## CONTENTS

## ABSTRACT

Title: Hello Baby
Applicant: Allegheny County Department of Human Services (DHS)
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DHS and the community collaborative in Allegheny County will improve the overall well-being of children and families and reduce children's entry into foster care by reaching, engaging, and supporting families with infants and young children. This program, called *Hello Baby*, will be available to all families in the target area (county), providing them with information, services and concrete resources. This voluntary program will use an approach that differentiates the types and intensity of resources, based on families' wants and needs:

1. Universal outreach to mothers, fathers and families. Because most families with newborns need information and places to turn for answers and help if they need it, Hello Baby will reach thousands of families through the county's primary birthing center and through public campaigns, under the Hello Baby banner. The hospital-based nurses will inform 5,950 parents of newborns about free home visiting, local family support, the warm line, the Hello Baby website, and texting help from friendly, trained peers who will answer their questions before and after they return home with their baby.
2. Family support center-based services. For the subset of families who need additional services and support, Hello Baby will build upon an existing place-based approach, reaching them through the 28 Family Support Centers. Their staff of experienced, trained peers will reach out to families with newborns to connect them with the rich support and services at their neighborhood Center.
3. Priority care and support. Hello Baby will leverage the community collaborative and the county's work in predictive modeling to help families with the greatest needs get services on a priority basis. From child care, housing, concrete goods, medical, legal assistance to social support with other families and peers, Hello Baby will provide continuity of care for willing families until their newborn reaches age three. Families with priority care (five percent of all families, selected using a validated predictive model that identifies families of infants with the greatest need for support and care) will have the support of a duo of a Family Engagement Specialist (peer) and a Navigator (social worker). These teams will use a strengths-based approach, will know how to quickly access the collaborative's resources, and are skilled at outreach and engagement. These teams will have a geographic base—working with a set of Family Support Centers—and will work with a supervisor/clinician who will conduct "rounds" with collaborative providers with/for individual families; and with the project director, who will lead systems-level reviews to ensure that DHS and the collaborative are addressing issues that impact these and other families.

The members of the county's community collaborative (Children's Cabinet) provided design guidance and feedback to DHS in developing this approach. Using an extensive community and family engagement process, an independent research and ethical review, and a literature review and site visits, DHS identified the approach, qualities/types of staff and the strategy for identifying and tackling systems-level changes to benefit children and families. The program will conduct a process evaluation and a randomized controlled trial (RCT) to measure its impact.

# 1. OBJECTIVES AND NEED FOR ASSISTANCE

## *1.1 Need*

Over the past 30 years, Allegheny County has built a community collaborative, the Children's Cabinet, to strengthen families and improve children's outcomes. The Cabinet began at the urging of family members and community members who saw that the county's child protective services department needed to focus on prevention: supporting families in raising thriving children. The Children's Cabinet guided the county in changing its approach to family services and, when the county decided to merge child protective services with five other services (forming the Allegheny County Department of Human Services (DHS)), it meant that services to families could be integrated in one department and prevention would become DHS's top priority.

Today, this is a county with a robust network of community-based services provided by peers, faith-based and other community organizations, serving thousands of families through local Family Support Centers. These community-based hubs are the place for families to go for social, health, educational, recreational, and support services, and provide home-based programs through evidence-based home visiting and mobile teams. These family services have been shown to reduce maltreatment investigations at the community level (See Chapin Hall study and DHS evaluation[1]).

This service integration and robust collaboration have brought services and support to more families. But reducing home removals and improving child and family well-being requires us to fill key gaps:

[1] Wulczyn, F. and Lery, B., Do family support centers reduce child welfare maltreatment investigations? Evidence from Allegheny County. Center for State Child Welfare Data, Chapin Hall at University of Chicago, 2018. See also: https://www.alleghenycountyanalytics.us/wp-content/uploads/2016/11/Final-Evaluation-of-the-Family-Support-Center-Network-1.pdf

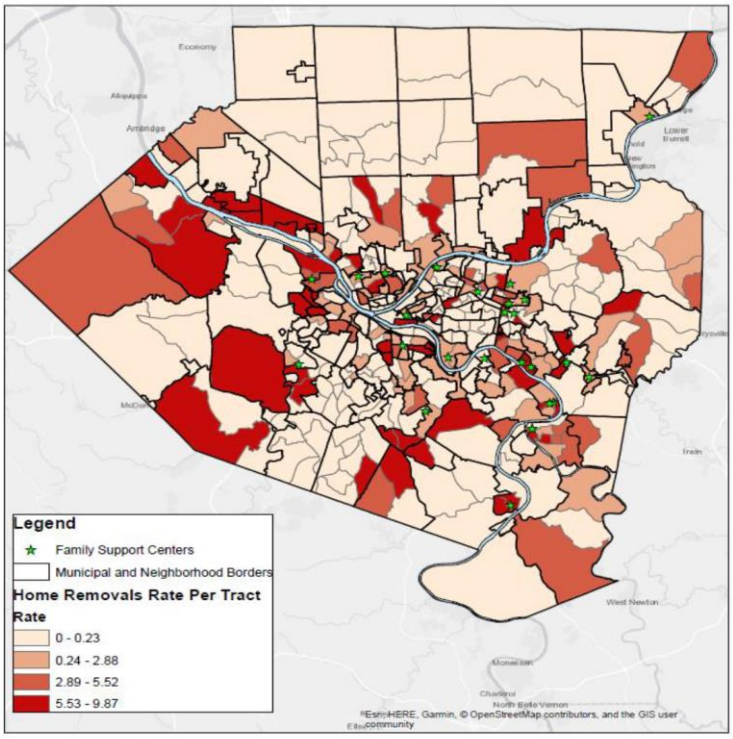
1. Our neighborhood-based Centers touch a small fraction of families with moderate-high needs for support and services. They need a **more robust outreach component**, if they are to connect with more of the families who live within bus/walking distance and who could benefit from the Center's and other community collaborative services.
2. For a smaller but crucial group of families (those with the highest needs), dropping by a Center or opening their doors to a visitor is not likely to happen and they need services that the Centers may not offer. Reaching and engaging them takes a different approach; and truly helping them requires **priority care and support**. These families are facing factors that research indicates are main drivers of child abuse:
   - Untreated maternal depression or mental illness[2]
     - DHS analysis shows 63% of the highest-need families with newborns received mental health services.
   - Substance use disorder (SUD) in caregivers[3]
     - DHS analysis shows 40% of these families had received SUD treatment services.
   - Age of the mother: under age thirty[4]
     - DHS analysis finds that 82% of the mothers of infants in high-need families are under 30.)
   - Intimate partner violence (IPV) in the home[5]
     - DHS does not have data about IPV, but its analysis shows that 38% of parents in high-need families have been in jail.

[2] https://onlinelibrary.wiley.com/doi/full/10.1111/j.1440-1819.2010.02063.x
[3] Levey et al, 2017.
[4] Herman-Giddens, M.E., et al., Newborns killed or left to die by a parent: A population based study. JAMA, 2003. 289(11): p. 1425-1429.).
[5] Bragg, H. 2003. Child Protection in Families Experiencing Domestic Violence. U.S. Department of Health and Human Services Administration for Children and Families Administration on Children, Youth and Families Children's Bureau Office on Child Abuse and Neglect

DHS's Office of CYF receives over 15,000 referrals for possible child maltreatment each year, but there are many children at risk for whom no one is making a referral. In half of all child fatalities due to abuse or neglect in Allegheny County, no one had made a referral to child welfare services for safety concerns before the fatal incident[1]. Of these child fatalities, 82% were under age 3. To understand the families of newborns who are most in need of care and support, Allegheny County developed analytics that will allow our collaborative to focus its resources and support on these families (voluntarily), in accordance with their needs.

3. Our prevention approach has been focused on high-poverty communities and families and we need to do even more. But home removal rates are high in some areas where the income levels are well above poverty. We still need to **reach all parents and caregivers of newborns about where to turn for help and support**. Illustration 1 shows that the per capita rate of home removal is beyond any one area of the county.

**Illustration 1: Per capita home removals, by census area and municipality (birth-3 yrs)**



Allegheny County needs to build upon its network of Centers to reach more families, focusing especially on those with newborns and young children, and provide voluntary support and services, in line with their need (differentiated support). The Children's Cabinet and DHS have designed the new, voluntary *Hello Baby* program to do this through an approach that will reach thousands of families each year while devoting the most resources and support to the highest-need families—building upon the families' strengths, using the deep well of community care and support, and making them the priority for our resources.

### *1.2 Objectives*

Hello Baby is a voluntary program for families of newborns and young children in Allegheny County. It will use a family-centered, collaborative, and strength-based approach to improve family and child well-being and prevent foster care placement (home removal). We will attain these goals through a community collaborative that reaches, engages, and assists families with newborns in getting the support and services they need, when they need it, until the baby is 3.

Hello Baby has three tiered components, each completely voluntary:

*Hello Baby—Universal*: Shortly after the baby is born, all parents of newborns in Allegheny County will get a visit at the hospital from a nurse who will provide them with information about Hello Baby and its community-wide resources. These resources include: a family-friendly website with helpful content, connections to services, and concrete aid for parents of infants and toddlers; a "warm line" (telephone line) that will provide specialized parenting support to all families in Allegheny County; and a texting service (Nurture PA) that connects families with trained peers who can answer their questions. These services and a public information campaign will give all parents of newborns access to information and help while normalizing the idea of

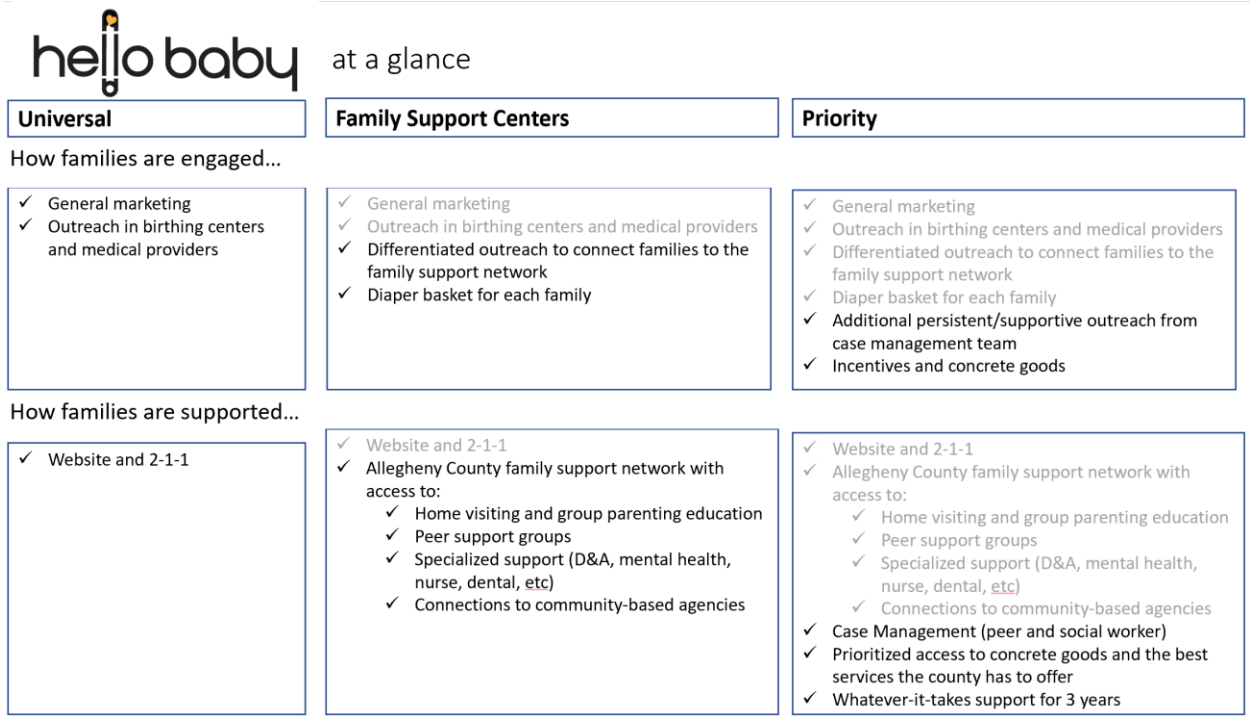
accepting help and introducing the concept of Hello Baby to families the program would like to engage later.

*Hello Baby—Family Support Center services.* For families who want additional, community-based resources and support, Hello Baby will provide community support through the 28 Family Support Centers. These community-run, family-led Centers, built across the City of Pittsburgh and Allegheny County over the past 25 years, have services and support that include home visiting, peer support, parenting education, social events (e.g., family dinners), and help in getting housing, child care and other vital services for children and family members, with some co-located with health care, recreation, and employment services. People will learn about these Centers when they are in the birthing hospital and know that they can contact them at any time, and every family also will get a postcard when they return home, reminding them of Hello Baby (and providing the chance to opt-out of further contact). The Centers' Community Outreach Workers also will reach out to families who are at moderate-high need of support to congratulate them, bring a gift to welcome the newborns, and invite them to be part of their nearest Center.

*Hello Baby—Priority*

A small group of families with the highest needs (five percent of all births) will receive priority care and service by an experienced peer-social worker team who work with the Centers. These teams will engage families, hear from them about their needs and hopes and develop a plan for leveraging their strengths, clear barriers to the services, concrete goods, and supports they want and need, and provide families with wraparound assistance for as long as the families wish (until their child turns three). For a snapshot of how this differentiated approach will work, please see Illustration 2.

**Illustration 2: Hello Baby at a glance**




The Actions and Strategies section (2.6) provides the details of how these components of Hello Baby will work, including information about the analytics that help us understand which families are most likely to need to be engaged in Center services and Priority services.

The Children's Cabinet includes Center mothers, fathers, grandparents and youth, direct service staff, and the other members of the community, and they have worked with DHS and other community members in designing Hello Baby. They provided this guidance, which is fully incorporated into Hello Baby's design:

- Strengths and needs for support can be very different, and they can fluctuate, so services must be able to respond as they change.
- Reframe the system's perspective: "Make it an alliance, not a hierarchy in which the provider is assumed to be more knowledgeable or in control than the family."

- Reduce the service burden on families (too many separate things delivered by too many people not talking with each other).
- Do not overpromise, be honest about what the services and systems can provide or do and what they can't.
- Hire and train staff with the skills, cultural competence, and comfort level to engage honestly and openly, building trust and meeting families where they are at.

The Cabinet and focus group interviews with family members, advocates, and providers also shaped how the program approaches families, the bounds of the information that the program will share within the collaborative, and the qualities of the people Hello Baby will hire. (See Section 2 for a description of these and other elements of the program and for a description of the target population.)

The Hello Baby program's measurable objectives are to:

A. Plan and implement a universal strategy that increases understanding of community resources and critical information for most parents of newborns in the county: 5,950 families/year. (This estimate is based on a pilot program that has succeeded in engaging 80% of parents and applying this rate to the 7,436 families of newborns at the primary birthing hospital in the county.)
B. Plan and implement a Family Support Center strategy to expand access to services and support for children and families with moderate-high needs. (2,500 families)
C. Plan and implement a strategy to improve child well-being and reduce foster care through priority care and intensive services and supports for families with the highest needs. (350 families)

D. Measure the impact of the most intensive strategy, including an RCT study of its impact on the highest-need families, against the goals of reducing foster care and improving wellbeing (as indicated in the outcomes evaluation plan).

E. Through a process evaluation, document the acceptance of families who receive the services (all three tiers); and document that the program has developed procedures and policies that foster continued program improvements and quality.

F. Integrate this program within the community collaborative's prevention and other services.

G. Disseminate the results of this program.

### *1.3 Outcomes*

The program's outcomes are listed below. The evaluation section and logic model (Section 3) provide more detailed information on how each will be measured.

*Universal service outcomes*

- 5,950 parents/year participate in this strategy, including texting service, website, and warmline
- At least 80% of warmline participants will say that their knowledge and sense of efficacy increased.

*Family Support service outcomes*

- Fewer maltreatment investigations than comparison areas (results similar to those found by the Chapin Hall study)
- Higher rate of engagement for families

*Priority family outcomes*

- Reduction in home removals (to foster care), compared with a control group (RCT)

- Reduced number of emergency room visits and hospitalizations, compared with control group (RCT)
- Increase in indicators of well-being, using validated indices:
  - Families will report lower levels of caregiving stress
  - Positive caregiver-child relationship
  - Parents feel more confidence and control in parenting role (self-efficacy)
  - Home physical environment will be safe for the child

This program has implications beyond Allegheny County because it offers the possibility for other communities to:

- Use the combination of a differentiated approach to make a marked impact on child and family well-being, including preventing the need for home removal.
- Applying a technological innovation (analytics) to make sure families who are likely to need and want help the most have priority care and support.
- Demonstrate how an existing community collaborative can amplify a community's positive impact on children and families.

# 2. APPROACH

## *2.1 Geographic area and target population*

The geographic area for the Hello Baby program is Allegheny County, PA. The county includes 130 municipalities, with the largest, the City of Pittsburgh, composed of 90 distinct neighborhoods. The demographic profile of the individuals and families differs significantly across the county, with variation in median income, age, and household size, depending upon the town and neighborhood. The demographic profile and key indicators for Allegheny County and the City of Pittsburgh are provided below.

**Table 2: Demographic profile of target area, Allegheny County, including Pittsburgh**

| | *Allegheny County* | | | | | *City of Pittsburgh* | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Population | 1,223,048 | | | | | 302,407 | | | | |
| Median income | $54,357 | | | | | $42,450 | | | | |
| Median per capita income | $33,830 | | | | | $29,196 | | | | |
| Race and ethnicity | White | Black | Asian | 2 or more races | Hispanic or Latino | White | Black | Asian | 2 or more races | Hispanic or Latino |
| | 80.3% | 13.4% | 4% | 2.2% | 2.1% | 66.3% | 24.3% | 5.5% | 3.2% | 2.8% |
| Poverty: All households | 11.7% | | | | | 19.2% | | | | |
| Poverty: Households with children | 15% | | | | | 22% | | | | |

**Table 3. Child welfare indicators for Allegheny County**

| | 2015 | 2016 | 2017 |
|---|---|---|---|
| Child welfare (abuse and neglect) | | | |
| Children referred | 13,081 | 14,409 | 15,666 |
| Children with substantiated/valid findings | 3,229 | 3,989 | 6,258 |
| Children placed out of home | 1,137 | 1,143 | 1,281 |

Sources: Allegheny County Referral File from KIDS System

The Hello Baby program's target population is:

- All babies delivered in the county, and their parents/caregivers.
- Within those families, the subset of families with moderate-very high need for services and supports. DHS will use analytics to identify families who have significant social service needs and provide them with differentiated support, if they wish to participate.

**About the analytics/model**

Auckland University of Technology (AUT) developed and validated a new model for DHS to use to differentiate the level of support for families. The analytics involved calculate, at a

child's birth, the possibility of her home removal by age three. (The predictive power of this model is strong, with an 85% chance of predicting a child's home removal by age three.) If her parents are willing to receive community services and support, there are perhaps no more deserving families in Allegheny County than those who are at highest risk, and Hello Baby will leverage the community collaborative to make these families our priority. For those at moderate-high risk, Hello Baby will provide augmented Family Support Center services, and for everyone, it will provide universal services.

This model is the second predictive model AUT has developed and validated for DHS. The first was the Allegheny Family Screening Tool (AFST). The implementation of the AFST has increased the identification of children in need of further child welfare intervention and led to reductions in disparities of case opening rates between black and white children[6].

To develop the new tool and how Hello Baby would leverage community collaborative services across a number of systems, we conducted community focus groups, ethical reviews, and interviews and reviews with:

- Children's Cabinet membership (Section 2.2 lists membership and systems included)
- Mothers, grandparents, and fathers (specifically recruited to ensure fuller representation)
- Families with child welfare involvement; Families with Family Support Center involvement
- Allegheny County Health Department, including Director and Program Manager of the Division of Maternal and Child Health
- Pediatricians, developmental psychiatrists, academic social workers
- Service providers/direct line staff and supervisors

[6] https://www.alleghenycountyanalytics.us/wp-content/uploads/2019/05/FAQs-from-16-ACDHS-26_PredictiveRisk_Package_050119_FINAL-8.pdf

- DHS leaders in child welfare, community services, behavioral health, communications
- Youth and family advocates
- Local funding agencies and foundations
- Civil liberties, civil rights, and social justice organizations, including the Pittsburgh Chapter of NAACP, ACLU, and Urban League of Greater Pittsburgh.

## *2.2 Collaboration*

### *2.2.1 Established collaborative*

The Children's Cabinet is the existing community-based collaborative, responsible for providing guidance, coordination, and an important point of accountability for all of the systems that work on behalf of children and families.

The Children's Cabinet began 25 years ago, as a way of bringing family advocates together with agencies and leaders of the systems that impact children and families most: child welfare, early care and education, family support, court and legal, housing, public benefits, and agencies. It has developed into an active body of parents, grandparents, youth advocates, agency and government leaders who are focused on the mission of improving the well-being of children and families by advocating for a community-based approach to family support and prevention; identifying the need for systems-level changes; and working to effect these changes, including through improved coordination across the county.

Over the past two decades, the Cabinet has supported families through its leadership, advocacy, and coordination on:

- The county's plans for family services, which serves thousands of families through prevention, child welfare, and juvenile justice programs.

- The Human Services Block Grant plan, which funds programs serving over 50,000 people in Allegheny County each year through mental health, substance use treatment, homelessness prevention, programs for immigrants and refugees, programs for formerly incarcerated individuals and their families, and programs for people with intellectual disabilities.
- The Systems of Care program, which has integrated early intervention and mental health services for children within community locations.

The Children's Cabinet is composed of:

| *Member* | *Agency* |
|---|---|
| Family members | Includes: mothers, fathers, grandparents |
| Child, Youth, Family advocates | - Allegheny Family Network (AFN)<br>- Allies for Children<br>- Center for Family Excellence<br>- KidsVoice (Child advocates)<br>- Youth Support Partners (YSPs) |
| Family Services and Community development | - A Child's Place<br>- A Second Chance<br>- FamilyLinks<br>- Gwen's Girls<br>- Pittsburgh Project<br>- Pressley Ridge<br>- Three Rivers Youth<br>- Wesley Family Services<br>- Family Support Centers (28 Centers) |
| Health | - Allegheny Health Choices Inc.<br>- Allegheny County Health Department<br>- Community Care Behavioral Health (CCBH)<br>- UPMC |
| Legal/Courts | - Family Division, Court of Common Pleas<br>- HSAO<br>- Juvenile Probation<br>- Shuman Center |
| Government | - Allegheny County DHS<br>- Allegheny County Health Department<br>- City of Pittsburgh, City Council<br>- CYF Advisory Board |
| Foundations and funding | - Eden Hall Foundation<br>- Forbes Funds<br>- Grable Foundation<br>- Pittsburgh Foundation |

| | |
|---|---|
| | - United Way |
| Academic | - University of Pittsburgh Office of Child Development; and School of Social Work |

Our community collaborative draws upon the ideas and resources of a network of organizations and volunteers who focus on strengthening families and communities; this is represented in the membership of the Cabinet and in DHS's contracts for family services. Taken together, the Cabinet and DHS coordinate most family services in Allegheny County.

### *2.2.2 Required partner organizations*

The required partners are part of the Children's Cabinet and have signed a joint Memorandum of Agreement (MOA) that outlines their commitments to Hello Baby. The table below summarizes their roles and responsibilities. Please see the MOA for more information about the services they provide to the families.

| *Partner* | *Organization* | *Role/Responsibility* |
|---|---|---|
| Child welfare<br><br>CBCAP grantee | Allegheny County DHS | - Joint accountability and shared outcomes<br>- Sharing administrative data<br>- Routine consultations and interactions with other agencies<br>- Financial commitment: matching funds** |
| Parents, youth with lived experience | Youth Support Partners | - Cross training<br>- Routine consultations and interactions with other agencies |
| Legal | KidsVoice | - Routine consultations and interactions with other agencies<br>- Joint accountability and shared outcomes<br>- Cross training; staff development |
| Judicial | Family Division, Court of Common Pleas | - Routine consultations and interactions with other agencies<br>- Joint accountability and shared outcomes<br>- Sharing administrative data |
| Public health | Allegheny County Health Department | - Routine consultations and interactions with other agencies |

| | | |
|---|---|---|
| | | - Joint accountability and shared outcomes<br>- Sharing data for use in analytics |
| Public housing | Housing Authority of City of Pittsburgh | - Routine consultations and interactions with other agencies<br>- Sharing administrative data |
| Family assistance | Family Support Centers | - Co-location of supports<br>- Routine consultations and interactions with other agencies<br>- Joint accountability and shared outcomes<br>- Cross training and staff development<br>- Sharing administrative data |

**Allegheny County DHS's financial commitments are detailed in the budget justification and letter of commitment by DHS Director Marc Cherna.

### *2.3 Management structure*

Governance structure: The Director of DHS co-chairs the Children's Cabinet with one of the family-serving agencies. The co-chairs' responsibility is to ensure the membership includes active representation from the key systems; to set the agendas; to facilitate open discussions and deliberations; and to frame recommendations to systems leaders, and request progress reports. The entire Cabinet meets quarterly, and work groups staffed by DHS meet more regularly to tackle issues and review outcomes for report-outs to members of the broader Cabinet.

Process for engaging partners: To reach and engage all of the people who can improve this county's support and resources for families:

- The Cabinet membership is extensive. It includes the required partners as well as other traditional family-serving agencies, many parents and youth with lived experience, and partners that might be considered non-traditional (foundations, juvenile probation, health insurers, elected officials, judges, academics and researchers).

- The Cabinet, with DHS staff support, contacts additional partners needed to enhance family well-being. For example, the Cabinet recently added members who are leaders and providers of quality child care, to enhance collaboration with the Early Learning Resource Centers.
- DHS contracts with over 200 community-based organizations to provide support, concrete goods, resources, and evidence-based services for children and families. DHS plans the co-location of these resources, the types of services, and their expected results with the Cabinet and through an extensive client engagement process. This client engagement team conducts focus group meetings, surveys on satisfaction, strengths and needs, and human centered design processes with family members. DHS uses this information to design and improve its systems of care and support; and the programs and services within those systems.

Management: DHS manages most of the publicly-funded services and supports for children and families in Allegheny County and therefore has the infrastructure to manage large-scale programs and staff the work of the community collaborative. Importantly, the fact that so many systems fit within one Department of Human Services means it can integrate services, placing families at the center. To coordinate the partners, subcontractors, technical assistance providers, and evaluators for Hello Baby, DHS and the Cabinet will use this existing structure:

- Overall management of Hello Baby: Amy Malen, who leads DHS's Bureau of Family and Community Services and is the project's Principal Investigator (PI), is responsible for the overall management of Hello Baby.
- System coordination: The project director is responsible for ensuring the many systems that impact families in the program are working together. The project director will do this through regular, multi-system case reviews of specific participants' progress and barriers, to identify

ways of improving coordination; developing action plans with the partners in those systems; and reporting on results to the PI and the Cabinet.

- Since DHS is responsible for a number of systems of care, coordination is enhanced. These systems include: Behavioral Health (mental health; drug and alcohol; and early intervention); Child Protective Services; Prevention services, including child care subsidies and improving the quality of child care provision; Aging services; services for people with Intellectual Disabilities; and Housing and Homeless services.
- Provider coordination: DHS contracts with hundreds of providers and will, for Hello Baby, need to tap the services already in place, as well as purchase additional supports. To manage coordination at the provider level, DHS's Office of Integrated Programs (IPS) convenes regular provider meetings, and the Hello Baby staff will use these meetings to communicate the purpose of the program and build communications among them. To further enhance coordination, DHS has built a robust Data Warehouse that includes information that feeds an application called ClientView. Providers can use ClientView to share assessments and plans, and to view service histories and key contacts in other agencies. ClientView will be a tool available to providers of Hello Baby services and supports.
- Planning and program design for prevention programs: DHS's Office of Community Services (OCS), led by Abigail Horn, and, within OCS, the Bureau of Family and Community Services, led by Amy Malen, are responsible for leading the community collaborative in developing a comprehensive plan. (It was through this planning process that they developed Hello Baby.)

- Recommending common outcomes: OCS staff is responsible for recommending goals, objectives, and outcomes for Hello Baby. The Cabinet is responsible for approving these outcomes and for routine review of results (accountability across systems).
- Policy and procedures: Apart from the state and federal policies that would govern prevention and other services available through Hello Baby, OCS's staff are responsible for preparing those policies and reviewing with DHS leadership and the Cabinet. Hello Baby's procedures will be documented in a program manual, which is the Project Director's responsibility to prepare and review with participating agencies and the Cabinet.

Monitoring implementation: DHS will monitor the program and report to the Cabinet on progress against timeline and deliverables (Section 2.8), providing monitors who will use DHS's Integrated Monitoring Tool and applying existing standards of practice in monitoring, as they do for hundreds of provider agencies and large-scale programs like Hello Baby. The Program Director will report to the Cabinet on the results of monitoring and, with agencies, will implement continuous quality improvement processes.

Continuing project in event of leadership change: DHS will staff the program so that several leaders understand the program's operations and have the relationships with the members of the collaborative. For example, if the Project Director should transition to another position, the PI and the other staff on her team, such as the project director of the ELRC, would understand the role and continue to implement it while the PI found a good person to fill that opening.

### *2.2.4 Organizational readiness and capacity*

In addition to the many systems for which it contracts for services, DHS consults with community members, faith-based organizations, and providers through advisory councils. For example, its Housing Advisory Board focuses on housing services and preventing homelessness;

The Jail Collaborative works with the Jail, Courts, and Health Department to improve reintegration for people returning to the community from the jail and maintain parent-child relationships; and the Immigrants and Internationals Advisory Council works with dozens of provider agencies and community members to improve the cultural competence of staff and providers and planning this system of care.

Because DHS is the primary funder of human services in the county (40% of all human services funding derives from DHS), it recognizes its responsibility in building the level of expertise, cultural competence, and collaboration across this network. It does this through:

- Co-location of services and supports. The community collaborative and DHS have made co-location and remote access a priority because of the difficulty families have faced in getting to places, given the cost of transportation and poor bus coverage in the county. The Family Support Centers now have multiple services on site, but the families, providers, and DHS are working to enrich these Centers to be hubs. Adding the child care subsidy and human service navigation of the ELRCs is an example of how we plan and then integrate services families request. Hello Baby's Community Outreach Workers will further augment these services—and bring more families to the Centers.
- Training. DHS has established a training unit within its IPS office that trains staff and providers in trauma-informed care, assessment and case planning, conferencing and teaming, and motivational interviewing; and with its Equity and Inclusion team, DHS contracts for expert training for caseworkers and other staff in recognizing and reducing bias and provides training and case consultation for staff through its SOGIE projects.
    - Hello Baby will add to this cross-training and staff development by partnering with the Camden Coalition for training and overall consultation in: RELATE, a relational

coaching model that promotes adaptability, flexibility, and positive team dynamics in staff engaged in care; and COACH, a case management model.

- Communication and information sharing. DHS's Office of Community Relations (OCR) communicates with the network of providers and across systems through its publications, email announcements, community events, and marketing campaigns. OCR will support the Project Director and PI in their communications about Hello Baby's communications with the broader community and among providers; and they will manage the contract with Blender Advertising, which will conduct the public campaign for Hello Baby.

### *2.4 Considerations in designing the approach*

Allegheny County DHS came to its approach for Hello Baby after extensive discussions with community members, case reviews with focus groups of family members and staff, reviews of the literature, and visits with/calls to programs in other states to learn about programs that had achieved the outcomes we are seeking. We were particularly interested in providing the right mix of services, and family engagement. This section summarizes the information we learned, which shaped our approach. (Approach is described in Section 2.)

*Engagement*

- There is some evidence that "high-risk families" may be more likely to engage in a universal intervention.[7] Some findings indicate that group-based maltreatment prevention efforts are more effective when participants are of mixed socioeconomic status, in comparison with selective high-risk groups (MacLeod & Nelson, 2000).

[7] Levey, E.J., Gelaye, B., Bain, P., Rondon, M.B., Borba, C.P., Henderson, D.C., & Williams, M.A. A systematic review of randomized controlled trials of interventions designed to decrease child abuse in high-risk families. *Child Abuse & Neglect*, 65, 48-57.

- Parents are more willing to engage if they find the program useful and if they think they are not being judged.[8]
- Extrinsic rewards (e.g., gift certificates, money, transportation, food) can increase engagement, especially in low-income families, and when receiving them is contingent on completing a certain number of sessions or the entire program.[9]
- Participants are twice as likely to accept services when assessed for program eligibility in person rather than by telephone.[10]Families tend to complete more home visits if their home visitor has a similar background or comes from the same culture.[11]
- Local leaders, program champions, and alignment with trusted community organizations bolsters participant trust and program acceptance.[12]

*Retention*

- Providers' level of experience and training, cultural competence and caseload have been associated with family engagement, as have program structure and rates of turnover.[13]

[8] Gross D., Julion, W., Fogg, L. (2001) What motivates participation and dropout among low-income urban families of color in a prevention intervention? *Family Relations,* 50:246–254.
[9] Ryan, R.M. & Deci, E.L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist,* 55:68–78.
[10] Duggan A, Windham A, McFarlane E, et al. Hawaii's Healthy Start Program of home visiting for at-risk families: evaluation of family identification, family engagement, and service delivery. *Pediatrics.* 2000; 105:250–259
[11] McCurdy, Gannon, and Daro, "Participation Patterns"; Brookes, Summers, Kornburg, et al., "Building Successful Home Visitor-Mother Relationships"; K. McCurdy and D. Daro, "Parent Involvement in Family Support Programs: An Integrated Theory." Family Relations 50, no. 2 (2001)
[12] Daro, McCurdy, and Nelson, Engaging and Retaining Participants; Welsh, Sullivan, and Olds, "When Early Crime Prevention Goes to Scale.
[13] Smith, B. D. & Donovan, S. E. F. (2003). Child welfare practice in institutional and organizational context. *Social Service Review,* 77(4), 541-563; K.L., Alvarado, R., Smith, P., & Bellamy, N. (2002). Cultural sensitivity in universal family-based prevention interventions. *Prevention Science,* 3:241–244.

- Flexibility in program delivery to adapt to the needs and aspirations of parents, and their abilities to participate has shown promise as a way of improving participant retention and completed home visits.[14]
- Families may be guarded with their service provider because they perceive an imbalance of power in the relationship and believe that direct service staff may influence key child welfare processes and outcomes.[15]
- Cultural sensitivity. Culturally-tailored prevention models have shown promising engagement and retention rates.[16]
- Community-level support and resources, when leveraged to promote community acceptance of home visiting, have promoted retention and engagement in home visiting programs.[17]

*Attrition*

- Early participation and attendance do not necessarily predict completion because families may not stay in the program long enough to receive the full number of planned visits. [18]

[14] Ingoldsby, E. M., Baca, P., McClatchey, M. W., Luckey, D. W., Ramsey, M. O., Loch, J. M., Lewis, J., Blackaby, T. S., Petrini, M. B., Smith, B. J., McHale, M., Perhacs, M., … Olds, D. L. (2013). Quasi-experimental pilot study of intervention to increase participant retention and completed home visits in the nurse-family partnership. *Prevention science: the official journal of the Society for Prevention Research*, *14*(6), 525-34.

[15] Mandell, D. (2008). Power, care and vulnerability: Considering use of self in child welfare work. Journal of Social Work Practice, 22(2), 235-248.

[16] Dillman Carpentier, F.R., Mauricio, A.M., Gonzales, N.A., Millsap, R.E., Meza, C.M., Dumka, L.E., German, M., & Genalo, M.T. (2007). Engaging Mexican origin families in a school-based preventive intervention. Journal of primary prevention, 28(6): 521-546

[17] Folger, A. T., Brentley, A. L., Goyal, N. K., Hall, E. S., Sa, T., Peugh, J. L., Teeters, A. R., Van Ginkel, J. B., … Ammerman, R. T. (2016). Evaluation of a Community-Based Approach to Strengthen Retention in Early Childhood Home Visiting. *Prevention science: The official journal of the Society for Prevention Research*, *17*(1), 52-61.

[18] Mauricio, A.M., Mazza, G.L., Berkel, C., Tein, J.Y., Sandler, I.N., Wolchik, S.A., & Winslow, E. (2017). Attendance trajectory classes among divorced and separated mothers and fathers in the new beginnings program. *Prevention Science*, 1-10.

Harding et al (2004)[19] reported a 50% dropout rate within 12 months for enrolled Healthy Families America participants. An evaluation of the Nurse Family Partnership model found that families received only half of the full number of expected visits.[20]

- Families who have dropped out of services frequently cite problems such as time demands and scheduling conflicts, need for child care, transportation and other barriers.[21] Parents who are struggling to meet basic needs have limited time and energy, and barriers to accessing services on their own.[22]
- Aarons et al (2014) documented comparatively low rates of attrition when community-level resources were leveraged to support family participation in a home visiting intervention than when the home visiting model was implemented alone.[23]

The literature review, with the information gained through local focus group discussions and community meetings, provided direction to Allegheny County DHS and its partners in designing a Hello Baby program that could engage and retain families in support and services they drive and that will help their children to thrive.

### *2.5 Theory of change*

Point 1. Prevention efforts aimed at reducing home removals/entry into foster care historically have targeted families living in high poverty. This is based on the incorrect assumption

[19] Harding, K., Reid, R., Oshana, D., Holton, J., & Representatives of the Healthy Families America Research Council. (2004). *Initial results of the HFA implementation study: A report submitted to the David and Lucille Packard Foundation*. Chicago, IL: Prevent Child Abuse America.
[20] Korfmacher, J., Kitzman, H., & Olds, D. L. (1998). Intervention processes as predictors of outcomes in a preventive home visitation program. *Journal of Clinical Child & Adolescent Psychology*, 26(1), 49-64.
[21] Garvey, C., Julion,W., Fogg, L., Kratovil, A., & Gross, D. (2006). Measuring participation in a prevention trial with parents of young children. *Research in Nursing and Health*, 29:212–222
[22] G. Allen Foundation. Unpublished manuscript. Marcenko, M. O., Newby, M., Lee, J., Courtney, M., & Brennan, K. (2009). Evaluation of Washington's solution based casework practice model: Baseline parent survey. Seattle, WA: Partners for Our Children, University of Washington, School of Social Work.
[23] Aarons, G.A., Fettes, D.L., Hurlburt, M.S., Palinkas, L.A., Gunderson, L., Willging, C.E., & Chaffin, M.J. (2014). Collaboration, negotiation, and coalescence for interagency-collaborative teams to scale-up evidence-based practice. *Journal of Clinical Child & Adolescent Psychology*, 43(6), 915-928.

that poverty is a driver for abuse when the propensity for child abuse is consistent across socioeconomic strata. (Neglect is correlated with poverty, and poverty exacerbates the reporting to child welfare agencies, but they are not causal nor always occur in tandem.)

Point 2. The drivers of maltreatment include untreated depression or mental illness, substance use disorder, intimate partner violence, and criminal justice involvement, which place children at greater risk. Families with these issues have complex, multi-system needs for service as well as for improved positive social connections and support, as they are often isolated, and chaos can overwhelm their lives.

Point 3. The children at highest risk of home removal are infants and babies (82% of children who suffered fatalities were under age 3, in Allegheny County).

Point 4. Reaching families with babies, who are spread throughout a large geographic area, requires a differentiated approach: universal approach to reach all families with information and to establish a positive association with the name, Hello Baby; moderate intensity of community-based services for families with moderate-high needs; and intensive, longer-term community-based services for families with the highest needs. Using analytics that can identify families by level of estimated need can allow community collaboratives to deliver voluntary assistance in accordance with need. This is an effective, sustainable way of improving child and family well-being.

Point 5. It is best to place this assistance within a broader prevention framework because getting support after a baby is born should be a normal expectation for all families.

Point 6. Providing both a universal and community-based strategies will reach, engage, and strengthen families, decreasing the need for foster care placements and improving well-being.

## *2.6 Actions and strategies*

Hello Baby will improve the well-being of children and families and reduce children's entry into foster care by reaching and engaging with infants and young children, then building upon family strengths and natural supports and providing the services and concrete resources families want and need. Because needs differ, the program will use a differentiated approach, informed by analytics that help identify families who deserve the greatest investment of resources. The community collaborative will then provide the widest reaching (and lowest-cost) strategy for all families of newborns, then increasing levels of community-based resources to families at moderate to higher needs.

### *2.6.2 Services based on needs, strengths*

To better understand which families, from among the thousands of families with newborns, need the most intensive support and greatest share of resources, Hello Baby will use the analytic tool described in Section 2.1. Shortly after birth, Hello Baby will use this tool to identify families with moderate-high levels of need, filter out those families who have opted out of being contacted by Hello Baby (every family will receive a post card giving them this option) and then begin to reach and engage them and provide services.

With the support of ACF's cooperative agreement, DHS will conduct a randomized control trial of Hello Baby's services for priority families in a specific geographic area that we will identify after selecting the provider of the community-based teams. After the analytics indicates families' levels of need, the program will randomly assign[24] high-need families to the

[24] The project does not have sufficient resources at this point to be able to serve all of the families, so the random assignment is a fairer way of determining who is selected; and it provides the opportunity for a stronger evaluation design.

treatment group, to receive additional resources (240 children and their families in the study group); or to the control group (110 children and their families). The control group will be able to access any of the community collaborative services but will not receive the more intensive services and support. The evaluation describes this RCT in detail.

*2.6.2 Detailed description of actions and strategies*

1. Hello Baby: Universal. Because most families with newborn babies need information and a place to turn for questions and help, Hello Baby will provide a set of services for most families of newborns, reaching them through the county's main birthing center and through a public campaign, under the Hello Baby banner. Through hospital-based nurses located at Magee Womens Hospital, the program will inform parents of newborns about free home visiting, local family support, the warm line, and texting help from friendly, trained peers who will answer their questions before and after they return home with their baby.

*How it will work for families: universal*

Hello Baby begins at the hospital with a "light touch" for every mom who has given birth, as well as other family members. This universal service has three aims:

- Send a message to all parents: "This community cares about you and your baby, and nothing is as important as us supporting you."
- Provide all parents with information about community resources and a low-cost way of getting help from peers.
- Provide parents the chance to hear about Hello Baby in the hospital from a nurse—so they make a positive association with the program at this first stage, increasing the chance they will agree to more extensive services when they are contacted later.

*Engagement and services: universal*

Every mother of a newborn who delivers at Magee Women's Hospital will receive a visit from a nurse who will introduce families to Hello Baby. The nurse will visit all of the moms and their family members who are present (in their rooms)—congratulating them and explaining there is a new program for all families with newborns, called Hello Baby. The nurse then will 1) provide information about resources in their own community for babies and families; 2) explain that the Hello Baby warmline is there for them, 24/7 for any calls or questions from parents of infants and babies, as is the Hello Baby website; and 3) explain that Hello Baby has a texting service, staffed by volunteers who answer questions (starting after delivery and continuing when the family returns home with their baby), and will give the family the chance to sign up by providing their cell number. The texting service is organized by Nurture Pa, a community-based agency that will recruit and train culturally and linguistically-diverse volunteers, and volunteers from across the socio-economic spectrum. DHS will contract for this service. We expect to be able to meet with parents of 80% of the babies born annually at Magee Womens Hospital; and that at least 10% will sign up for the texting service and use texting, the warmline, and website while in the hospital or later, after they return home and review the Hello Baby brochure and receive a postcard from Hello Baby.

*Resources: universal*

Grant resources, combined with DHS funding, will support:

- The Hello Baby Program Director, who is responsible for leading all aspects of the program to achieve its intended outcomes. For the universal strategy, the director will work with the hospitals and the University of Pittsburgh (which will hire the nurses through a foundation grant they have secured) to arrange the nurses' integration into the hospital teams so that they are supporting, not impinging on the hospital's procedures. The director also will arrange

specialized training for the nurses so they can have a deep understanding of community collaborative resources, including Family Support Centers, home visiting, behavioral health. The director also will oversee the development of quality marketing and materials, respond to inquiries about the program, coordinate dissemination, and ensure communications among all of the partners in the project.

- The texting service contract. DHS will augment its current pilot project with Nurture PA, a community-based organization that recruits, screens, and trains volunteers to do the texting with family members. Since volunteers' incomes might preclude them from having a cell phone, the contract will cover the cost of cell phones and service for some of the volunteers (based on need).
- The Hello Baby website; and Warmline contracts. DHS has contracted with a company to develop a website that is easily accessible, positive, and appealing and useful to families who have questions about where to find resources important to families with babies. DHS is now reviewing proposals from organizations who wish to develop and implement the Warmline for parents of newborns and babies. (In both cases, DHS used a competitive bidding process.)
- Marketing contract. DHS will contract with a marketing firm, Blender, to craft the message for Hello Baby and design the platforms and materials so that we are reinforcing a consistent message through our work at the hospital and through other services. Blender developed an effective public campaign for home visiting that helped increase the number of calls for DHS and Health Department home visiting services.

2. Hello Baby: Family Support Centers. For families who need additional services and support (analytics show that 25% of newborns are in families with levels of need that are moderate-high; Hello Baby will reach them through the existing network of Centers).

*About the Centers*

Each Center provides a place for families to come together to meet other parents and caregivers and children, and where they can get the programs, services, and support they want. The Centers, which are family-driven, are in sites as varied as schools, apartment buildings and health centers, but they share the common aim of helping children and families to thrive. Their staff (primarily parents from the community) and volunteers (also from the community) create a welcoming place for children and families to spend time with others, but also provide home visiting and provide or connect families with health, educational, and human services. These services include: evidence-based home visiting, parenting education and coaching, fatherhood programs, job search assistance, housing navigation, ESL and translation services, enrollment in public benefits, health care for children and adults, legal assistance, including in cases of intimate partner violence, and behavioral health assessment and services. Some Centers are co-located with respite services, pediatric care, and training programs. An evaluation has shown that areas with Family Support Centers had fewer maltreatment investigations, after adjusting for population and social disadvantage.[25]

The rich array of services at the Centers soon will include child care subsidies and assistance in finding quality child care. In July 2019, Allegheny County will be opening the Early Learning Resource Center (ELRC) at six of the Family Support Center locations and at a downtown site. The ELRC will provide child care subsidies, human services navigation services, and early intervention screenings, making Centers even more like one-stop-shops for family services in their communities.

[25] Evaluation of the Family Support Network: https://fcda.chapinhall.org/publication/do-family-support-centers-reduce-maltreatment-investigations-evidence-from-allegheny-county/; and https://www.alleghenycountyanalytics.us/index.php/2016/11/09/evaluation-family-support-center-network/

*How it will work for families: Center*

Hello Baby will add Community Outreach Workers (experienced, trained peers) to the Centers, with the role of engaging families with newborns who are likely to be at moderate-high need (based on analytics) and connect them with the rich support and services at their neighborhood Centers and other services of the community collaborative. Families will learn about these Centers when they are in the birthing hospital and know that they can contact them at any time, and every family also will get a postcard when they return home, reminding them of Hello Baby (and providing the chance to opt-out of further contact).

*Engagement: Centers*

The Centers will recruit and hire Community Outreach Workers who are peers with the qualities that families and research have shown are important (accepting and understanding; meeting them in person, but not unexpectedly dropping by; culturally competent and similar culture). The Camden Coalition will train our Community Outreach Workers in their successful approach to engagement and support. These outreach staff will call and meet with families, congratulating them, bringing a gift to welcome the newborn, and inviting them to be part of their nearest Center.

*Resources: Centers*

Grant resources, combined with DHS funding, will support:

- The Hello Baby Program Director, who is responsible for leading all aspects of the program to achieve its intended outcomes. For the Center strategy, the director will work with the Centers to assist with recruitment; provide specialized training in Hello Baby; and coordinate training by the Camden Coalition. The director also will include the Center directors and staff in sharing information and ideas with the community collaborative.

- Contract with Family Support Center agencies to hire the new Community Outreach Workers.

3. Hello Baby: Priority. Families with the highest level of need will have received the universal service in the hospital. When they return home, Hello Baby will reach out to them to provide consistent, respectful wraparound care and support for as long as families wish (or up to the time their newborn turns three years of age). Priority families will be able to receive expedited care and enrollment in services, including child care, housing assistance, job search assistance, and treatment—whatever the family needs.

For these families, the program will select a provider to hire and deploy teams of Family Engagement Specialists (peers) and Navigators (social workers) who are skilled in reaching, engaging, supporting and connecting families. The peer-social worker teams will use a strengths-based approach, know how to build upon family strengths, including involving and leveraging natural supports, and have the experience and skill to tap and advocate for resources. They will work with their supervisor, who will be a clinician, to expedite services from the community collaborative, including within DHS, so families are getting the services they need and want. (Please see Section 4.3 for job positions and roles.)

Each team will have a geographic base, working with families across a set of Centers. The supervisor will bring service providers together through weekly "rounds" to be sure that priority families are getting what they want and need; and to identify systems-level issues that they will bring to the Children's Cabinet to address.

*Engagement: Priority*

The peer-navigator teams will be creative and persistent in how they reach families, including through home visits, telephone calls and hand-written notes with gift cards and small

incentives, and by leveraging families' existing relationships with community partners and providers. We know that engagement will be challenging; while national estimates of enrollment rates in home visiting programs range between 46% and 97%, we expect enrollment rates in this program to be much lower given the high and complex needs characterizing the families. In the first year we hope to learn about the number of families who enroll in the program and lessons on how to improve rates over time.

To help with engagement, the teams will check with an existing data system called ClientView to gain context on the family's service and systems history and, if the family has a good connection already (for example, with an Early Head Start program staff person or a faith-based provider), they will ask that person to introduce them to the family. For families without a good connection, the team will need to be resourceful. They may call the families or send them a nice card to welcome the baby. They will talk with the people they know in the nearby community (church or other faith-based, Boys and Girls Club staff, Food Bank staff), to explain that they are going to visit families with newborns and they are trying to see if anyone could introduce them to a couple of people in the community. They will accompany the nearest home visitor to bring welcome baskets to families in the area with a new baby. They will not, however, drop in on families without such a community connection or without invitation. Both the literature and focus groups advise against just dropping in on families ("anytime someone is knocking on the door, I think it's CYF" [26]"call me first, don't show up at my door. Because of where I live, it scares my kids when the door buzzes. I don't want to answer if I'm not expecting anyone.[27])

[26] Family support staff worker, during focus group (June 2018)
[27] Family member, during focus group (June 2018)

When the team meets parents or caregivers, they will introduce themselves and explain that they are part of Hello Baby program, and that the family might remember that they met her friend, who also works for Hello Baby, at Magee. What the team says during the first and second visits is critical, and DHS is continuing to work to shape those messages with the community collaborative and focus groups so that they:

- Show the family that their team understands, listen more than talk, is very supportive, and is willing to do something to help that day.
- Explain what the Hello Baby program can offer; and use an asset-based approach
- Explain why their family has been selected
- Ask families to sign up

If families choose not to enroll or want to think about it, the Family Engagement Specialist will stop by for another visit when in the area, making several more visits, if possible. If families ultimately decide against participating, they can always call later if they change their minds.

*Ongoing Support: Priority*

Once the family is engaged, the team will share responsibility for the ongoing case management and support of the family. This includes:

- Conducting a comprehensive needs assessment with the family
- Developing a goal plan with the family that has actionable steps

  NB: The assessment and plan may happen through conversations with family or by reviewing other program documentation, so families do not have to tell their stories multiple times. In most cases, it will be a combination of the two.
- Connecting families to the best services the county has to offer, based on their specific needs and requests. These can include: child care, housing, drug and alcohol treatment, mental

health treatment, early intervention services, parenting, respite care, immigrant and refugee services, services for individuals with court involvement, victims' services and support, and employment.

- Provide ongoing follow-up for families with a "whatever it takes" approach to support, navigation and advocacy for families--with providers and including basic needs

*Case management framework: Priority*

Hello Baby's case management framework is based on the COACH model, developed by the Camden Coalition, The Camden Coalition is a national exemplar in reaching and connecting with the most vulnerable populations and Allegheny County has visited and consulted with the Coalition, which also has agreed to providing continuing technical assistance. The Camden Coalition will train all of Hello Baby's staff as empowerment coaches, so that families are co-creating their plans, focused on their own long-term goals (vs. "receiving services" from a provider).

The team visits with enrolled families will build upon their strengths (including seeking ways of connecting with positive natural supports and community resources), help them work through crises, and connect them with specialized services. If the family already has a trusted care manager (for example, a home visitor), the team will check with them to be sure that care manager has the time to devote to the family, has done a good assessment of their needs, and can help the family with their goal plan. If not, the team support the care manager or, if the family prefers, assume primary responsibility for as long as the family is enrolled in Hello Baby.

For those families where there is not someone like a home visitor with a trusted relationship (and where the family agrees to enroll), the team will serve as their empowerment coaches. They will work with the family to build a strong network of natural and community

supports; identify family strengths and challenges to develop their plan and goals; and use motivational interviewing to help families identify and apply their intrinsic motivation to reach their goals. The team also will help with immediate needs that reduce stress, (transportation to the pediatrician, diapers, food, formula—the team will have resources for concrete goods) and call upon the community collaborative as needed (e.g., for eviction prevention, emergency housing, child care, and treatment). The team will have access to several novel programs DHS has developed for families, including Family Residential Treatment, which provides substance use treatment for at least one family member, in an apartment building where the whole family can live (up to 8 people); and recovery housing for families.

Each family's team will be the people they can turn to for help in a crisis or when they are facing stress. They also will screen for untreated depression (10% of all mothers reported experiencing symptoms and 20% of low-income mothers have been found to suffer from postpartum depression but only half of them received treatment[28]); be able to apply Mental Health First Aid; and follow safety and health protocols to respond to IPV and any concerns that they and/or the family may have about the safety and development of the baby or other children in the home.

*Expediting service: Priority*

The teams will work with their supervisors to:

- Ensure they are prioritizing families for all services in their plans (and as they arise)
- Confirm their rapid entry into services, such as child care
- Conduct weekly "rounds" to check with providers in the community collaborative (Cabinet/DHS services) about each of the families who are enrolled in the program, to check

[28] Minnesota Department of Health, "Minnesota and Perinatal Mood and Anxiety Disorders," accessed March 15, 2017, http://www.health.state. mn.us/divs/cfh/topic/pmad/mnfacts.cfm.

on status/progress, identify cases of miscommunication and gaps in care, and to coordinate service and avoid overwhelming the family. The expeditors will work across systems to streamline care and support; and will raise persistent systems-level issues to the Children's Cabinet for resolution.

*Retention: Priority*

Initial engagement is crucial, but the family's retention in the program is equally important because we need to be able to support families during their children's early years. Most of the families will have complex issues to resolve and crises that occur, and the Hello Baby program should be available to help them. To retain families, Hello Baby will, as the research on engagement and retention suggests, provide them with a service they value and staff who understand and are empathetic and who can get things done. That is why we have experienced peers and social workers as our primary staff, to complement the community collaborative and expedited DHS services.

*Resources: Priority*

The grant and DHS resources will be used to support:

- The Program Director (same person and role as described in the Universal description)
- Contract with provider for Family Engagement Specialist-Navigator teams, based in communities, each duo with a set of 40 families for whom they provide intensive support and connections to care, for up to three years (an expected average of two years); and additional families they attempt to engage but who ultimately chose not to participate. The calculation of staffing needs is included with the Budget. The program will begin with 1 field-based team in year 1 and increase to 6 field-based teams in years 2 and beyond.)

- 1 supervisor, who supervises all the community-based staff involved in the intensive/wraparound case management and helps them expedite services and conduct weekly rounds
- Resources for incentives for families with moderate and highest needs, such as gift cards; and for priority families, concrete goods.
- Evaluation contract

### *2.7 Collaborative planning process*

The Children's Cabinet team that has worked on this program design will continue to serve as part of the Hello Baby planning team. This team will complete the development of the full plan during the planning period, so we are ready to implement the program according to the timeline. The planning team is composed of the Children's Cabinet co-chairs, two family members and two family services providers who are members of the Cabinet, the Principal Investigator, Program Director, Chief Analytics Officer at DHS. Family members will be paid for their time participating in planning, including any time they devote to site visits.

During the planning phase, this collaborative planning team will:

- Visit at least three other jurisdictions, identified in collaboration with the designated evaluation TA provider, to learn about community-based programs that are focusing on similar needs for similar populations.
- Use what they learn from these visits (and from the designated evaluation TA provider) to refine the program's strategies for engaging and retaining the targeted families and for communicating with families and providers.

- Develop detailed job descriptions, and a set of qualifications and competencies of staff, including a profile of the qualities/capacity of prospective staff to be able to relate well with the men and women who participate in the targeted approach and with all families we serve.
- Develop a training plan for program staff to ensure that they know how to address the barriers to engagement that we have identified in the target population and neighborhoods; navigate human services for multi-system involved families; develop and maintain productive working relationships with DHS's contracted providers; and gain the trust of participants. The staff will undergo extensive training that includes direct instruction, role play, and mentoring to develop understanding in how to support families facing substance use disorders, intimate partner violence, and criminal justice involvement; mental health first aid and depression screening; community resources; motivational interviewing; and being part of the Hello Baby program team.
- Recruit and hire quality staff and begin training.
- Continue to develop the framework for team visits with families.
- Develop the program's strategy for ensuring the safety of all program participants and staff.
- Operationalize the principles of Motivational Interviewing, which has been shown to be an effective technique for facilitating engagement and positive change across domains29 and is consistent with the public health approach to harm reduction. Given what we know about our target families, and the reasons why they might not engage, every contact must be informed by messaging that reduces stigma and promotes trust.
- Finalize all partnership agreements and articulate clear process objectives for mobilizing and coordinating those resources in a continuum of prevention-focused services.

[29] See, e.g., Dunn C, Deroo L, Rivara FP. The use of brief interventions adapted from motivational interviewing across behavioral domains: a systematic review. Addiction 2001;96:1725–42)

- Prepare policies and procedures; and the program manual
- Establish continuous quality improvement processes that include the information gained through the process evaluation.

At the end of collaborative planning process, the program will submit revised implementation and evaluation plans and timelines for review and approval by the Children's Bureau. (Please see the Program Timeline and Milestones, below, for additional information on the planning phase.)

### *2.8 Implementation phase; and Timeline and Milestones*

| **Timeline and Milestones** | | | |
|---|---|---|---|
| PI=Principal Investigator | Family Specialist + Navigator = Team | | |
| Director=Project Director | | | |
| CAO=Chief Analytics Officer | | | |
| Supervisor=Supervisor of the Family Specialists and Social Workers | | | |
| *Planning* | *Lead* | *Month* | *Milestone* |
| Launch planning team with Children's Cabinet | PI | 1 | |
| Biweekly meetings with planning team | Director | ongoing | |
| Identify technical assistance needs and communicate to ACF | PI | 1-ongoing | |
| Finalize messaging/approach with planning team, which includes family members; and with community collaborative members | Director | 1-3 | |
| Hire Program Director | PI | 1 | |
| Contract with Hello Baby providers:<br>- Camden Coalition<br>- Provider to hire/supervise teams<br>- Family Support Centers for staff<br>- Nurture PA<br>- Blender Advertising | PI | 1 | |
| Issue RFP for evaluator | CAO | 1 | |
| Attend kick-off meeting in D.C. | PI | 1-3 | |
| Request/coordinate change in DHS system to allow priority services | CAO | 1-6 | |
| Identify and coordinate visit to 3 sites | Director | 1-3 | |
| Expand contract and set expectations with Nurture Pa for texting service | PI | 1-3 | |
| Develop staff training curriculum, including with Camden Coalition and providers | PI | 1-2 | Curriculum |
| Hire Supervisor | PI | 2 | |

| | | | |
|---|---|---|---|
| Recruit and hire teams, consulting with community collaborative | Supervisor | 1-4 | |
| Contract with evaluator | CAO | 1 | |
| Finalize evaluation plan | CAO | 2 | Eval. Plan |
| Finalize Data Use Agreements | CAO | 2 | DUAs signed |
| Initiate process evaluation | Evaluator | 2 | |
| Train new staff | Supervisors; Camden Coalition | 1-ongoing | |
| Train community providers (FSCs, home visiting staff, others) in program | Director | 1-ongoing | |
| Document processes for analytics | CAO | 1-2 | |
| Document processes for universal | Director | 1-2 | |
| Document processes for Center strategy; and Priority strategy | Director | 1-2 | |
| Prepare program manual | Director | 1-2 | |
| Initiate pilot in one geographic area | All staff | 4-ongoing | |
| Establish program quality improvement teams | Director | 2-3 | |
| Review plan with Children's Cabinet and amend | PI | 3 | |
| Submit final Plan to ACF | PI | 4-5 | Completed Plan |
| *Implementation* | *Lead* | *Month* | *Milestone* |
| Launch universal strategy | Director | 4 | First family contacted |
| Launch strategies based in Centers; and Priority | Director | 4 (pilot) | |
| Predictive Model run | CAO | 4-ongoing | |
| Random assignment | CAO | 4-ongoing | |
| Families contacted/visited | Family Support Centers | 4-ongoing | First family contacted |
| Teams contact/visit priority families | Teams | 4-ongoing | First family contacted |
| Priority services available | Teams | 4-ongoing | |
| Expedite services | Director | 4-ongoing | |
| "Rounds" with providers | Supervisor | 4-ongoing | |
| Hello Baby works with community collaborative | Teams | 4-ongoing | |
| Team meetings | Director | biweekly | |
| Staff supervision | Supervisor | biweekly | |
| Children's Cabinet meeting guidance and updates | Director | bi-monthly | |
| Continuing education for staff | Director, Supervisor, Camden Coalition | monthly | |

| | | | |
|---|---|---|---|
| Meet with state policy and budget offices (PA-DHS) to update on progress, results, and prepare for potential Family First funding of evidence-based elements | Director | 15-annually | |
| Initiate dissemination plan | Director | 24-continual | |
| Annual Report | Director | annual | |
| Initiate impact evaluation | Evaluator | 4 | |
| Process Evaluation Reports | Evaluator | annual | |
| Review spending vs. budget | Director | monthly | |
| Reports to ACF | PI | As required | |
| Review key indicators (numbers reached, engaged, served) | Director | weekly | |
| Review program results with planning team | PI | monthly | Monthly program reports |
| Outcomes report | CAO | Annual | Annual report |
| Final Evaluation: process and outcomes | Evaluator | Year 6, month 6 | Final Evaluation |

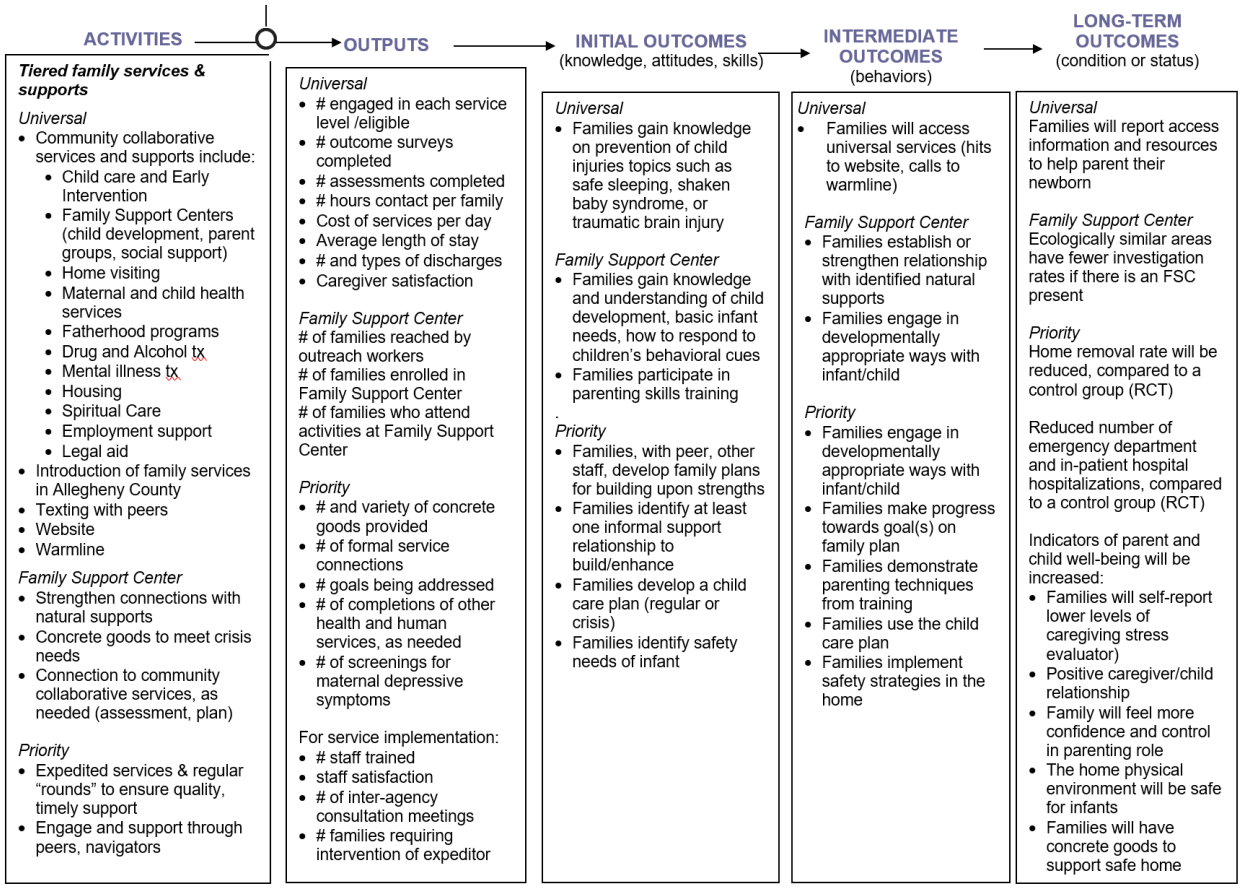
# 3. Evaluation Plan

## *3.1 Purpose of the evaluation*

The evaluation aims to demonstrate that this program reduces home removals and improves child and family well-being. DHS will select an independent evaluator to conduct a process evaluation and evaluate the program's outcomes on key measures, including through using a randomized controlled trial (RCT). The evaluator will have the support of an experienced research team at DHS, including its Chief Analytics Officer, Dr. Kathryn Collins and an analyst from her team who will assist with data extraction and use of the Data Warehouse information. The process evaluation will inform our ongoing quality improvement efforts and provide important information for the program manual we use during the program's implementation and can share with other communities who may wish to apply this approach to reducing child maltreatment. The logic model that follows shows how our activities and resources lead to outcomes in the near and longer terms.

## 3.2 *Logic model, Hello Baby program*

The Illustration below shows the program's logic, from activities to outcomes.




## 3.3 *Outcome evaluation*

The outcome evaluation will use the information from the RCT, surveys, and other sources to answer these key questions:

1. For the population in the targeted services treatment group, is there a reduction in the number of valid/indicated/substantiated events of maltreatment, compared to a control group of the same risk level?
    - Method: RCT
    - Data sources: Data Warehouse; birth record and hospitalization records

2. For the treatment group, is there a reduction in the number of emergency department and in-patient hospital hospitalizations as compared to a control group of the same risk level?
    - Method: RCT
    - Data sources: Data Warehouse; birth record and hospitalization records
3. For the families who received the universal service, do they feel that the service helped them acquire important information and improve their ability to parent a newborn? And was the texting service helpful?
    - Method: survey
    - Data sources: DHS's analytic team includes a Client Experience Unit. This unit designs surveys and leads focus group interviews. For this project, it will deliver text message surveys to these participants
4. Do caregivers report lower stress, improved parent-child relationships, and safe home environments?
    - Methods: Assessments and surveys
    - Data sources: team-administered Parenting Stress Index, HOME inventory
5. Are families engaged in services they need?
    - Method: review of DHS administrative records
    - Data sources: care management system that measures (1) number of families who refuse services, (2) the number who accept services and receive one visit from teams (i.e., enroll), and (3) team caseloads.

**About the RCT**

The outcomes evaluation will include a randomized controlled trial of the targeted service. The evaluation will randomly assign 240 babies and their families/year to the treatment

group (these families will have the chance to receive additional resources) and 110 babies and their families to the control group (whose will be able to access any of the community collaborative services but will not receive the targeted services and support). The evaluator may adjust these numbers, which are based on these calculations and assumptions:

1. Number of babies born at Magee whose families have high needs

**Table 5. Calculation of total high-need births at Magee-Womens Hospital**

| | | | |
|---|---|---|---|
| Births in Allegheny County in 2016 | | | 13,222 |
| | Births at Magee-Women's Hospital | | 6,300 (48% of total) |
| | | High-need Births | **350** births |

Source of information on total births and births at Magee: Division of Health Informatics, Pennsylvania Department of Health.

2. The point at which "treatment" starts. All analyses for the impact evaluation study will use a two-tailed "intent-to-treat" design that will included all randomly-assigned interviewed families without regard to intervention adherence. This means that, from the point of identifying a family as in the treatment group, they are counted in the sample.
3. Number in the treatment group. To achieve the required sample size of children who have been in the treatment group for 0-3 years, we need 240 families in the treatment group. A recent meta-analysis of 3,578 studies of the effectiveness of parenting programs in reducing maltreatment found a total random effect size of .296. This supports the expectation for relatively small effects (under guidelines from Cohen, 1988). A power analysis using the Gpower computer program (Faul & Erdfelder, 1998) indicated that a total sample of **300 children** would be needed to detect small effects (d=.2) with 90% power using a t test between means with alpha at .05.

### *3.4 Process evaluation*

The evaluator selected for the program will also conduct a process evaluation, working with the TA provider and partners to establish targets for the identified outcomes. They will have the support of the CAO and an analyst who will provide access to data and assist with the documentation required for the process evaluation. The process evaluation will be an important tool for the program team and leadership to be able to use during their implementation, so they can make improvements throughout.

The key questions the process evaluation will answer are:

- What processes did the planning team and other stakeholders follow in developing the program, and how did they identify and overcome obstacles?
- Is the process including stakeholders to an appropriate extent, including family members?
- Are there standards for timeliness of responses to families and coworkers; and how is the program doing in communicating, measuring, and reporting on those standards?
- Is the program meeting its stated goals of respect and openness with family members?
- What is the program's quality assurance approach and is it effective?
- What are the policies and procedures for the program; and are team members using them?

The methods that we expect the evaluator to use to conduct this part of the evaluation are observations of stakeholders, analysis of meeting notes and other documents, surveys and interviews with staff and providers.

### *3.5 Data collection strategy*

With few exceptions (the emergency department records, which DHS obtains through a separate process; and the survey information required for the evaluation) all the data required for the evaluation are within the DHS Data Warehouse—provided by collaborating organizations

through signed data-sharing and security agreements, which include the plan for approvals of and secure transfer of data between DHS and organizations. (See sample data sharing agreement in the Appendices.)

The Data Warehouse is a central repository of social and human services data related to DHS clients and the services they receive through DHS, as well as through a number of other public entities. DHS created the Data Warehouse by consolidating its internal human services data (e.g., behavioral health, child welfare, intellectual disability, homelessness and aging) and has expanded it to include data from other sources. The Data Warehouse now includes data from 29 sources (including PA Department of Human Services, Allegheny County and City of Pittsburgh Housing Authorities, almost 20 local school districts, the Allegheny County Medical Examiner, and the criminal justice system) and contains more than a billion records from over one million distinct clients. DHS's care management systems also connect to the Data Warehouse, so the systems that the staff for the Hello Baby program use will be part of the data available for evaluation as well.

Each new data source added to the Data Warehouse involves a process that requires the development of trust and a shared vision as well as coordinating details such as the form in which data will be provided. Most partners send information weekly, and it is loaded into the Data Warehouse through an Extract, Transform and Load (ETL) Platform. The ETL is set up to accept data in different formats and load them into the central data area. At DHS, a team of programmers use IBM DataStage to create each ETL, and Oracle database management software to store it. Setting up the ETL is the most complex function involved; it accounts for about 80 percent of the technological work of the Data Warehouse. Once client data are loaded into the Data Warehouse, each client is assigned a unique identifying number. In this way, all client-

specific information can be pulled together to provide a comprehensive picture of client needs. It also ensures that individuals are not counted more than once. The Data Warehouse's ongoing data quality management is the responsibility of an administrator who coordinates data, as well as a support team that loads information and an operational team that provides weekly maintenance and performs data archiving. (See Allegheny County Analytics for detailed information about the advanced data sharing, data collection, and data security of the Data Warehouse: *https://www.alleghenycountyanalytics.us/index.php/dhs-data-warehouse/).*

**About data security and confidentiality**

DHS takes the care and confidentiality of its clients very seriously. Our goal is to ensure quality care and services through collaboration and coordination only so far as it is supported by appropriate use and sharing of client data. Under the federal Health Insurance Portability and Accountability Act (HIPAA), DHS is a covered component of Allegheny County, which means that we must comply with HIPAA's privacy and security rules for any client information we receive.

Operationally, DHS has established and maintained safeguards to prevent any use or disclosure of information. These include implementing administrative, physical, and technical safeguards that protect the confidentiality, integrity, and availability of the electronic information that is created, received, maintained, or transmitted. DHS limits data use and disclosure to the minimum necessary to accomplish the stated purpose of this program. All electronic communications are secure when sending or receiving data (e.g. encrypted email or similar security measures). DHS has several audit processes for our analytic tools to ensure that data are not accessed beyond institutionally determined situations. Finally, DHS requires an external data sharing agreement when sharing data between organizations, which outlines the parties that will

be accessing the data, procedures for storage and disposal of confidential information, and minimum identifying information for participants (See Appendices for a copy of agreement.)

### *3.6 Geographic location*

The geographic location for the Hello Baby program is Allegheny County, in Western Pennsylvania. It is bounded by Butler County to the north, Westmoreland County to the east, Beaver County to the West, and Greene County to the south. Its largest city is Pittsburgh (population 300,000). It also includes another city, McKeesport (population 19,200). During the pilot period of the program, we will roll-out the universal program at Magee Womens Hospital, the Family Support Center strategy at the 28 centers, and the Priority strategy in one geographic area of the county, to allow us to hone our strategy and test this component of the program.

### *3.7 Legal status*

A copy of Allegheny County's IRS tax-exempt status is provided as an uploaded document.

### *3.8 Sustainability plan*

This program is among the most important initiatives this community has developed, because of its potential for making measurable improvements in families' lives through the combination of Universal, Center and Priority strategies. After two years of developing this design with family members, national experts, and local stakeholders, we are prepared to demonstrate this program's ability to reduce home removals and improve child and family well-being—results that will prove Hello Baby is worth sustaining.

To continue this program, Allegheny County will:

- Secure state and federal resources through the Family First Prevention Services Act (FFPSA). DHS will work in the short-term to both implement services and programs identified by the Prevention Services Clearinghouse as well as register evidence-based

programs and strategies used by Hello Baby with the Clearinghouse. Hello Baby plans to use strategies and approaches to engage families, such as motivational interviewing, which the Clearinghouse is currently reviewing for inclusion. Based on the goal of Hello Baby to prevent home removals, DHS believes that most participants will meet the definition of "candidates for foster care." Once the program's evaluation is completed, DHS will submit for inclusion in the Prevention Services Clearinghouse. Funding through FFPSA would provide a sustainable source of revenue for the program as long as the babies served continue to meet the Pennsylvania state candidacy definition.

NB: DHS is working with the Pennsylvania State Department of Human Services to identify interventions to submit to the Prevention Services Clearinghouse, including programs and services used by Family Support Center.

2. Secure state resources through Act 148 funding (PA Needs Based Plan and Budget). DHS has sustained programs in the past through requests of the state for these state tax dollars, when it has been able to show the need in our county and the impact on children and families. A recent example is a program shown to reduce homelessness for families with young children; DHS piloted the program, showed results, and secured state Needs Based funding.

# 4. Organizational Capacity

## *4.1 Organizational charts*

Please see Appendix 1 for organizational charts.

## *4.2 About DHS*

DHS is responsible for providing and administering publicly-funded human services in Allegheny County. It serves over 200,000 people every year, with an annual budget of

approximately $900 million. As a primary member of the community collaborative, it provides funding, technical assistance, and the data infrastructure for most family-serving organizations in the county. DHS also employs staff who deliver services directly, including through its:

- Office of Children Youth and Families, whose caseworkers and other staff help strengthen families and protect children. CYF's services include in-home services to prevent a child's removal from the home; a team of specialists in each regional office who provide the staff with guidance and training in their areas of expertise: mental health, intimate partner violence, substance use disorders, and children's physical health; and permanency services.
- Office of Community Services, which operates the FSCs, the ELRC, housing programs, independent living for youth, the Allegheny LINK, which is the front door to housing and other services, and an array of prevention programs.
- Office of Behavioral Health, which administers the county's publicly-funded mental health and drug and alcohol services (prevention, treatment, peer support) for youth and adults; and its early intervention services for young children.
- AAA, which provides care management and other services for older adults and their caregivers, including grandparents raising their grandchildren.
- Office of Intellectual Disabilities and Autism, which provides care management for individuals with ID and/or autism diagnoses.

Through these direct services and its partners in human services, DHS touches one in every five people in Allegheny County, particularly its most vulnerable individuals and families.

These are indicators of our approach to working *with* communities and families:

- The family-led Family Support Centers, started over 25 years ago, have grown to 28 locations across the county. The new Early Learning Resource Center also will be

community-based (co-located with the Family Support Centers, in most locations). Years of working with families and community leaders in these settings has helped to establish trusted partnerships and a physical presence in communities. We could design the Hello Baby program because families and staff know us and help guide us, and we would not move forward without their support.

- We prefer and seek to hire individuals with lived experience (people who would understand those who need social services and support because they have, as well). DHS has hired young adults with experience in foster care or the behavioral health system as Youth Support Partners; formerly incarcerated individuals as Reentry case managers and as planning staff; fathers and mothers who have experience with CYF as family advocates; and certified specialists to support their peers in behavioral health. People with lived experience advise our plans and help evaluate our services, as well. The Allegheny Family Network is an example of this effort; it is a composed of parents who have experience in the child protective services system and both support families going through the system and advocate for system improvements.
- In addition to seeking advice from families, DHS relies on the support and advice we receive from the communities in which we work, including through their representation on the Children's Cabinet.

### *4.3 Staff and resumes*

The Hello Baby program will hire the Program Director, Supervisor, Family Specialists, Social Workers, and Clinicians/expeditors. The program staff currently in place includes:

*Amy Malen,* Assistant Deputy Director of Family and Community Services, Office of Community Services (DHS). She is the program's Principal Investigator.

*Kathryn Collins, Ph. D.*, Chief Analytics Officer (DHS). She is responsible for the selection, oversight and data access for the evaluator; and the implementation of the prevention model algorithm and the priority service notifications in the IT systems.

*Erin Dalton,* Deputy Director (DHS). She is responsible for overseeing DHS's prevention model project with AUT, and for setting DHS strategy for decision support for staff, the data warehouse, and information and technology.

*Julia Reuben,* Analyst, Children and Families Analytics (DHS). She is responsible for providing research support and analysis, particularly with the evaluator's use of the Data Warehouse.

Staff resumes are in Appendix 2.

### *4.4. Fiscal control and accountability*

DHS is fiscally strong with a fund balance higher than rating agencies typically require, and an A1 Moody's Rating. Its independent audit and annual report have received the highest award, the GFOA certificate. Its Office of Administration, whose deputy reports to the director of DHS, manages all budgeting, fiscal, contracts, compliance, HR, and grants management. DHS has met or exceeded performance standards on its state and federal programs: HUD increased our award because of high performance, and DHS has received high ratings from the Commonwealth of PA for our management of Title IV-E eligibility.

### *4.5 Dissemination plan*

The Program Director is responsible for implementing the dissemination plan shown below, in accordance with the Timeline shown in Section 2.8:

| *Goal* | *Target audience* | *Strategy* | *Measuring effect* |
|---|---|---|---|
| Provide information to build support | Foundations, other funders | DHS, community collaborative members present to funders in their quarterly meetings | Financial support for expanding the program |

| | | | |
|---|---|---|---|
| Provide information for replication | Communities seeking programs to prevent maltreatment and improve health and wellbeing of babies and families | - Prepare replication guide<br>- Request opportunity to present the program and distribute guide to replication at national conferences attended by staff, agency directors (e.g., APHSA, National Conference on Child Abuse and Neglect) | Number of attendees at workshops/presentations |
| | | - Host visits to county by other communities | |
| | | - Write and submit final evaluation to appropriate clearinghouses | Number of clearinghouses; and analytics from clearinghouse on number of downloads |

## BUDGET

The pages that follow provide the budget for Years 1 through Year 5 and justifications for individual line items.

### *Indirect Costs*

Please note the following:

The Allegheny County Department of Human Services:
1) Is eligible to use the *de minimis* rate described in the Part 200 Uniform Requirements, as set out at 2 C.F.R. 200.414(f), having no federally approved indirect cost rate; and

2) Elects to use the *de minimis* rate in its application for Community Collaborations to Strengthen and Preserve Families, HHS-2019-ACF-ACYF-CA-1559: CFDA Number 93.670

| Budget - TOTAL | | Federal | DHS |
|---|---|---|---|
| **Personnel** | **$ 99,000** | **$ 56,300** | **$ 42,700** |
| **Fringe** | **$ 39,600** | **$ 25,200** | **$ 14,400** |
| **Travel** | **$ 92,064** | **$ 92,064** | **$ -** |
| Site visits | $ 15,000 | $ 15,000 | $ - |
| National conferences | $ 15,500 | $ 15,500 | $ - |
| Year 1 kick-off meeting in D.C. | $ 3,100 | $ 3,100 | $ - |
| Local travel by field staff | $ 58,464 | $ 58,464 | $ - |
| **Equipment** | **$ 26,000** | **$ 26,000** | **$ -** |
| lap tops & phones for staff | | | |
| **Supplies** | **$ 5,000** | **$ 5,000** | **$ -** |
| **Contractual** | **$ 4,530,850** | **$ 2,304,970** | **$ 2,225,880** |
| *Great Lakes staffing* | Total | Federal | DHS |
| Chief Analytics Officer | $ 77,350 | $ 29,750 | $ 47,600 |
| Analyst | $ 84,000 | $ 16,800 | $ 67,200 |
| Project Director | $ 455,000 | $ 91,000 | $ 364,000 |
| Family Specialists | $ 1,281,000 | $ 735,000 | $ 546,000 |
| Navigators | $ 1,281,000 | $ 844,200 | $ 436,800 |
| Supervisor | $ 336,000 | $ 90,972 | $ 245,028 |
| *Nurture PA Texting service* | | | |
| recruitment and management | $ 714,000 | $ 194,748 | $ 519,252 |
| cell phone service for 10 | | | |
| *Evaluation contract* | $ 302,500 | $ 302,500 | $ - |
| **Other** | **$ 288,466** | **$ 240,466** | **$ 48,000** |
| Marketing | $ 88,466 | $ 88,466 | $ - |
| | $ - | $ - | $ - |
| retention incentives for familie | $ 200,000 | $ 152,000 | $ 48,000 |
| **Construction** | **$ -** | **$ -** | **$ -** |
| **Total Direct charges** | **$ 5,080,980** | **$ 2,750,000** | **$ 2,330,980** |
| **Indirect charges** | **$ 130,013** | **$ -** | **$ 130,013** |
| **Totals** | **$ 5,210,993** | **$ 2,750,000** | **$ 2,460,993** |

| | Year 1 | | | | | Year 2 | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Budget** | | | Total | Federal | DHS | | Total | Federal | DHS |
| | | FTE yr 1 | | | | FTE yr 2 | | | |
| **Personnel** | $ 90,000 | 0.25 | $ 22,500 | $ 22,500 | $ - | 0.25 | $ 22,500 | $ 15,800 | $ 6,700 |
| **Fringe** | | 0.4 | $ 9,000 | $ 9,000 | $ - | | $ 9,000 | $ 9,000 | $ - |
| **Travel** | | | $ 23,984 | $ 23,984 | $ - | | $ 11,452 | $ 11,452 | $ - |
| | cost | people x visits | | | | | | | |
| Site visits | $ 500 | 30 | $ 15,000 | $ 15,000 | $ - | | | | |
| National conferences | $ 3,100 | | $ 3,100 | $ 3,100 | $ - | | $ 3,100 | $ 3,100 | $ - |
| Year 1 kick-off meeting in D.C. | $ 3,100 | | $ 3,100 | $ 3,100 | $ - | | $ - | $ - | $ - |
| Local travel by field staff | | | $ 2,784 | $ 2,784 | $ - | | $ 8,352 | $ 8,352 | $ - |
| **Equipment** | **cost/computer** | **staff #** | | | | | | | |
| lap tops & phones for staff | $ 2,000 | 13 | $ 26,000 | $ 26,000 | $ - | | $ - | $ - | $ - |
| **Supplies** | | | $ 5,000 | $ 5,000 | $ - | | $ - | $ - | $ - |
| **Contractual** | | | $ 367,050 | $ 367,050 | $ - | | $ 699,700 | $ 465,748 | $ 233,952 |
| *Great Lakes staffing* | Salary | FTE yr 1 | Year 1 | Federal | DHS | FTE yr 2 | Year 2 | Federal | DHS |
| Chief Analytics Officer | $ 85,000 | 0.25 | $ 29,750 | $ 29,750 | $ - | 0.1 | $ 11,900 | | $ 11,900 |
| Analyst | $ 60,000 | 0.2 | $ 16,800 | $ 16,800 | $ - | 0.2 | $ 16,800 | | $ 16,800 |
| Project Director | $ 65,000 | 1 | $ 91,000 | $ 91,000 | $ - | 1 | $ 91,000 | $ - | $ 91,000 |
| Family Specialists | $ 45,000 | 0.5 | $ 31,500 | $ 31,500 | $ - | 2.5 | $ 157,500 | $ 157,500 | |
| Navigators | $ 45,000 | 0.5 | $ 31,500 | $ 31,500 | $ - | 2.5 | $ 157,500 | $ 157,500 | |
| Supervisor | $ 60,000 | 0.5 | $ 42,000 | $ 42,000 | $ - | 0.5 | $ 42,000 | $ 42,000 | |
| *Nurture PA Texting service* | | | | | | | | | |
| recruitment, management and cell phone servi | $ 168,000 | 3 mos/12 | $ 42,000 | $ 42,000 | $ - | 12 mos | $ 168,000 | $ 53,748 | $ 114,252 |
| *Evaluation contract* | | | $ 82,500 | $ 82,500 | $ - | | $ 55,000 | $ 55,000 | $ - |
| **Other** | | | $ 96,466 | $ 96,466 | $ - | | $ 48,000 | $ 48,000 | $ - |
| Marketing | | | $ 88,466 | $ 88,466 | $ - | | $ - | $ - | $ - |
| | Cost/family | Families | | $ - | $ - | Families | $ - | | |
| retention incentives for families | $ 200 | 40 | $ 8,000 | $ 8,000 | $ - | 240 | $ 48,000 | $ 48,000 | |
| **Construction** | | | $ - | $ - | $ - | | $ - | $ - | $ - |
| **Total Direct charges** | | | $ 550,000 | $ 550,000 | $ - | | $ 790,652 | $ 550,000 | $ 240,652 |
| **Indirect charges** | | | $ 33,295 | | $ 33,295 | | $ 24,095 | | $ 24,095 |
| **Totals** | | | $ 583,295 | $ 550,000 | $ 33,295 | | $ 814,747 | $ 550,000 | $ 264,747 |

| | Year 3 | | | | | Year 4 | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Budget** | | | **Total** | **Federal** | **DHS** | | **Total** | **Federal** | **DHS** |
| | | FTE yr 3 | | | | FTE yr 4 | | | |
| **Personnel** | | **0.2** | **$ 18,000** | **$ 18,000** | | **0.2** | **$ 18,000** | | **$ 18,000** |
| **Fringe** | | | **$ 7,200** | **$ 7,200** | **$ -** | | **$ 7,200** | | **$ 7,200** |
| **Travel** | | | **$ 17,020** | **$ 17,020** | **$ -** | | **$ 19,804** | **$ 19,804** | **$ -** |
| Site visits | | | $ - | $ - | $ - | | $ - | $ - | $ - |
| National conferences | | | $ 3,100 | $ 3,100 | $ - | | $ 3,100 | $ 3,100 | $ - |
| Year 1 kick-off meeting in D.C. | | | $ - | $ - | $ - | | $ - | $ - | $ - |
| Local travel by field staff | | | $ 13,920 | $ 13,920 | $ - | | $ 16,704 | $ 16,704 | $ - |
| **Equipment** | | | | | | | | | |
| lap tops & phones for staff | | | $ - | $ - | $ - | | $ - | $ - | $ - |
| **Supplies** | | | **$ -** | **$ -** | **$ -** | | **$ -** | **$ -** | **$ -** |
| **Contractual** | | | **$ 1,098,700** | **$ 459,780** | **$ 638,920** | | **$ 1,182,700** | **$ 506,196** | **$ 676,504** |
| *Great Lakes staffing* | | FTE yr 3 | Year 3 | Federal | DHS | FTE yr 4 | Year 4 | Federal | DHS |
| Chief Analytics Officer | | 0.1 | $ 11,900 | | $ 11,900 | 0.1 | $ 11,900 | | $ 11,900 |
| Analyst | | 0.2 | $ 16,800 | | $ 16,800 | 0.2 | $ 16,800 | | $ 16,800 |
| Project Director | | 1 | $ 91,000 | | $ 91,000 | 1 | $ 91,000 | | $ 91,000 |
| Family Specialists | | 5 | $ 336,000 | $ 168,000 | $ 168,000 | 6 | $ 378,000 | $ 189,000 | $ 189,000 |
| Navigators | | 5 | $ 336,000 | $ 201,600 | $ 134,400 | 6 | $ 378,000 | $ 226,800 | $ 151,200 |
| Supervisor | | 1 | $ 84,000 | $ 2,180 | $ 81,820 | 1 | $ 84,000 | $ 2,396 | $ 81,604 |
| *Nurture PA Texting service* | | | | | | | | | |
| recruitment, management and cell phone service | | 12 mos | $ 168,000 | $ 33,000 | $ 135,000 | 12 mos | $ 168,000 | $ 33,000 | $ 135,000 |
| *Evaluation contract* | | | $ 55,000 | $ 55,000 | $ - | | $ 55,000 | $ 55,000 | $ - |
| **Other** | | | **$ 48,000** | **$ 48,000** | **$ -** | | **$ 48,000** | **$ 24,000** | **$ 24,000** |
| Marketing | | | $ - | $ - | $ - | | $ - | $ - | $ - |
| | | Families | $ - | $ - | | Families | $ - | $ - | |
| retention incentives for families | | 240 | $ 48,000 | $ 48,000 | | 240 | $ 48,000 | $ 24,000 | $ 24,000 |
| **Construction** | | | **$ -** | **$ -** | **$ -** | | **$ -** | **$ -** | **$ -** |
| **Total Direct charges** | | | **$ 1,188,920** | **$ 550,000** | **$ 638,920** | | **$ 1,275,704** | **$ 550,000** | **$ 725,704** |
| **Indirect charges** | | | **$ 24,022** | | **$ 24,022** | | **$ 24,300** | | **$ 24,300** |
| **Totals** | | | **$ 1,212,942** | **$ 550,000** | **$ 662,942** | | **$ 1,300,004** | **$ 550,000** | **$ 750,004** |

| Year 5 | | | | | |
|---|---|---|---|---|---|
| **Budget** | | **Total** | **Federal** | **DHS** | |
| | FTE yr 5 | | | | |
| **Personnel** | **0.2** | **$ 18,000** | | **$ 18,000** | |
| **Fringe** | | **$ 7,200** | | **$ 7,200** | |
| **Travel** | | **$ 19,804** | **$ 19,804** | **$ -** | |
| Site visits | | | | $ - | |
| National conferences | | $ 3,100 | $ 3,100 | $ - | |
| Year 1 kick-off meeting in D.C. | | $ - | $ - | $ - | |
| Local travel by field staff | | $ 16,704 | $ 16,704 | $ - | |
| **Equipment** | | | | | |
| lap tops & phones for staff | | $ - | $ - | $ - | |
| **Supplies** | | **$ -** | **$ -** | **$ -** | |
| **Contractual** | | **$ 1,182,700** | **$ 506,196** | **$ 676,504** | |
| *Great Lakes staffing* | FTE y5 | **Year 5** | **Federal** | **DHS** | |
| Chief Analytics Officer | 0.1 | $ 11,900 | | $ 11,900 | |
| Analyst | 0.2 | $ 16,800 | | $ 16,800 | |
| Project Director | 1 | $ 91,000 | | $ 91,000 | |
| Family Specialists | 6 | $ 378,000 | $ 189,000 | $ 189,000 | |
| Navigators | 6 | $ 378,000 | $ 226,800 | $ 151,200 | |
| Supervisor | 1 | $ 84,000 | $ 2,396 | $ 81,604 | |
| *Nurture PA Texting service* | | | | | |
| recruitment, management and cell phone ser | 12 mos | $ 168,000 | $ 33,000 | $ 135,000 | |
| *Evaluation contract* | | $ 55,000 | $ 55,000 | | |
| **Other** | | **$ 48,000** | **$ 24,000** | **$ 24,000** | |
| Marketing | | $ - | $ - | $ - | |
| | Families | $ - | $ - | $ - | |
| retention incentives for families | 240 | $ 48,000 | $ 24,000 | $ 24,000 | |
| **Construction** | | **$ -** | **$ -** | **$ -** | |
| **Total Direct charges** | | **$ 1,275,704** | **$ 550,000** | **$ 725,704** | |
| **Indirect charges** | | **$ 24,300** | | **$ 24,300** | |
| **Totals** | | **$ 1,300,004** | **$ 550,000** | **$ 750,004** | |

## Budget Justification

(Please see for staffing FTE and federal/non-federal break out, by year)

| *Budget Item* | *Five year total* |
|---|---|
| **Personnel -**Principal Investigator, salary of $90,000 x 1.4 (Great Lakes benefits rate). Level of effort varies by year (see budget). 5 year total of $99,000 | $99,000 |
| **Fringe -** Calculated by 40% benefits rate, 5 yr total of $39,600 | $39,600 |
| **Travel** | $92,064 |
| ***Years 1-5*** | |
| Distance Travel for 10 individuals to participate in 3 site visits. Calculated as follows: 3 x 10 individuals x $800 pp for: (hotel: $200 + airfare: $400 + per diem: $50 x 2 days + ground transport: $100). Five year total of **$15,000** | $15,000 |
| Distance travel to national conferences: 4 people x 2 nights x (300/night hotel + 50 per diem) + 500 RT transportation. Five year total of **$15,500** | $15,500 |
| Distance travel to kick-off meeting: 4 people x 2 nights x (300/night hotel + 50 per diem) + 500 RT transportation. Year 1 expense of **$3,100** | $3,100 |
| Local travel for every year (5 years). For Family Specialist and Navigator to travel as a duo to visit with families and providers. Calculated at .58/mile x 400 miles/month x 12 months/yr x number of Family Specialist and Navigator duos. Five year total of **$58,464** | $58,464 |
| **Equipment** | $26,000 |
| Equipment – Laptop computers and phones for the 10 new staff (Great Lakes employees, see Contracts, below). One time cost in Year 1, calculated at ($1,200 per computer + $300 per phone) x 13 staff = $26,000 | |
| **Supplies** | $5,000 |
| Consumable office supplies ($5000 to pay for toner for printer, copy paper, pens, paper) for 13 staff. Year one total of **$5,000** | |
| **Contractual** | $4,530,850 |
| **Years 1-5** | |
| A. Contract with Great Lakes Behavioral Health for these program staff: | |
| Chief Analytics Officer, salary of $85,000 x 1.4 (Great Lakes benefits rate). Level of effort varies by yr. (See budget.) 5 year total of **$77,350** | $77,350 |
| Analyst, salary of $60,000 x 1.4 (Great Lakes benefits rate) Level of effort varies by year. 5- year total of **$84,000** | $84,000 |
| Project Director, salary of $65,000 x . 1.4 x 5 years (Great Lakes benefits rate) 5 year total of **$455,000** | $455,000 |
| Family Specialist, beginning in year 1 with one FTE, increasing to 6 FTEs in Year 3 salary of $45,000 x 1.4 (Great Lakes benefits rate); Amount of workers vary by year, see budget (5-year total of **$1,281,000)** | $1,281,000 |

| | | |
|---|---|---|
| Navigator, beginning in year 1 with one FTE, increasing to 6 FTEs in Year 3 salary of $45,000 x 1.4 (Great Lakes benefits rate). Amount of workers vary by year, see budget (5-year total of **$1,281,000)** | | $1,281,000 |
| Supervisor, begins in year 1, increases to 1 FTE. salary of $60,000 x 1.4 (Great Lakes benefits rate).Year 1 prorated. (see budget) 5-year total of **$336,000** | | $336,000 |
| B. Contract with Nurture PA for all 5 years, to recruit and manage volunteers who provide texting service ($150,000 per year); and cell phone service for (10 of the volunteers x $150/month x 12 months).Prorated in Year 1. Nurture PA provides texting services for the universal strategy. Total 5 year cost of **$714,000** | | $714,000 |
| C. Contract with evaluator to be identified after competitive bidding process. Estimate that the design and initial work on process evaluation will require more time and expertise in year 1 because of research design and initial evaluation($82,500) and in subsequent years, the cost will be $55,000 annually, and will implement RCT and process evaluation. Total 5 year cost of **$357,500** | | $357,500 |
| **Other** | | $288,466 |
| Marketing by Blender Advertising. to develop ABF communications , cards, and materials in year 1. Total of **$94,466** | | $94,466 |
| Incentives for retention for families. Calculated at $200/family x number of families offered targeted service (1,000 total, across the five yrs (See budget since numbers vary as number of families increases). Five year total of **$200,000** | | $200,000 |
| **Direct costs** | **$5,080,980** | |
| **Indirect Costs** | **$130,013** | |
| *Sum of All Above* | | |
| **Total Project Costs** | **$5,210,993** | |
| **DHS Funding** | | $2,460,993 |
| **Federal Request** | | $2,750,000 |