hierarchical model. This philosophy is strength-based, process-oriented, culturally sensitive and often described as a parallel process. West Virginia requires all managers to complete reflective supervision training as part of the Development Grant. The critical elements of reflective supervision include regularly-scheduled, in-person meetings between staff and supervisors, which are designed to help home visitors to reflect on their actions when working with families and then begin to apply what they learn in their work in the homes. These sessions also provide an opportunity to discuss concerns and develop corrective plans if needed. Open lines of communication are intended to help to develop strong relationships and retain staff members who become increasingly competent and confident in their roles.

In addition to required training in reflective supervision, the WVHVP adheres to the model developers’ recommendations and requirements for supervisor qualifications in regard to education, number of home visitors supervised, training length and timing, and format and frequency of observations of home visitors. For instance, the PAT requirement is that staff members working more than part-time meet monthly, one-on-one, for a minimum of two hours. PAT also requires a minimum of two hours per month for all-staff team meetings (which is in addition to the one-on-one sessions). This is not necessarily the case for HFA or MIHOW.

“Overall I am very comfortable with my work, but I would have to say that the people who support me in my work are what make it all worthwhile.”
With the variety of curricula used by the different programs, the schedule for supervision sessions varies, too.

All supervisory respondents stated they had participated in reflective supervision training, while none of the home visitors had taken part. Nearly 60 percent of supervisors reported that they implement most or all elements of reflective supervision, while just over half (52%) of home visitors indicated during the interview that most or all aspects of reflective supervision are used in their supervision sessions.

The use of reflective supervision varied by home visiting model, as noted in Figure 9. Every interviewee from HFA programs indicated that most or all elements of reflective supervision were used in their agency. Meanwhile, about 20 to 25 percent of MIHOW and PAT interviewees indicated that no elements of reflective supervision were used. The majority of interviewees from these programs say that at least some elements of reflective supervision are implemented.

**Figure 9: Perceived Helpfulness of Training Based on Job Tenure**
In the survey, a slight majority (55%) of all staff reported that their agency adhered to the reflective supervision model, which involves regularly scheduled one-on-one meetings, structured to follow the guidance promoted and practiced during the statewide training on reflective practice.

A key element is the frequency of supervisory sessions themselves, which should be at least monthly. Figure 10 shows that only 12 percent of home visiting staff say they receive supervision less often than monthly. Since 46 percent report incomplete adherence to the model and only 12 percent report meeting less than monthly in supervisory sessions, there must be other aspects of the model that are not being recognized by about a third of the home visiting staff.

Perhaps not surprisingly, people who are interviewed express more consistently positive views than those who are surveyed. Consistent with the intent of reflective supervision, all interviewees described very supportive work environments in which their colleagues and supervisors were readily available to help address concerns, either in person or through other means such as email or text messaging. Most staff members had the opportunity to discuss specific cases or situations with their supervisors and troubleshoot problems or brainstorm solutions. Not all programs have one-on-one supervision sessions; however some supervisors stated they would like to make time for formal and regularly scheduled one-on-one supervision in addition to group sessions.
Effectiveness of Supervision

As shown in Figure 11 on the following page, it is clear that home visitors rate their supervisors fairly highly, with the overwhelming majority expressing agreement or strong agreement with the ten positively-framed statements. The index created to examine the overall quality of supervision and support as perceived by the home visitors revealed a mean score of 4.4 out of a possible 5. There was also a moderate to strong correlation between those who rated their supervisors as high quality also reporting high levels of job satisfaction. Not surprisingly, a low quality rating of supervision and support was moderately, but still significantly correlated with a greater intent to leave. There was no significant correlation between the staff person’s education level or age and his or her overall job satisfaction.

This analysis of supervision, based on both the surveys and interviews, suggests that staff generally feel supported and valued by their supervisor. Likewise, the majority reported other positive aspects of their managers, such as being approachable, helpful and knowledgeable about home visiting-related issues; all of which are influential in the home visitors’ sense of job satisfaction.
Professional Development Indices

This section provides an overview of findings on broader professional development themes, including any significant correlation or connection between and among variables found to date. Information is again derived from the staff survey. The discussion is presented by the categories assessed, such as burnout and job satisfaction. Consistent with the overall evaluation design, the same questions will be asked at two more intervals during the MIECHV development grant cycle. Thus, this report presents a type of baseline assessment.
Burnout and Intent to Leave

This evaluation examines variables that are positively associated with less burnout and reduced intent to leave. The results from this phase showed a positive correlation between staff who said they had high quality supervision and low burnout—if the program the staff person worked for used reflective supervision the way it is intended, they were less likely to express feelings of emotional drain and negative physical impacts.

Based on the index created to examine these variables, the average level of burnout was 2.2 (on a scale of 1 to 5 with 1 being low), and the correlation to the supervision quality rating was moderate, as shown by the Pearson’s r value of -.529, demonstrating some relationship between burnout and supervision. Not surprisingly, there were solid correlations between feelings of burnout and low job satisfaction, on one side, and a low sense of mastery or competence in the work required, on the other (the strength of Pearson’s r here was -.632, even more significant than the supervision quality index score). That means that people who had low job satisfaction also expressed feeling burned out. Those people also did not feel as competent to do the job or believed they had little control over their work environment. See Figure 12 on page 31 for a full visual representation of professional development findings.

A similar process was used to examine the specifics related to a home visitor’s intent to leave. Staff who had high scores on the Burnout Index were significantly more likely to have a high intent to leave score. Also those who scored high on burnout tended to score low on the Job Mastery Index. Overall, responses to the survey revealed a very low average score for the intent to leave index (.81), but the high standard deviation (1.06) indicates that the results are skewed, with some staff members showing a much higher intent to leave.

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4 Using the Correlation Coefficient Pearson’s r, a strong correlation is between the number -.6 and -1; the closer the value to 1, the stronger the correlation. A weak correlation is typically between -.3 and -.2
Figure 12: Job Satisfaction

HIGH JOB SATISFACTION
- HIGH QUALITY OF SUPERVISION
- STRONG SENSE OF JOB MASTERY
- INTENT TO LEAVE
- HOURS OF FACE-TO-FACE TRAINING

LOW JOB SATISFACTION
- LOW QUALITY OF SUPERVISION
- WEAK SENSE OF JOB MASTERY
- LOW INTENT TO LEAVE
- HOURS OF FACE-TO-FACE TRAINING

JOB BURN-OUT
- STRONG INTENT TO LEAVE
- PERCEIVED USEFULNESS OF TRAINING

HOURS OF WEB-BASED TRAINING
- DEGREE OF REFLECTIVE SUPERVISION

PERCEIVED USEFULNESS OF TRAINING
- STRONG POSITIVE CORRELATION
- WEAK POSITIVE CORRELATION
- STRONG NEGATIVE CORRELATION
- WEAK NEGATIVE CORRELATION

NO CORRELATION
The figure on page 31 illustrates the relationships between the main survey measures in terms of positive and negative correlations. In each case, an arrow is drawn between two metrics if their correlation is statistically significant at the 0.05 level or better, and a bold arrow indicates statistical significance at the 0.001 level.

Those who reported high levels of training usefulness were extremely likely to report high levels of job satisfaction, and likely to report high quality of supervision, and also having received a large number of hours of face-to-face training. Those who reported high quality of supervision were extremely likely to report low burnout levels, and likely to report a low intent to leave.

In general, the results were as expected, but there were some unexpected outcomes as well. The number of hours of web-based training was not significantly correlated with any other measure, nor was the degree of reflective supervision. This suggests that factors other than the mode of delivery were more important in assessing the impact of training. The fact that the quality of supervision was significantly correlated with several other factors—while the degree of reflective supervision per se was not—may reflect the importance of other characteristics of supervisors and their relationship with home visitors, not only the model used. Given the relatively recent introduction of the reflective supervision model in West Virginia, subsequent survey analysis may provide more information related to this issue.

Looking more closely at variables associated with the participant’s satisfaction in their current position, as shown in Figure 13, we see that those who had been in their position for one year or less, 45 percent said they had looked for another job in the past year. In the same group, a total of 80 percent indicated that they had gone as far as sending a resume or application. This number seems somewhat high for staff who were employed for a year or less, however it is not possible to tell from the data if those “resumes sent” included sending a resume and securing their current position with the home visiting program. Conversely, and perhaps not surprisingly, those who had been in their position for more than seven years were fairly unlikely to have looked for another job or sent a resume in the past year.
Staff who indicated they were looking for a job and submitting resumes tended to differ by age. Figure 14 shows that the age group most likely to be looking for another job was the 30 to 40 year old group, followed closely by 41 to 50 year olds. There were no other demographic characteristics that correlated to intent to leave, such as marital status, education level or whether the staff person had children of her own.
Job Satisfaction and Job Mastery

The research questions addressing overall satisfaction and home visitor’s perception of job mastery seek to address what additional efforts (presumably from the state and/or agencies themselves) produce greater satisfaction and mastery as well as decreased burnout, and reduced intent to leave. It is clear that the free or very low-cost training opportunities are highly valuable to staff. In the open-ended questions asking about what additional support is needed, many stated the gratitude for the direct support from the State office in providing training on additional requirements for MIECHV funds. Likewise, program supervisors, in particular, said they were grateful for the funds and assistance in sending their staff to training hosted by the State or partner agencies.

Staff were also asked about the aspects of the work they felt most comfortable and competent with. Out of the 69 surveys completed during the first phase, 41 participants answered this question, and the great majority (76%) shared that they were most comfortable working directly with children and families during the home visits. A few also said they felt competent with the curriculum and also community outreach with other programs.

![Figure 15: Job Satisfaction](image)

**Figure 15: Job Satisfaction and Intent to Leave**

- Satisfied with job: 82% YES, 18% NO
- Plan to stay for 1-2 yrs: 96% YES, 4% NO
- Looked for new job: 44% YES, 56% NO
- Plan to leave: 0% YES, 100% NO
- Applied or sent resume: 16% YES, 84% NO
Community Collaboration: State-Level Efforts

The evaluation of collaboration and community relationships is still in progress, though it is clear from interviews, surveys, and document review that collaboration efforts are in place and are being prioritized by the state leadership team. Partners in Community Outreach (PiCO), designated by OMCFH to be the coordinating organization with membership from each of the three home visitation groups (HFA, MIHOW and PAT), is one resource that has been available and has provided valuable insight on the connections among the state, the major home visitation programs and their partners.

PiCO also provides resources for staff development and networking at both the management and direct staff level, so while this evaluation does not formally assess the degrees of effectiveness of this organization, it is acknowledged that PiCO is an important part of community collaboration development. For instance, PiCO has taken action toward providing community linkages to address many of the state’s objectives under the grant including:

- Working with and serving on the Early Childhood Advisory Council and Stakeholders Team;
- Working with and serving on the Advisory Panel for the Our Babies, Safe and Sound project;
- Voting on the West Virginia Campaign to Raise Children Out of Poverty key issues;
- Participating in the development of Home Visiting Core Knowledge and Competencies;
- Attending and assisting with the state Home Visiting Conference;
- Attending the Perinatal and Child Health Summit;
- Communicating priorities for home visitation with partners by generating, for example, articles on In-Home Family Education to the Sisters of Saint Joseph Health and Wellness Foundation and the West Virginia Nurses Association; and
- Providing ongoing communications and meeting facilitation for each home visiting program.

“The training has been invaluable. Also the collaborative efforts with ECCS, Birth To Three, Right From The Start and all of the state folks getting to come together.”
While the next phase of the evaluation will include a more in-depth analysis of the state-level collaboration efforts, the Stakeholders and Early Childhood Advisory Council have had a successful beginning. There are many activities to highlight from the first phase, including the establishment and working plan for a formal Home Visitation Stakeholders Team. Meetings are held quarterly and include full representation from not only all home visitation model providers, but also invested community professionals in partner organizations such as Prevent Child Abuse West Virginia, the Department of Education, the Head Start Director’s Association, Child Care, and all Early Childhood Advisory Council members. This group has worked to understand each partner’s program and mission, and participated in a tour of home visitation sites to learn first-hand about the experiences of service providers. Likewise, the team has worked with OMCFH staff to successfully organize and host the first statewide Home Visitation Conference in May 2013.

Other substantial tasks have included the development of a marketing initiative and a complete rebranding to establish a positive and consistent image for the WVHVP. The Stakeholders Team is currently leading designated subcommittees in reviewing and revising the Core Competencies for all programs to use as guidance in implementing their programs with fidelity.

The state has also worked diligently with the federal technical assistance provider to establish plans for continuous quality improvement (CQI) that is still in process. At the time of this report, the state began the process to kick off the Help Me Grow initiative, with the major goal being to coordinate services and resources to children and families more effectively. Help Me Grow is a free referral service that connects families with critical developmental resources for their children birth through five years. The goal of Help Me Grow is to identify children at risk and link them to the help they need. This is a program used by others states which West Virginia OMCFH decided to adopt.

**Community Collaboration: Local-Level Activities**

Information on community collaboration comes from four sources: interviews with home visiting staff and supervisors, the Staff Survey, the Points of Contact forms completed by the home visitors and the Community Partner Survey. All of these sources provide insight into the kinds of collaboration in which the home visiting programs are engaged.

*Types of collaboration:* Home visiting staff interviews indicated that collaboration occurs at least at two levels: referrals of families to services and participation in community activities. On one hand, because the home visitors live in the communities in which they work, many have developed personal connections which give them access to services for their client families which might otherwise be less accessible. At a broader level, home visitors and the
administrative and supervisory staff also participate in joint efforts, such as task forces, created to address specific community concerns.

Although the Community Partner Survey has produced only 30 responses to date, it is notable that one of the most frequently cited forms of collaboration reported was participation in joint meetings, task forces and coalitions. In fact, only five of the 30 respondents indicated that this type of collaboration never occurred. The only connection between the home visiting programs and their community partners which seems to occur more frequently is sharing of information.

Some of the community partners were more expansive in describing the kinds of community-wide collaboration. Several people noted the community baby showers, health fairs, literacy events and Halloween parties as excellent collaborative activities. Some noted that their inclusion in community events over the years has allowed for the sharing of more information with families about the services available, indicating that the broader efforts have paid dividends for specific families.

Community partners also report relatively frequent connections with home visiting programs through referrals of specific families. Seven of the 30 respondents indicated that they refer families to the home visiting program “a lot,” while four indicated that they received referrals “a lot.” Nearly all of the community partners, however, either receive some referrals from or make some referrals to the home visiting programs. Only three of the 30 reported not referring any families and only four not receiving any referrals.

Need to connect to medical services: Despite the reports of extensive collaboration, both supervisory and direct service staff from the home visiting programs expressed a desire to have more and better connections with local medical professionals. One issue here relates to the programs’ goal of enrolling families before or immediately following the birth of a baby. Home visitors need referrals from medical staff to know who is pregnant. However, the home visiting staff also want better connections with medical professionals because they recognize that the latter are highly regarded by parents and are therefore valuable potential partners for the in-home staff when providing guidance on the health and development of the child. That is, if a home visitor expresses a concern about the child’s development and the parent seeks help from a medical professional, the home visitor would like medical professionals to be proactive rather than taking a “wait and see” approach. Staff also indicated that they would like to have better access to mental health and substance use professionals. These types of services were mentioned at nearly every interview site as being lacking or having a long wait list.

Visibility of home visiting agencies: The data provide somewhat conflicting information about some of the other possible challenges home visiting programs face. For instance, while staff indicated that their organizations had limited visibility in the community or were often
confused with others, particularly Child Protective Services, over 80 percent of the community partners reported that the home visitors had high levels of visibility in the community and over 95 percent indicated that the programs have strong reputations. Similarly, while home visiting staff expressed some concerns about competing with other programs, only four of the 28 community partners with an opinion thought they competed either for clients or for funds.

Service availability and use: The Staff Survey and the Points of Contact forms completed by the home visitors also showed that home visitors access and partner with a wide variety of service providers. These include the state early intervention providers (called Birth to Three), public schools, health departments, hospitals and clinics, WIC and nutrition services, and churches and faith-based organizations, just to name a few. On the other hand, 25 percent of the Staff Survey respondents reported that homeless services and/or shelters were not available, followed by 21 percent for alcohol or substance abuse services and 20 percent for legal services or courts.

More systematic information comes from both the Staff Survey and the Points of Contact form home visitors complete during the course of their work with families. The survey presented home visiting staff with a list of services and asked them to indicate how readily available each of the services was.

The figure on the following page shows the results. It is probably no surprise that programs supported by the federal government such as WIC and food stamps/SNAP are perceived by home visitors as being most accessible.
Figure 16: Availability of Community Programs

Availability of Community Programs

- **WIC**: 77% Always Available, 22% Sometimes/Often Available, 2% Never Available
- **Food Stamps/SNAP**: 73% Always Available, 27% Sometimes/Often Available, 0% Never Available
- **Child Health Insurance (CHIP)**: 72% Always Available, 28% Sometimes/Often Available, 0% Never Available
- **Birth to Three/Early Intervention**: 70% Always Available, 31% Sometimes/Often Available, 0% Never Available
- **Medicaid**: 66% Always Available, 34% Sometimes/Often Available, 0% Never Available
- **Head Start**: 62% Always Available, 38% Sometimes/Often Available, 0% Never Available
- **Family Planning/Women's Health**: 62% Always Available, 30% Sometimes/Often Available, 8% Never Available
- **Right From the Start**: 57% Always Available, 41% Sometimes/Often Available, 2% Never Available
- **Family Resource Centers**: 57% Always Available, 35% Sometimes/Often Available, 8% Never Available
- **Child Protection Services**: 56% Always Available, 43% Sometimes/Often Available, 2% Never Available
- **Domestic Violence Prevention**: 55% Always Available, 37% Sometimes/Often Available, 8% Never Available
- **Food Pantries or Similar**: 55% Always Available, 45% Sometimes/Often Available, 0% Never Available
- **Early Head Start**: 49% Always Available, 38% Sometimes/Often Available, 13% Never Available
- **Baby Pantry**: 48% Always Available, 46% Sometimes/Often Available, 7% Never Available
- **Mental Health Services**: 39% Always Available, 56% Sometimes/Often Available, 5% Never Available
- **Services for Child w/ Special Health Care Needs**: 34% Always Available, 62% Sometimes/Often Available, 3% Never Available
- **Skill Building/Vocational Service**: 33% Always Available, 59% Sometimes/Often Available, 8% Never Available
- **Alcohol or Substance Abuse Counseling or Services**: 33% Always Available, 59% Sometimes/Often Available, 8% Never Available
- **Child Care (home or center-based)**: 30% Always Available, 59% Sometimes/Often Available, 8% Never Available
- **Fuel or Utilities Assistance**: 26% Always Available, 69% Sometimes/Often Available, 5% Never Available
- **Prenatal Classes**: 20% Always Available, 53% Sometimes/Often Available, 28% Never Available
- **Parent Support Groups**: 18% Always Available, 71% Sometimes/Often Available, 12% Never Available

Legend:
- Always Available
- Sometimes/Often Available
- Never Available
The 1143 Points of Contact records home visitors completed during the last six months of 2012 provide a different angle with a similar result. The home visitors record information about the actual contacts they have made referring a family to specific services. The service itself is not recorded, but the type of agency sometimes provides an indication of the kind of service. Because some of the agencies are quite broad in scope, the following table classifies nearly one-third of the contacts as “other”.\(^5\) Excluding the “other” category, the most frequent types of referrals were health-related, followed by those for basic needs which encompasses food, clothing and shelter unless the need was related directly to a baby, in which case it was classified as baby-related. The overlap of high usage and high availability of services to fulfill basic needs demonstrates consistency of response between the two data sources.

\(^{5}\) Examples of referrals that could not be classified with the information available are: news media, APA, FRN, American Red Cross, Board of Director, and County Government.
Community agency views of collaboration: Overall, collaboration appears to be one of the strong points of the in-home family education programs. Community partners value the shared focus of the various agencies, the tangible support that the agencies have provided one another and the joint training activities. In fact, when asked what could improve their relationships with the home visiting programs, nearly every person who commented on this question (more than half the respondents) said that nothing could be done to improve the relationship. One said, “Nothing, we work very well with the home visitors,” while another reported, “The people are wonderful and loyal and dedicated and as long as the leadership has passion, the relationship will continue to be strong.” Still another wrote, “Can’t think of a single thing.”

When asked what one thing they might want from the home visiting programs, more people said “nothing” than any other response. One commented, “They continue to work to prevent child abuse and have become leaders in our state.” The few suggestions made included: more community education and outreach to help the community know about available services, the desire to share information and training, and the interest in expanding home visiting to serve more families in counties that do not have as many resources available.
“The people [involved in the IHFE program] are wonderful and loyal and dedicated and as long as the leadership has passion, the relationship will continue to be strong.”
Summary

The next phase of the evaluation is already in process with the lessons learned from the initial phase along with considerations from the leadership and partner agencies. Results from the first phase of data collection were generally positive and show the State which efforts have been effective, and what is needed next for programs to be as successful as possible.

Staff are grateful for the support provided to participate in free and low-cost training. While the training takes time away from the job, having it sponsored by the state agency relieves the local agency of the burden and is highly appreciated. Staff are also pleased with the supplies and materials provided to help them work with families. At the same time, many home visitors and supervisors expressed the desire for more intermediate and advanced training with a practical focus on how to handle the complex situations that families experience. These include, particularly, situations involving domestic violence and mental illness.

A concern that was expressed on the Staff Survey and during interviews is the challenge experienced with new paperwork requirements and the time-consuming nature of the additional documentation. They do not fully understand where the data goes or how it is used. Many staff members describe how helpful the leadership was in providing first-hand guidance and suggestions for handling data collection requirements, though many still felt stretched between completing the requirements and conducting regularly scheduled visits with families. Conversely, there were some who expressed dissatisfaction when new requirements were passed on without thorough training and without a rationale for the change.

Home visiting programs are very comfortable networking across models. Any sense of competitiveness is missing. On the contrary, programs welcome looking at the other models for management strategies that they can use. They want to borrow creative ideas for networking in their own communities.

Supervisors trained on reflective supervision are committed to the process. They are making efforts to follow a more formalized process such as meeting regularly and having agendas, both
of which are suggested by the reflective supervision model. While the home visitors themselves are not familiar with the reflective supervision concepts per se, as a group they feel supported by their supervisors.

While it was difficult to get a lot of community agencies and partners to respond to the anonymous Community Partner Survey, those that did respond were unanimously positive about the in-home family education service in their community. They perceived home visitors to be collaborative and helpful to families. They could identify numerous types of community activities in which their agency collaborated with one providing home visiting services

**Next Steps**

Following HRSA’s pending approval of the State CQI and Data Collection Plans, the evaluation team will meet with the leadership to review the objectives related to professional development and community collaboration and make adjustments to the evaluation plans as necessary. Using this report as the set of preliminary findings, the upcoming activities include:

- Phone interviews with stakeholders and Early Childhood Advisory Council members to answer research questions about state efforts for professional development and community collaboration;
- Second-round staff interviews and site visits to continue the evaluation of professional development and collaboration;
- Second-round Staff Surveys to continue the evaluation of professional development and collaboration (this includes an attempt to reach staff who have left their position through email to complete Exit Surveys);
- Review of federally-required benchmark data with program director and epidemiologist to determine which, if any, have been affected by the project efforts;
- Collection of relevant documents to supplement compiled information;
- Collection of Group Functioning Scales from any stakeholder and ECAC meetings held to date; and
- Assessment of the Help Me Grow screening and referral system via interviews with the Stakeholders Team.

Reporting on the activities and efforts related to how West Virginia’s Home Visiting Stakeholders Team is sharing and acting on the data collected from the Development Grant as well as other relevant sources.
**Recommendations**

This section provides a few general recommendations for West Virginia’s OMCFH and Stakeholders Team to consider as they approach the next phase of program evaluation and self-assessment embedded in their process of continuous quality improvement.

1. **Continue to provide training relevant to home visiting profession, particularly higher-level skill-based training.**

West Virginia OMCFH has increased the opportunities and access to more training specifically designed for this field. OMCFH has gone to extensive lengths to assure trainings are either a reasonable cost and/or free to participants. Likewise, these opportunities have been made available to community partners so that the information can be beneficial to others as well. Building on this year’s foundational training, OMCFH should consider offering more intermediate or advanced level training. Furthermore, these advanced trainings can specifically address the topic areas that staff have expressed needing, including working with families who have serious mental illness, serious depression or substance use and working with families who have babies affected by drug use.

For staff members who do have extensive knowledge and experience, the State could also consider supporting home visitors through formal coursework and working toward a specific credential. Staff who feel competent in their roles are more likely to feel fulfilled and ideally, the State will retain a cadre of highly-trained professionals.

2. **Organize a formal venue to release the recently-revised Core Competencies for Home Visitation.**

The State has worked diligently to revise a set of standards that all in-home family education programs in West Virginia could use as part of their self-assessment to adhering to evidence-based guidelines relevant to each curriculum. From this mid-project standpoint, an official “kick-off” or formal review of the Core Competencies, including all Stakeholders and home visiting professionals, would aid in the State’s interest of strengthening partner relationships and community collaboration. This type of event, similar to others such as the Home Visitation Conference and the Help Me Grow Kick-Off, would unite all providers in a common goal of assuring the highest quality services are provided to families. In addition, this would give the leadership an opportunity to review the Core Competencies and outline their expectations for program use and adherence. (Core Competencies could be revisited during the biannual site visits, which were greatly appreciated by home visiting supervisors and staff.)
3. **Expand training on Reflective Supervision and/or Reflective Practice.**

Given that nearly 60 percent of supervisors reported implementing “most or all” elements of reflective supervision, it is clear that the emphasis OMCFH has put on training and support to that end has been beneficial. If the goal is to have all programs successfully using this model of reflective practice, the State could continue to work with supervisors on the essential requirements of supervision and support. In addition, it is recommended that training be extended to direct service staff as well, with the idea that if both parties who are engaging in this process fully understand the intent and purpose of reflection, they will be more successful in applying the same principles when working with families.

Assuming that the basic elements of reflective practice can easily be described though short two-to-three hour interactive sessions, the State could consider outlining (and offering) training required as part of either home visitor orientation or annual updates on related topics such as: conducting case reviews, motivational interviewing, using a strengths-based approach, maintaining professional boundaries and developing cultural competence.

4. **Arrange for Regional Team Meetings.**

As part of the State’s effort to improve community linkages, reduce duplication of services and maximize resources, it successfully organized Regional Team Meetings at the Home Visitation Conference in Charleston. These meetings were facilitated by an outside provider and were viewed by staff to be a positive experience in terms of fostering local-level relationships and mutual understanding of program purpose. OMCFH could continue to lead this effort by arranging for quarterly or bi-annual meetings to include regional home visiting programs and their partners, fitting nicely into their goal of coordinating efforts to improve efficiencies and a healthy working environment across early childhood programs.

5. **The Early Childhood Advisory Council should meet with physicians’ groups to discuss issues of coordination and support.**

Two of the issues raised by home visitors and supervisors warrant addressing with medical professionals such as the West Virginia Chapter of the American Academy of Pediatrics (who also work with the population of families seen by home visitors). One is to develop strategies for more prenatal and neonatal referrals. The second is to garner support for the referral made by home visitors that address the developmental needs of children. Home visitors would like more pro-active support from the medical profession on addressing issues such as early learning, literacy, motor, emotional and social development. An agenda item for the joint Stakeholders Team and Early Childhood Advisory Council meeting could be finding ways to partner with pediatricians and obstetricians for these purposes.
Appendix: Group Functioning Scale
West Virginia Home Visitation
Partnerships and Collaborative Functioning Scale

**Instructions:** Please indicate how well you think the group is **currently** functioning by circling the number closest to your view. Your responses are anonymous; the surveys will be collected and analyzed all together. The group should discuss each item and what actions are needed.

### Shared Vision

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### Goals & Objectives

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### Decision Making Procedures

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<td>5</td>
<td>6</td>
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<tr>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

### Changing Membership

<table>
<thead>
<tr>
<th>We do not have procedures for changing members</th>
<th>We have defined procedures for changing members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<tr>
<td>3</td>
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<td>5</td>
<td>6</td>
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<tr>
<td>7</td>
<td></td>
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</tbody>
</table>

### Conflict Management

<table>
<thead>
<tr>
<th>Conflict keeps us from doing anything</th>
<th>We are able to successfully manage conflict</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<td>3</td>
<td>4</td>
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<td>5</td>
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<td>7</td>
<td></td>
</tr>
</tbody>
</table>
**Partnerships and Collaborative Functioning Scale, continued**

### Leadership

<table>
<thead>
<tr>
<th>Leadership is not shared and is inadequate</th>
<th>Leadership is effective and shared when appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6 transient 7</td>
</tr>
<tr>
<td>2</td>
<td>6 transient 7</td>
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<tr>
<td>3</td>
<td>6 transient 7</td>
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</tr>
<tr>
<td>7</td>
<td>6 transient 7</td>
</tr>
</tbody>
</table>

### Plans

<table>
<thead>
<tr>
<th>We do not follow work plans</th>
<th>Plans are well developed and followed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6 temporary 7</td>
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<tr>
<td>2</td>
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<tr>
<td>7</td>
<td>6 temporary 7</td>
</tr>
</tbody>
</table>

### Relationships & Trust

<table>
<thead>
<tr>
<th>People do not trust each other</th>
<th>People highly trust each other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>2</td>
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</tr>
</tbody>
</table>

### Internal Communication

<table>
<thead>
<tr>
<th>Members do not communicate well with one another</th>
<th>Members communicate very well with one another</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

### External Communication

<table>
<thead>
<tr>
<th>We do not communicate well externally</th>
<th>Our external communication is open and timely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6 temporary 7</td>
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### Evaluation

<table>
<thead>
<tr>
<th>We never evaluate our own performance</th>
<th>We have built evaluation into all of our activities</th>
</tr>
</thead>
<tbody>
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2013. Adapted for use with West Virginia DHHR Leadership Team from *Evaluating Collaboratives*, University of Wisconsin Cooperative Extension, 1998.