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SafeCare Colorado

*Colorado Department of
Human Services*

Pilot Project Evaluation
Report



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Research for Results

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Colorado Department of Human Services SafeCare Colorado Pilot Project Evaluation Report

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SafeCare Colorado Pilot Project Evaluation Report

Executive Summary

SafeCare® is an evidence-based in-home parent education program designed for high risk families with children birth to five. The program in Colorado is currently piloting in 11 community-based agencies serving 39 counties and two tribal nations. SafeCare Colorado (SCC) is designed to be home based, voluntary, and preventive. The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect (Kempe) oversees the implementation of SCC. Statewide program oversight is provided by the Division of Community and Family Support in the Office of Early Childhood at the Colorado Department of Human Services. The evaluation of the pilot project is conducted by the Social Work Research Center in the School of Social Work at Colorado State University. The executive summary highlights key findings and implications.

Process Evaluation: Summary of Key Findings

The process evaluation includes program data collected by parent support providers (PSP) at each community-based site. Caregiver perspectives from surveys and focus groups are also included, as are interviews with coordinators at each site.

Program Referral and Participation Results

Overall, 8,157 families were referred to SCC sites from January 2014 through June 2016. Of these referrals, 68% came from child welfare departments. Of these, 47% were referred to the program by a caseworker after conducting an assessment and determining an open child welfare case was not warranted but additional supportive resources were needed. Consistent with other voluntary prevention programs, the majority of families (79%) referred to SCC do not participate in the program: either they cannot be contacted or they decline to participate.

A total of 1,752 unique families were served by the SCC program, meaning they enrolled and had an intake session. Of those families with SCC session data ($N = 1,701$), 69% received a minimum of three sessions. Caregivers are given the option of which topic to begin with, and the majority of families who begin a topic finish that topic. Overall, there was a 74% completion rate for the Home Safety topic; 79% for the Child Health topic; and 65% for the Parent-Child Interaction (PCI) or Parent-Infant Interaction (PII) topic. Overall, 44% of families do not complete any topics, while 25% of families complete all three topic areas. In addition, 51% of

caregivers received supportive resources to address issues outside of the SafeCare® topic areas, such as mental health, housing, food, child care, and other resources.

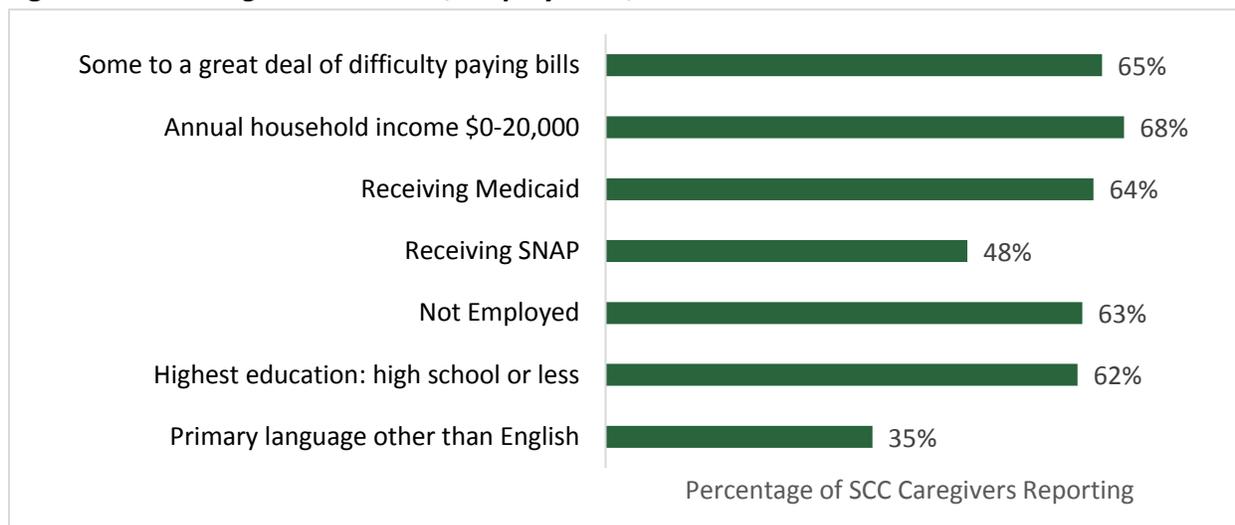
Caregiver, Children, and Household Characteristics

Caregivers participating in SCC are overwhelmingly women (93%). Close to half report being of Hispanic race or ethnicity (44% and 46% respectively), while 43% reported being Caucasian. Other key demographics include:

- The average age of caregivers is 29
- Household size ranges from two to six, with an average of 1.4 children under the age of six.
- For SCC child age group, 43% were under two years old at referral, while 57% were two years or older at referral.
- 51% of caregivers report living together or are married, while 34% are single parents.

Figure 1 below presents education, employment, and income characteristics summarized from the full evaluation report. As shown, 62% of SCC caregivers had a high school education or less, 63% were not employed, and 68% reported an annual household income under \$20,000.

Figure 1: SCC Caregiver Education, Employment, and Income



Caregiver Perspectives

Caregivers who completed SafeCare® satisfaction surveys and/or participated in focus groups reported very high satisfaction with all aspects of the program. A majority of caregivers who completed all three topics and participated in focus groups reported that they would definitely

recommend it to other caregivers without question. Participants easily identified examples of aspects learned about the Safety, Health, and Interaction topics.

Another commonly mentioned benefit was related to the emotional and social support that caregivers received from their parent support providers. Participants used the following words to describe their PSP: encouraging, caring, friendly, calm, welcoming, open, knowledgeable, supportive, emotionally invested, non-judgmental, responsive, thorough, helpful, well-trained, informative, and accommodating. As measured by the Working Alliance Inventory, caregivers and parent support providers each reported highly positive views of their relationship.

Site Implementation Successes and Challenges

Compared to the first year of the SCC pilot, site supervisors noted having more productive referral sources and processes in place, more families engaging in the program, and greater community awareness of SCC. Another success is the number of families self-referring to the program, as self-referrals represented 23% of all enrolled families. An ongoing challenge for sites is the initial engagement with referred families and continuing to keep families involved in the program. Another challenge is the lack of bilingual staff and services available to refugee families who speak languages other than Spanish or English. Recommendations from sites for enhancing SCC implementation include: 1) emphasize the importance of building relationships to help facilitate collaboration; 2) provide more opportunities for mentorship and peer support; and 3) increase training opportunities and enhance program support.

Outcome Evaluation: Summary of Key Findings

The outcome evaluation data includes short-term skill uptake for each topic area. Descriptive outcomes without a comparison group were collected from the Trails system for a minimum of six months following SCC participation, and are presented in the evaluation report by level of SCC participation. Child welfare recidivism outcomes with a comparison group were analyzed using Trails data for both treatment and control groups.

Short-term outcomes

SafeCare® assessments completed by families at the beginning and end of each topic were analyzed to assess the level of skill acquisition by caregivers.

- For the Safety topic, completed assessments show an average decrease of 45 hazards per household or 87%.

- For the Health topic, the average changes in skill scores were a 9% increase for emergency room scenarios, a 33% increase for doctor appointment scenarios, and a 27% increase for care at home scenarios.
- For PCI assessments, the average percentage point improvement was 43%. For PII, the average change was 20%. Assessments include such things as preparing a child for an activity and using appropriate discipline strategies.

Descriptive Outcomes

Descriptive results suggest that families who are more engaged in the SafeCare Colorado program receive a larger benefit, shown by lower rates of recidivism across all child welfare service levels, from referrals to out-of-home (OOH) placements. For example, families who completed all three topics had rates of subsequent assessment 9% lower than families who only enrolled and did not continue. However, it may also be the case that families more likely to complete the program are also less likely to recidivate, regardless of SCC participation.

Comparison Group Outcomes

The evaluation team used propensity score matching (PSM) to create a comparison group of dyads who did not complete SCC. Based on availability and theoretical relationships, 21 matching variables were selected. After creating the two matched groups, outcomes were compared for the SCC group and the comparison group. Results are as follows:

- There were no statistically significant differences between the SCC group and the comparison group on subsequent referral, subsequent assessment, and subsequent OOH placement during the follow-up period (six months after the referral which selected the dyad into the comparison group).
- The percentage of subsequent founded assessments and subsequent open cases for the SCC group is lower than for the comparison group, and the differences are statistically significant.

Cost Evaluation: Summary of Key Findings

Between February 2015 and June 2016, staff at SCC sites and Kempe completed a web-based survey reporting their agency's cost data pertaining to SafeCare Colorado. This survey makes use of the "ingredient" method, which identifies ingredients used by the intervention that have a value or cost. These overarching ingredients are personnel, facilities, equipment and materials, and other inputs, such as volunteer time.

Average Costs

Over the course of the evaluation, the total cost of SCC was \$8,484,260, with 1,752 families served. Therefore, the average total cost per family served by SCC during the pilot project was \$4,843. Of the 1,687 families with data on family size, a total of 2,334 children under age 6 lived in the homes receiving SCC services during the pilot project. Therefore, the average cost per child during the pilot project was \$3,635.

Future Cost Evaluation

Programs that have long-term impacts are seldom cost-beneficial in the short term. However, when accounting for the accrual of benefits and cost reductions over the life course and across multiple systems (e.g., child welfare, education, public assistance, judicial), it is likely that these programs provide a return greater than the upfront investment. Therefore, the cost evaluation for SCC in 2017 will include a cost-benefit analysis using outcome data, cost data from child welfare, and historical estimates of the costs of child abuse and neglect from the child welfare and prevention literature to estimate the projected return on investment for the program.

Conclusion

The SafeCare Colorado pilot was successful in bringing an evidence-based in-home parenting education program to scale. The SafeCare® curriculum was implemented with fidelity across 11 diverse community-based agencies serving 39 counties and two tribal nations. Training, coaching, and ongoing program support was successfully provided by Kempe with support from SafeCare® program developers. Program data show that SCC is effectively reaching a highly vulnerable population of families, as intended.

SafeCare Colorado shows promise for families who complete all three topics compared to a matched group of similar families within a six month follow-up period. Twenty-five percent of enrolled families completed the entire SCC program, which is comparable to other voluntary prevention programs. Parent support providers and caregivers rate the quality of their relationship very high, and both report that the program is meeting the needs of families in their communities.

The 2017 SafeCare Colorado evaluation report will include an analysis of outcomes by program dosage and a review of child welfare outcomes 12 months post-program completion. This enhanced analysis of program impacts will help inform future SCC implementation and aid in the effort to understand SCC costs and benefits.

SafeCare Colorado Pilot Project Evaluation Report

1. Introduction

In Colorado, SafeCare® began in 2009 with a federal grant awarded to the Colorado Judicial Department and the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect (Kempe). In 2013, SafeCare® was selected as part of a group of cornerstone prevention programs formed or expanded under Governor Hickenlooper’s master child welfare plan, “Keeping Kids Safe and Families Healthy 2.0”. Kempe was selected by the Office of Children Youth and Families at the Colorado Department of Human Services (CDHS) to oversee the implementation of SafeCare Colorado (SCC). In May 2015, SCC state funding and statewide program oversight moved to the Division of Community and Family Support in the Office of Early Childhood (OEC) at CDHS.

The Social Work Research Center (SWRC) in the School of Social Work at Colorado State University (CSU) serves as the independent evaluator of the SCC program for CDHS. The evaluation is designed to measure the implementation process, program outcomes, and costs of the three-year SCC pilot project. As such, this evaluation report is organized to align with the methods and results from the process, outcome, and cost evaluations.

1.1. Description of SafeCare®

SafeCare® is an evidence-based in-home parent education program designed for high risk families with children ages 0-5. SafeCare® is designed to be home based, voluntary, and preventive. It relies on behavior reinforcement, modeling, and skill practice, through staff observations and parent training developed from social learning theory. The program is structured into three distinct topic areas described below:

1. **Home Safety** – Safety goals are to identify and reduce the number of hazards in the home environment that are accessible to children. Safety hazard categories include poisons, choking, firearms, and sharp objects. Safety latches are provided to families and a validated and reliable assessment checklist helps home visitors identify hazards and provide training to parents.
2. **Child Health** – Health goals are to teach parents to recognize and assess when children are sick or injured and when to provide or seek appropriate treatment. Parents are

provided with a health manual that includes a guide to symptoms and instructions on when to call a nurse or doctor. They are also provided with recording charts and basic health supplies such as a thermometer.

3. **Parent-Infant Interaction (PII) or Parent-Child Interaction (PCI)** – PII goals (for newborns to about one year) are to promote positive interactions; promote age appropriate and stimulating activities; and promote bonding and attachment. Bonding skills training include: looking, talking, touching, smiling, holding, imitating, and rocking. PCI goals (for toddlers and preschoolers) are to increase positive interactions; engage children; and prevent challenging child behavior. Positive behaviors are reinforced and problem behaviors are addressed during the sessions.

Each of the SafeCare® topics is conducted over six 1-1.5 hour sessions that typically occur weekly. All topics use a similar teaching model (an assessment session, followed by four sessions of training, and a final re-assessment session). The program is delivered by parent support providers who receive intensive coaching from coach trainers who are certified by The National SafeCare Training and Research Center (NSTRC), established in 2007 at the Georgia State University School of Public Health.

1.2. Overview of the SafeCare Colorado Implementation

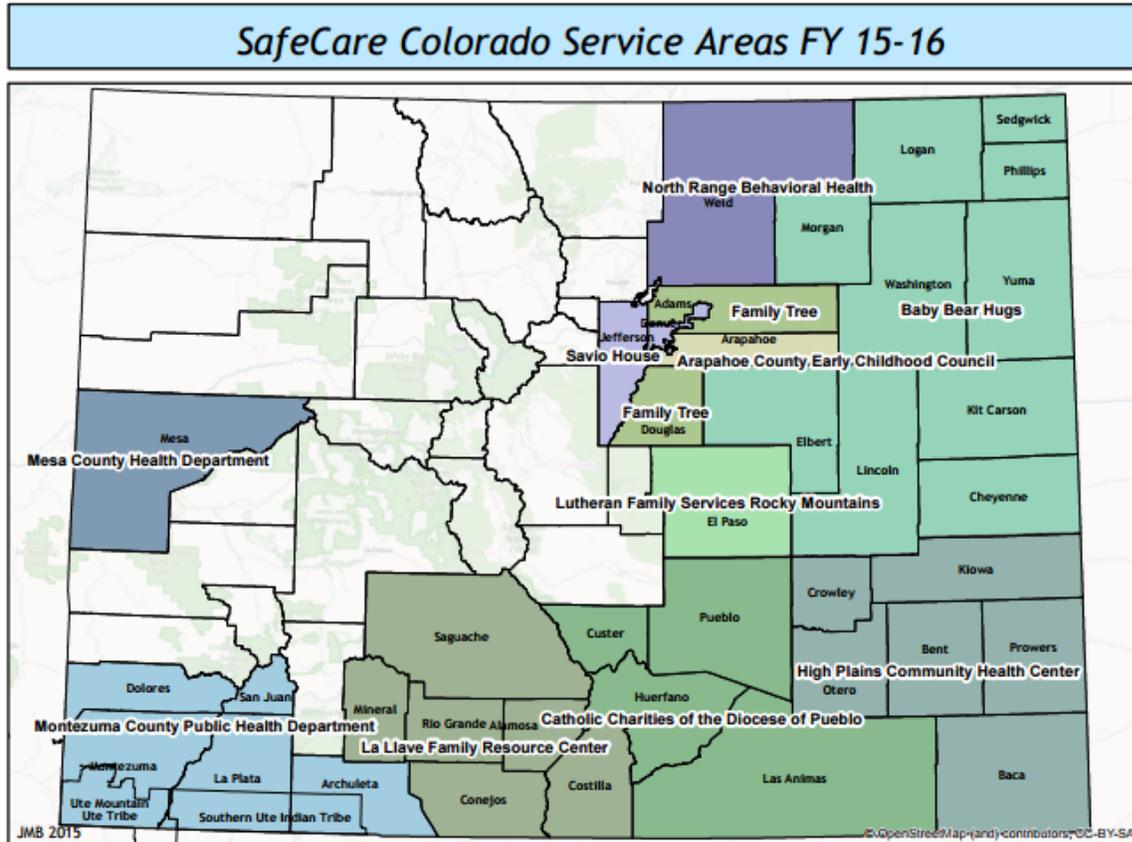
The implementation of the SCC pilot project was designed as a gradual rollout, with sites phased in over three years. This report presents data from all three cohorts. Eleven diverse organizations were selected to implement SafeCare Colorado, serving 39 counties and two tribal nations across Colorado. Selected through a competitive process, these agencies were required to demonstrate the need for the program in their communities as well as their ability to implement effectively. On the following page, Table 1 displays the cohort year, region served, agency type, and primary services provided by the different implementing agencies.

Table 1: Implementing Agency Characteristics

Site	Cohort	Year	Region Served	Agency Type	Primary Services
Baby Bear Hugs	1	2014	Northeast CO	Community Based Organization	Prevention services, parenting classes, and parent support
Savio House	1	2014	Central CO	Community Based Organization	Intensive services (child placement, residential, family counseling, adolescent services) for families involved in child welfare
Mesa County Health Department	1	2014	Western CO	Public Health	Public Health (WIC, family planning, immunization clinic)
Montezuma County Public Health	1	2014	Southwestern CO	Public Health	Public Health (health inspections, immunization clinic, WIC, dental services)
Family Tree	2	2015	Central CO	Community Based Organization	Prevention services and family support, domestic violence, homelessness
Arapahoe County Early Childhood Council	2	2015	Central CO	Early Childhood Council	Early Childhood Council (services for child care providers, parenting support, advocacy)
Catholic Charities Diocese of Pueblo	2	2015	Southern CO	Community/Faith Based Organization	Housing assistance, immigration family law, parent support
High Plains Community Health Center	2	2015	Southeastern CO	Federally Qualified Community Health Center	Primary medicine
Lutheran Family Services Rocky Mountain	3	2016	Central CO	Community/Faith Based Organization	Refugee and asylee programs, pregnancy counseling and adoption services, disaster response, foster care, older adult and caregiver services, prevention services
North Range Behavioral Health	3	2016	Northern CO	Behavioral Health Center	Crisis support, therapy, addiction treatment, integrated services, medical services
La Llave Family Resource Center	3	2016	Southern CO	Community Based Organization	Prevention services and family support, parenting, resource and referral

Figure 1 shows a map of the counties in which SafeCare Colorado currently operates and where the sites are located.

Figure 1: Map of SafeCare Colorado Sites Fiscal Year (FY) 2015-2016



2. Process Evaluation

The process evaluation section features analyses of referrals to SCC, characteristics of program participants, participation outcomes, perspectives from program site staff, and caregiver perspectives from surveys and focus groups.

2.1. SafeCare Colorado Referrals

Families are eligible to participate in SCC if they have at least one child under the age of six and if they: 1) had past child welfare involvement; or 2) met a minimum of three risk factors, such as “young caregiver under 20” or “single parent”, as outlined on the referral form developed by Kempe. If a referring party did not know this information, the SCC site would contact the family for a phone screening or to set a visit to further determine eligibility. Additional eligibility

criteria for child welfare involved families was added in 2014. Initially, a family had to be screened out, have a closed case, or a closed assessment. Expansion criteria included open Family Assessment Response (FAR) assessments (only available in select counties), non-court involved open cases, and open assessments.

Recruitment

All site coordinators reported a similar process for contacting families and further reported that their recruitment protocols are consistent among each parent support provider (PSP) at their sites. Typically, three attempts are made to contact a family. This process starts by making a telephone call; however, many times a phone number is disconnected and they cannot reach the parent by phone. In this case, the PSP may visit the home. One site noted that they typically visit in pairs for safety. Another common practice is to send a postcard to the home address providing details about the program. Some sites attempt to follow up with a phone call after the postcard has been sent. Several sites mentioned that they frequently need to contact the referring source again for additional contact information if the family cannot be reached after three attempts are made. At most sites the recruitment practices may differ slightly based on the referral source. If the referral comes from a community agency, commonly parent support providers will attempt to meet with the parent while they are at the community agency – a practice known as a warm handoff.

Multiple sites mentioned the importance of building relationships with referral sources, especially child welfare departments. Differences in how referrals from a child welfare department are handled were noted across sites. Several sites stated that they send a postcard or letter prior to calling a screened out child welfare referral. This eases the introduction over the phone as the focus is placed on the postcard rather than how contact information was received. Several sites also mentioned that they do not volunteer where the referral came from, but if parents ask they will tell them. One site noted continued difficulty surrounding the screened out referrals due to confidentiality issues. A few sites are currently maintaining a waitlist for all families and reported that they prioritize the child welfare referrals.

Finally, site coordinators noted the importance of getting quality referrals from community partners; that there is an important difference between the volume of referrals versus quality of referrals – the ones that lead to engagement from families. These site coordinators mentioned that developing relationships with community agencies makes a critical difference to engaging families successfully.

Incentives

Caregivers may receive various incentives for enrolling and participating in SCC: Kempe research incentives, materials associated with the topics, and local agency incentives. Sites are also able to use their budgets to provide incentives or resources to families. Site supervisors stated that the provision of additional resources are available to families on a case-by-case basis. For example, if a parent support provider notices that a family has a food shortage they may be able to provide a gift card to meet a temporary need.

The materials associated with the SafeCare® topics may also provide an incentive for families to enroll in the program and continue to participate. Examples of these incentives would be a thermometer which is often provided as a part of the Health topic; a baby gate or other child-proofing supplies are commonly provided as part of the Safety topic. Finally, some sites have secured means to provide additional resources to families through local non-profit agencies. These resources include blankets, books, and toys. PSPs deliver these to families at the same time they arrive for a visit. Offering these small gifts to a parent at the beginning of a visit helps the PSP get the visit off to a nice start. Another benefit noted was that the books keep the children entertained during the visit.

Nearly all site coordinators placed a high degree of importance on the incentives that were offered to families. In other words, they thought that the ability to offer incentives encouraged parents to say yes to enrolling and continued engagement in SCC. Multiple site coordinators mentioned that they hope their site can continue a budget to support families with these additional resources.

2.1.1. Referral Pathways

As displayed in Table 2 on the following page, 8,157 families were referred to SCC sites from January 2014 through June 2016.¹ The majority of these referrals came from child welfare departments at 68%. The next most frequent referral category was self-referrals at 11%, followed by medical providers at 6%. All other referral source types combined comprised approximately 15% of total referrals.

¹ Referrals with a referral date recorded between January 2014 and June 2016 were included.

Table 2: Frequency of Referrals by Referral Source (N = 8,157)

Referral Source	Frequency	Percent
Department of Human Services (DHS) – Child Welfare	5,515	67.6
Self-Referral	857	10.5
Medical Provider	522	6.4
Other Home Visiting Programs	309	3.8
Other	211	2.6
DHS – Other	184	2.3
Public Health – Women Infants Children (WIC)	152	1.9
Early Childhood Education/Child Care	147	1.8
Family Resource Centers	140	1.7
Early Intervention	63	0.8
Mental Health	36	0.4
Community Centers	20	0.2
Substance Treatment	1	0.0

Table 3 shows that the majority of child welfare referrals were closed high risk assessments at 47%, followed by screened out referrals at 26%, FAR open or closed assessments at 20%, open assessments or non-court involved open cases at 3% and 2%, respectively, and closed cases at 2%.²

Table 3: Child Welfare Referrals by Referral Type (N = 5,380)

Child Welfare Referral Type	Frequency	Percent
Closed High Risk Assessment (HRA)	2,527	47.0
Screen Out	1,396	25.9
FAR (Open or Closed)	1,064	19.8
Open HRA	169	3.1
Non-Court Involved Open Case	123	2.3
Closed Case	101	1.9

On the following page, Table 4 shows the percentage of referrals that resulted in an intake by referral source.³ Of the 8,157 referrals made to SCC, 1,730 resulted in an intake, which is an acceptance rate of 21%. The referral source with the highest percentage of accepted referrals was community centers at 80%. Half of the referral sources had an acceptance rate ranging

² An additional 135 child welfare referrals are not included in the table as they were missing child welfare referral type.

³ Intakes missing referral source data are not included in the table.

between 44% and 52%. Although child welfare referrals from DHS represent the highest proportion of overall referrals, they had a lower rate of referrals leading to an intake at 11% across all sites.

Table 4: Percent of Referrals that Resulted in an Intake by Referral Source (N = 8,157)

Referral Source	Number of Referrals	Number of Intakes	Percent of Accepted Referrals
Community Centers	20	16	80.0
Early Intervention	63	33	52.4
Other	211	106	50.2
Public Health – WIC	309	147	47.6
Other Home Visiting Programs	152	72	47.4
Self-Referral	857	401	46.8
Mental Health	36	16	44.4
DHS – Other	184	72	39.1
Family Resource Centers	140	46	32.9
Early Childhood Education/Child Care	147	48	32.7
Medical Provider	522	149	28.5
DHS – Child Welfare	5,515	624	11.3
Substance Treatment	1	0	0.0
Total	8,157	1,730	21.2

As displayed in Table 5 on the following page, the most frequent referral source for SCC enrolled families was DHS – Child Welfare at 36%, followed by self-referral at 23%, medical provider at 9%, other home visiting programs at 9%, and ‘other’ at 6%. For the 624 referrals from DHS – Child Welfare, 45% were from closed high risk assessments, 20% were from screen-outs, 14% were open or closed FAR assessments, 6% were non-court involved open cases, 6% were uncategorized in the data, 6% were open high risk assessments, and 3% were closed cases.

Table 5: Referral Source and Child Welfare Referral Pathways for Enrolled Families (N = 1,730)

Referral Source	Frequency	Percent
DHS – Child Welfare*	624	36.1
Self-Referral	401	23.2
Medical Provider	149	8.6
Other Home Visiting Programs	147	8.5
Other	106	6.1
DHS – Other	72	4.2
Public Health – WIC	72	4.2
Early Childhood Education/Child Care	48	2.8
Family Resource Centers	46	2.7
Early Intervention	33	1.9
Community Centers	16	0.9
Mental Health	16	0.9
*Child Welfare Referral Pathway (N = 624)		
Closed HRA	283	45.4
Screen Out	125	20.0
FAR (Open or Closed)	86	13.8
Non-Court Involved Open Case	38	6.1
DHS – CW (Not specified in the data)	38	6.1
Open HRA	36	5.8
Closed Case	18	2.9

2.2. SafeCare Colorado Participation

A total of 1,752 unique families were served by the SafeCare Colorado program from January 2014 through June 30, 2016, meaning they enrolled and had an intake session. This section presents descriptive results, using frequencies and means, for case characteristics, number of topic sessions, topic completion, program engagement, and program completion for caregivers from all cohorts. While households may have several caregivers and multiple children in the home, they are asked to select one primary caregiver who the PSP will work with each week (SCC Caregiver) as well as one primary child who is under age six (SCC Child).

2.2.1. Case Characteristics

As displayed in Table 6 on the following page, there were 880 caregivers enrolled in Cohort 1; 731 enrolled in Cohort 2; and 117 enrolled in Cohort 3. Kempe enrolled 24 families during the trainer/coach certification process. The site with the most caregivers enrolled was Savio House at 20%, followed by Family Tree at 16%, Mesa County Health Department at 14%, Arapahoe

County ECC at 12%, Baby Bear Hugs at 9%, High Plains Community Health Center at 8%, Montezuma Public Health at 8%, Catholic Charities Diocese of Pueblo at 7%, North Range Behavioral Health Center at 3%, Lutheran Family Services at 2%, La Llave at 2%, and Kempe at 1%. It should be noted that the capacity to enroll families varied by site based on the number of providers hired and the number of months the programs were operating.

Table 6: Cohort and Site Frequencies

Characteristic	Frequency	Percent
Cohort (N = 1,728)*		
Cohort 1	880	50.9
Cohort 2	731	42.3
Cohort 3	117	6.8
SafeCare Sites (N = 1,752)		
Savio House	349	19.9
Family Tree	271	15.5
Mesa County Health Dept.	247	14.1
Arapahoe County ECC	205	11.7
Baby Bear Hugs	151	8.6
High Plains Community Health Center	141	8.0
Montezuma Public Health	133	7.6
Catholic Charities Diocese of Pueblo	114	6.5
North Range Behavioral Health Center	48	2.7
Lutheran Family Services	37	2.1
La Llave	32	1.8
Kempe	24	1.4

*Note: those enrolled by Kempe were not part of a cohort and thus were not included.

2.2.2. Family Engagement

Table 7 shows that 69% of caregivers were engaged in the SafeCare Colorado program, which means that they participated in at least three SafeCare® sessions.

Table 7: Family Engagement Outcome for Closed and Open Cases (N = 1,701)*

Outcome	Frequency	Percent
Family engaged		
Yes	1,172	68.9
No	529	31.1

*Note that 51 caregivers did not have session data recorded but received an intake. They are not included as the number of sessions they participated in is missing.

2.2.3. Topic Sessions

Caregivers are given the option of which topic to begin with. When they do not choose a topic, the parent support provider chooses the topic based on the family’s needs. As displayed in Table 8, of the 618 closed cases with Health topic sessions, the average number of sessions completed was 4.9. Of the 683 closed cases with Safety topic sessions, the average number of sessions completed was 4.4. Of the 805 closed cases with Interaction topic sessions, the average number of sessions completed was 5.4. For the 1,468 closed and open cases with recorded session data, the average number of total sessions completed across the three topics was 8.8.

Table 8: Number of Sessions by Topic for Closed Cases

Topic	Min	Max	Mean
Health (N = 618)	1	11	4.9
Safety (N = 683)	1	11	4.4
Interaction (N = 805)	1	14	5.4
Total sessions (N = 1,468)	1	30	8.8

2.2.4. Topic Completion

The first topic completion outcome was calculated for cases that were either open or closed at the time of data collection. As displayed in Table 9, 73% of the 791 caregivers who participated in at least one health session completed the Health topic; 68% of the 877 caregivers who participated in at least one safety session completed the Safety topic; and 60% of the 1,017 caregivers who participated in at least one interaction session completed the Interaction topic.

Table 9: Topic Completion Outcomes for Closed and Open Cases*

Topic	Frequency	Percent
Health (N = 791)		
Did not complete or in progress	217	27.4
Completed	574	72.6
Safety (N = 877)		
Did not complete or in progress	285	32.5
Completed	592	67.5
Interaction (N = 1,017)		
Did not complete or in progress	409	40.2
Completed	608	59.8

*This outcome is based on families that participated in at least one session of the respective topics.

The second topic completion outcome was calculated for cases that were closed at the time of data collection. As displayed in Table 10, 79% of the 618 caregivers who participated in at least one health session completed the Health topic; 74% of the 683 caregivers who participated in at least one safety session completed the Safety topic; and 65% of the 805 caregivers who participated in at least one interaction session completed the Interaction topic.

Table 10: Topic Completion Outcomes for Closed Cases*

Topic	Frequency	Percent
Health (N = 618)		
Did not complete	130	21.0
Completed	488	79.0
Safety (N = 683)		
Did not complete	180	26.4
Completed	503	73.6
Interaction (N = 805)		
Did not complete	285	35.4
Completed	520	64.6

*This outcome is based on families that participated in at least one session of the respective topics.

2.2.5. Program Completion

As displayed in Table 11, 44% of caregivers did not complete any topics, while 20% completed one, 11% completed two and 25% completed all three. Thus, 25% of caregivers with a closed case completed the SafeCare® program, which means they completed all three topics.

Table 11: Program Outcomes for Closed Cases (N = 1,299)

Outcome	Frequency	Percent
Topics completed		
None	571	44.0
One	263	20.2
Two	147	11.3
All three (program completed)	318	24.5

2.2.6. Client Support

In addition to the SafeCare® curriculum, caregivers may also receive “client support” visits, in which parent support providers provide resources and referrals to other organizations or offer problem solving support outside of the SafeCare® topic areas.

Client support may occur in a stand-alone visit or during a SafeCare® session visit. Of all families served who also had visit data, 51% (N = 871) had at least one visit that included client support. Of these, there was a maximum of 31 visits including client support and an average of 3.6 client support visits per family.

As displayed in Table 12, the most commonly selected service provided during a client support visit was “other client services” (41%). The write in text for this category includes such things as: custody issues, school related issues, providing diapers and other concrete supports, referrals to other parenting classes, support groups, car seat safety, auto repairs, financial management, help for the holidays, and a variety of other issues.

Table 12: Resource and Referrals Provided during Client Support Visits

Client support	Frequency	Percent
Other client services (N = 628)	1,873	40.5
Other referrals (N = 265)	501	10.8
Mental health (N = 264)	416	9.0
Housing (N = 227)	394	8.5
Benefits (N = 232)	337	7.3
Food (N = 195)	252	5.4
Daycare (N = 167)	239	5.2
Extended phone session (N = 130)	223	4.8
Medical (N = 146)	193	4.2
Domestic violence (N = 101)	121	2.6
Substance abuse (N = 66)	76	1.6

2.3. Caregiver, Children, and Household Characteristics

This section provides demographics and characteristics of caregivers and children served by the SCC program. Caregivers were asked to complete demographic forms during the intake session which were then entered into an Access database maintained by Kempe. The total N varies in each table based on the amount of complete data for each self-reported category.

As displayed in Table 13 on the following page, 93% of SCC caregivers are female and 46% of SCC caregivers are Hispanic. The most common SCC caregiver race is Hispanic at 44%, followed by Caucasian at 43%, African American at 6%, bi-racial at 4%, and Native American at 2%.⁴ For

⁴ Note that the bi-racial category includes the selection of two or more non-Hispanic race categories.

marital status, 34% of SCC caregivers are single, 19% are living together, and 32% are married. For age group, 7% of SCC caregivers are 14-19 years old, 31% are 20-25 years old, 22% are 26-29 years old, 31% are 30-39 years old, and 9% are 40 years or older.

Table 13: SCC Caregiver Demographics

Characteristic	Frequency	Percent
Caregiver gender (N = 1,374)		
Female	1,281	93.2
Male	93	6.8
Caregiver Hispanic (N = 1,371)		
Yes	627	45.7
No	744	54.3
Caregiver race (N = 1,357)		
Hispanic	602	44.4
Caucasian	586	43.2
African American	76	5.6
Bi-racial	57	4.2
Native American	28	2.1
Asian	6	0.4
Hawaiian	2	0.1
Caregiver marital status (N = 1,183)		
Single	406	34.3
Living together	223	18.9
Married	378	32.0
Separated	90	7.6
Divorced	80	6.8
Widowed	6	0.5
Caregiver age (N = 1,026)		
14-19 years old	70	6.8
20-25 years old	321	31.3
26-29 years old	223	21.7
30-39 years old	319	31.1
40+ years old	93	9.1

As displayed in Table 14 on the following page, 35% of SCC caregivers reported that a language other than English was spoken in their household. For educational level, 26% of SCC caregivers have less than a high school diploma, 11% have a GED, 26% have a high school diploma, 22% have 1-2 years of college (no degree), 6% have an associate's degree, 4% have 3-4 years of college (no degree), 5% have a bachelor's degree, and 2% have some graduate study or an

advanced degree. For employment status, 30% of SCC caregivers are homemakers, 20% work full-time, 16% work part-time, 13% are out of work/looking for work, 7% are unable to work, 6% are out of work/not currently looking for work, 6% are students, 2% are self-employed, and less than 1% are retired. For housing situation, 66% of SCC caregivers rent, 16% own, 13% share housing with relatives/friends, 4% have temporary housing, and less than 1% are homeless.

Table 14: SCC Caregiver Characteristics

Characteristic	Frequency	Percent
Language other than English (<i>N</i> = 1,288)		
Yes	452	35.1
No	836	64.9
Education (<i>N</i> = 1,334)		
Less than high school	342	25.6
GED	145	10.9
High school diploma	341	25.6
1-2 years of college (no degree)	288	21.6
Associate's degree	83	6.2
3-4 years of college (no degree)	50	3.7
Bachelor's degree	62	4.6
Graduate study (no degree)	7	0.5
Master's degree	10	0.7
Doctoral or professional degree	6	0.4
Employment status (<i>N</i> = 1,345)		
Homemaker	403	30.0
Full-time	262	19.5
Part-time	209	15.5
Out of work/looking for work	169	12.6
Unable to work	97	7.2
Out of work/not currently looking for work	85	6.3
Student	83	6.2
Self-employed	31	2.3
Retired	6	0.4
Housing situation (<i>N</i> = 1,337)		
Rent	887	66.3
Own	207	15.5
Sharing with relatives/friends	178	13.3
Temporary	57	4.3
Homeless	8	0.6

Table 15 shows that 48% of SCC caregivers reported receiving SNAP (Supplemental Nutrition Assistance Program), 64% received Medicaid, 9% received earned income tax credit, 16% received TANF/Colorado Works, and 12% received Head Start services. Overall, 69% of SCC caregivers reported receiving at least one form of public assistance.⁵

Table 15: SCC Caregiver Public Assistance (N = 1,705)

Characteristic	Frequency	Percent
SNAP		
Yes	812	47.6
No/no answer	893	52.4
Medicaid		
Yes	1,094	64.2
No/no answer	611	35.8
Earned income tax credit		
Yes	146	8.6
No/no answer	1,559	91.4
TANF/Colorado Works		
Yes	279	16.4
No/no answer	1,426	83.6
Head Start		
Yes	196	11.5
No/no answer	1,509	88.5
Overall public assistance		
Yes	1,171	68.7
No/no answer	534	31.3

As displayed in Table 16 on the following page, 43% of SCC caregivers make \$0-\$10,000, 26% make \$10,001-\$20,000, 13% make \$20,001-\$30,000, 8% make \$30,001-\$40,000, 5% make \$40,001-\$50,000, and 6% make more than \$50,001. For difficulty paying bills in the last year, 16% of SCC caregivers reported no difficulty, 19% had a little difficulty, 29% had some difficulty, 17% had quite a bit of difficulty, and 20% had a great deal of difficulty. For annual savings in the past year, 3% of SCC caregivers reported having more than enough, 20% had some money left over, 42% had just enough, and 36% had not enough annual savings.

⁵ Note that these are likely conservative estimates as "yes" is indicated by a check mark in the data entry field. If there was no check mark, this indicated either a "no" or the respondent chose to skip the question.

Table 16: SCC Caregiver Socioeconomic Status

Characteristic	Frequency	Percent
Annual household income (N = 1,306)		
\$0-\$10,000	556	42.6
\$10,001-\$20,000	334	25.6
\$20,001-\$30,000	167	12.8
\$30,001-\$40,000	104	8.0
\$40,001-\$50,000	61	4.7
More than \$50,001	84	6.4
Difficulty paying bills (N = 1,379)		
No difficulty	215	15.6
A little difficulty	264	19.1
Some difficulty	395	28.6
Quite a bit of difficulty	231	16.8
A great deal of difficulty	274	19.9
Annual savings (N = 1,378)		
More than enough	37	2.7
Some money left over	269	19.5
Just enough	573	41.6
Not enough	499	36.2

Responses to four health and mental health screening questions are displayed in Table 17 on the following page. These questions are asked of SCC caregivers to help the home visitor identify if further assessment and referral are needed. For nervousness/anxiety, 38% responded they were currently experiencing it, 20% responded they had experienced it in the past year, 9% responded they had not experienced it in the past year, and 32% responded they had never experienced it. For sadness/depression, 30% responded they were currently experiencing it, 23% responded they had experienced it in the past year, 15% responded they had not experienced it in the past year, and 32% responded they had never experienced it.

For sleep difficulties, 34% responded they were currently experiencing it, 15% responded they had experienced it in the past year, 10% responded they had not experienced it in the past year, and 40% responded they had never experienced sleep difficulties. For physical challenges/disabilities, 21% responded they were currently experiencing it, 8% responded they had experienced it in the past year, 12% responded they had not experienced it in the past year, and 58% responded they had never experienced it. Overall, 24% of SCC caregivers

reported having none of the challenges, 18% reported having one, 19% reported having two, 23% reported having three, and 16% reported having all four, currently or in the past year.⁶

Table 17: SCC Caregiver Health and Mental Health Screening Questions

Challenges/Issue	Frequency	Percent
Nervousness/anxiety (<i>N</i> = 1,248)		
Currently	478	38.3
In the past year	255	20.4
Not in the past year	116	9.3
Never	399	32.0
Sadness/depression (<i>N</i> = 1,248)		
Currently	377	30.2
In the past year	283	22.7
Not in the past year	187	15.0
Never	401	32.1
Sleep difficulties (<i>N</i> = 1,250)		
Currently	430	34.4
In the past year	191	15.3
Not in the past year	128	10.2
Never	501	40.1
Physical challenges/disabilities (<i>N</i> = 1,243)		
Currently	263	21.2
In the past year	101	8.1
Not in the past year	154	12.4
Never	725	58.3
Number of challenges (<i>N</i> = 1,261)		
None	302	23.9
One	232	18.4
Two	234	18.6
Three	294	23.3
All four	199	15.8

As displayed in Table 18 on the following page, 75% of SCC caregivers reported having a primary care provider, and 56% reported having a regular dentist.

⁶ It should be noted that responses from 2014 were not included because they had a different response scale. However, data patterns from 2014 are consistent with the data presented here.

Table 18: SCC Caregiver Health Indicators

Characteristic	Frequency	Percent
Primary care provider (N = 1,203)		
Yes	903	75.1
No	300	24.9
Dentist (N = 1,198)		
Yes	671	56.0
No	527	44.0

As displayed in Table 19, the SCC child was male in 56% of the cases and Hispanic in 53% of the cases. For SCC child race, 50% are Hispanic, 36% are Caucasian, 7% are bi-racial, 5% are African American, and 2% are Native American.⁷ For SCC child age group, 43% were under two years old at referral, while 57% were two years or older at referral.

Table 19: SCC Child Demographics

Characteristic	Frequency	Percent
Child gender (N = 1,629)		
Male	910	55.9
Female	719	44.1
Child Hispanic (N = 1,616)		
Yes	850	52.6
No	766	47.4
Child race (N = 1,619)		
Hispanic	808	49.9
Caucasian	586	36.2
Bi-racial	112	6.9
African American	79	4.9
Native American	27	1.7
Other	7	0.5
Child age group* (N = 1,670)		
Under 6 months	290	17.4
6-12 months	158	9.5
12-18 months	155	9.3
18-24 months	119	7.1
2 years old	288	17.2
3 years old	248	14.9
4 years old	243	14.6
5 years old	169	10.1
*Age range lower bound is inclusive, upper bound is exclusive.		

⁷ Note that the bi-racial category includes the selection of two or more non-Hispanic race categories.

As displayed in Table 20, 21% of SCC caregivers reported children in the home to have challenges with nervousness/anxiety, 17% to have challenges with sadness/depression, 28% to have challenges with sleep difficulties, 17% to have physical challenges/disabilities, 43% to have challenges with attention, 49% to have challenges with being defiant, 28% to have challenges with developmental delay, 25% to have challenges with eating/feeding, and 25% to have challenges with learning disabilities. Furthermore, 28% were reported to have no challenges, 71% reported to have at least one challenge, and 1% reported to have all nine challenges.

Table 20: Health and Mental Health Screening Questions for Any Child in the Home

Characteristic	Frequency	Percent
Nervousness/anxiety (<i>N</i> = 1,183)		
Yes	253	21.4
No	930	78.6
Sadness/depression (<i>N</i> = 1,180)		
Yes	200	16.9
No	980	83.1
Sleep difficulties (<i>N</i> = 1,175)		
Yes	323	27.5
No	852	72.5
Physical challenges/disabilities (<i>N</i> = 1,157)		
Yes	198	17.1
No	959	82.9
Attention deficit (<i>N</i> = 1,192)		
Yes	511	42.9
No	681	57.1
Child defiant (<i>N</i> = 1,186)		
Yes	580	48.9
No	606	51.1
Developmental delay (<i>N</i> = 1,184)		
Yes	329	27.8
No	855	72.2
Eating/feeding (<i>N</i> = 1,181)		
Yes	292	24.7
No	889	75.3
Learning disabilities (<i>N</i> = 1,179)		
Yes	296	25.1
No	883	74.9
Number of challenges (<i>N</i> = 1,205)		
None	342	28.4
Between one and eight	851	70.6
All nine	12	1.0

As displayed in Table 21, 95% of SCC caregivers reported that all children in the home had a primary care provider, and 68% of SCC caregivers reported that all children in the home had a regular dentist.

Table 21: SCC Child Health Indicators

Characteristic	Frequency	Percent
Primary care provider (N = 1,170)		
Yes	1,106	94.5
No	64	5.5
Dentist (N = 1,159)		
Yes	791	68.2
No	368	31.8

As displayed in Table 22, the average SCC caregiver age was 29.0 years, the average SCC child age was 2.3 years, the average number of people in the household was 3.7, the average number of children in the household was 1.9, and the average number of children under six in the household was 1.4.

Table 22: SCC Household Characteristics

Characteristic	Min	Max	Mean
Caregiver age (N = 1,026)	14.0	70.0	29.0
Child age (N = 1,670)	0.0	5.9	2.3
Number of people (N = 1,687)	2.0	6.0	3.7
Number of children (N = 1,687)	1.0	5.0	1.9
Number of children under six (N = 1,687)	1.0	4.0	1.4

2.4. Caregiver Perspectives

This section presents data collected from caregivers who participated in SafeCare Colorado. Surveys were conducted and focus groups administered to learn how caregivers experience the SCC program and their recommendations.

2.4.1. Methods

Caregivers were administered a satisfaction survey at the end of each SafeCare® topic. In addition, focus groups were conducted throughout the state with caregivers who completed all three topics. Survey and focus group methodology is described below.

Satisfaction Survey

All caregivers who completed one of three SafeCare® topics were invited to complete a Parent Satisfaction Survey developed by NSTRC (see Appendix A for surveys). Participation in the survey was voluntary, with each topic having its own satisfaction survey tailored to the subject matter. Each satisfaction survey also included six questions common across surveys, related to program delivery and parent support providers. Caregivers were asked to indicate their satisfaction with the content of each topic, in addition to program delivery and experiences with their parent support providers. Satisfaction survey data reported here were primarily collected between January 2015 and May 2016, with a handful of surveys completed in the last few months of 2014 ($N = 7$). Total completers reported for each topic are also from the same time period of January 2015 through May 2016.

Focus Groups

Focus groups were conducted in May through June of 2016 with caregivers who completed all three topics of the SafeCare® program (see Appendix B for focus group protocol). A list of randomly sampled families selected by the evaluation team were provided to six different SCC program sites for recruitment. Overall, nine of the 30 participants were from rural areas: seven from High Plains Community Health Center serving the area around Lamar in southeastern Colorado and two from Baby Bear Hugs serving the northeastern corner of the state. Eleven participants were from mid-sized urban areas: four from Catholic Charities serving families in and around Pueblo and seven from Mesa Public Health serving the area in and around Grand Junction. It should be noted that some of the participants in these groups reported living in rural areas as well. Ten participants were from urban areas: eight from Arapahoe County Early Childhood Council and two from Savio House.

Of the 30 participants, 26 were mothers and four were fathers who attended with their spouses. Focus groups at five of the sites were conducted in English by two evaluators. Participants from Savio House were interviewed in Spanish by Spanish speaking facilitators hired by the evaluation team. A written consent letter was provided to each participant and explained by the interviewers. Lunch or dinner was provided and child care was available during the focus groups. Participants also received a \$35 gift card for their time. Focus groups were audio recorded and transcribed by a professional transcription company. Transcripts were uploaded into a qualitative software program called Dedoose. Three evaluators reviewed the transcripts and developed the coding scheme/template.

The General Inductive Approach was used to analyze the data. This method of data analysis was particularly well-suited for this study because of the interest in reporting on specific research

questions (Thomas, 2006). Interview protocols closely reflected the research questions being investigated. Interrater reliability was established by all three raters independently coding the same transcript without seeing the coding completed by the other two raters. Meetings were held to refine and finalize the coding frame. Codes were either added or collapsed based on the discussion and consensus of all three raters. In addition, a description for each code was discussed and agreed upon. All transcripts were systematically reviewed and coded. A total of three interrater reliability meetings took place to develop the final coding template for the caregiver focus groups. Once the coding frames were finalized the transcripts were equally divided and coded. Next, the codes were divided among the three raters. The data associated with each code was analyzed and the findings were written based on the themes which emerged from the data.

2.4.2. Caregivers: Family and Community Context

This section presents the qualitative results from focus groups with caregivers related to family characteristics and community resources. Focus groups were recruited from willing families who had completed all three topic areas of the SafeCare® program. While not representative of all families participating in the SafeCare Colorado program, the qualitative data provides important stories of the contexts in which some families are raising their children as well as their initial experiences with enrolling into the SCC program.

Family Characteristics

Focus group participants reported struggling with the following challenges: working multiple jobs, odd hours, lack of flexibility in their work schedule, inconsistent employment, lack of paid parental leave, and suddenly losing a job. Participants also had difficulty accessing affordable child care, in some cases leaving the workforce due to the high costs of child care. While some caregivers reported having strong support from extended family members, others discussed difficult and unsupportive family relationships.

In terms of personal challenges, focus group participants reported learning disabilities, health issues, experiencing post partem depression, grief over lost loved ones, and intense anxiety. Several mothers reported struggling with intimate partner violence. Participants also discussed the challenges their children are facing, including repeated illnesses and health issues, sensory delays, diagnosed syndromes and disorders, behavioral issues, bullying, and speech delays.

It is not surprising, given the complex challenges discussed, that many of the caregivers reported feeling overwhelmed and isolated in their parenting role. Some described physical isolation, “living in the middle of nowhere,” while others described feeling socially isolated,

incompetent as a parent, judged by others, depressed, and bored. However, other participants described more typical parenting challenges such as discipline, co-parenting with their spouse or partner, and lack of time for self-care.

Community Resources

Families were asked to identify resources in their communities that they find helpful in raising their children, along with what resources are needed. Material or concrete supports, supportive services, and social/community activities were described by participants as being helpful. The concrete supports noted as valuable included child care, gas vouchers, utility assistance, WIC, and housing for domestic violence victims. Caregivers also described helpful services such as occupational therapy, speech therapy, special education services, pediatrics, counseling, pregnancy support, parenting classes, and reading programs that include books and activities for young children. Social events and free family oriented activities were noted as important, such as movie nights, holiday parties, play groups, open gyms, swimming, bike repair, and support groups for mothers.

In terms of specific agencies, several participants mentioned the Nurse-Family Partnership program as being particularly helpful. Specifically, caregivers noted the flexibility of the program, the support provided, and the long term relationships they were able to develop with the nurses. Other organizations that were mentioned as particularly helpful include the Home Instruction for Parents of Preschool Youngsters (HIPPO) parenting program, Catholic Charities, Resource Center, Healthy Places, Project Access, YMCA, Elks, Library District, Mothers of Preschoolers (MOPS), Denver Health, SDS (a program focused on providing services for children with disabilities), Bright Beginnings, and Family Leadership Training Institute. Perspectives on child welfare and social services varied. Several families noted negative past experiences with child welfare and child welfare caseworkers, but others spoke highly of their caseworkers. One family who was reported to child welfare described it as “a blessing in disguise” because they were able to get the support they needed with their baby, including the SCC program.

When asked if there were resources they would like to see more of in their communities, the common theme was child care. Some caregivers noted how difficult it is to find any child care, especially for children under the age of two. Another caregiver commented: “It’s not feasible for moms to go back to work, because almost everything that you make you’re putting into daycare for your kids.” Other resources that families reported as lacking include local behavioral therapists and other specialists, especially for rural families, services for children with special needs, and more support in finding resources.

2.4.3. Caregivers: Satisfaction

This section presents program satisfaction findings by topic area as reported by caregivers in surveys and focus groups. The data presented may not be representative of the entire population of SCC participants, as satisfaction surveys were voluntary and dissatisfied participants may not have completed them.

Overall, caregivers who completed the satisfaction surveys and/or participated in the focus groups reported very high satisfaction with all aspects of the program. In the surveys⁸, average satisfaction scores for each area ranged from 4.4 to 4.9 out of 5.0, indicating high levels of satisfaction. In the focus groups, participants reported positive impressions of SCC and expressed disappointment that it had to end. One caregiver noted that “when I finished my last appointment with [my parent support provider]...it was the saddest time ever.”

Safety Topic Satisfaction

Of the 359 caregivers who completed the safety topic between January 2015 and May 2016, 301 chose to complete a corresponding satisfaction survey, for a response rate of 84%. Caregivers were asked seven questions related to what they learned about safety, including whether they thought their home was safer since completing the topic, whether their ability to identify safety hazards had improved, and their thoughts about the usefulness of the SafeCare[®] home safety curriculum. As displayed in Table 23, scores indicated very high satisfaction, with a range of 4.6 to 4.8.

Table 23: Satisfaction with Safety Topic (N = 301)

Survey question	Mean
My home is safer since I did the Home Safety topic	4.6
I am better able to identify hazards in my home	4.7
I am better able to get rid of hazards in my home	4.7
I plan to continue the home safety changes I made during the home safety training	4.7
The amount of time it took to make my home safer was reasonable	4.6
I was comfortable letting the home visitor check out my home and help me reduce hazards	4.7
I believe that this home safety training program would be useful to other parents	4.8

⁸ For each question, caregivers were asked to choose a response ranging from Strongly Disagree, Disagree, Neutral, Agree and Strongly Agree on a scale of 1 to 5.

Health Topic Satisfaction

Of the 340 caregivers who completed the Health topic between January 2015 and May 2016, 267 chose to complete a corresponding satisfaction survey, for a response rate of 79%. Respondents were asked five questions specific to the subject matter covered by the child health curriculum, including whether they thought caring for their child’s health was easier, if determining when to visit the emergency room had become easier, and their thoughts about the usefulness of the topic. As displayed in Table 24, scores indicate very high satisfaction, ranging from 4.6 to 4.8.

Table 24: Satisfaction with Health Topic (N = 267)

Survey question	Mean
Caring for my child’s health when s/he is sick or injured has become easier	4.6
Deciding when to take my child to the doctor has become easier	4.6
Deciding when my child needs emergency treatment has become easier	4.6
I believe that this health training would be useful to other parents	4.8

Interaction Topic Satisfaction

For the Interaction topic, caregivers had the option of completing content tailored for children over the age of one (PCI) or infants younger than one year (PII). Of the 321 caregivers who completed the PCI topic between January 2015 and May 2016, 301 chose to complete a corresponding satisfaction survey, for a response rate of 94%. Caregivers were asked whether interacting with their child had become easier since completing PCI, and whether they found the curriculum useful overall. As displayed on Table 25, average satisfaction scores ranged between 4.4 and 4.7.

Table 25: Satisfaction with Parent-Child Interaction Topic (N = 301)

Survey question	Mean
Interacting with my child has become easier	4.5
I have more ideas about activities I would like to do with my child	4.5
Routine activities, like feeding my child and bathing her/him, have become easier	4.4
I believe that this training would be useful to other parents	4.7

Of the 58 caregivers who completed the PII topic between January 2015 and May 2016, 48 chose to complete a corresponding satisfaction survey, for a response rate of 83%. On the following page, Table 26 shows that caregivers were similarly satisfied with the PII topic,

reporting average satisfaction scores between 4.5 and 4.8. Caregivers largely indicated that interacting with their infant had become easier and believed that the PII training would be useful to other caregivers.

Table 26: Satisfaction with Parent-Infant Interaction Topic (N = 48)

Survey question	Mean
Interacting with my infant has become easier	4.8
I have more ideas about activities I would like to do with my infant	4.5
Routine activities, like feeding my infant and bathing her/him, have become easier	4.6
I believe that this training would be useful to other parents	4.8

Survey results also indicate that caregivers found practicing what they learned during sessions with their parent service providers useful, and thought the written materials provided were helpful, with satisfaction scores averaging at 4.6 across all topics for both questions. Caregivers thought PSPs were very punctual, with respondents averaging a score of 4.8 out of 5. Caregivers also thought parent service providers were extremely warm and friendly, with satisfaction averaging a high of 4.9, with strong disagreement (4.7) that their provider was negative or critical. Caregivers also thought that PSPs did a good job at explaining the program content, with average satisfaction scores at 4.8.

Elaborating on the high satisfaction reported in the surveys, focus group participants reported greatly enjoying the program content and the way the SCC program is delivered. Specifically, they reported that the SafeCare® manual was clear and well organized. They appreciated being able to refer back to the manual when questions arise. Caregivers reported liking the videos and felt that it would be a good way to share the program materials with their husbands. Focus group participants indicated that SCC exceeded their expectations. Caregivers also were impressed by the program and looked forward to their sessions every week. One participant was surprised at how quickly and easily she could apply what she learned, observing changes in her son almost immediately after starting the program. She stated, “we saw changes in him, and we’re like, ‘Is it really this easy? What’s the catch?’ I was totally waiting for it to bomb.”

These positive impressions of the program are in stark contrast to expectations prior to enrolling in the program. Caregivers shared that they were initially “a little leery” and “nervous” about letting a stranger into their home. One caregiver worried about being judged, “I thought someone would come in and say, ‘She’s a terrible mother.’” Another believed that the referral to SCC from child welfare was “a bad thing turned good...it was a huge blessing in disguise, I

mean everything they [SafeCare] helped us out with.” A majority reported that they would definitely recommend SCC, with many caregivers sharing that they already have recommended the program to others. One caregiver summarized, “I love the program. I think everybody should do it.”

2.4.4. Caregivers: Program Benefits

SCC caregivers were asked to share their thoughts about each SafeCare® topic and the program overall. One of the most commonly mentioned benefits was lessons learned from each topic. Participants easily identified examples of aspects learned about home safety, child health, and interacting with their children. Another commonly discussed benefit was related to the emotional and social support received from the parent service providers. Caregivers pointed to the multiple ways in which their provider helped them to learn while also becoming a valuable source of support and friendship. For example, some participants noted that their PSP clearly explained the program and were knowledgeable with the program content. One caregiver explained, “I enjoyed the way that she presented the materials. It didn’t matter how many questions you had. She would always want to answer them and always went into detail, which I appreciated.” Several participants commented that the parent support providers are well trained and enjoy their jobs.

Learning Related to SafeCare® Topics

Many caregivers provided numerous examples of what they found useful about the Safety topic, including how to correctly install childproof locks and alarms on doors, how to safely secure cabinets and storage areas, and how to recognize potential areas of injury around their home. Participants also indicated learning how to rearrange their home to help prevent accidents, such as keeping cords out of sight and temptation of children, or having their children play on soft rugs in open areas instead of near edges or tables with glass tops. Parent support providers helped identify specific areas in need of attention and assisted with installing locks and other devices, even bringing over power tools when needed. Some caregivers were unaware of everyday items around the home that are toxic for children, including, for example, some cosmetics.

“They opened my eyes to see things that I hadn’t noticed could be a risk for my daughter. They gave me the tools to get rid of the dangers and maintain a safe house.”

“The little book that they gave you with all the different symptoms and how to treat it, and if it’s [an] ER visit or not [an] ER visit... that’s wonderful because there’s so much stuff in there that you don’t think about happening.”

Focus group participants also learned a great deal from the Health topic, with many specifically praising the reference manual provided with the curriculum. One participant indicated that she still references her manual even after completing the SafeCare® program. The Spanish version of the manual was also appreciated. Resources provided with the health topic were viewed as highly useful.

For example, one caregiver learned that her existing first aid kit was incomplete and was able to complete it with help from her PSP. Another appreciated learning about different methods for taking a child’s temperature.

Focus group participants also gave much praise for what they learned from the Interaction topic. Caregivers noted differences in their relationships and communication with their children, believing the topic had helped them become better listeners. One mother of three shared that while she did not have any issues interacting with her first two children, her third child is “completely different” and what she learned helped her “to communicate more with her son.” One father attributed the PII curriculum to playing an important role in facilitating his relationship and stronger connection with his infant. Caregivers identified specific techniques that they found particularly useful. For example, some lauded the technique of giving children preparation and advance notice before transitioning between activities or moving locations. Many participants found this strategy very helpful, especially in reducing their children’s tantrums and behavioral difficulties. ‘Labeled praising’ was another technique caregivers found useful, which is relating praise to a specific situation or behavior.

While caregivers voiced as much appreciation for PCI/PII as with the other two topics, they may have also struggled with this topic more. More than one caregiver shared that while they seemed to make progress with interacting with their child, their child’s difficult behaviors returned

“From a kid that just wanted to do whatever he wanted and throw fits every 10 seconds to now, he’s sitting and eating and not throwing a fit or running around or if I ask him to do something, he does it and it’s done. It [Parent Child Interaction] really, really changed him.”

once they completed the program and the parent support provider no longer made visits to their home. One participant noted that interacting with their child seemed to go smoothly while the provider was present, but became challenging as soon as they left. This caregiver

thought that perhaps more frequent visits may be helpful in ensuring both parent and child successfully adapt to the new way of communicating.

Emotional and Social Support

In addition to the intended educational goals of the program, focus group participants reported gaining emotional and social benefits from being in SCC. For example, many believe that the program had made them overall more confident. A few participants also believe that SCC had helped their relationships with their spouses and family. Caregivers looked forward to their time spent with their PSP, appreciating the “adult time” and “getting a break.” These comments

“It makes you more of a positive parent. You don’t think negatively as much – there’s days that it does calm you down and makes you actually feel like you’re good at something. It just makes you feel, overall, more confident.”

especially stand out when related to the physical and social isolation some participants reported. Providers also helped link caregivers to needed resources; for example, helping secure food and clothing during a time of unemployment, or finding safe, locally available child care. Caregivers of children with special needs also appreciated support received from their PSP.

Focus group participants described the importance of non-judgmental attitudes from the parent service providers, especially regarding the cleanliness of their houses and the way they parented their children. Several caregivers reported feeling like they could count on their PSP to help meet their needs during all times of the day, potentially blurring professional boundaries. For example, one provider answered a phone call in the middle of the night to provide advice on how to calm a crying baby. Support for providers in how to set and maintain professional boundaries may be important to prevent unhealthy attachments or burnout.

Caregivers overwhelmingly stated that they were happy with the program and would not make any changes. However, a few did provide some noteworthy suggestions. One mother recommended adding a fire/disaster plan to the Safety topic. One caregiver suggested presenting the Interaction topic first, so the parent support provider has more time to observe the interaction between parent and child over the remaining visits. Another caregiver mentioned that it is infrequent to have one-on-one time when there are multiple children living in the same household. Therefore, the PII topic could present strategies for interacting with multiple children at the same time.

2.5. Parent Support Providers

This section describes the background and characteristics of parent support providers with SCC, including certification status and turnover, as well as caregiver perspectives on their PSPs.

2.5.1. Parent Support Providers: Characteristics

Data on parent support providers was collected by the National SafeCare Training and Research Center (NSTRC) and Kempe between January 2014 and May 2016, encompassing all PSPs hired during this period, including those who have since left SCC. Demographic data on gender, race, and previous education and experience were collected voluntarily by survey, and may not be available for all parent support providers.

A total of 75 personnel were employed to provide SafeCare Colorado from January 2014 through May 2016. Three of the 75 personnel hired were responsible for strictly supervisory and administrative duties and did not carry a caseload at any time (two site supervisors and one coordinator/site supervisor). Some PSPs served as SafeCare® coaches (a designation that requires training, certification, and ongoing fidelity monitoring) while also carrying a caseload. Training site level coaches has been an important priority for the statewide implementation. Local coaches are able to offer expertise on-site as well as promote long term sustainability of the program. Parent support providers at two sites held roles as a team lead, acting as a liaison between the site supervisor and PSPs, while also carrying a caseload. Of all personnel hired, 15 parent support providers (20%) left their positions before becoming certified. PSPs and their certification status are displayed in Table 27. The seven PSPs listed as not certified were either undergoing certification status at the time of data collection or are not case-carrying personnel.

Table 27: Certification Status for Parent Support Providers (N = 75)

Type of PSP	Not Certified	Certified	Left before Certification
Coordinator and Site Supervisor	0	0	0
Parent Support Provider	5	36	12
Parent Support Provider, Coach	0	4	0
Parent Support Provider, Team Lead	0	3	0
Site Supervisor	1	1	0
Site Supervisor/PSP	1	8	3
Total	7	53	15

The SCC workforce was comprised mostly of female (93%), Caucasian (56%), and Hispanic (24%) individuals. Most were also college educated, with 16% having completed some college, 60% having a bachelor's degree, and 16% having a master's degree. Almost 50% reported studying a human services related field, while 21% studied a social science field.

PSPs also brought a range of experience providing evidence-based therapeutic interventions, direct services to at-risk populations, and structured parenting programs. Approximately 31% of parent support providers reported having experience providing an evidence-based intervention prior to SafeCare®. Similarly, 36% of parent support providers reported having provided a structured parenting program. Many PSPs had provided direct services to at-risk populations, with close to one-third (29%) coming in with over five years' experience in direct services, 12% with 3-5 years' experience, and 21% with 1-3 years' experience. Most also had some experience providing services related to child abuse, with only 17% reporting no experience in this area.

While a total of 75 people have been employed by SafeCare Colorado since January 2014, there were 48 parent support providers and site supervisors providing SCC as of May 31, 2016. About 85% of current PSPs ($n = 40$) are certified, with the remaining PSPs working toward certification status. Parent support providers attain certification status after completing a series of training and fidelity monitoring requirements. Time to certification ranged greatly due to variation in the number of families available to serve. This was tied to a site's stage of implementation, flow of referrals received, and the engagement and attrition of families in the program. The shortest time to certification completed by a PSP was just under two months, while the longest duration was over 10 months. The average time to completion was approximately five months.

On the following page, Table 28 presents the total number of parent support providers employed at each site in 2014, 2015, and the first 5 months of 2016. The last two columns provide data regarding the current number of PSPs at each site, as well as their certification status as of May 31, 2016. A total of 27 PSPs ended their employment with SCC between January 2014 and May 2016, with 12 leaving after having achieved certification status and 15 leaving before they were certified. The overall turnover rate was 36%, slightly higher than the rate observed in 2014 with Cohort 1, which had a turnover rate of 32%. The average time to departure from training to exit was 13 months.

Table 28: Parent Support Providers by Site, Year Hired, and Certification Status

SCC Site	2014	2015	2016	Total	Current	Certified
ACECC	4	3	0	7	5	5
Baby Bear Hugs	6	1	0	7	4	4
Catholic Charities	3	2	2	7	5	3
Family Tree	4	4	0	8	7	7
High Plains	1	5	0	6	4	4
La Llave	0	2	0	2	2	2
Lutheran Family Services	0	3	0	3	2	1
Mesa	8	0	0	8	5	5
Montezuma	6	2	0	8	3	2
NRBH	0	4	2	6	5	2
Savio	8	5	0	13	6	5
Total	39	31	4	75	48	48

2.5.2. Parent Support Providers: Engagement with Caregivers

Focus group participants were asked to describe their experiences in working with parent support providers. Participants used the following words to describe their PSPs: encouraging, caring, friendly, calm, welcoming, open, knowledgeable, supportive, emotionally invested, non-judgmental, responsive, thorough, helpful, well-trained, informative, and accommodating (with regard to scheduling visits). Findings suggest PSPs played an important role in initially engaging families as well as facilitating their continued participation in the program. One caregiver noted, “...she had to reach out and really grab me and pull me into the program...it was probably five calls before I was like, ‘Okay, let’s meet’ ...[my PSP] did have to reach out a lot, and I’m grateful that she did.”

Many caregivers also referenced the flexibility of the program, commonly reporting that parent support providers were very accommodating with regard to the frequency, duration, and location of visits. Several caregivers suggested that the willingness of PSPs to meet individual scheduling requests made it possible for them to participate. Parent support providers were also willing to meet at other locations. For one participant in a domestic violence situation, the willingness of the PSP to meet her at the park, rather than her house, made it possible for her to benefit from SafeCare®. Caregivers also mentioned that PSPs were willing to stay longer than an hour if the visit was going smoothly or to cut visits short if needed.

Working Alliance Inventory

Positive experiences with parent support providers were also found in surveys conducted with both parents and parent support providers. The Working Alliance Inventory (WAI) is a validated, self-report measure created to assess the quality of the helping relationship between PSPs and parents (Horvath & Greenburg, 1989). The measure contains 12 items which respondents rate on a 7-point Likert scale (see Appendix C for WAI measures). A higher mean score indicates a more positive perception of the quality of the relationship.

The WAI data collection was supervised and maintained by the staff at Kempe. Survey administration began in a hard copy format but changed to computer based once tablets were available to the providers. Both methods allowed caregivers to submit their responses confidentially. Ideally, the survey was administered twice (initial and final) while families were enrolled in SCC. The standard protocol was for the initial WAI to be conducted during the third visit of the first topic and the final WAI was to be conducted during the third visit of the third topic. Kempe staff mentioned that the WAI was not always able to be consistently administered and was more frequently given to caregivers who completed the program.

Two general questions were explored with regard to the WAI. First, do caregiver and PSP scores on the WAI change over time (from initial to final)? Second, how do caregivers and PSPs rate their relationships with each other? To address the first question, caregiver initial and final WAI scores were matched to explore change over time. Initial and final surveys were able to be matched for 83 caregivers. The mean score for the initial caregiver WAI was 6.5 and the mean for the final caregiver WAI score was 6.5, showing no change between the pre and post-test. Forty-eight initial and final PSP surveys were able to be matched. For PSPs, the initial WAI mean score was 6.2 and the final mean score was 6.4, showing a slight increase from pre to post-test.

To explore how caregivers and parent support providers rated their relationship, 193 initial and 77 final caregiver and PSP surveys were matched. Within these matching sets, the mean for the initial PSP score was 6.2 and the mean for the initial caregiver score was 6.6, which shows parents having a slightly more favorable view of the relationship than did the parent support providers. The mean for the final PSP score was 6.4 and the mean for the final caregiver was 6.6. Thus, both caregivers and parent support providers rated their relationships very favorably from the start to the end of the program. These results are consistent with previous studies which utilized the WAI survey.

2.6. Strengths, Challenges, and Recommendations

Site supervisors were interviewed by phone in June and July 2016. They were asked to share their experiences with implementing SafeCare Colorado, including successes, challenges, and recommendations (see Appendix D for interview protocol). Interviews lasted approximately 30-45 minutes and site supervisors from 10 of 11 sites were interviewed.⁹

2.6.1. Program Implementation Successes

Site supervisors across all cohorts had successes to share related to the implementation of SCC. Many supervisors noted having more productive referral sources and processes in place, more families engaging in and completing the program, and greater awareness of SCC from the communities they serve.

“I think SafeCare is a great service; I think in terms of our support as an agency, SafeCare has been unwavering. I think it’s a needed intervention in the community and we’re happy to be a part of it.”

Supervisors indicated that their sites have started to realize greater results from their recruitment efforts, with more referrals that “translate into engagement from families.” Sites that have been implementing the program longer reported encountering more public awareness. One supervisor proposed that consistent efforts in building relationships and trust with their local communities has helped to raise awareness and engage new families in the program. Another supervisor noted that their outreach efforts have led to “great collaboration with a lot of different agencies around here.”

One supervisor shared that a growing source of referrals for their site has been families who participate and complete the program, “That’s word of mouth, which is again, I think, one of the strengths of this program. Once people experience it, they tell their friends or relatives.” Another supervisor reinforced this claim by noting the increases they have seen in self-referrals.

“We love the program. I think it’s a great program, and once we get people in it, they don’t want it to end, so it’s very good.”

Sites also reported achieving success in reaching out to and engaging with Spanish-speaking families. One site described attending community events and fairs, such as health fairs, targeting Spanish-speaking communities to reach out to families. Another site shared that they have seen a growing number of self-referrals, especially

among Spanish-speaking families. As a result of their successful outreach and recruitment efforts, many sites have grown their teams and added more parent support providers to their

⁹ One site declined to be interviewed due to recent turnover.

staff. Supervisors had much praise for their PSPs. One supervisor appreciated how hard their team works to communicate, learn from each other, and support one another as a “unified front.” Another supervisor stated that they had “established a solid team” and have been able to build on skills gained from providing SafeCare® to talk with families more confidently. Supervisors from other sites similarly shared about the dedication, hard work, and stability observed among their teams and parent support providers.

Program Administration Successes

Site supervisors were asked to discuss the support received from the Office of Early Childhood. Supervisors were largely pleased with their relationship with OEC, with one supervisor stating they “couldn’t ask for more support.” Supervisors appreciated working with the SCC Program Manager, especially noting her responsiveness, support, and knowledge. Several supervisors valued her prompt response to questions, while others lauded her consistent, clear, and direct communication. Supervisors highlighted that the SCC Program Manager also does very well with ensuring sites receive information related to implementation, fidelity, and policies in a timely manner, while also making sure staff receive necessary training. Some supervisors reported that OEC does well with ensuring implementation is going as planned, and also works effectively with sites to explore ways to better meet their needs.

Supervisors also provided specific examples of ways in which support from OEC was especially helpful. Many applauded the change to sending referrals through Trails and pointed to the support they received from OEC in both navigating Trails and the new referral process. More than one supervisor noted that OEC provided valuable support in examining the referral process between DHS and SCC sites, and helping smooth out any gaps in the process.

Site supervisors had many positive comments to share about their collaboration with Kempe. Specifically, supervisors appreciated Kempe’s SCC coaches, identifying them as “amazing,” “approachable,” “supportive,” and “responsive.” They also noted that coaches were extremely thorough, and were willing to hunt down information if they didn’t have it readily available. Kempe was reported to be efficient in providing and coordinating trainings, and helping to ensure site needs were addressed. Several of the supervisors also found Kempe’s coaching calls to be very valuable.

Site supervisors gave specific examples of ways in which Kempe provided support. Some noted the progress made since the initial stages of implementation and highlighted that before “the only thing that was consistent was change and that has decreased immensely...it is nice that it [the program] has kind of settled into a routine.” Another supervisor referenced challenges

with data management and reporting, and was pleased that these processes also seemed to be improving. One site appreciated the assistance they received from Kempe in brainstorming around outreach and recruitment, while another supervisor appreciated coming together once a year to discuss SCC. Finally, one coordinator believed that the change in Kempe's intermediary role will help simplify things and allow them to solely focus on providing training and support.

2.6.2. Program Implementation Challenges

Some sites noted struggling to initially engage and keep families involved in the program, with one coordinator stating: "that initial contact, I think is one of the biggest challenges." A related issue is families who need more support in order to engage in SCC, sometimes requiring two to three visits before beginning the program. Some supervisors noted that while this support is necessary, it is viewed as less valuable than delivering SafeCare® sessions. Newer sites struggle to get referrals from partner agencies, while other sites who have been operating for longer reported having a difficult time keeping up with the volume of referrals, especially entering each referral into the Access database. New sites also discussed the initial challenge of having a parent support provider hired prior to families enrolling in the program.

Some sites struggle to meet the needs of Spanish speaking families during the program due to limited bilingual staff. Others noted that after SCC is over, Spanish speaking families have very limited resources for continued bilingual support in the community. Other challenges include not being able to serve refugee families who speak languages other than Spanish or English. Some issues unique to rural sites include the stigma that can be associated with a service provider coming to the door in a small community. Rural sites also lamented the lack of understanding about how long it takes to travel (sometimes 1.5 hours to one home visit) in order to deliver SCC.

Program Administration Challenges

The sites reported challenges in database access and some noted inconsistent communication when working with Kempe. Collecting data from Access was reported by most site coordinators as a high priority. This includes being able to check their own data; having the ability to report their data to management; developing more efficient workflow processes, such as automatic uploads of data from one provider to the supervisor so it does not have to be double entered; and having a real-time, interactive database that is more user friendly. Some sites noted the data issues have improved significantly, but they still feel there is "a long way to go." Others reported challenges with contract issues and paperwork, specifically taking too long to get

hiring approvals or long delays in receiving their first payments. To address this challenge, the contracts are now being administered by the Office of Early Childhood.

2.6.3. Program Implementation Recommendations

Supervisors were asked what they would recommend to other sites interested in implementing SCC or to OEC and Kempe to improve the support provided to them and their staff. The following are a summary of their recommendations.

Emphasize the importance of building relationships in outreach efforts

When site supervisors were asked to provide advice for potential new implementers of SCC, their recommendations primarily focused on outreach and recruitment, and peer mentorship and support. Supervisors repeatedly underscored the importance of doing outreach to raise awareness of the program in the community, and building relationships with community groups and organizations to help facilitate collaboration and eventually sources of referrals. One supervisor suggested that sites closer in proximity to one another or serving nearby communities might benefit from coordinating and working together to maximize resources and serve a greater number of families. Related to their work with families, supervisors observed that using text messaging to communicate with families, even for initial outreach, works well.

Provide more opportunities for mentorship and peer support

Site supervisors recommended greater peer learning, especially with more experienced sites. “I would say it’d be beneficial for them [new implementers] to visit sites that are already up and running before they launch so they can kind of get a better understanding of where to focus their efforts and their energies, how to really engage with families, what has worked, what hasn’t worked.”

Another supervisor suggested that experienced sites could share what they’ve learned with new implementers and serve as an additional resource to ask questions and receive support. One site explicitly called for facilitating mentor and mentee relationships where sites could share lessons learned or things they have found helpful in getting started and throughout the implementation process. Another supervisor pointed to the annual convening and one of its benefits being that all sites are brought together and given an opportunity to meet and learn from one another.

Aligned with suggestions for peer learning, some supervisors indicated they would like to see more availability of supervisor-focused support. While there seems to be much support for training and supporting parent support providers, support targeting supervisors could be

improved. Supervisors recommended that having less structured regular conference calls in between quarterly meetings would provide more opportunities to exchange information and brainstorm ideas useful to supervisors and their roles and responsibilities.

Increase training opportunities and enhance program support

Other recommendations focused on details around work with families, staff training and general administration of the program. For example, one supervisor discussed the use of incentives and their role in engaging and supporting families while completing SCC. This supervisor noted that incentives already built into the program, such as providing childproofing supplies during the Safety topic and the reference manual given during the Health topic, are greatly appreciated and widely utilized by parents. Providing more frequent incentives may help maintain and facilitate parents' engagement in the program through completion; for example, giving a gift card for a small amount, for completing each session.

Supervisors also pointed to ways training and administration of the program could be improved. For example, one supervisor suggested that for new sites, it would be best if all training is addressed and completed before starting implementation so "things are ready to go" on day one. One supervisor stated that it would also be beneficial for new sites to explore supplemental funding to help ensure all costs are covered up front and throughout implementation. Another supervisor noted that they appreciate the existing training and thought staff (including supervisors) could benefit from having brief refresher courses or training six months or a year after beginning implementation. Similarly, one suggestion highlighted a need for training specific to supervisors and their roles and responsibilities.

Experienced sites offered other recommendations regarding existing program structures and processes. One supervisor indicated that the monthly implementation team meeting calls seemed less useful now that their site was past the initial stages of implementation and called for stopping those calls at a certain stage of implementation and scheduling them on an as needed basis. Another supervisor stated that support from OEC and Kempe could be even better from a strengths-based perspective.

3. Outcome Evaluation

The outcome evaluation section includes the following three sections: short term outcomes from SafeCare® surveys assessing skill uptake within each topic; longer term descriptive outcomes without a comparison group from the Trails database for caregivers with differing

levels of SafeCare Colorado engagement; and child welfare recidivism outcomes with a comparison group.

3.1. Changes in Caregiver’s Skill Level

Whether or not a family passes a topic of SafeCare® is determined by their scores on assessments designed for each SafeCare® topic: Safety, Health and Interaction. The SafeCare® program establishes the criteria for a passing score on a topic. Assessments were completed by families at the beginning and end of each SafeCare® topic (see Appendix E for assessments). The following assessment results are based on several small datasets and provide an overall picture of families’ progress when compared to the required passing scores.

Success is defined as follows for each of the three SafeCare® topics. For Safety, success includes a plan for removal of all hazards or a plan for increased supervision, with a note that it may be difficult to remove all hazards and 1-3 remaining is acceptable. For Health, success is defined by SafeCare® as a score of 100% for emergency room scenarios; a score of 80% for doctor’s appointment scenarios, and a score of 80% for care at home scenarios. Finally, for Interaction, success is defined as demonstrating at least one positive behavior in each of the observed categories being assessed. For example, before the observed activity begins (e.g., getting dressed), the parent is taught to explain the activity to the child, which includes “gets the child’s attention” and “explains the activity”. If the parent does just one of these, they would meet success for that observed area.

Assessments were only analyzed for families recorded as completing the specified topic (for example, home safety assessments were only included for families who completed the Safety topic). Assessments occurring in session 1 or 2 were counted as “pre-tests” and only assessments occurring in session 5 or 6 were included as “post-tests”. A family was only included in this analysis if they had completed both a pre- and post-test.

3.1.1. Safety Topic

A sample of 408 families had home safety assessment data which could be analyzed for changes in caregiver skill level.¹⁰ As shown in Table 29 on the following page, the average

¹⁰ There was inconsistency in the text data entry for data recording hazards in three rooms of the home across the two time points. For example, “living room” may have been defined as room 1 at the pre-test and room 3 at the post-test. Therefore assessments were only included in this analysis if all three rooms were checked at both time points. Furthermore, the data collection interface was designed to default to “0” for the number of hazards in a room instead of a blank field. Therefore, a “0” was only considered to be assessment data if that score had a corresponding and valid room name.

number of hazards in the home for this group of families at pre-test was 52; the post-test average number of hazards was 7, for an average decrease of 45 hazards per household or 87%. Although in principle all hazards should be removed from a home, this goal is not always realistic. Based on the training criterion selected by Gershater-Molko, Lutzker, and Wesch (2003), families who complete the Safety topic should achieve a reduction of 85% or more in the number of hazards. As shown in the last row of Table 29, 68% of families with home safety assessment data met this criterion. However, recent published studies of SafeCare® do not report on family assessments, making it difficult to place these results in the context of other implementations.

Table 29: Change in SCC Home Safety Skills (N = 408)

	Pre-test hazards	Post-test hazards	Percent change in hazards
Average hazard count	52	7	87%
Number of families meeting 85% reduction in hazards			279 (68%)

3.1.2. Health Topic

Only families with all three child health areas completed at both time points were included in the child health assessment analyses. This resulted in a sample of 395 families with child health data which could be analyzed. To complete the Health topic, families had to achieve a 100% score for the emergency room scenario and at least an 80% score for the doctor appointment and care at home scenarios. As shown in Table 30, the average post-test scores for child health skills were: 100% for emergency room scenarios¹¹, 96% for doctor appointment scenarios and 96% for care at home scenarios. These results are comparable to the baseline and “posttraining” scores as reported by Gershater-Molko et al. (2003).

Table 30: Change in SafeCare Child Health Skills (N = 395)

	<u>Emergency Room</u>		<u>Doctor Appointment</u>		<u>Care at Home</u>	
	Baseline Score	Post-test Score	Baseline Score	Post-test Score	Baseline Score	Post-test Score
Average Score	91%	100%	63%	96%	69%	96%
Percent Change	9%		33%		27%	

¹¹ The underlying data showed that many families scored 100% on the pre-test for the emergency room scenario, suggesting that this scenario was not one where parents needed as much education as for the others.

3.1.3. Interaction Topic

Similar to the Health topic, interaction assessments were only included in this analysis if all three activities were observed and scored at both time points.¹² This resulted in a sample of 115 families with PCI data and 28 families with PII data which could be analyzed. In order to pass these modules, parents had to demonstrate at least one positive behavior in each of ten observed categories being assessed.

As shown in Table 31, the average percentage point change for PCI skills was 113% with a final score of 47 points (out of 60 possible). The average percentage point change for PII skills was 28%, with a final average post-test score of 23 points (out of 24 possible). Note that baseline scores were closer to the maximum for the PII data (18 out of 24). Parents assessed using the PCI data started lower, relative to the maximum score, but achieved substantial gains.

Table 31: Change in Parent-Child Interaction and Parent-Infant Interaction Skill Scores

	Baseline Score	Post-test Score	Percentage Change
Parent-Child Average Score (N = 115)	22	47	113%
Parent-Infant Average Score (N = 28)	18	23	28%

3.1.4. Unsuccessful Completion

The SafeCare® assessments were developed to measure the level of skill uptake within each topic area. Some caregivers improve their skills but do not meet the criteria developed by SafeCare® for success or mastery within a topic. The following section presents the assessment data for these caregivers.

Health

There were very few families who did not meet success criteria for all of the three child health skills assessed (N = 13). For this small group, average percentage changes in health scores (pre- to post-test) were +10 percentage points for emergency room, +4 for doctor appointment, and -6 percentage points for care at home. However, even several of these families who did not

¹² There was inconsistency in the text data entry for activities observed by the parent support provider in the Interaction topic. For example, “snack time” may have been defined as the first activity at the pre-test but as the last activity at post-test.

formally meet success for the percentages assessment scores had scores for all three child health skills around 90%.

Interaction

For participants not meeting success criteria in PCI ($N = 32$), the average change was an increase of 26%, compared to average change of 43% for caregivers meeting success criteria, suggesting the caregivers not meeting success for PCI are also not improving as much as the caregivers who are meeting the criteria for success. The minimum change was a decrease of 7% and the maximum change was an increase of 55%. For PII activities, there were no families who did not meet success criteria.

3.2. Child Welfare Descriptive Outcomes

This section presents descriptive child welfare data by engagement level into SafeCare^{®13}. Child welfare data were obtained from Trails. Engagement categories are defined as follows:

- Enrolled = received an intake only
- Engaged = participated in at least three sessions for any topic
- Served (1) = completed one topic
- Served (2) = completed two topics
- Completed = completed all three topics

3.2.1. Prior Child Welfare Referrals

On the following page, Table 32 shows the number of referrals for SCC caregivers in the year prior to starting the program. While referral data show that only 36% of SCC caregivers come from child welfare, administrative data from Trails shows that over 75% of SCC caregivers had a child welfare referral in the year prior to beginning the program. The rate of prior referral does not vary by engagement level, staying relatively stable at about 78%. This suggests that a prior referral in child welfare may not be related to SafeCare[®] attrition or completion.

¹³ Six SCC caregivers did not have accurate dates of program participation and thus were not included in the descriptive outcome tables.

Table 32: SCC Caregivers with a Child Welfare Referral in the Year Prior to SafeCare by Level of Engagement

Engagement Level	Frequency with a Prior Referral	Percent with a Prior Referral
Enrolled (N = 868)	685	78.9
Engaged (N = 559)	439	78.5
Served (1) (N = 178)	144	80.9
Served (2) (N = 100)	77	77.0
Completed (N = 171)	134	78.4

3.2.2. Subsequent Child Welfare Involvement

The following tables present subsequent child welfare involvement (referrals, assessments, founded assessments, open cases, and out of home placement) for SCC caregivers a minimum of six months after their last SCC visit to June 30, 2016. This may include a follow-up longer than six months for families who participated in SCC in 2014 or early in 2015.

Table 33 displays subsequent **referrals** to child welfare within a minimum of six months for caregivers who enrolled or participated in SCC by levels of engagement. As shown, caregivers who enroll and then do not continue the program have a subsequent referral rate of 35%, compared to 30% of caregivers who complete all three topic areas.

Table 33: SCC Caregivers with a Subsequent Referral within Six Months by Level of Engagement

Engagement Level	Frequency with a Subsequent Referral	Percent with a Subsequent Referral
Enrolled (N = 868)	306	35.3
Engaged (N = 559)	179	32.0
Served (1) (N = 178)	59	33.1
Served (2) (N = 100)	27	27.0
Completed (N = 171)	51	29.8

On the following page, Table 34 displays subsequent **assessments** to child welfare within a minimum of six months for caregivers who enrolled or participated in SCC by participation level. A similar pattern also emerges, with a 9% difference in the rate of subsequent assessments

between families who enroll and then do not continue SCC compared to caregivers who complete the program.

Table 34: SCC Caregivers with a Subsequent Assessment within Six Months by Level of Engagement

Engagement Level	Frequency with a Subsequent Assessment	Percent with a Subsequent Assessment
Enrolled (N = 868)	211	24.3
Engaged (N = 559)	119	21.3
Served (1) (N = 178)	43	24.2
Served (2) (N = 100)	16	16.0
Completed (N = 171)	26	15.2

Table 35 displays subsequent **founded assessments** to child welfare within a minimum of six months for caregivers who enrolled or participated in SCC by participation level. As shown, 8% of caregivers who only enrolled in SCC but did not continue had a subsequent founded assessment, while 4% of caregivers who completed the program had a founded assessment.

Table 35: SCC Caregivers with a Subsequent Founded Assessment within Six Months by Level of Engagement

Engagement Level	Frequency with a Subsequent Founded Assessment	Percent with a Subsequent Founded Assessment
Enrolled (N = 868)	68	7.8
Engaged (N = 559)	33	5.9
Served (1) (N = 178)	11	6.2
Served (2) (N = 100)	5	5.0
Completed (N = 171)	7	4.1

On the following page, Table 36 displays subsequent **open cases** in child welfare within a minimum of six months for caregivers who enrolled or participated in SCC by participation level. As shown, 8% of caregivers who enrolled in SCC had a subsequent open case, compared to 4% of caregivers who completed the program.

Table 36: SCC Caregivers with a Subsequent Open Case within Six Months by Level of Engagement

Engagement Level	Frequency with a Subsequent Open Case	Percent with a Subsequent Open Case
Enrolled (N = 868)	67	7.7
Engaged (N = 559)	35	6.3
Served (1) (N = 178)	13	7.3
Served (2) (N = 100)	4	4.0
Completed (N = 171)	6	3.5

Table 37 displays subsequent **OOH placement** in child welfare within a minimum of six months for caregivers who enrolled or participated in SCC by participation level. As shown, 5% of caregivers enrolled in SCC had an OOH placement, compared to 2% of caregivers who completed the program.

Table 37: SCC Caregivers with a Subsequent OOH Placement within Six Months by Level of Engagement

Engagement Level	Frequency with a Subsequent OOH Placement	Percent with a Subsequent OOH Placement
Enrolled (N = 868)	39	4.5
Engaged (N = 559)	18	3.2
Served (1) (N = 178)	6	3.4
Served (2) (N = 100)	4	4.0
Completed (N = 171)	3	1.8

3.2.3. Child Welfare Descriptive Outcomes Discussion

The descriptive results presented above may suggest that families who are more engaged in the SCC program receive a larger benefit, as shown by lower rates of recidivism across all child welfare service levels, from referrals to out-of-home placements. However, the differences in child welfare recidivism among the different levels of engagement may also be due to unmeasured intrinsic characteristics that relate to both SCC participation and child welfare involvement. For example, a caregiver who completes the program may also be more motivated, have more of a desire to change, or be a more engaged caregiver *before* any participation in SCC occurs, compared to someone who chooses not to participate in the program. These intrinsic factors may also predict child welfare re-involvement.

There may also be measurable differences between caregivers who engage more with SCC and those who do not in terms of risk characteristics that could meaningfully predict child welfare recidivism, such as past child welfare involvement, economic status, and age. Therefore, the differences in child welfare recidivism by levels of engagement may be entirely due to characteristics that are unrelated to any benefits of program participation.

It is important to note that the descriptive data presented in the tables above include a longer time frame for some families than the outcome analysis with a comparison group described in the section below. Families were tracked for only six months in the outcome study in order to get a consistent time frame across all groups. Descriptive results are for a *minimum* of six months, but include longer time periods for families who may have participated in SCC in 2014 or early in 2015.

3.3. Child Welfare Comparison Group Outcomes

To determine if SCC is effective in reducing child welfare recidivism for parents and children who complete all three topics, it is necessary to estimate incidence of maltreatment for these same dyads *if they had not completed the program*. This is, of course, hypothetical, as there is no way of measuring what maltreatment *would have occurred* in SCC families *if they had not completed SafeCare*[®]. The only observable outcomes are actual outcomes for SCC families. Since it is not possible to compare families' outcomes with what would have happened if they had not completed the program, the next best estimate for whether SCC works to reduce child welfare recidivism is to build a comparison group of families. These families should be similar to families that completed SCC, but should not have received a referral to the program. Such a comparison group is best constructed using random assignment of families which qualify for SCC into two groups: those who receive the program and those who do not. Random assignment was originally planned for the SCC implementation, but was ultimately deemed not feasible due to program scale up and a limited participant pool. Therefore, an alternative, quasi-experimental evaluation design for SCC child welfare outcomes is presented below.

3.3.1. Methods

The evaluation team used propensity score matching (PSM) (Rosenbaum & Rubin, 1983; Stuart, 2010) to create a comparison group of dyads who did not complete SCC. Propensity score matching creates a matched group for comparison with SCC families; it does not create matched pairs (Gelman & Hill, 2007). A large number of variables are generally used for matching and these variables must be available both for families who completed the program and those in the comparison group. Therefore, of necessity, this evaluation is limited to families

who have a history in Trails because Trails provides the needed information for matching variables.

Using the literature from prior propensity score studies in child welfare, a list of 41 characteristics that were desirable to include as matching variables were identified. Not all 41 were available in Trails. Based on availability and theoretical relationships, 21 matching variables were selected. These are listed in Table 38. Eighteen variables came from referral or assessment information in Trails. The remaining three were accessed through the Colorado Benefits Management System (CBMS). Using state identification numbers, information regarding medical and cash benefits eligibility could be determined from CBMS for individuals identified in Trails.

Table 38: Propensity Score Matching Variables for Child Welfare Recidivism Outcome Analysis

Variable Names		
County	Prior caregiver referrals (3 years)	Domestic violence
Child year of birth	Prior caregiver assessments (3 years)	Prior neglect investigations child
Caregiver year of birth	Prior caregiver case involvement (3 years)	Caregiver mental health problems
Caregiver relationship to child	Current physical abuse	Risk level
Child ethnicity	Current sex abuse	Recent receipt of SNAP
Number of children in household	Caregiver abused as child	Recent receipt of TANF
Caregiver age at birth of first child	Any caregiver substance use	Recent receipt of Medicaid

Ninety-nine parent-child dyads were identified who had met the following criteria for being included in the matched study: (1) they completed all three topics and (2) they had a recent child welfare assessment in Trails (2010 or subsequent). There were 173 dyads who completed all three topics. Of these 173 dyads, 145 could be found in Trails and 99 had a risk assessment no earlier than 2010 but before they entered the SCC program. These 99 dyads formed the SCC group for the matched study. The sample is small; however, there is precedent for using small samples with propensity score analysis in the child welfare literature (Barth, Gibbons, & Guo, 2006; Guo, Barth, & Gibbons, 2006; Karatekin, Hong, Piescher, Uecker, & McDonald, 2014;

Pollock & Green, 2015). Furthermore, use of propensity score matching offsets loss of statistical power that generally occurs with reduced sample size (Stuart, 2010).

The evaluation team began by constructing a matched comparison group for the SCC completers, selecting a large pool of potential comparison dyads from Trails. First, referrals were selected which simulated several pathways by which individuals could be referred to the program. For the period from January 20th, 2014 (start of SCC) through December 31st, 2015 (end of the evaluation period for comparison group outcomes) these included: referrals ending in a closed case (excluding adoptions), referrals closing after a High Risk Assessment (HRA) and referrals closing after services through a Family Assessment Response (FAR). Referrals were excluded from the match pool if there was already an open case at January, 2014 which remained open through December 2015. Other exclusions included: any referral that did not receive a risk assessment in 2010 or later, any referral that was also referred to SCC from Trails in 2015 (in 2014 the functionality to identify these was not in Trails) and any referral that lacked complete information to populate matching variables. If there were multiple risk assessments for an individual in the study timeframe, the one with the most information was used. Finally, for each referral in the match pool, a child on the referral (aged 0-5) was randomly selected to create a parent-child dyad. This child could be a potential victim of maltreatment or could be a sibling in the same household as another victim. At the end of this process, the match pool consisted of 8,123 dyads to be used for propensity score matching.

Propensity score matching was run using the MatchIt algorithm in the R statistical software package (Ho, Imai, King, & Stuart, 2011). This algorithm offers a number of ways to select a propensity matched sample from a large pool of potential matches. Logistic regression was used to calculate a propensity score for completion of SCC for each completing dyad and each match pool dyad. Then, nearest neighbor matching was performed on the propensity score to choose two match dyads for each completing dyad. This yielded a comparison group of 198 dyads. Nearest neighbor matching works well in the situation where there are many matches to choose from (Stuart, 2010). Use of a caliper distance was tried in the propensity matching, but it did not improve the selected matched group.

The child welfare recidivism outcomes selected by the evaluation team for this analysis were: subsequent referrals, assessments, open cases, and OOH placements. CDHS requested that founded assessments were also included. The timeframe for observing child welfare recidivism outcomes for SCC is the six months following the last home visit. For the matched group, there was a wait time of six months after the selected referral because this was the approximate length of time that it took SCC families to complete the program. Outcomes were then

observed for the matched group for six months after the wait time. A dyad was coded as having subsequent involvement for these four outcomes if the caregiver was associated with a referral, assessment, finding or open case in Trails during the six month outcome period. A dyad was coded as having a subsequent placement if the child was associated with an out-of-home placement during the six month outcome period. Bivariate chi-square analyses with Fisher's exact test were used to determine whether differences in frequency of child welfare outcomes exist between SCC and non-SCC groups for any of the five outcomes.

3.3.2. Results

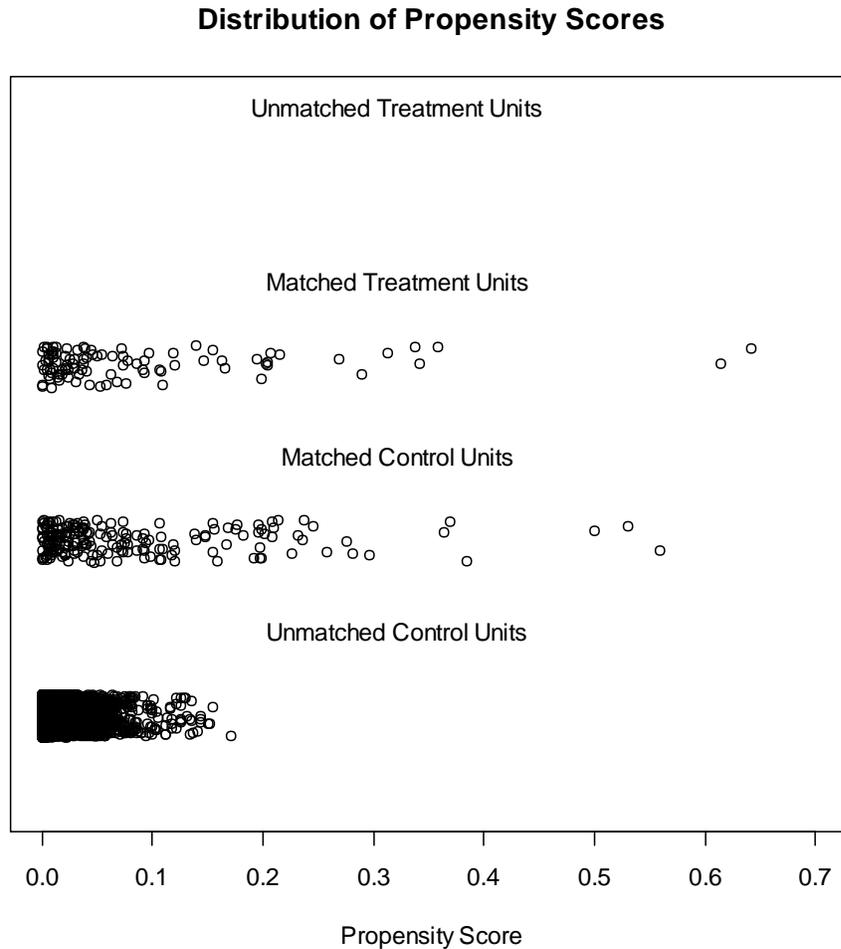
A well-matched comparison group was successfully constructed using the MatchIt propensity score algorithm. On the following page, Table 39 displays the percentage balance improvement for each of the twenty-one matching variables. Using a scale from 0% to 100%, percentage balance improvement statistics show that the matched group of 198 dyads simulates the distribution of characteristics in the SCC group ($n = 99$) better than does the unmatched comparison pool ($n = 8,123$). Percent balance improvement is calculated by subtracting the matched mean difference (between SCC and comparison) from the unmatched mean difference. Then, the difference of differences is divided by the unmatched mean difference to determine percentage improvement. Seventeen of 21 variables showed clear improvement after matching. County match was also improved, with fifteen of nineteen counties improving after matching. The three characteristics which did not improve with matching (caregiver year of birth, caregiver substance use and TANF eligibility) were unable to improve because they were very well matched to begin with.

Table 39: Percent Balance Improvement for Propensity Score Matching

Variable	Percent balance improvement	Variable	Percent balance improvement	Variable	Percent balance improvement
County	Varies	Prior caregiver referrals (3 years)	88%	Domestic violence	76%
Child year of birth	88%	Prior caregiver assessments (3 years)	82%	Prior neglect investigations child	29%
Caregiver year of birth	Not improved	Prior caregiver case involvement (3 years)	16%	Caregiver mental health problems	72%
Caregiver relationship to child	89%	Current physical abuse	81%	Risk level	89%
Child ethnicity	49% - 79%	Current sex abuse	27%	Recent SNAP eligibility	42%
Number of children in household	52%	Caregiver abused as child	100%	Recent TANF eligibility	Not improved
Caregiver age at birth of first child	99%	Any caregiver substance use	Not improved	Recent Medicaid eligibility	93%

On the following page, Figure 1 displays both the SCC (treatment) and comparison (control) samples in a jitter plot. The top of the figure (labeled “Unmatched Treatment Units”) is empty, indicating that none of the 99 SafeCare dyads remained unmatched. The middle two sections of the figure show the distribution of SCC dyads (“Treatment Units”) and match dyads (“Control Units”). Finally, the bottom section shows the distribution of unmatched comparison dyads which were not used in the study. A visual scan of the figure clearly shows that the distribution of matched comparison dyads is much more like the distribution of the 99 SCC dyads than is the distribution of unmatched dyads.

Figure 1: *Distribution of Propensity Scores*



After creating the two matched groups, outcomes were compared for the SCC group and the comparison group. On the following page, Table 40 displays results for subsequent referrals. Twenty-one percent of SCC dyad caregivers experienced a child welfare referral during the six months following the completion of the program. Twenty-six percent of the comparison dyad caregivers experienced a referral during the follow-up period (six months after the referral which selected the dyad into the comparison group). **Although the percentage of subsequent referrals for the SCC group is lower than for the comparison group, the difference is not statistically significant (Fisher’s exact 2-way test, $p = .39$).**

Table 40: Subsequent Referral Outcome

Group	Referral Frequency	Referral Percent	No Referral Frequency	No Referral Percent
SafeCare (<i>n</i> = 99)	21	21.2	78	78.8
Without SafeCare (<i>n</i> = 198)	52	26.3	146	73.7
Total	73	24.6	224	75.4

Table 41 displays results for subsequent assessments. Ten percent of SCC dyad caregivers experienced an assessment during the six months following the completion of the program. Fifteen percent of the comparison caregivers experienced an assessment during the follow-up period. **Although the percentage of subsequent assessments for the SCC group is lower than for the comparison group, the difference is not statistically significant (Fisher’s exact 2-way test, $p = .28$).**

Table 41: Subsequent Assessment Outcome

Group	Assessment Frequency	Assessment Percent	No Assessment Frequency	No Assessment Percent
SafeCare (<i>n</i> = 99)	10	10.1	89	89.9
Without SafeCare (<i>n</i> = 198)	30	15.2	168	84.8
Total	40	13.5	257	86.5

On the following page, Table 42 displays results for subsequent founded assessments. Zero percent of SCC dyad caregivers experienced a founded assessment during the six months following the completion of the program. Six percent of the comparison caregivers experienced an assessment during the follow-up period. **The percentage of subsequent founded assessments for the SCC group is lower than for the comparison group, and the difference is statistically significant (Fisher’s exact 2-way test, $p = .02$).**

Table 42: Subsequent Founded Assessment Outcome

Group	Founded Assessment Frequency	Founded Assessment Percent	No Founded Assessment Frequency	No Founded Assessment Percent
SafeCare (<i>n</i> = 99)	0	0.0	99	100.0
Without SafeCare (<i>n</i> = 198)	11	5.6	187	94.4
Total	11	3.7	286	96.3

Table 43 displays results for subsequent open case. Zero percent of SCC dyad caregivers experienced an open case during the six months following the completion of the program. Six percent of the comparison caregivers experienced an open case during the follow-up period. **The percentage of subsequent open cases for the SCC group is lower than for the comparison group, and the difference is statistically significant (Fisher’s exact 2-way test, *p* = .02).**

Table 43: Subsequent Open Case Outcome

Group	Open Case Frequency	Open Case Percent	No Open Case Frequency	No Open Case Percent
SafeCare (<i>n</i> = 99)	0	0.0	99	100.0
Without SafeCare (<i>n</i> = 198)	11	5.6	187	94.4
Total	11	3.7	286	96.3

On the following page, Table 44 displays results for subsequent OOH placement. Zero percent of SCC dyad caregivers experienced an OOH placement during the six months following the completion of the program. Three percent of the comparison caregivers experienced an OOH placement during the follow-up period. **Although the percentage of subsequent OOH placements for the SCC group is lower than for the comparison group, the difference is not statistically significant (Fisher’s exact 2-way test, *p* =.18).**

Table 44: Subsequent OOH Placement Outcome

Group	OOH Placement Frequency	OOH Placement Percent	No OOH Placement Frequency	No OOH Placement Percent
SafeCare (<i>n</i> = 99)	0	0.0	99	100.0
Without SafeCare (<i>n</i> = 198)	6	3.0	192	97.0
Total	6	2.0	291	98.0

3.3.3. Child Welfare Comparison Outcomes Discussion

The following discussion presents the conclusions, strengths, and limitations of the propensity score matching analysis of child welfare outcomes for the SCC program.

Conclusions

While preliminary, the results for the SCC matched comparison group study are promising. Two of the five recidivism outcomes (subsequent founded assessment and open case) had statistically significant differences between the SCC treatment group and the comparison group. Furthermore, the SCC treatment group had lower frequencies of subsequent referral, assessment, and OOH placement, although none of these outcomes were statistically significant. Because the treatment group had no incidence of either statistically significant outcome, the data were not suitable to run analyses that calculate the *magnitude* and *direction* for these differences. However, it is reasonable to assume that the differences are due to a *lower* rate of subsequent case involvement and founded assessment for SCC parent-child dyads. Interpreting the results for founded assessments must be done with caution. Some counties served by SCC also utilize FAR for a large proportion of their caseload. For FAR assessments, there *can be no finding* of abuse or neglect; thus the founded assessment outcome cannot occur. Furthermore, families are eligible for SCC at the same time as they are eligible for services through FAR, so there could be a substantial number of families receiving both SCC and FAR. This means that a large portion of SCC families in some counties cannot experience the outcome at all, which makes it difficult to measure decreased child welfare involvement due to SCC using the founded assessment outcome.

Strengths and Limitations

There are two very substantial strengths of the evaluation study. The first is the availability and accessibility of Trails data to include in this evaluation, which provides a large data source from which potential matches meeting very specific criteria can be accessed. Second, nearest

neighbor matching works very well with a large group of potential matches (Stuart, 2010). This substantially improves the quality of the matched group.

Despite these strengths, there are three key limitations of the matched comparison group study. The first limitation is that the child welfare outcomes are only examined for a six month follow-up period. According to the literature, six months does not appear to be a sufficient timeframe to evaluate the outcomes of SafeCare®. For example, one of the seminal studies for the efficacy of the program followed parents with a history of prior maltreatment for an average of six years (Chaffin, Hecht, Bard, Sinofsky & Beasley, 2012). Thus, it is the short follow-up period which necessitates categorizing the outcome results as preliminary. As a result, the evaluation team suggests that any future SCC reports allow for an evaluation of at least one year of child welfare outcomes for both the SCC treatment and the comparison group.

Secondly, a literature review suggested several additional characteristics that have been used in other propensity matched studies of children and youth involved in the child welfare system. These characteristics would improve the matched comparison group beyond what the current study could accomplish because these characteristics may relate either to a dyad's chances of completing the program and/or to the risk of future child welfare involvement. These characteristics include: caregiver marital status, education and employment, poverty level, household income, caregiver history of arrest, child low birth-weight, child birth order, caregiver physical health and warmth/harshness, child's access to learning/enriched home environment, spanking as discipline, caregiver born in the U.S. and/or lived with both parents at age 15 and/or caring for a child at age 19, prenatal exposure to alcohol, tobacco or drugs, parental stress, recent parental depression, parental cognitive ability and whether the second parent (not the primary caregiver) is in relationship with child. If some of these variables had been accessible, they could have provided additional information for creating a higher quality matched group. However, as child welfare administrative data was the only source for matching variables, characteristics from the aforementioned list were not used.

Despite the necessity of limiting the evaluation to SCC completers with a history in Trails, the evaluation team remains confident that the group of 99 completers are reasonably representative of the entire SCC population. This is because 78% of the entire group of 173 completers had experienced child welfare involvement in the prior 12 months before starting the program. In other words, many families involved voluntarily with SCC have also been involved with child welfare.

A third limitation is due to a condition of the data known as quasi-complete separation (Allison, 2012). This occurred because no completers of SCC experienced a subsequent founded assessment, open case, or OOH placement. Also, in many counties there was no incidence of these outcomes for either group. This situation prevented the use of logistic regression analysis, which in turn precluded the use of covariates in the analysis. Therefore, the evaluation team conducted bivariate analyses instead of the generally recommended multivariate analyses that optimally follow propensity score matching (Ho et al., 2011). However, the limitation due to quasi-complete separation will likely be solved if a one-year follow-up outcomes study is conducted, in which the likelihood of these recidivism outcomes occurring will be greater.

4. Cost Evaluation

This section presents the methodology, results, and limitations from the cost evaluation for SafeCare Colorado across the entire pilot project implementation phase (2013-2016).

4.1. Cost Methodology

Between February 2015 and June 2016, staff at SCC sites and Kempe completed a web-based survey reporting their agency's cost data pertaining to SafeCare Colorado for Calendar Year (CY) 14, CY15, and costs between January 1, 2016 and June 30, 2016 (see Appendix F for cost survey). The survey was an adaptation from a comparable report on costs of evidence-based home visiting programs published by the Mathematica Policy Research group in 2014¹⁴. This survey makes use of the "ingredient" method, which identifies ingredients used by the intervention that have a value or cost. These overarching ingredients are personnel, facilities, equipment and materials, and other inputs, such as volunteer time.

Online access to the survey, including instructions for how to complete it, were sent to each site director, who filled out the survey themselves or assigned a staff member to complete it (e.g., controller, administrator). Following completion of the survey, the evaluation team contacted completers for any questions or concerns pertaining to its information. All eleven sites and Kempe provided enough information to be included in the cost analysis.

The survey covered expenses related to each site's expenditures on: (1) non-durable and durable goods; (2) salaries and fringe benefits of all employees spending a portion of their time on SCC; (3) donated labor, supplies and materials; (4) equipment and capital assets; (5)

¹⁴ This report can be retrieved from http://www.mathematica-mpr.com/~media/publications/PDFs/Earlychildhood/EBHV_costs.pdf

contracted services (e.g., Information Technology (IT) staff); (6) buildings and facilities; (7) miscellaneous costs (e.g., mileage reimbursement related to client services, travel for purposes other than client services); and (8) indirect costs.

Most agencies were unable to provide full information on costs pertaining to durable equipment and office space. Therefore, the cost estimations leave out costs related to durable equipment including furniture, desks, copiers, printers, etc. However, Kempe provided costs on computers and tablets purchased for use by SafeCare Colorado agencies (the distinction between costs for computers vs. tablets was not provided in the survey). These computer costs are included, and are amortized because they have a projected useful life of five to seven years. Thus, computer costs are included and are the only amortized expenses in the study. For CY15, 11 sites completed the cost survey, and eight sites provided estimates of office space and/or rent costs, as did Kempe. All reporting sites gave an estimate of the rent for this office space or reported that building costs and rent were included in indirect costs.

Sites also reported indirect cost rates and items the rate is meant to cover (e.g., utilities, building costs, etc.), but not all sites reported indirect costs as a total sum. However, the sites that did not report a total indirect cost all reported items that were covered by indirect costs, and these costs were covered in other areas of the survey. Thus, indirect costs were mostly included for each site either through direct reporting or through other sections of the survey. Finally, for sites that did report indirect costs, items covered under other sections of the survey that were also included in indirect costs were subtracted from the indirect cost totals (to prevent double counting).

4.2. Total Costs

The results for the total costs accrued by SafeCare Colorado are reported in this section along with total costs for SCC sites and Kempe.

4.2.1. SCC Total Costs

The total cost of SCC included the market value of all resources used to start up and operate the program across the eleven sites. This included salaries and fringe benefits of all employees spending a portion of their time on SCC, including site directors, donated labor, supplies and materials, equipment and capital assets, contracted services (e.g., IT staff), buildings and facilities, miscellaneous costs (e.g., mileage reimbursement related to client services, travel for purposes other than client services), and indirect costs. Computer costs incurred as a result of purchase by Kempe are amortized over five to seven years; however, no other goods were

amortized or depreciated. Buildings were not depreciated or amortized because all agencies rent their respective buildings, and rent is expected to remain constant over the foreseeable future. Only one site reported the use of a volunteer. Donated goods, including diapers and educational items, such as books, were reported by various sites and are included.

As displayed in Table 45, the total cost of implementing SafeCare Colorado across eleven sites was \$8,484,260 as of June 30, 2016. The total cost for the implementing agencies was \$5,498,175 and the total cost related to Kempe’s services was \$2,986,085 (see section 4.2.2. for full description of Kempe-related costs).

Table 45: Total Costs of SafeCare Colorado by Resource Category

Resource Category	Site Costs (\$)	Kempe Costs (\$)	Cost (\$) [% of total]
Salaries and Fringe Benefits	4,030,593	1,761,381	5,791,974 [68.3%]
Indirect Costs	616,476	683,370	1,299,846 [15.2%]
Training and Travel Unrelated to Client Services	61,863	88,976	150,839 [1.8%]
Supplies and Equipment	337,139	202,047	539,186 [6.4%]
Other Costs	293,378	208,113	501,491 [5.9%]
Building Costs	158,723	42,197	200,920 [2.4%]
Total	5,498,175	2,986,085	8,484,260

The majority of expenses related to SCC are for personnel costs. Salaries and fringe benefits accounted for 68% of the total costs of SCC. The majority of staff costs come from parent support providers, although supervisor and director costs made up a substantial portion of the overall personnel costs as well. Salaries and fringe benefits accounted for a minimum of 61% of total costs and a maximum of 85% for sites. Indirect costs accounted for approximately 15% of total costs. Indirect costs and cost rates varied widely between sites. For example, some sites reported that salaries, fringe benefits, administrative costs, and building costs were covered by indirect costs, while other sites reported that indirect costs covered insurance or supplies. Building costs made up approximately 2% of total costs. All sites made use of office space already rented by their respective agencies, implying that new office space was typically not purchased or rented out.

Training and travel not related to client services (e.g., attending professional development symposiums) accounted for 2% of costs as well. This number dropped from last year’s estimate of 4% as Kempe did not require as much consulting related to program design as was needed during the planning and beginning implementation stages. Cohorts one and two did not require

additional training either. Supplies and equipment made up another 6% of costs, including donated goods, family incidentals, and office materials. The final 6% included miscellaneous costs, such as an IRB fee, travel related to client services, utilities, and other costs that could have been included under indirect but were not specifically reported.

4.2.2. Kempe Total Costs

Kempe was responsible for developing the protocol for the implementation and management of SafeCare Colorado over CY14, and then management and administration of the program through June of 2016. This included startup costs that were required before families could be reached, such as consultation by the SafeCare® developers, planning and selecting sites for different implementation periods, training staff from each of the sites, and supporting implementation at the state and site levels. The cost survey completed by Kempe was slightly adapted from the original survey intended for sites to more accurately capture staffing and resource expenditures related to management and implementation costs that sites may not have experienced. Kempe also served 14 families in 2014, as part of the certification process for coaches, and these are included in the overall calculation of costs per family served.

As displayed in Table 46, the cost of SCC attributed to Kempe is estimated to be \$2,986,085. The majority of costs (\$1,761,381) came from salaries and fringe benefits of staff, which equaled 59% of total expenditures. The second highest category of expenditures was indirect costs. Kempe applied an established indirect cost rate of 26%, amounting to approximately \$683,000 (23% of costs).

Table 46: Total Costs Associated with Kempe

Resource Category	Cost (\$) [% of total]
Salaries and Fringe Benefits	1,761,381 [59.0%]
Indirect Costs	683,370 [22.9%]
Training and Travel	88,976 [3.0%]
Office and Supplies (including computers, printing, etc.)	202,047 [6.8%]
Building costs	42,197 [1.4%]
Other costs	208,114 [7.0%]
Total	2,986,085

Additionally, Kempe purchased goods to be distributed among their own staff and for home visitors across sites. Kempe purchased approximately \$64,000 worth of computers and tablets for home visitors in CY 2014 and another \$44,000 in computers and laptops during CY15. This equipment is expected to last for five years, and thus the total cost will be amortized over the

five year period, resulting in an annual cost of approximately \$21,600. Kempe also purchased approximately \$11,000 worth of educational materials for sites and families in CY14 and another \$52,000 in CY15.

4.3. Average Costs

Average costs are the estimated value of all resources for a family or child that was served by SCC. These estimates may be useful in comparing sites and average costs of SCC with other programs tailored to preventing child maltreatment. Caution should be used, however, in making comparisons between studies as other cost studies may not have used the ingredient method to calculate costs. For example, some costs studies analyze budget or expenditure information, which is typically an underestimate of true costs (Levin & McEwan, 2001).

4.3.1. Cost per Family

In CY14, 318 families were considered to be served by SCC. To calculate average costs per family served for the prior report, the total cost of SCC in CY14 (\$2,397,360) was divided by the number of families served (318) for an **average total cost per family served of \$7,539**. Comparatively, over the course of the evaluation, the total cost of SCC was \$8,484,260, with 1,752 families served. Therefore, the **average total cost per family served by SCC during the pilot project was \$4,843, which is a decrease of \$2,696 per family**. This difference is largely the result of an increase in the number of families served which “spreads out” upfront and fixed costs (such as building rent) across more families; although other factors, such as the decrease of costs related to parent support provider trainings resulting from low turnover likely contribute as well. It is useful to compare costs per family during CY14 to cost per family over the entire evaluation period to illustrate the importance of serving the maximum amount of families.

4.3.2. Cost per Child

Of the 1,687 families with data on family size, a total of 2,334 children under age 6 lived in the homes receiving SCC services during the pilot project, for an average of approximately one and one-half children (1.4) per household. Therefore, the **average cost per child during the pilot project was \$3,635**.

4.3.3. Cost per Home Visit

Cost per home visit is calculated by estimating the cost of a parent support provider’s time to travel to and from a home and complete a visit with a family. The cost of materials, such as Safety First Kits or No Choke Tubes, is also included in the calculation. However, other

miscellaneous goods, such as diapers or books that may have been donated, are not included because it is not clear how much of these resources were devoted to individual families. Furthermore, the time spent by home visitors on administrative tasks for families, such as outreach prior to the home visit; preparing for home visits; or data entry and other documentation, was not quantified in the cost evaluation and is not included in the calculation. Finally, any costs associated with the caregiver's time were not included. Thus, the cost per home visit should be considered a conservative estimate of the actual cost of a home visit.

- Cost per home visit = PSP time (total travel time + total visit time) + Materials and goods provided to families + Mileage reimbursement

Data on travel and visit length was provided for all families that had a recorded visit. In total, 1,891 families had information on travel time, travel mileage, and visit length. Families that did not complete all topics were included because a minority of families completed the program. Thus their costs should be incorporated as well.

- Average travel time per visit was calculated by summing the total amount of time driving to and from home visits for each family, and dividing this result by the total number of visits for the 1,891 families. On average, families received 10 visits, a decrease of one visit from the previous report. This likely has to do with the change in criteria for inclusion in calculations of costs (all families included). PSPs spent, on average, 51 minutes driving to and from home visits. PSPs spent, on average, 57 minutes in an actual visit with a family as well, for a total time per visit, including travel time, of 108 minutes. Average PSP hourly rate was calculated using data from all sites on PSP monthly salaries and fringe benefits. PSPs were paid approximately \$33.05 per hour, on average, including fringe benefits. Given that total time per visit was 108 minutes (1.8 hours), the cost of a parent support provider's time per home visit was \$59.49.
- Based on information provided by sites, PSPs also gave families \$48.72 worth of materials and goods, on average, or approximately \$4.87 per visit.
- Average mileage per visit was calculated by summing total mileage to and from a home, then dividing this result by the total number of visits. PSPs, on average, drove approximately 21 miles roundtrip to and from home visits. Thus, sites reimbursed PSPs approximately \$10.50 per round trip for travel (\$.50/mile).

As displayed in Table 47 on the following page, **the estimated average cost per home visit for the pilot project was \$74.86**. The average number of visits a family received was calculated by

summing the total number of visits recorded by parent support providers for families and dividing by 1,891. On average, families with valid data had 10 visits with a SCC home visitor. Thus, the **average cost of total visits per family for the pilot project was approximately \$745**. This cost is an underestimate, however, for reasons cited above, such as the exclusion of time parent support providers used to plan for home visits and documentation following visits. It also does not include the significant amount of time PSPs spent on outreach and marketing to eligible families, supervision of home visitors, or other site costs associated with employing a PSP (e.g., space, equipment, administrative costs).

Table 47: Estimated Per Visit Cost for SafeCare Colorado in CY14

Resource Category	Per visit Cost (\$)
Provider Support Provider time	59.49
Materials and goods to families	4.87
Mileage	10.50
Total	74.86

4.4. Cost Evaluation Limitations

The total and average cost evaluation has several limitations that should be noted. First, CDHS costs associated with managing the program and the costs of the external evaluation are not included in any of the cost calculations. These costs are substantial and should be included in future analyses. Second, sites are heterogeneous in geographical context and diversification of structure; therefore, costs are expected to be different based on geography alone due to cost-of-living differences and building costs, for example.

Most sites did not report durable equipment that may have been used “free of charge,” such as printers, copiers, or desks. Therefore, durable equipment costs may be underestimated. Because not all sites reported data on office space and office costs, these estimates may be somewhat inaccurate, as rent may vary widely across Colorado due to urbanization. Staff time pertaining to preparation for clients, such as outreach and initial screening time was not recorded. As a result of this, the estimated cost per home visit is much lower than the actual cost.

Lastly, outside of home visit time and travel to home visits, the administrative, outreach, and training costs per family were not captured in the cost survey. When sites are operating at capacity, new parent support providers will need to be hired. The costs associated with hiring and coaching a new home visitor to certification will require more extensive data collection at

the individual level. Therefore, estimates of marginal costs are likely to be incomplete at this time.

4.5. Future Cost Evaluation

The purpose of future cost evaluation for SafeCare Colorado will be to determine if SCC provides long-term cost savings via reduction of child welfare recidivism. This question cannot be answered in the short-term, as savings from prevention are expected to accrue over many years. Programs that have long-term impacts are seldom cost-beneficial in the short term. However, when accounting for the accrual of benefits and cost reductions over the life course and across multiple systems (e.g., child welfare, education, public assistance, judicial), it is likely that these programs provide a return greater than the upfront investment (Fang, Brown, Florence, & Mercy, 2012). Therefore, the cost evaluation for SCC in 2017 will include a cost-benefit analysis using outcome data, cost data from child welfare, and historical estimates of the costs of child abuse and neglect from the child welfare and prevention literature to estimate the projected return on investment for the program.

5. Conclusion

The SafeCare Colorado pilot was successful in bringing an evidence-based in-home parenting education program to scale. The SafeCare® curriculum was implemented with fidelity across 11 diverse community-based agencies serving 39 counties and two tribal nations. Training, coaching, and ongoing program support was successfully provided by Kempe with support from SafeCare® program developers. Program data show that SCC is effectively reaching a highly vulnerable population of families, as intended.

SafeCare Colorado shows promise for families who complete all three topics compared to a matched group of similar families within a six month follow-up period. Twenty-five percent of enrolled families completed the entire SCC program, which is comparable to other voluntary prevention programs (e.g., Korfmacher, O'Brien, Hiatt, & Olds, 1999). Parent support providers and caregivers rate the quality of their relationship very high, and both report that the program is meeting the needs of families in their communities.

The 2017 SafeCare Colorado evaluation report will include an analysis of outcomes by program dosage and a review of child welfare outcomes 12 months post-program completion. This enhanced analysis of program impacts will help inform future SCC implementation and aid in the effort to understand SCC costs and benefits.

References

- Allison, P. D. (2012). *Logistic regression using SAS: Theory and applications, 2nd ed.* Cary, NC: SAS Institute.
- Barth, R. P., Gibbons, C., & Guo, S. (2006). Substance abuse treatment and the recurrence of maltreatment among caregivers with children living at home: A propensity score analysis. *Journal of Substance Abuse Treatment, 30*, 93-104.
- Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in child protective services. *Pediatrics, 129*, 509-515. doi: 10.1542/peds.2011-1840
- Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect, 36*, 156-165.
- Gelman, A., & Hill, J. (2007). *Data analysis and using regression and multilevel/hierarchical models.* New York: Cambridge University Press.
- Gershater-Molko, R. M., Lutzker, J. R., & Wesch, D. (2003). Project SafeCare: Improving health, safety, and parenting skills in families reported for, and at-risk for child maltreatment. *Journal of Family Violence, 18*, 377-386.
- Guo, S., Barth, R. P., & Gibbons, C. (2006). Propensity score matching strategies for evaluating substance abuse services for child welfare clients. *Children and Youth Services Review, 28*, 357– 383.
- Ho, D. E., Imai, K., King, G., & Stuart, E. A. (2011). MatchIt: Nonparametric preprocessing for parametric causal inference. *Journal of Statistical Software, 42*(8), 1-28.
- Karatekin, C., Hong, S., Piescher, K., Uecker, J., & McDonald, J. (2014). An evaluation of the effects of an integrated services program for multi-service use families on child welfare and educational outcomes of children. *Children and Youth Services Review, 41*, 16–26.
- Korfmacher, J., O'Brien, R., Hiatt, S., & Olds, D. (1999). Differences in program implementation between nurses and paraprofessionals providing home visits during pregnancy and infancy: A randomized trial. *American Journal of Public Health, 89*, 1847-1851.

- Levin, H., & McEwan, P. (2001). *Cost-effectiveness analysis*. Thousand Oaks, CA: Sage Publications, Inc.
- Pollock, M. D., & Green, S. L. (2015). Effects of a rural family drug treatment court collaborative on child welfare outcomes: Comparison using propensity score analysis. *Child Welfare, 94*(4), 139-159.
- Rosenbaum, P. R., & Rubin, D. B. (1983). The central role of the propensity score in observational studies for causal effects. *Biometrika, 70*, 41–55.
- Stuart, E. (2010). Matching methods for causal inference: A review and a look Forward. *Statistical Science, 25*(1), 1–21. doi: 10.1214/09-STS313
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation, 27*, 237-246.

Appendix A: SafeCare® Parent Satisfaction Survey

Safety Parent Satisfaction Survey

Thank you for being part of the Home Safety training offered by SafeCare®. We would like to learn some of your thoughts and feelings about the training. This will help us make the program better. Please read the following comments and circle the answer that best describes how you feel about each statement. Be as honest as you can. What you tell us will not affect your interactions with SafeCare® or other agencies. You can refuse to answer any question you don't want to. Please write any comments you have on the bottom of this form or on the back. Thank you for helping us by filling out this survey.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. My home is safer since I did the Home Safety Module.	1	2	3	4	5
2. I am better able to identify hazards in my home.	1	2	3	4	5
3. I am better able to get rid of hazards in my home.	1	2	3	4	5
4. I plan to continue the home safety changes I made during the home safety training.	1	2	3	4	5
5. The amount of time it took to make my home safer was reasonable.	1	2	3	4	5
6. I was comfortable letting the Home Visitor check out my home and help me reduce hazards.	1	2	3	4	5
7. I believe that this home safety training program would be useful to other parents.	1	2	3	4	5
8. Practicing during the sessions was useful.	1	2	3	4	5
9. The written materials were useful.	1	2	3	4	5
10. The Home Visitor was on time to appointments.	1	2	3	4	5
11. The Home Visitor was warm and friendly.	1	2	3	4	5
12. The Home Visitor was negative and critical.	1	2	3	4	5
13. The Home Visitor was good at explaining the material.	1	2	3	4	5

COMMENTS _____

Thank you for your help!

Health Parent Satisfaction Survey

Thank you for being part of the Health training offered by SafeCare®. We would like to learn some of your thoughts and feelings about the training. This will help us make the program better. Please read the following comments and circle the answer that best describes how you feel about each statement. Be as honest as you can. What you tell us will not affect your interactions with SafeCare® or other agencies. You can refuse to answer any question you don't want to. Please write any comments you have on the bottom of this form or on the back. Thank you for helping us by filling out this survey.

	Strongly Agree	Agree	Neutral	Disagree	Strong Disagree
1. Caring for my child's health when he/she is sick or injured has become easier.	1	2	3	4	5
2. Deciding when to take my child to the doctor has become easier.	1	2	3	4	5
3. Deciding when my child needs emergency treatment has become easier.	1	2	3	4	5
4. I believe that this health training would be useful to other parents.	1	2	3	4	5
5. I do not feel the health training gave me new or useful information or skills.	1	2	3	4	5
6. Practicing during the sessions was useful.	1	2	3	4	5
7. The written materials were useful.	1	2	3	4	5
8. The Home Visitor was on time to appointments.	1	2	3	4	5
9. The Home Visitor was warm and friendly.	1	2	3	4	5
10. The Home Visitor was negative and critical.	1	2	3	4	5
11. The Home Visitor was good at explaining the material.	1	2	3	4	5

COMMENTS _____

Thank you for your help!

PCI Parent Satisfaction Survey

Thank you for being part of the Parent-Child Interaction (PCI) training offered by SafeCare®. We would like to learn some of your thoughts and feelings about the training. This will help us make the program better. Please read the following comments and circle the answer that best describes how you feel about each statement. Be as honest as you can. What you tell us will not affect your interactions with SafeCare® or other agencies. You can refuse to answer any question you don't want to. Please write any comments you have on the bottom of this form or on the back. Thank you for helping us by filling out this survey.

	Strongly Agree	Agree	Neutral	Disagree	Strong Disagree
1. Interacting with my child has become easier.	1	2	3	4	5
2. I have more ideas about activities I would like to do with my child.	1	2	3	4	5
3. Routine activities, like feeding my child and bathing him/her, have become easier.	1	2	3	4	5
4. I believe that this training would be useful to other parents.	1	2	3	4	5
5. I do not feel the PCI training gave me new or useful information or skills.	1	2	3	4	5
6. Practicing during the sessions was useful.	1	2	3	4	5
7. The written materials were useful.	1	2	3	4	5
8. The Home Visitor was on time to appointments.	1	2	3	4	5
9. The Home Visitor was warm and friendly.	1	2	3	4	5
10. The Home Visitor was negative and critical.	1	2	3	4	5
11. The Home Visitor was good at explaining the material.	1	2	3	4	5

COMMENTS _____

Thank you for your help!

PII Parent Satisfaction Survey

Thank you for being part of the Parent-Infant Interaction (PII) training offered by SafeCare®. We would like to learn some of your thoughts and feelings about the training. This will help us make the program better. Please read the following comments and circle the answer that best describes how you feel about each statement. Be as honest as you can. What you tell us will not affect your interactions with SafeCare® or other agencies. You can refuse to answer any question you don't want to. Please write any comments you have on the bottom of this form or on the back. Thank you for helping us by filling out this survey.

	Strongly Agree	Agree	Neutral	Disagree	Strong Disagree
1. Interacting with my infant has become easier.	1	2	3	4	5
2. I have more ideas about activities I would like to do with my infant.	1	2	3	4	5
3. Routine activities, like feeding my child and bathing him/her, have become easier.	1	2	3	4	5
4. I believe that this training would be useful to other parents.	1	2	3	4	5
5. I do not feel the PII training gave me new or useful information or skills.	1	2	3	4	5
6. Practicing during the sessions was useful.	1	2	3	4	5
7. The written materials were useful.	1	2	3	4	5
8. The Home Visitor was on time to appointments.	1	2	3	4	5
9. The Home Visitor was warm and friendly.	1	2	3	4	5
10. The Home Visitor was negative and critical.	1	2	3	4	5
11. The Home Visitor was good at explaining the material.	1	2	3	4	5

COMMENTS _____

Thank you for your help!

Appendix B: Caregiver Focus Group Protocol

Section 1: Community context/resources; Parent needs/resources

We would like to learn a little more about your community:

1. *** What organizations, services, and programs in your community do you think are valuable in supporting you in raising your children?

We are also interested in how programs can make families feel more welcomed and involved when they seek out support.

2. Could you talk about a time when you had a really good experience getting help from a program or service in your community?
3. Is there anything currently not available in your community that you wished you had in supporting you to raise your children?

Section 2: Practitioner-led recruitment; Program approach; Parent needs/resources

Now we would like to ask you some questions about how you first learned about the SafeCare program and your enrollment in the program.

1. How did you hear about the SafeCare program?
2. Can you talk about your experience with enrolling in and getting started with the program?

Prompts: What was it like? Was it confusing, frustrating, easy, welcoming, etc.?

3. *** If you feel comfortable sharing: what were some of the challenges you were experiencing at the time that you were hoping the SafeCare program could help with?
 - a. Did the program end up being helpful for those issues?

Section 3: Provider characteristics and turnover; Frequency of contact

Now, we would like to ask you some questions about your parent support provider/home visitor.

1. *** Tell me about your PSP/home visitor.

Prompts: What did you like about your PSP/home visitor?
 Was there anything you didn't like or care for about your PSP/home visitor?
 If you can, describe your relationship with your home visitor.
 Is there anything you wish your PSP/home visitor did differently?
 How often did you have contact with your PSP?

2. Did you change PSPs/home visitors at any time during the program?
 - a. If so, why? (PSP quit, parent requested different PSP, etc.)

Section 4: Program approach; Match between parent expectations and program goals; barriers to participation

Now we would like to ask you about your overall experience with the SafeCare program.

1. Was the program what you were expecting? Why or why not?
2. What do you think you gained or learned from the program?
 - a. Can you talk about a SafeCare visit or module you thought went especially well.
3. Is there anything you wish your PSP/ home visitor would have spent more time on or done differently or anything you think should change to make the program better?
4. *** Did you find it challenging or difficult to participate in SafeCare for any reason?
 - a. *1-module completers only:* If you exited the program early, is there anything that would have helped you complete the full program?
5. *** Would you recommend the program to your friends or family members? Why or why not?

Wrap-up

4. Do you have any additional comments or suggestions about anything that we did not cover today?

Appendix C: Working Alliance Inventory

Home Visitor ID Number: _____

Date: ____/____/____
MONTH DAY YEAR

Parent ID Number: _____

INITIAL

Working Alliance Inventory-Home Visiting Short Form Parent Version

INSTRUCTIONS: Below are statements that describe ways a parent might think or feel about his or her home visitor. For each statement, please check the box that describes how often you think or feel that way. For example, if the statement describes the way you *always* think or feel, check the “Always” box. Work fast, your first thoughts are the ones we would like to see. Please don't forget to respond to every item.

	How often do you think or feel this way?						
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
1. My home visitor and I agree about the things I will need to do with home visiting to benefit me and my family.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶	<input type="checkbox"/> ⁷
2. What I am doing with home visiting gives me new ways of looking at my family's situation.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶	<input type="checkbox"/> ⁷
3. I believe my home visitor likes me.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶	<input type="checkbox"/> ⁷
4. My home visitor does not understand what I am trying to accomplish with home visiting.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶	<input type="checkbox"/> ⁷
5. I am confident in my home visitor's ability to help me.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶	<input type="checkbox"/> ⁷
6. My home visitor and I are working toward mutually agreed upon goals.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶	<input type="checkbox"/> ⁷
7. I feel that my home visitor appreciates me.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶	<input type="checkbox"/> ⁷
8. We agree on what is important for me to work on.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶	<input type="checkbox"/> ⁷
9. My home visitor and I trust one another.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶	<input type="checkbox"/> ⁷
10. My home visitor and I have different ideas on what I want and need.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶	<input type="checkbox"/> ⁷
11. We have established a good understanding of the kind of changes that would be good for me.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶	<input type="checkbox"/> ⁷
12. I believe the way we are working towards my goals is correct.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁶	<input type="checkbox"/> ⁷

Did this parent fill out the form herself or did someone read the items to her? filled out form herself had form read to her

This form is being completed: beginning services (3rd-5th visit)

Cross-Site Evaluation of Children's Bureau Grantee Cluster on Evidence-Based Home Visiting
Working Alliance Inventory (WAI) © Horvath 1994; Short form by Tracey and Kokotovic 1989, modified by Santos 2005 for home visiting

V01_10/30/09

Home Visit Number: _____

Parent ID Number: _____



Date: ____/____/____
MONTH DAY YEAR

FINAL

**Working Alliance Inventory-Home Visiting Short Form
Parent Version**

INSTRUCTIONS: Below are statements that describe ways a parent might think or feel about his or her home visitor. For each statement, please check the box that describes how often you think or feel that way. For example, if the statement describes the way you *always* think or feel, check the “Always” box. Work fast, your first thoughts are the ones we would like to see. Please don't forget to respond to every item.

	How often do you think or feel this way?						
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
1. My home visitor and I agree about the things I will need to do with home visiting to benefit me and my family.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
2. What I am doing with home visiting gives me new ways of looking at my family's situation.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
3. I believe my home visitor likes me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
4. My home visitor does not understand what I am trying to accomplish with home visiting.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
5. I am confident in my home visitor's ability to help me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
6. My home visitor and I are working toward mutually agreed upon goals.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
7. I feel that my home visitor appreciates me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
8. We agree on what is important for me to work on.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
9. My home visitor and I trust one another.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
10. My home visitor and I have different ideas on what I want and need.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
11. We have established a good understanding of the kind of changes that would be good for me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
12. I believe the way we are working towards my goals is correct.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

Did this parent fill out the form herself or did someone read the items to her? filled out form herself had form read to her
 This form is being completed: end of services (|__|__| months after 1st visit) or 12 months after 1st visit, whichever comes first

Cross-Site Evaluation of Children's Bureau Grantee Cluster on Evidence-Based Home Visiting
 Working Alliance Inventory (WAI) © Horvath 1994; Short form by Tracy and Kokotovic 1989, modified by Santos 2005 for home visiting

V01_10/30/09

Home Visitor ID Number: _____ First Name: _____ Last Name: _____
 Family ID Number: _____ First Name: _____ Last Name: _____

Date: |__|_| / |__|_| / |__|_|_|_|
 MONTH DAY YEAR

INITIAL
Working Alliance Inventory-Home Visiting Short Form
Home Visitor Version

INSTRUCTIONS: Below are statements that describe ways a home visitor might think or feel about the parent with whom she/he is working. For each statement, please check the box that describes how often you think or feel that way. For example, if the statement describes the way you *always* think or feel, check the "Always" box. Work fast, your first thoughts are the ones we would like to see. Please don't forget to respond to every item.

	How often do you think or feel this way?						
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
1. The parent and I agree about the steps to be taken to benefit her/him and her/his family.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
2. The parent and I both feel confident about the usefulness of our current activity in home visiting.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
3. I believe the parent likes me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
4. I have doubts about what we are trying to accomplish with home visiting.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
5. I am confident in my ability to help the parent.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
6. We are working toward mutually agreed upon goals.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
7. I appreciate the parent as a person.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
8. We agree on what is important for the parent to work on.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
9. The parent and I have built a mutual trust.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
10. The parent and I have different ideas on what he/she wants and needs.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
11. We have established a good understanding between us of the kind of changes that would be good for this parent.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
12. The parent believes the way we are working toward her/his goals is correct.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

This form was completed: soon after the start of services (3rd-5th visit)

Home Visitor ID Number: _____ First Name: _____ Last Name: _____
 Family ID Number: _____ First Name: _____ Last Name: _____

Date: |__|_| / |__|_| / |__|_|_|_|_|
 MONTH DAY YEAR

FINAL
Working Alliance Inventory-Home Visiting Short Form
Home Visitor Version

INSTRUCTIONS: Below are statements that describe ways a home visitor might think or feel about the parent with whom she/he is working. For each statement, please check the box that describes how often you think or feel that way. For example, if the statement describes the way you *always* think or feel, check the "Always" box. Work fast, your first thoughts are the ones we would like to see. Please don't forget to respond to every item.

	How often do you think or feel this way?						
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
1. The parent and I agree about the steps to be taken to benefit her/him and her/his family.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
2. The parent and I both feel confident about the usefulness of our current activity in home visiting.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
3. I believe the parent likes me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
4. I have doubts about what we are trying to accomplish with home visiting.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
5. I am confident in my ability to help the parent.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
6. We are working toward mutually agreed upon goals.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
7. I appreciate the parent as a person.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
8. We agree on what is important for the parent to work on.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
9. The parent and I have built a mutual trust.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
10. The parent and I have different ideas on what he/she wants and needs.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
11. We have established a good understanding between us of the kind of changes that would be good for this parent.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
12. The parent believes the way we are working toward her/his goals is correct.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

This form was completed: at the end of services (|__|_|_| months after 1st visit) or 12 months after 1st visit, whichever comes first

Appendix D: Site Supervisor Interview Protocol

I would like to tape-record our discussion. I am taping our discussion so we can type it into a computer program and analyze the content for themes that will go into our summary report. If you want to say anything that you don't want taped, please let me know and I will glad to pause the tape recorder. Do you have any objection to being tape recorded?

Engagement and use of incentives

I would like to begin by asking you about your process for engaging families in SafeCare.

1. When you get a referral, how does your site engage with families and get them into the program?
 - a. Is there a set protocol for number of times you try to contact families?
 - b. Do you conduct the intake on the first visit or do an information only session first?
 - c. Do all home visitors do this the same way?
2. Are referrals from different sources handled any differently? Please explain the differences.
3. What incentives are you able to offer to families for signing up and continuing in the program?
 - a. What incentives are you able to provide and how often?
 - b. Does the funding for incentives come from your agency, private donors, grants?
 - c. How important do you think the incentives are in getting families involved in SafeCare?
 - d. How important are they to keeping families involved?

Successes and Challenges

Now I would like to ask about overall successes and challenges you have encountered in the implementation of SafeCare Colorado this year.

1. In your opinion, what have been the greatest successes of the implementation of SafeCare Colorado in the past year?
2. What challenges have you encountered?
3. How would you describe the support you have received this year from the Kempe Center?
 - a. What have you appreciated the most about working with them? What do you think they could be doing better?
4. How would you describe the support you have received this year from Julia and the Office of Early Childhood?
 - a. What do you think OEC (Julia) and other state partners have done well? What do you think they could be doing better?
5. Is there additional assistance from CDHS or Kempe that you think would be helpful for your site in the future?
6. What advice do you have for future grantees/communities/states for implementing this type of initiative?

Wrap Up

Thank you so much for taking the time to talk with me today. Is there anything else you would like to add before we end the discussion?

Appendix E: SafeCare® Assessment Forms

Home Accident Prevention Inventory—HAPI Home Visitor Assessment Form

Parent _____ Child _____ HV _____

Child's Reach _____ Child's Eye-level _____

Room _____ Date _____

Assessment Baseline Training End of Module Assessment Type Formal Informal

POISON	Total	Notes
<i>Beauty Products</i>		
<i>Medications</i>		
<i>Cleaning products</i>		
<i>Paints, solvents, etc.</i>		
<i>Pesticides, herbicide, etc.</i>		
<i>Poisonous plants</i>		
<i>Alcoholic beverages</i>		

CHOKES	Total	Notes
<i>Small objects—toys, candies, push pins etc.</i>		

SUFFOCATION	Total	Notes
<i>Cords</i>		
<i>Plastics</i>		
<i>Sleep Hazards (infant homes)</i>		

DROWNING	Total	Notes
<i>Standing water in basins</i>		
<i>Unsecured toilet</i>		

FIRE/ELECTRICAL	Total	Notes
<i>Combustibles</i>		
<i>Fireplaces w/o screens</i>		
<i>Outlet/switch w/o plate/safety cover</i>		
<i>Appliances w/o covers</i>		
<i>Damaged electrical cords/plugs</i>		

FALL/ACTIVITY RESTRICTION	Total	Notes
<i>Balconies</i>		
<i>Steps</i>		
<i>Windows</i>		
<i>Objects in walkway</i>		
<i>Activity restriction</i>		

SHARP OBJECT	Total	Notes
<i>Knives, scissors, corkscrews, vegetable peelers, etc.</i>		

FIREARM	Total	Notes
<i>Guns, rifles, BB guns, etc.</i>		

CRUSH	Total	Notes
<i>Objects over 10 pounds—TV, bookshelf, boxes, etc.</i>		

ORGANIC/ALLERGEN	Total	Notes
<i>Decaying food/dirty dishes</i>		
<i>Excess dust, dirt, animal hair, and other allergens</i>		
<i>Evidence of insect/rodent infestation</i>		

TOTAL HAZARDS: _____ **Progress** **In Progress** **Success** **Mastery**
 Circle one

Sick or Injured Child Checklist—SICC HV

Home Visitor Assessment Form

Parent _____ Child _____ HV _____

Session # _____ Date _____

Assessment Baseline Training End of Module Assessment Type Formal Informal

Baseline and End of Module Assessment Directions:

- Administer 3 scenarios in any order:
 - 1 Emergency—ER
 - 1 Doctor’s Appointment—DA
 - 1 Care at Home—CH
- Use the notes section to document any relevant observations that will assist future training with the parent.
- For “Emergency” scenarios, score N/A for Part 3 and 5.
- Calculate Total using the following formulas:

ER Scenarios	DA & CH Scenarios	
$1/3 \times 100\% = 33\%$	$1/5 \times 100\% = 20\%$	$4/5 \times 100\% = 80\%$
$2/3 \times 100\% = 66\%$	$2/5 \times 100\% = 40\%$	$5/5 \times 100\% = 100\%$
$3/3 \times 100\% = 100\%$	$3/5 \times 100\% = 60\%$	

Training Assessment Directions:

- Administer as many scenarios as needed for each type of scenario until parent achieves mastery (as time allows).
- For “Emergency” scenarios, score N/A for Part 3 and 5.

Scenario	Score	Notes
Scenario # _____ Scenario Type: ER DA CH	Part 1 Score _____ Part 2 Score _____ Part 3 Score _____ Part 4 Score _____ Part 5 Score _____ Percentage correct: _____	
Scenario # _____ Scenario Type: ER DA CH	Part 1 Score _____ Part 2 Score _____ Part 3 Score _____ Part 4 Score _____ Part 5 Score _____ Percentage correct: _____	
Scenario # _____ Scenario Type: ER DA CH	Part 1 Score _____ Part 2 Score _____ Part 3 Score _____ Part 4 Score _____ Part 5 Score _____ Percentage correct: _____	

Progress In Progress Success Mastery
 Circle one



Child Planned Activities Training—cPAT

Home Visitor Assessment Form

Parent _____ Child _____ HV _____

Activity _____ Session # _____ Date _____

Assessment Baseline Training End of Module Assessment Type Formal Informal

- Scoring**
- ✓+ Demonstrated the behavior consistently and with ease
Parent must perform all bulleted items to receive this score
 - ✓ Needs improvement in ease and/or consistency of the behavior
Parent must perform at least one bulleted item to receive this score
 - Did not demonstrate behavior at all

	Parent Behavior	Score	Notes
BEFORE	Prepare in advance <ul style="list-style-type: none"> Gets supplies/toys ready in advance (includes items already present) Informs child activity is going to happen 		
	Explain activity <ul style="list-style-type: none"> Gets the child's attention Explains the activity 		
	Explain rules & consequences <ul style="list-style-type: none"> Gives 1+ positively stated rule Gives 1+ positive consequence 		
DURING	Talk about what you and your child are doing <ul style="list-style-type: none"> Talks warmly about activity Uses incidental teaching 		
	Use good physical interaction skills <ul style="list-style-type: none"> Gets on child's level Uses good eye-contact 		
	Give choices <ul style="list-style-type: none"> Lets child have 2+ choices during activity 		
	Praise desired behaviors <ul style="list-style-type: none"> Uses 2+ labeled praises 		
	Ignore minor misbehavior <ul style="list-style-type: none"> Ignores minor misbehavior Score N/A if no misbehavior 		
	Provide consequences <ul style="list-style-type: none"> Follows through with positive and/or negative consequences as appropriate 		
END	Wrap-up and give feedback <ul style="list-style-type: none"> Informs child activity is ending Describes what child did well Lets child know what to do better next time (if applicable) 		

Number of (—) _____ **Progress** *In Progress*
 Number of (✓) _____ **Success** *Success*
 Number of (✓+) _____ **Mastery** *Mastery*

Negative Behaviors:



Infant Parent Activities Training—iPAT

Home Visitor Assessment Form

Parent _____ Child _____ HV _____

Activity _____ Session # _____ Date _____

Assessment Baseline Training End of Module Assessment Type Formal Informal

Scoring

✓+	Demonstrated the behavior consistently and with ease
✓	Needs improvement in ease and/or consistency of the behavior
—	Did not demonstrate behavior at all

	Parent Behavior	Score	Notes
LoTTS of Bonding	Looking		
	Talking		
	Touching		
	Smiling		

Number of (—) _____

Number of (✓) _____

Number of (✓+) _____

Progress
Circle one *In Progress* *Success* *Mastery*

Score the following behaviors (Score N/A if not applicable)

	Parent Behavior	Score	Notes
Other Bonding Behaviors	Holding		
	Imitating		
	Rocking		

Negative Behaviors:

Appendix F: SafeCare Colorado Cost Survey

Introduction and Instructions

The Site Cost Survey for SafeCare Colorado agencies aims to document the costs associated with implementing a SafeCare Colorado site. The survey was developed at the Social Work Research Center at Colorado State University, and borrows heavily from a recent study on Evidence-Based Home Visiting Programs published by Mathematica Policy Research and Chapin Hall at the University of Chicago. The Colorado Department of Human Services has contracted with Colorado State University to evaluate costs associated with SafeCare Colorado.

What is the survey about?

This survey is for SafeCare Colorado implementing agencies, and asks questions pertaining to the resources required to implement SafeCare Colorado at your respective agencies between January 2014 and December 2014, or from the inception of your site through December 2014. The survey is designed to gather information on all resources that have been used by your site, including resources that may not reflect directly in expenditure records (such as volunteer time). How is the survey organized? The survey is divided into sections, with each section pertaining to a specific type of cost or resource. Please complete the questions in all sections.

What time period is covered? You should report costs for the 12 months of January 2014 through December 2014 if your SafeCare program began in program year one. If you began in program year two, please report costs from the day and month which your site began operating through December 2014.

What information or records are needed to complete the survey? You will need information about agency expenditures and use of resources, such as facilities and equipment. Please use actual expenditure records rather than budgets when gathering information to answer survey questions. Information from budgets does not always represent actual expenditures or resource use. It may be helpful to review the entire survey before starting it to identify the kinds of information that are required.

How will survey data be used? Information gathered through this survey will be treated in a confidential manner. Only members of the research team will have access to survey responses. We will use the data to develop estimates of the annual and per-participant costs for SafeCare Colorado, and to examine cost variation among agencies. Thank you for your participation in this important study.

If you have questions about how to complete this survey, please contact Zach Timpe at zacharytimpe@gmail.com or Kristy Beachy-Quick at kristy.beachy-quick@colostate.edu 970-491-5511.

SECTION 1: YOUR AGENCY

This section requests basic information about your agency.

Q1. Please select your agency from the list below

- Baby Bear Hugs
- Savio House
- Mesa County Department of Public Health
- Montezuma County Department of Public Health
- Arapahoe County Early Childhood Council
- Catholic Charities
- Family Tree
- High Plains

Q2. Please provide contact information for the person primarily responsible for completing this survey.

Name	
Position/Title	
Email	
Telephone	
Address	

Q3. What is the total approximate budget for your agency (including SafeCare and other programs your agency runs)? (enter numeric value in the following format xxxxx.xx)

Q4. Approximately what percentage of your agency's budget is allocated to SafeCare Colorado?

- 0-10%
- 11-20%
- 21-30%
- 31-40%
- 41-50%
- 51-60%
- 61-70%
- 71-80%
- 81-90%
- 91-100%

Q5. Please report costs incurred by your agency during the 12 months of January 2014 through December 2014. If you began implementation in year one of the program, please provide costs incurred from January 1, 2014 through December 31, 2014. If you began implementation in year two of the program, please provide costs from the first day of implementation through December 31, 2014.

Q6. In which program year did you began implementation of SafeCare Colorado?

- Program year one (fall 2013)
- Program year two (fall 2014)

Answer If "In which program year did you began implementation of SafeCare Colorado?" Program year one (fall 2013) is Selected

Q7. Are you reporting costs during the 12 months spanning from January 2014 to December 2014?

- Yes
- No (please explain) _____

Answer If "In which program year did you began implementation of SafeCare Colorado?" Program year two is Selected

Q11. What is the period for which you are reporting costs (the "reporting period")?

SECTION 2: SALARIES AND FRINGE BENEFITS

This section asks questions about salary and fringe benefit expenses for staff working on SafeCare Colorado.

NOTE: if you have employees who are Home Visitors part-time and another position part-time, please include them in both questions on Home Visitors and other staff and indicate how much time they spent in each position.

Q12. Please fill out this information on Home Visitors for SafeCare Colorado at your agency, the number of months worked during the reporting period, their monthly salary, and values of payroll taxes and fringe benefits.

	Number of months worked in 2014	Monthly salary (this will be reported as an average across home visitors)	Percentage of time allocated as a Home Visitor to SafeCare Colorado	Value of Payroll Taxes and Fringe Benefits as a percentage of salary	Value of Payroll Taxes and Fringe Benefits as a total monthly dollar amount
SafeCare Home Visitor 1					
SafeCare Home Visitor 2					
SafeCare Home Visitor 3					
SafeCare Home Visitor 4					
SafeCare Home Visitor 5					
SafeCare Home Visitor 6					
SafeCare Home Visitor 7					

Q13. Please fill out this information on staff working on SafeCare Colorado at your agency, their average full-time annual salary, percentage of time allocated in this position to SafeCare Colorado, and values of payroll taxes and fringe benefits.

	Number of months worked in 2014	Monthly salary (before taxes)	Percentage of time allocated to this position for SafeCare Colorado	Value of Payroll Taxes and Fringe Benefits as a percentage of salary	Value of Payroll Taxes and Fringe Benefits as a total monthly dollar amount
SafeCare Supervisor					
SafeCare Supervisor 2					
Director 1					
Director 2					
Program Administrator 1					
Program Administrator 2					
Other					

Q14. Are there any FTEs that were not mentioned in the previous question? If there are any FTEs not mentioned, please list the positions below, along with the salary, percentage time, and tax and payroll benefits information.

Q15. Did SafeCare Colorado incur any costs for overtime during the reporting period?

- Yes
- No

Answer If “Did SafeCare Colorado incur any costs for overtime during the reporting period?” Yes Is Selected

Q16. What was the total cost of overtime during the reporting period?

SECTION 3: DONATED LABOR

This section asks about the value of any labor donated to the home visiting program (volunteers) during the reporting year.

Q17. Did your agency's home visiting program use any donated labor/volunteers during the reporting period?

- Yes
- No

Answer If “Did your agency's home visiting program use any donated labor/volunteers during the reporting period?” Yes Is Selected

Q18. How many volunteers worked at your agency on SafeCare Colorado?

Answer If “Did your agency's home visiting program use any donated labor/volunteers during the reporting period?” Yes Is Selected

Q19. Please fill in the following information to estimate the value of donated labor for each volunteer

	Position or job description	Number of hours worked per month	Number of months worked during the reporting period	Estimated hourly wage for a paid employee in that position
Volunteer 1				
Volunteer 2				
Volunteer 3				
Volunteer 4				
Volunteer 5				
Volunteer 6				
Volunteer 7				
Volunteer 8				

Answer If “Did your agency's home visiting program use any donated labor/volunteers during the reporting period?” Yes Is Selected

Q20. Please describe the source of your estimate for hourly wages, and enter any explanatory notes on the information provided on volunteers

Answer If “Please fill in the following information to estimate the value of donated labor for each volunteer Volunteer 3 - Estimated hourly wage for a paid employee in that position” Is Not Empty And “Please fill in the following information to estimate the value of donated labor for each volunteer Volunteer 3 - Number of months worked during the reporting period” Is Not Empty And “Please fill in the following information to estimate the value of donated labor for each volunteer Volunteer 3 - Number of hours worked per month” Is Not Empty

Q21. If you had more than 8 volunteers, please write in any other volunteers not described above and indicate their position or job description, number of hours worked per month, number of months worked during the reporting period, and the estimated hourly wage for a paid employee in that position.

SECTION 4: SUPPLIES AND MATERIALS

This section asks questions about the cost or value of supplies and materials used by the home visiting program during the reporting year.

Q22. In the table below, please indicate the cost of supplies and materials used by SafeCare Colorado during the reporting year. For the purposes of this survey, supplies and materials are items used and replenished regularly, not capital assets such as computers. If a listed supply or material was not used enter 0.

	Cost during reporting year
Office Supplies	
Computer software	
Postage	
Educational materials	
SafeCare Visitor Materials (Audio recorder, batteries, screwdrivers, baby doll, rolling case for files)	
SafeCare Family Materials (Safety First Kits, No Choke Tubes)	
SafeCare Family Incidentals (Food, incentives, toys/games/books, gas/gift/cell minute cards)	
Marketing (e.g., Incentives to referral agencies)	
Cellular phones (including service fees)	

Q23. Did the program receive and use any supplies or materials free of charge (for example, through donations)?

- Yes
- No

Answer If “Did the program receive and use any supplies or materials free of charge (for example, through donations)?” Yes Is Selected

Q24. Please list the supplies and materials the program received free of charge and estimate what your agency would have paid for them.

SECTION 5: EQUIPMENT/CAPITAL ASSETS

This section asks questions about durable equipment and/or capital assets used by the SafeCare Colorado program during the reporting period.

Q25. Please use the table below to itemize any durable equipment or capital asset used by the SafeCare Colorado program during the reporting period. For the purposes of this survey, durable equipment and capital assets are items with an expected useful life of more than 1 year. Examples include computer systems, automobiles, office furniture, etc.

	Type of equipment/ asset	Year purchased	Total purchase price	Expected useful life
1				
2				
3				
4				
5				
6				
7				

Q26. Are there any supplies or materials not mentioned above? If so, please describe below, along with an estimate of the cost during the reporting year.

Q27. Was any equipment leased or rented for SafeCare Colorado during the reporting period?

- Yes
- No

Answer If “Was any equipment leased or rented for SafeCare Colorado during the reporting period?” Yes Is Selected

Q28. If you answered yes to the previous question, please enter the type of equipment leased or rented and the total amount paid during the reporting period

	Type of Equipment Leased or Rented	Amount Paid During the Reporting Period (Dollars)
1		
2		
3		
4		
5		
6		
7		

Q29. Did your SafeCare Colorado program receive and use any equipment free of charge during the reporting period (for example, through donations)?

- Yes
- No

Answer If “Did your SafeCare Colorado program receive and use any equipment free of charge during the reporting period (for example, through donations)?” Yes Is Selected

Q30. Please enter the type of equipment received free of charge, its approximate value at the time of donation, and its expected remaining useful life (in years).

	Type of Equipment	Approximate Value at Time of Donation (Dollars)	Expected Remaining Useful Life (Number of Years)
1			
2			
3			
4			
5			

SECTION 6: CONTRACTED SERVICES

This section asks questions about the value of contracted services that your program purchased during the reporting period.

Q31. Did your agency contract with a company or organization to provide services for your SafeCare Colorado program during the reporting period?

- Yes
- No

Answer If “Did your agency contract with a company or organization to provide services for your SafeCare Colorado program during the reporting period?” Yes Is Selected

Q32. If so, please enter the information below on the contracted services purchased and their cost

during the reporting year.

	Name of Contractor or Service Provider	Type of Contracted Service	Cost Incurred During Reporting Year (Dollars)
1			
2			
3			
4			
5			

Q33. Did your SafeCare Colorado program contract with a professional or technical consultant during the reporting year?

- Yes
- No

Answer If “Did your SafeCare Colorado program contract with a professional or technical consultant during the reporting year?” Yes Is Selected

Q34. Please list consultants below with whom the program contracted and the amount paid during the reporting year.

	Name of Consultant	Type of Service Provided	Cost Incurred During Reporting Year (Dollars)
1			
2			
3			
4			
5			

Answer If “Did your SafeCare Colorado program contract with a professional or technical consultant during the reporting year?” Yes Is Selected

Q35. What were the total expenses for consulting services during the reporting year, in dollars?

SECTION 7: BUILDINGS AND FACILITIES

This section asks questions about cost of office space or other facilities used by your SafeCare Colorado site during the reporting period.

Q36. Please use the table below to list all buildings or other facilities regularly used by your SafeCare

Colorado program during the reporting year, including office space and off-site facilities.

	Building or Facility Name	Type of Building or Facility (office, hospital, school, etc.)	Address of the Building or Facility	Approximate Size of Space Used By SafeCare Colorado (in square feet)	Approximate Percentage of Total Building or Facility Space Used by Your SafeCare Colorado Program	Days Per Year Space was Used by SafeCare Colorado during the reporting period
1						
2						
3						
4						
5						

Q37. Please enter the total amount paid during the reporting year for each building or facility used by your SafeCare Colorado program. If the agency does not pay to use the building or facility, please enter 0.

	Building or facility name	Total building use fees for your agency operations	Percent of building used and paid for by the SafeCare Colorado program	Does amount paid represent fair market value? (Yes/No)
1				
2				
3				
4				
5				

Q38. If your SafeCare Colorado program uses any building or facility free of charge or for below market rates, please use the table below to provide an estimate of the annual cost of leasing or renting the space in each building or facility based on fair market value.

	Building or facility name	Estimate of the annual cost of leasing or renting space for use by the SafeCare Colorado program based on fair market value
1		
2		
3		

SECTION 8: MISCELLANEOUS/OTHER RESOURCES

This section asks questions about miscellaneous items and services used by the SafeCare Colorado program during the reporting period.

Q39. Please enter the cost of miscellaneous items and services purchased by the SafeCare Colorado program during the reporting year and not reported elsewhere in the survey. If your program did not use a listed item or service, enter 0. Use the blank lines to enter additional items or services if necessary.

	Cost (Dollars)
Transportation/mileage reimbursement related to client services	
Staff travel for purposes other than client services	
Staff training or professional development (not including travel costs)	
Fees paid to SafeCare model developers	
Photocopying/printing	
Building utilities (e.g., electric, gas, internet)	
Insurance (e.g., liability insurance)	
Taxes (federal, state, local)	
Click to write	
Click to write	
Click to write	

Q40. Enter the estimated value of any miscellaneous items and services donated to your SafeCare Colorado program during the reporting year and not reported elsewhere in the survey.

	Type of Item or Service Donated	Estimated Value (Dollars)
1		
2		
3		
4		
5		

SECTION 9: INDIRECT COSTS

This section asks questions about indirect costs during the reporting period. Indirect costs are costs for shared agency functions, such as accounting, human resources, and marketing. These functions may benefit multiple programs or departments. Costs for these shared functions are often allocated through an indirect cost rate or a total charge for indirect expenses. Agencies differ in the way that they calculate and allocate indirect costs.

Q41. Does your agency calculate indirect costs for SafeCare Colorado using an established indirect cost rate?

- Yes
- No

Q42. What is the established indirect cost rate your agency used during the reporting period?

Q43. To what expenses is the established indirect cost rate applied?

- Salaries only
- Salaries and fringe benefits
- Salaries, fringe benefits, and other direct costs

Q44. Does your agency calculate indirect costs for SafeCare Colorado without an established indirect cost rate?

- Yes
- No

Answer If "Does your agency calculate indirect costs for SafeCare Colorado without an established indirect cost rate?" Yes Is Selected

Q45. Please describe the method below, and provide a total estimate of indirect costs.

Q46. If your agency calculated total indirect costs for your SafeCare Colorado program, please enter that amount below.

Q47. Do any indirect costs charged to your SafeCare Colorado program cover costs you have reported in other sections of this survey?

- Yes
- No

Q48. Please itemize below the resources covered under indirect costs charged to your SafeCare Colorado program, including any resources reported in other sections of the survey.