GOALS

Exploring United Way for Southeastern Michigan's Program for Supporting Children and Families from the Bib to the Backpack

United Way
for Southeastern Michigan

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Final Report

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Detroit skyline image by Ryan F from Pixabay

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AmeriCorps

The layout of the various sections of this report responds to a prompt provided by AmeriCorps.

Table of Contents

List of Figures

EXECUTIVE SUMMARY

Families in the Southeastern Michigan counties of Wayne, Oakland and Macomb face social and economic challenges that affect the health and developmental readiness of their young children. When this study was proposed, a quarter of the children under the age of eighteen were living in poverty and a third lived in families receiving public assistance. Eleven percent of the labor force was unemployed. In Wayne County, where Detroit is located, the percentages were, and are, even higher. More than a third of children were living in poverty, half receiving public assistance, and 15% of the labor force was unemployed. All of these percentages were higher than the United States as a whole.

In these communities there are few comprehensive systems that connect people to the resources they need to support themselves as parents and to meet their objectives as families. While many resources are available, they are often underused and lack continuity and connectedness to ensure that families can easily identify and access supports they need.

> *"One of the lessons I learned working with residents of Wayne County is that I had heard of the poverty and food insecurity occurring, but going to see and hear firsthand, it was worse than I had anticipated."*
>
> - Family Check-Up Model Specialist, National Kidney Foundation of Michigan

This project was designed to impact the system of care, the families they serve, and the children they raise. At the system level, the intention of programming was to expand the scope of interventions offered to families and to strengthen the connections between programs and agencies. At the family level, the project meant to grow essential skills of parents, to expand their social and resource networks, and to increase their self-sufficiency and use of resources. Among children, improvement in developmental readiness and health was targeted, intending to increase their probability of lifelong success.

The intervention model was named GOALS, Gain Opportunities to Achieve Lasting Success. GOALS utilized an adapted version of the Family Check-Up model. The Family Check-Up model is a strengths-based, family-centered intervention that motivates parents to use effective parenting practices in support of child competence. It is designed for families with risk factors including socioeconomic disadvantage, maternal depression, family and child risk factors for child conduct problems, and academic failure. Using principles of strengths-based motivational interviewing, the model prompts parents to change problematic behavior in their children by modifying their own parenting behavior. By sharing assessment findings, identifying strengths and potential problem areas, and providing developmental readiness information and referrals, parents are empowered to improve their children's developmental readiness.

The project made key adaptations to the Family Check-Up model. GOALS was nested in a multi-agency integrated service delivery model which included the 2-1-1 information and referral hotline. GOALS included a unique suite of assessments and specially designed feedback form to communicate results to families. GOALS placed increased emphasis on goal

setting and referral tracking. Finally, GOALS used multiple service/resource "pathways" to support families in key areas of challenge.

The purpose of this study was to evaluate the implementation of this intervention model serving families from five agencies in the Greater Detroit area. Families from these agencies were given the opportunity to participate in the Family Check-Up model if they had a child five years old or younger and were living at 200% of the federal poverty level or less.

The study was designed as a randomized control trial of an intent-to-treat model. Despite transitioning to an implementation study due to an unanticipated shortened project period, the study continued to use a robust experimental framework to address both the required implementation questions and the exploratory impact questions.

A total of 518 families were enrolled into the GOALS intervention and 474 families were enrolled into the comparison group. More than three quarters (77%) of these families were receiving public assistance at the time of enrollment, most were Families of Color (77%). Nearly all (97%) of the parents were female and less than half were living with a spouse (45%). These families reported having myriad needs at baseline. Most frequently they identified having needs with regards to housing, clothing, and food. Most (73% at six-month follow-up and 71% at 12-month follow-up) of these families stayed enrolled in the program.

The evaluation used t-tests to determine whether families enrolled in the GOALS program showed improvement between pre and post-tests. GOALS families showed significant gains in parenting. In particular, their levels of affection, responsiveness, encouragement, and teaching as measured by the Parenting Interactions with Children Checklist of Observations Linked to Outcomes (PICCOLO) all showed significant improvement at both six- and 12-month follow-up. GOALS families also showed significant improvement on four domains of the Arizona Self Sufficiency Matrix (ability to meet basic needs, parenting skills, social support, and behavior issues) at both six- and 12-month follow-up.

The evaluation also looked at improvement on Protective Factors to prevent child abuse and neglect. At six-month follow-up, GOALS families demonstrated significant improvement on two of these protective factors: concrete support and child development/ knowledge of parenting. At 12-month follow-up, GOALS families demonstrated significant improvement on three protective factors: concrete support, child development/ knowledge of parenting, and social support.

GOALS families' scores on the Feeding Your Child survey, which examines the practices parents use when feeding their children, also showed significant improvement at both six- and 12-month follow-up. Similarly, at both six- and 12-month follow-up, GOALS families showed a significant decrease in the number of areas of concern identified by the Ages and Stages Questionnaires.

GOALS families also outperformed the comparison families in some key areas. Regression analysis was used to determine whether there were differences between GOALS and comparison families at six and twelve months. GOALS families scored significantly higher than comparison families on social support as measured by the Protective Factors survey at six-month follow-up. In addition, GOALS families had significantly higher scores than the comparison group on the Feeding Your Child survey at both six- and 12-month follow-up.

However, comparison families scored significantly higher than GOALS families on the ability to meet basic needs and on parenting skills as measured by the Arizona Self-Sufficiency matrix at six-month follow-up and on parenting skills at 12-month follow-up. Comparison families also demonstrated significantly higher scores than GOALS families on the nurturing and attachment protective factor at six-month follow-up setting the stage for further research and analysis.

The COVID-19 global health pandemic started during the last seven months of the GOALS evaluation. In response to the global health pandemic and the state of emergency orders put in place by the Governor of Michigan, the GOALS study adapted its implementation protocol to protect the health and safety of GOALS staff and participants. In addition, the project added two COVID-19 assessments that looked at two time periods, with Phase 1 defined as the period from March 13, 2020 (one week before the Michigan Shelter-In-Place Order) to April 30, 2020 (the first curve flattening in Michigan), and Phase 2 extended from May 1, 2020 thru August 30, 2020. The study found that there was a significant increase in the likelihood of either staying in or moving into the high-risk category for both the intervention and control groups during the COVID-19 Phase 1 period across multiple ASSM domains: Health Care, Employment, Family Social Connections, Community Engagement, Parenting, and Mental Health.

However, during Phase 2, the families enrolled in the GOALS program were significantly more likely to move to a lower-risk category in areas of Mental Health, Parenting, Family Connection, and Health Care. The odds ratios for these analyses ranged from 1.8 to 3.5 indicating a nearly two-fold decrease in risk across these domains at a minimum. We speculate that this positive buffering effect is at least in part related to the GOALS program providing an established and trusted support system to help navigate the needs of families in the face of the COVID-19 pandemic.

GOALS families showed significant improvement in many areas between pre and post-test. However, the results indicate that they only outperformed the comparison group in two areas. Several factors including recruiting families out of high quality, evidence-based programs at the agencies and providing a higher level of care for comparison families than they would have received in the absence of this study likely contributed to the fact that the two groups looked similar in many ways at follow-up.

Several lessons were learned through the implementation of the GOALS program. Many of these lessons involved the assessment measures used. Feedback from agency staff indicated that the items on some of the measures were difficult for families to understand, that the Likert

scales used on many of the assessments were confusing for some families, and that the assessments did not always detect marginal progress. Further, the assessment package was lengthy and could be trimmed in future implementations. Feedback from staff also indicated that the ongoing training and support offered by the project was critical. Several challenges arose over the course of the project including difficulty managing technology, scoring assessments, and providing negative feedback to families, that required additional training for agency staff to manage. Finally, while staff turnover was anticipated and the levels of turnover were consistent with other similar programs, the challenges in addressing turnover was greater than anticipated. Leaders of future implementations should be intentional about planning for the impact of turnover on program implementation.

Introduction

INTRODUCTION

Program Background and Problem Definition

Families in the Southeastern Michigan counties of Wayne, Oakland and Macomb face social and economic challenges that affect the health and developmental readiness of their young children. When this study was proposed, reports from the Kids Count Data Center (https://datacenter.kidscount.org/) showed a quarter of the children under the age of eighteen were living in poverty and a third lived in families receiving public assistance. Eleven percent of the labor force was unemployed. In Wayne County, where Detroit is located, the percentages were, and are, even higher. More than a third of children were living in poverty, half receiving public assistance, and 15% of the labor force was unemployed (https://www.bls.gov). All these percentages were higher than the United States as a whole. Prior to March 2020, circumstances had not meaningfully changed. It is also well documented that COVID-19 has disproportionately negatively affected vulnerable communities, which likely exacerbated the challenges faced by families in Southeastern Michigan (Michigan.gov, n.d.).

Additionally, in the years preceding this study, United Way for Southeastern Michigan analyzed screening data on almost 150,000 children under the age of five to assess their level of development using the Ages & Stages Questionnaires. Over a third of the children screened were found to be below level on each domain screened: communication skills, gross motor skills, fine motor skills, problem solving skills and social skills. These delays were believed to have resulted, at least in part, from the conditions in which these children live.

In these communities there are few comprehensive systems that connect people to the resources they need to support themselves as parents and to meet their objectives as families. While many resources are available, they are often underutilized and there is a lack of continuity and connectedness to ensure that families can easily identify and access the supports they need.

> *"It was painful to hear how often these well-intentioned programs had appeared to knock people down instead of lifting them up…The system remains utterly broken.*
>
> - Family Check-Up Model Specialist, Oakland Family Services

This project was designed to impact the system of care, the families they serve, and the children they raise by creating a new integrated service delivery model. At the system level, the intention of programming was to expand the scope of interventions offered to families and to strengthen the connections between programs and agencies through an integrated service delivery model. At the family level, the project meant to grow essential skills of parents and other adults who care for young children, to expand their social and resource networks, and to increase their self-sufficiency and use of resources. Among children, improvement in developmental readiness and health was targeted, intending to increase their probability of lifelong success.

A note for our early partners and AmeriCorps reviewers: As the study developed, organizational shifts required that the original project title Bib-to-Backpack be changed and the entire initiative was renamed GOALS, Gain Opportunities to Achieve Lasting Success.

Overview of Prior Research

GOALS adapted the Family Check-Up (FCU) model, a strengths-based, family-centered intervention that motivates parents to use positive parenting practices in support of child competence. It is designed for families with risk factors including socioeconomic disadvantage, maternal depression, family and child risk factors for child conduct problems, and academic failure. The FCU uses principles of strengths-based motivational interviewing to prompt parents to change problematic behavior in their children by modifying their own parenting behavior. By sharing assessment findings, identifying strengths and potential problem areas, and providing developmental readiness information and referrals, parents are empowered to improve their children's developmental readiness.

Much of the research on the impact of the FCU in families with young children has been done by Daniel Shaw, Thomas Dishion and their colleagues. In 2006, they published the results of a randomized trial of the 2-year effects of the model. The test of 120 toddler-aged boys found reductions in disruptive behavior and greater maternal involvement (Shaw et al., 2006).

In 2008, the team published the results of a larger study of 731 low-income families with 2 and 3-year-old children. Compared to those in the control group, those who received the FCU model demonstrated decreased behavior problems among children and increased positive behavior support among parents (Dishion et al., 2008).

The findings from these two randomized control trials have resulted in dozens of publications in peer reviewed clinical and developmental research journals. According to the Social Innovation Fund – the original project funder – guidelines, the evidence base for the FCU model meets the criteria for strong evidence.

However, neither of these prior studies of the FCU model included large numbers of families who were recent immigrants to the United States with their own norms and customs, which was a key population included in this study. The prior studies also did not offer the scope of support services available to families through GOALS.

Overview of Implementation Study

Introduction

This project began at the now closed Corporation for National and Community Service (CNCS) and is now housed with AmeriCorps. It was part of the 2016 Social Innovation Fund (SIF) portfolio and was United Way's second Social Innovation Fund Award. In 2016, United Way was awarded $6 million with a required one to one match on every dollar. There was also a majority

pass through stipulation meaning that at least 51% of the federal award had to go to subgrantees (referred to in this report as partner agencies) who were also required to match their awards dollar for dollar. With the shortened period of performance, United Way's total budget was just over $4 million with a pass-through rate of approximately 76 percent. For more information on United Way's previous SIF project and current 2016 SIF budget see Appendix AA.

In addition to the intermediary, United Way for Southeastern Michigan, there were five partner agencies. Philliber Research and Evaluation was the lead evaluator. Professors from Wayne State University provided technical, statistical and FCU expertise, and financial assistance and strategic advice were provided by private consultants. Advarra served as the project's Institutional Review Board (IRB). A Glossary of project terms and partners is provided in Appendix A.

Program Design Approach and Methodology Used

The purpose of this study was to evaluate the implementation of an adapted FCU model - GOALS - among families recruited by five partner agencies in the Greater Detroit area. Families from these agencies were given the opportunity to participate in the study if they had a child five years old or younger and were living at 200% of the federal poverty level or less. A total of 525 families were expected to participate in the Family Check-Up model between February 2018 and April 2019. Another 525 families were expected to make up the comparison group.

The intervention, or GOALS, families were interviewed and received a set of assessments. The assessment data was reviewed and synthesized by a specialist working with the family and during a feedback session, the family was encouraged to set goals. Referrals were made and the family selected pathways - a set of evidence-based, in-network programs - or other services meant to help meet those goals. Six- and 12-month assessments and feedback were provided.

The comparison group received the same set of assessments, except for the PICCOLO. These families typically had two sessions, compared to the three sessions that the GOALS families typically had. Comparison families also had six- and 12- month follow-up assessments. These families worked with trained staff called Data Collection Specialists (DCS) who provided brief feedback on the assessments, a list of resources, and a level of care consistent with their agency's practices.

GOALS is based on the theory that by building a parenting continuum/system that will recruit, engage, and empower parents to improve their family's self-sufficiency and parenting skills, their children's developmental readiness will improve. Building this system on a foundation of evidence-based parenting strategies - the pathways - and technology-based care-coordination supports, parents can be educated and empowered to improve the developmental readiness and well-being of their children. The FCU was selected as the foundation of this system because it was an empirically validated model that had already demonstrated substantial promise as an

effective prevention intervention. The strengths of the FCU include comprehensive assessment, family engagement grounded in a motivational interviewing approach, and goal setting. These strengths, combined with the community networking and resourcing capacity of United Way, provided a powerful framework for a truly community level intervention that could significantly impact the Southeast Michigan region in a way that would facilitate systemic change in the long-term. Specifically, this model allowed families to determine goals consistent with their own priorities after reviewing their assessment data, use pathways providing resources consistent with their goals, and leverage 2-1-1, an established information and referral system, that could direct families to resources, even if there was not a specific pathway for that goal.

Key FCU Adaptations:

- GOALS was nested in a multi-agency integrated service delivery model, including 2-1-1 resource and referral hotline.
- GOALS included a unique suite of assessments.
- GOALS used a specially designed feedback form.
- GOALS placed increased emphasis on goal setting and referral tracking.
- GOALS used multiple service/resource "pathways."

The first steps of GOALS, relying heavily on the Family Check-Up framework, were to engage in a rapport-building "get-to-know-you" session with a trained Family Check-Up Model Specialist (FCMS) and complete an assessment of the family's self-sufficiency and their child's developmental readiness. For each family, the youngest child under the age of five was designated as the "target child" and was the focus of the child-specific assessments. There was a primary adult identified as well. These individuals had to be the child's legal guardian and because of this status the study uses the term "parent" to identify them. Working with their FCMS, each family completed an assessment of their family's ability to meet basic needs, parenting skills, social supports, child behaviors and feeding practices. They also completed assessments of their child's communication skills, gross motor skills, fine motor skills, problem solving skills, social development, and health.

The assessments included the Arizona Self-Sufficiency Matrix (by completing a Family Profile Form); the age-appropriate Ages & Stages Questionnaires, Third Edition (ASQ-3) and Ages & Stages Questionnaires: Social Emotional, Second Edition (ASQ:SE-2); the age-appropriate Rothbart Temperament Scale; the PICCOLO; and a Feeding Your Child survey. A description of each assessment can be found later in the Program Design section of this report. Several of these assessments and screening tools were selected to align with other program evaluations being conducted by United Way. Each family also completed a Participant Intake Form that captured demographics.

The second step of GOALS was to review the assessments with the FCMS during a feedback session in order to identify goals the family wished to work toward and be guided toward programs that would help them achieve those goals. The Family Check-Up Model Specialist discussed relevant options with the family such as assistance with specific child behavior

problems or parent issues; enrollment into an intervention as identified by family goals; and/or community referrals. All service referrals were to be accompanied by regular follow-up support, either in person or by phone; These families were to continue to meet with the Family Check-Up Model Specialist at least every six months to discuss their progress and refine their goals.

The third step was to connect with pathways, programs, and service providers who can help families achieve their goals. These services could have been provided by the enrolling agency or referrals could be made to other GOALS partner agencies or out-of-network providers. Text messaging was to be used by FCMSs to further keep families informed and involved.

The process of assessment, feedback and goal setting, and connection to services was to be repeated every six months.

Figure 1: Program Logic Model

Inputs	Intervention	Outcomes
Agency partners provide: • Recruitment support • Evidence-based programs • Other services in-house • Referrals for outside services United Way provides: • Funding for Family Check-Up Specialists to deliver Family Check-Up model • Technical assistance • Financial assistance • Evaluation support	Families who receive the Family Check-Up model will receive: • Assessments of strengths and potential problems • Motivational interviewing to identify goals and provide coaching • Services to achieve identified goals • Follow-up to monitor progress and keep on track	Families who receive the Family Check-Up model are expected to demonstrate greater self-sufficiency as evidenced by: • Increased ability to meet basic needs • Increased social supports • Increased parenting skills • Improved feeding practices • Decreased behavior problems Children in families who receive the Family Check-Up model are expected to demonstrate improved development as evidenced by: • Fine motor skills • Problem solving skills • Social development • Social-emotional health

Research Questions

Implementation Questions

The primary purpose of this study was to document the implementation of the GOALS model in five agencies serving the greater Detroit area. The study was designed to answer the following questions about the implementation:

Confirmatory Questions

The study was to address several confirmatory questions about the implementation of the GOALS model.

1. How successful is GOALS in enrolling families? i.e., ***How many families enroll?***
2. What are the characteristics of families who enroll? ***In addition to their demographic characteristics, what kinds of needs are identified at the time of enrollment?***
3. How well is GOALS implemented? ***Do families move from assessment to services and continue engagement in services?***
4. What services do families receive? ***Do families who receive the GOALS model participate in more services than families typically do?***
5. How long do families continue to participate in GOALS? ***Do families who participate in GOALS participate longer in services than families typically do?***
6. Do families who participate in GOALS improve levels of self-sufficiency as demonstrated by ***improved ability to meet basic needs, parenting skills, social supports, feeding practices and reduced risk behaviors?***
7. Do children whose families participate in GOALS improve levels of development as demonstrated by ***improved communication skills, problem solving skills, social development, social-emotional and health?***

Exploratory Questions

The study was to address two exploratory questions about the implementation of GOALS.

1. Is the amount of improvement a family experiences increased by the number of services received?
2. Is the amount of improvement a family experiences increased by the length of time they participate in the program?

Impact Questions and Findings to Date

Confirmatory Questions

At the study's start, we intended to determine moderate level impact, but were limited to exploratory impact questions due to changes in CNCS' funding model, which reduced the study's timeframe.

Exploratory Questions

An exploratory impact study to determine the effects of participation in the FCU model was possible and, despite no longer being required to do so, United Way chose to include an

exploratory impact analysis. The study was designed to provide evidence to answer the following questions about the impact of GOALS.

1. Do families who receive the FCU model make significantly greater improvements in self-sufficiency compared to families who only receive standard services as evidenced by improved:
    a. Parenting skills
    b. Ability to meet basic needs
    c. Social supports
    d. Risk behaviors
    e. Feeding practices
2. Do children in families who receive the FCU model make significantly greater improvements in development compared to children in families who only receive normal services as evidenced by improved:
    a. Communication skills
    b. Problem solving skills
    c. Social development
    d. Social-emotional health

Contribution of the Study

Level of Evidence Targeted by the Impact Study

This study documents the ability to implement the Family Check-Up (through our GOALS adaptation) among a low-income population, many of whom are first generation Arabic and Spanish speaking immigrants, and a quarter of whom identify Arabic or Spanish as the language of their home. The study assesses the implementation of the model among such populations and seeks a preliminary level of evidence. While the original plan targeted a moderate level of evidence, and despite the changes necessary to address the shortened period of performance, the exploratory portion of the evaluation had a sample size that is adequate for the study to contribute to preliminary evidence as described in the Findings section.

Strengths and Limitations of the Implementation Study

The shifting landscape stemming from the length of the study being shortened and the onset of COVID-19 required nimbleness on the part of United Way and its partners to continue to serve families well and created several unique strengths and limitations.

The backend of this model was complex to set up and implement, but the outward relationships to the families served were simple and straightforward. United Way, five non-profit agencies, Philliber Research and Evaluation, consultants from Wayne State University, and private financial and strategy consultants worked closely together to design, implement, monitor, and evaluate the model. Jointly, assessments were selected, trainings developed and modified, forms designed, data collected and analyzed, case management provided – all as a group. Required matching funds were raised and monitored for compliance. The collaborative manner in which

the model was managed allowed for synergies to develop and granted agency to the families (as they used assessment feedback to help develop their own goals) and to the partner agencies (as they offered best practices/programs of their own agencies and directed families to resources they did not provide when necessary).

A pilot phase (October 1, 2017 - February 1, 2018) allowed for creation and modification of the study's Family Profile Form and refinement of the randomization protocol and also tested staff's ability to employ the data platform Efforts to Outcomes by Social Solutions (ETO) effectively. FCMSs received training in the FCU model and worked with a small number of families to learn how to implement.

In terms of staff, caseworkers had the opportunity to learn assessments and to earn a certification in the Family Check-Up. One of the United Way project team consultants became a certified Family Check-Up supervisor and trainer. Data specialists and staff who worked with the comparison families learned how to use ETO. Staff met regularly as part of Learning Communities to share best practices and collectively problem solve. A challenge in staffing - one often seen in this sector and in early childhood education - stemmed from turnover and from staff taking parental leave. This sometimes impacted who the families met with, so trust and relationships needed to be redeveloped. While there was also turnover at United Way and Philliber, there was enough continuity to mitigate most negative effects.

"Being that I worked with families who primarily did not speak English as their first language I was able to help simplify documents and be an additional support for them."

- Family Check-Up Model Specialist, Leaps & Bounds Family Services

Not all families were primary-English speakers, which required that assessments and forms be translated into Arabic and Spanish, and some of the response formats were adapted to be more culturally appropriate. These translations are now available for the community and some, such as the READY4K texting pathway, nationwide. Translations, however, did not address cultural differences, which had to be handled on a case-by-case basis. The Family Check-Up certification requires a caseworker to be videotaped during a family session. There was concern at the onset that given the political climate and policies toward Arabic immigrants following the election in 2016, that large numbers of families might be reticent. This did not turn out to be the case. On the other hand, the concept of setting personal goals, rather than community goals, was a new idea to some of the families.

When COVID-19 hit and disproportionately affected people in Detroit, communities of color and low-income neighborhoods, the project needed to go virtual. The implementation transition was almost seamless. One assessment (PICCOLO) had to be dropped because it was decided that a virtual assessment of parenting was not feasible, but otherwise the project continued virtually.

COVID-19 affected both intervention and comparison families and was a discrete event, so we do not believe that it adversely affected the impact part of the evaluation.

Connection of this Implementation Study to Future Research

The evaluation of the GOALS program contributes to the existent literature in a number of important ways. The FCU, as noted above, has been well-studied and subjected to two relatively large-scale randomized control trials of families with young children. However, in the GOALS program the FCU has been extended in several important ways. First, as far as we know it will be the first empirical study examining the implementation of an FCU-style intervention on a community systems-level scale. This evaluation will allow for a preliminary assessment of the impact of having multi-agency coordination and community-wide resource access available to FCMSs. This will provide valuable information to the field about the potential scalability of an FCU-style intervention as well as broaden the scope of family supports that can be provided, which would typically be beyond the capacity of any one agency. Secondly, Dishon, Shaw, and colleagues (e.g., Dishion et al., 2008) extended the original FCU from a pre-teen / adolescent intervention to an early childhood intervention. The GOALS project takes this extension further by including families with newborns to toddlers, as well as early childhood.

We know from a large body of research that the period between 0-3 is critically important for setting the stage for positive development across the lifespan as well as overall family functioning (https://www.zerotothree.org/). The potential for promoting positive long-term effects through a comprehensive but scalable intervention during this critical developmental period for children and families is tremendous. The effects of interventions like GOALS have the potential to be more empowering and self-sustaining within the family because it potentially puts the entire family on a different developmental trajectory from the beginning. Finally, no intervention is one-size fits all, but the GOALS program has separated out universal program components and culturally adaptable implementation strategies, and the evaluation includes a target population with a unique constellation of cultural, racial, and ethnic diversity. The large proportion of MENA (Middle Eastern, North African, Arabic) families in our sample is particularly salient here because these families have been largely absent from previous studies. The study was also able to add several measures to analyze the impact of COVID-19 on families and future research might look at the specific long-term effects of COVID-19 on these families. In summary, the GOALS program contributes to the broader literature on early childhood and family prevention substantially across multiple domains.

Study Approach & Methods

STUDY APPROACH AND METHODS

Data System

With an already established financial relationship with Social Solutions through other related programs and a well-trained internal staff member, selecting Efforts to Outcomes (ETO) was a straightforward process. ETO is a HIPAA compliant case management and customer relationship management system with comprehensive security protocols and unique form-building tools.

With experience building two other databases using Social Solutions' proprietary system, the program was able to leverage internal staff capacity to begin the build-out and maintenance process in house. As assessments shifted post-pilot and necessary changes were implemented throughout the course of the program, having easy access to report building and assessment editing facilitated a nimble and responsive build out experience. While using said proprietary system did limit some of the staff's ability to code some of the more complex assessments, automated scoring was eventually successful for most assessments. Several of the ASSM domains in the Family Profile Form remained challenging to automate scoring on and hand scoring was required.

Implementation Study Design

An implementation evaluation was conducted to determine the ability to successfully implement an adapted version of the Family Check-Up to improve self-sufficiency and child development readiness for families in low-income communities. The study used a series of markers including recruitment (sampling/eligibility and strategy), enrollment, randomization protocols, retention, receipt of services, and fidelity to the model.

Recruitment: Sampling Plan & Eligibility

Participants living in the Southeast Michigan counties of Wayne, Oakland, or Macomb were eligible to participate in GOALS if they met the criteria listed in the call-out box here.

Families that did not meet the income requirements were still eligible if they resided in a zip code determined to be automatically eligible. Zip codes pre-identified as being automatically eligible met at least one of three criteria: high concentration of poverty, high concentration of children five and under living in poverty, or a high concentration of

GOALS Eligibility Criteria:

- Earned less than 200% of the Federal Poverty Line (based on the year of enrollment) or lived in a zip code deemed automatically eligible for service regardless of income as outlined below.
- Were at least 18 years of age.
- Had at least one child aged 5 years or younger.
- Were the legal guardian of that child.
- Lived within the tri-county region (Wayne, Oakland, and Macomb Counties) at the time of recruitment.

school-aged enrollment in the free/reduced school meal program. Concentrated is defined by the United States Census Bureau as a threshold of at or above 40% of the population.

Recruitment: Strategies

Agencies were asked at the beginning of the project to outline their recruitment strategies. A combination of strategies was recommended including posting flyers, advertising at community events, recruiting from the agencies' existing programs, and word of mouth. Most of the agencies used all of these strategies to recruit families at some point over the course of the study. For example, each agency created a flyer to post in their buildings and throughout their communities that gave information about the study and how to join (See Appendix B for an example of the flyers). All recruitment flyers were approved by the Advarra IRB (See Appendix AA for a full description of human subjects protections in place during the study) and adjusted when the amount of evaluation supports a family could receive increased, and again when 12-month follow-up sessions were no longer applicable to newly enrolled families. An overview of the recruitment strategies used by each agency can be found in Appendix C.

Taking into account the eligibility criteria and to support efficient enrollment at the network level, each partner agency identified recruitment zones that represented target zip codes where the agency was already actively serving clients. Recruitment zones were not meant to be exclusive; rather, they provided a snapshot of the agency's service footprint. If a family lived outside of an agency's recruitment zone and sought services from that agency, the agency was not precluded from serving them. The family's existing relationship with the agency, the cost and feasibility of transportation for the family and staff members, as well as other factors were considered before a decision was made about whether the agency would enroll the family in their GOALS study or provide a warm hand-off to another partner agency whose target community included the family's home. Each agency had its own self-selected enrollment targets that were determined based on overall agency make-up and capacity, project budget, and evaluation needs. Maps of each agency's recruitment zones can be found in Appendix D.

It should be noted that there was a significant shift in recruitment strategy at the beginning of the project, as United Way had identified a unified recruitment strategy that they were unable to implement. The strategy consisted of creating a network of agencies (partners and others) to provide families with a Baby Box – a cardboard box filled with materials for families that can also be used as safe-sleep space and is based on the Finnish safe-sleep intervention that has been in existence since the 1930s – to both promote safe-sleep and the GOALS project. However, local concerns around optics, safety, and liability ultimately resulted in United Way not using that strategy.

In response to the Baby Box feedback, United Way adjusted the recruitment strategy by instead creating Baby Bundles. These Baby Bundles were a diaper bag give-away filled with caregiving essentials and parenting materials aimed at supporting a child's development. In an effort to support parent engagement and recruitment efforts, all partner agencies had access to Baby Bundles on an as needed basis.

United Way also utilized their connections with other service agencies throughout the GOALS service areas to get Baby Bundles out into the community. These agencies distributed the bundles through their programs and community events and completed the brief form found in Appendix E. Once per month the recipient information from these Baby Bundle Distribution Forms was filtered by zip code and sent to the GOALS partner agency serving the area. The partner agency would then reach out to the parent to discuss possible participation in the study. Over the course of the entire project over 2,000 Baby Bundles were distributed throughout Wayne, Oakland, and Macomb Counties.

Parents interested in enrolling into the study were asked to fill out a Recruitment Form (Appendix F) which included their name, address, phone number, age, and list of children with gender and age. After the form was returned, a GOALS staff member verified that the zip code in which the parent resided was included in the list of automatically eligible zip codes. If a parent's zip code was not automatically eligible, the SIF staff member was instructed to verbally confirm (either in person or via phone) that the parent met income eligibility requirements. These verifications were recorded on the Recruitment Form.

Additionally, an online platform was developed using Microsoft Forms to track Baby Bundle recipient information along with the corresponding paper distribution form. Agencies were required to complete the Baby Bundle Distribution Form for each participant receiving a bundle within 30 days of receipt. Information could either be collected on the paper form and inputted into the online database or could be entered directly into the database via a tablet.

Enrollment Goals

When GOALS was designed, an objective was set to enroll 1050 families in order to have enough participants to provide sufficient power for a valid impact study. Late in the third year, it became apparent that the enrollment goal would not be reached by the original deadline of April 30, 2019. United Way conferred with Philliber regarding the length of time needed to complete a final analysis. As a result of these conversations, the enrollment period was extended to December 31, 2019. The final date for data collection was also extended from April 30, 2020 to August 31, 2020. This extension would give partner agencies more time to recruit and enroll families, but also meant that any family enrolled after June 30, 2019 would not receive a 12-month follow-up session. It was also decided at this time that families would not be receiving an 18-month follow-up as originally designed so that agencies could focus more energy on recruitment.

Randomization Protocols and Study Retention

Philliber designed randomization protocols for each of the five partner agencies (See Appendix G). It is of note that randomization strategies varied based on how agencies were recruiting families into the project. All of the agencies were using some combination of the following three strategies: recruiting families from existing programs within their agencies, recruiting families through flyers and word of mouth, and recruiting families at wide scale community

events. Once families were recruited into the study, agencies were instructed to follow the randomization protocol to assign them to the intervention or comparison group.

Initially, the randomization protocols instructed agencies to begin the randomization process for families recruited via word of mouth or at large recruitment events as soon as they expressed interest in the project. Families who expressed interest in the study were immediately randomly assigned to either the intervention or comparison group by the agencies. The agencies would then follow up with families to set up the initial assessment appointment. There was often a gap of days or weeks between when a family initially expressed interest and when they were contacted by the agency to set up an appointment. Agencies found that some families lost interest during that time period and never actually enrolled in the study. Other families, particularly those recruited at large community events, may have never been interested or may not have understood what enrollment in the study entailed. As a result, a large number of families who were randomized early in the study never actually enrolled in the study. This led to high baseline attrition numbers.

In order to reduce baseline attrition, Philliber and the United Way worked with agencies in February of 2019 to revise enrollment and randomization protocols. Under the new protocols, agencies did not immediately randomize families that expressed interest in the study. Instead, the agencies recorded contact information from these families and let the families know that they would receive a call from the agency when there was room to immediately enroll new families into the study. Whenever Family Check-Up Model Specialists and Data Collection Specialists had appointment times available, families were contacted to determine if they were still interested in enrolling in the study. Families were also given more information about what was involved in the study and asked whether they were ready to set up an initial appointment right away. If the families expressed both that they remained interested in enrolling and that they were prepared to set up an appointment immediately, they were offered a spot in the study. After the phone call, the agency would randomly assign the family to the intervention or comparison group using the updated randomization protocol. If a family was randomly assigned to the intervention group, a Family Check-Up Model Specialist immediately contacted them to set up the first appointment. If a family was randomly assigned to the comparison group, a Data Collection Specialist immediately contacted them to set up a first appointment.

Additionally, onsite randomization protocols were developed to be used strictly for families that presented themselves to the agency and were ready to enroll in the study and complete their data collection session with an FCMS or DCS *immediately* onsite. These protocols can be found in Appendix H. These protocols were not to be used if a family and/or FCMS or DCS were not readily available.

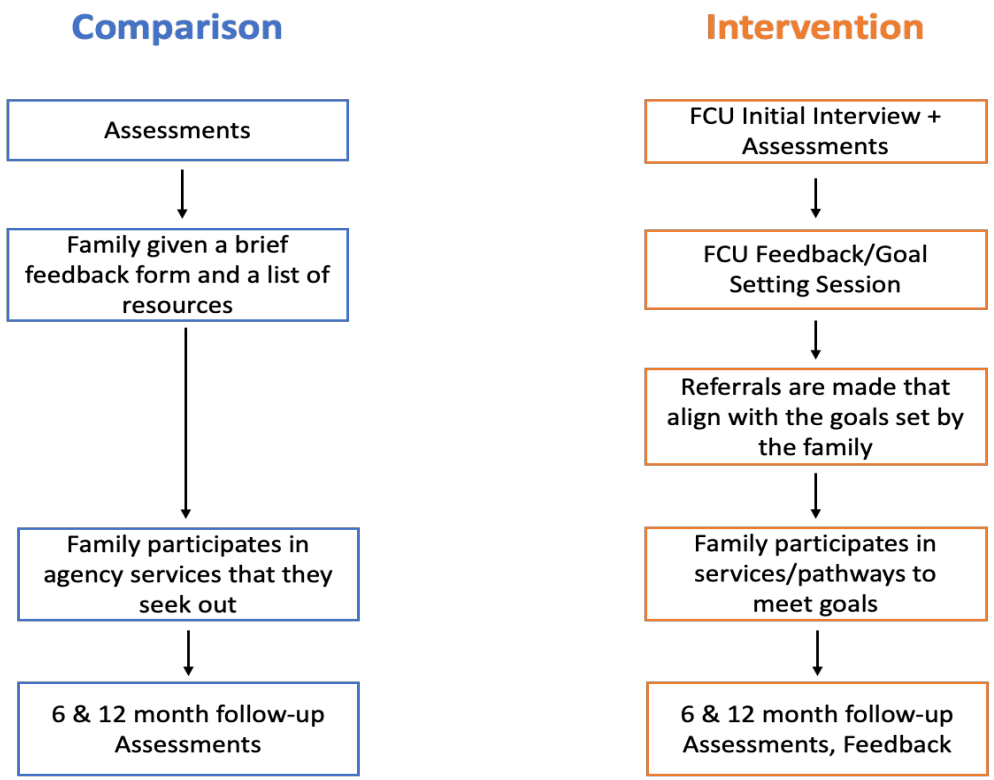
In addition to the protocol changes, the support provided to families for participating in the study increased. Instead of receiving $25 for each set of assessments, families were given $50 for each set of assessments. After these changes, the baseline attrition rate, which was monitored monthly, began to decrease.

What do families receive?

GOALS families received the adapted FCU model and worked with a Family Check-Up Model Specialist (FCMS) who took them through a process where they completed assessments at 6-month intervals that identified their strengths and potential domains for improvement as well as those of their children. Participants identified areas they wanted to strengthen and set goals they wished to attain through comprehensive feedback sessions. The FCMS recommended GOALS pathway programs and other non-pathway services (often using the 2-1-1 information and referral hotline) that could help them achieve those goals. For each timeframe (baseline, 6-month, and 12-month), the entire process typically took place over the course of three or more appointment sessions.

Depending on the recruitment method, comparison families were provided the services they were originally seeking from the agency and/or a standard list of referrals from the agency without the additional support of the FCMS. Comparison families were also assessed in 6-month intervals using the same assessments as GOALS families with the exception of the PICCOLO (a description of this assessment is given later in the report). These families also received a less intensive feedback session (see Appendix O) by their assigned Data Collection Specialist and were given a list of pre-determined resources based on their assessment scores. This process typically took place over the course of two appointment sessions.

Figure 2: Comparison vs. Intervention Process



Fidelity of Implementation

To maintain fidelity to the implementation of the model, monthly reporting between agencies and Philliber were used to track randomization protocol adherence, assessment completion, and participant enrollment. Eligibility, as determined by the participant's Recruitment Form, was established before the actual enrollment process and validated using the Participant Intake Form. Monthly summaries examining follow-up rates, feedback session completion rates, and enrollment rates were used to both monitor attrition rates and proximity to enrollment goals.

Impact Evaluation Design

The evaluation was initially designed as a randomized controlled trial. However, in the early months of the study there were higher than expected baseline attrition rates and lower than expected follow-up rates. This, coupled with a shortened recruitment window, led to a redesign. The project worked to address these setbacks and continued to operate within an experimental framework. The goal of the evaluation was to determine the effects of participation in this adapted version of the FCU model. The study used a series of assessments to determine growth in specific areas that may impact families. Parenting skills (determined by both the Family Profile Form and PICCOLO for GOALS families), the ability for families to meet basic needs, family vulnerabilities, protective factors like community involvement and social supports were markers for areas of growth for parents.

The impact of the FCU model on child development was explored using several developmentally appropriate assessments and screens, including the ASQ-3, ASQ:SE-2, the Rothbart Temperament Scale as well as the Family Profile Form.

GOALS Program Design

One of the adaptations to the standard FCU model made for this study involved changes to the assessment package typically used in the FCU model to determine a family's needs. A number of assessments were used to support families and the evaluation.

Assessments

The assessments used for GOALS were aimed at one primary child and one primary parent but gave a picture of the larger family context as a whole. According to Arizona State University's Research and Education Advancing Children's Health institute (REACH):

> Ecological assessment allows us to assess and learn about child behavior and well-being with each of these different relationships/contexts/perspectives. A multi-contextual assessment of the whole of the child's ecology gives us a broader picture and promotes a better understanding about child and family well-being as well as providing more opportunities to find strengths and to identify issues (2016).

Following is the description of each assessment/screening tool utilized during the study.

The Family Profile Form: Beginning in May 2017, a committee comprised of United Way staff, Philliber, site managers from four partner agencies, FCU model specialists, and three consultants from Wayne State University and Here2There, LLC developed a questionnaire based off of the Arizona Self-Sufficiency Matrix (ASSM). A full description of how this was developed and tested for reliability and validity can be found in Appendix I. This questionnaire, known as the Family Profile Form, was used to assess 17 key family-functioning domains: housing, income, food, adult education, employment, transportation, health care access, mental health, substance abuse, disability, childcare, child education, parenting skills, family social supports, community involvement, safety, life skills, and judicial system involvement (labeled "legal" in the ASSM). You can find the full Family Profile Form and Scoring Guide in Appendices J and K.

The Protective Factors Survey (PFS) was included in the Family Profile Form. The PFS measures protective factors in five areas to prevent child abuse and neglect: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development. The PFS is validated for use with parents of children of all ages. Scores can range from 1 to 7. A higher score reflects a higher level of the protective factors.

Ages & Stages Questionnaires: The Ages & Stages Questionnaires - 3rd Edition (ASQ-3) and the Ages & Stages Questionnaires: Social-Emotional - 2nd Edition (ASQ:SE-2) are widely used developmental screening tools that assess core domains of development during infancy and early childhood. Specifically, the ASQ-3 assesses gross motor functioning, fine motor functioning, problem solving, communication, and personal/social development. The ASQ-SE:2 assesses social-emotional aspects of development as well. These are parent or parent report measures that do not require extensive training to administer. Both ASQs use age-graded norms to indicate levels of developmental delay or "risk" at a given age.

Rothbart Temperament Scales: Parents of target children aged three months and older completed two scales from an age appropriate Rothbart Temperament Scale for children. Parents of target children between the ages of three and 12 months completed the Infant Behavior Questionnaire (IBQ-R). Parents of target children between the ages of 13 and 36 months completed the Early Childhood Behavior Questionnaire (ECBQ). Parents of target children ages three years and older completed the Children's Behavior Questionnaire (CBQ). It is of note that there is no Rothbart Temperament Questionnaire specifically designed for children between the ages of 13 and 17 months. For the purposes of this study, parents of children in that age range were instructed to complete the ECBQ.

The IBQ-R and ECBQ are parent report assessments comprised of 7 and 12 items respectively. Items are on a 7-point Likert scale. Both the IBQ-R and ECBQ have acceptable psychometric properties with Cronbach's alphas ranging from .72 - .75.

The two Rothbart Temperament sub scales used for this study were the Effortful Control scale and the Negative Affect scale. Effortful Control refers to the dimension of temperament that relates to a person's ability to maintain sustained attention and focus and regulate their own

behavior (Rothbart, Ellis, Rueda, & Posner, 2003). Negative Affect relates to the part of temperament that involves a person's ability to cope with negative emotions (Putnam, Gartstein, & Rothbart, 2015).

Feeding Your Child: The Feeding Your Child questionnaire is a 15-item questionnaire about the practices parents use when feeding their children. The items use a 4-point Likert scale rating different practices based on how frequently they used each practice. This survey was included as part of the GOALS project because it is a key assessment in the Feeding Eating and Succeeding Together (FEAST) pathway which is a GOALS pathway. The Feeding Your Child questionnaire can be found in Appendix L.

PICCOLO: The Parenting Interactions with Children Checklist of Observations Linked to Outcomes (PICCOLO) assesses positive parenting based on observations of interactive parent-child play activities. In the study, only intervention families were given the PICCOLO assessment. In GOALS, parent-child play occurred during the assessment session for families who were randomized to the Family Check-Up condition. Specific toys and other materials for the parent-child play activities were agreed upon by agency managers and Family Check-Up Model Specialists (FCMS) across sites. Materials were developmentally appropriate, meaning that many of the play materials differed for infants, toddlers, and preschool-aged children. FCMSs typically scored the PICCOLO from video recordings of the play session, unless families declined to have their play sessions recorded. The PICCOLO includes 29 items across 4 domains: Affection, Responsivity, Encouragement, and Teaching. Each item is scored as 0 (not at all there), 1 (barely there), or 2 (mostly there). Each item focuses on a specific observable parenting behavior (e.g., "Speaks in a warm tone of voice."). Each PICCOLO domain is scored by tabulating the sum of the 7 to 8 items in the domain. FCMSs received training in PICCOLO scoring and the PICCOLO manual provides detailed explanations to guide scoring decisions for individual items.

Case Closure Form: Halfway through the study, FCMSs and DCSs expressed that the current assessments did not show the incremental growth families experienced while participating. As a result, the Evaluation Team created a Case Closure Form for specialists to complete after their final feedback sessions with a family. This form was completed by the FCMSs and DCSs and allowed them to provide feedback about whether and how much families had shown improvement while enrolled in the program. This form was not completed for families that had closed out their cases with a specialist that had already left the program by the end of March 2020. Specialists who worked with a family solely for case closure were also not required to complete the form if they were uncomfortable commenting on the growth of the family. The Case Closure Form can be found in Appendix M.

Feedback Sessions

Every family enrolled in the GOALS program received a feedback session that reviewed the family's strengths and areas in need of attention, as reflected in the assessments listed above. Families enrolled in the GOALS program received the Family Feedback Form found in

Appendix N. On these forms, FCMSs marked where the family fell on the scale from Strength to Needs Attention for each area listed. FCMSs used these forms to guide their conversations with families and to help parents reflect on how they saw their family. FCMSs were instructed to ask parents if the strengths and areas of improvement aligned with how the parent viewed their family.

After reviewing results from the assessments GOALS families worked with their FCMS to set SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) goals that supported the family's growth. Family goals could be small (e.g., cleaning out the garage) to life-changing (e.g., obtaining a GED). After goals were set, FCMSs completed the Family Goals Form (see Appendix P) with the family that included three goals, steps to reach the goals, and resources needed. A copy of this colorful sheet was given to families, who, based on the successful past use of a similar tool by one of the partner agencies, were encouraged to display it somewhere in the house it would often be seen (e.g., the refrigerator).

The last part of the feedback session included providing resources and referrals for the family. Referrals were made based on growth areas that needed attention as highlighted in the Family Feedback Form, as well as on goals that the family had set. FCMSs were instructed to enter their Feedback Session prepared with a menu of resources to which they could refer the family, but to be prepared to only share as much information with the family as was appropriate based on their interest in resources and their capacity for follow-through. Referrals were made to pathway programs as described below, to 2-1-1 – a United Way managed information and referral hotline, and/or other community and agency resources.

> *"Resources can be difficult to navigate and take time and perseverance that families in crisis often must use elsewhere."*
>
> - Family Check-Up Model Specialist, Oakland Family Services

Pathways were a portfolio of evidence-based programming offered by each of the GOALS partnering agencies. These previously established programs were adapted to support a "no wrong door" approach to offering services. This approach allowed families to be referred into a pathway when assessment data indicated a need, but also allowed families to be recruited into GOALS from a pathway program.

Prior to the selection of pathways, three need areas were identified as being focal points of the GOALS project: Parenting Education, Health Care Access and Support; and Nutrition/Family Feeding Practices.

To be considered for the GOALS project, all pathways were required to meet specific criteria:

- Aligned with the key need areas.
- Had measurable outcomes or data to reflect participation success, such as pre-/post-test or other measurements.

- Ability to reflect gains in relevant assessment areas of GOALS.
- Were on-going, rather than episodic or one-time.
- Did not address significant or complex crisis situations or offer specialized services. FCMSs were trained to address crisis situations immediately and refer to specialized supportive services when needed.

After implementation of GOALS began, pathways were occasionally added if there seemed to be a large need based on participant assessment data. The final list of pathways and descriptions can be found in Appendix Q.

The process for referring into pathway programs varied depending on the home agency of each FCMS. Should a specialist refer to a program within their own agency, the FCMS followed their agency's internal protocols. For pathway programs existing outside their own agency FCMSs adhered to the referral protocols that were included in the GOALS Implementation Manual for each program.

Families whose need(s) could not be met through a GOALS pathway were either referred to other programs within the partner agency, to the 2-1-1 information and referral hotline, or to programs outside the five SIF partner agencies. These referrals often addressed more immediate needs like food, utility assistance and housing, as well as hard to find services like transportation and material goods. FCMSs who needed to make a referral to a community resource for an identified basic need were encouraged to call 2-1-1 together with their family during the Feedback Session. Referrals made outside of the partner agencies and 2-1-1 were based on the FCMS's knowledge of local resources.

Referral Follow-Up

In the months following the feedback session FCMSs occasionally reached out to families for a brief check-in. Families would report on if they had successfully connected with the resources provided and received additional resources/referrals if needed. FCMSs also used this time to check if parents had made any progress towards the goals they had developed during their last feedback session. These check-ins were often arranged around key dates in a family's goals.

Preparing for the GOALS Program

The Family Check-Up Training and Certification

All Family Check-Up Model Specialists (FCMS) received structured training in the Family Check Up (FCU) model. Initial training consisted of two primary components: E-learning that was available via Arizona State University's Research and Education Advancing Children's Health (REACH) Institute website and in person learning. E-learning was completed before the in person learning and included several modules that provided an overview of the three core components of the FCU (the Initial Interview, Assessments, and the Feedback Session) as well as the FCU's "COACH" fidelity rating system. E-learning also included quizzes to assess basic knowledge of the components. In person learning included approximately one day of didactic

learning of FCU components along with several opportunities to perform role plays of specific aspects of the FCU.

The first in person FCU training took place in September 2017 at Wayne State University and was led by two certified FCU trainers who are affiliated with the REACH Institute. FCMS who joined the GOALS project after September 2017 also completed e-learning and in person training that was led by either a certified FCU trainer affiliated with the REACH Institute or Dr. Christopher Trentacosta, a United Way consultant and Associate Professor of Psychology at Wayne State University who became a certified FCU supervisor and trainer in June 2018. The in-person training that was conducted after September 2017 followed the same overall structure, but typically included smaller groups of 2 to 3 FCMSs.

FCMSs were also encouraged to pursue certification in the FCU. Certification involved pre- and post-feedback consultation with REACH Institute providers or Dr. Trentacosta, project consultant, who also rated the FCMS's video-recorded Feedback Sessions using the COACH rating system. FCMSs who received COACH ratings at the "component" level or higher for all five COACH domains for two cases became certified. Many FCMSs became certified in the FCU; however, several FCMSs did not become certified, either because they chose not to pursue certification or because they left their position before completing the certification process. Unfortunately, the COVID-19 pandemic interfered with some FCMSs becoming certified since sessions with families were no longer being held in person.

Assessment of Program Readiness

United Way provided ongoing comprehensive training and support to partner agencies to help them implement The Family Check-Up model. Surveys were conducted during the pilot phase to gauge how prepared FCMSs felt for the implementation phase of the project. Appendix R shows a summary of the survey responses from 20 of the initial 22 agency staff persons either working directly with families (n=11), serving as supervisors (n=5), or serving in some other capacity (n=4) after initial program training.

At the conclusion of the four-month pilot phase of the project, evaluators submitted a pilot report that provided a comprehensive overview of successes and challenges that arose during the pilot. Key findings and actions included the following:

- *All agencies developed appropriate plans to recruit the required number of participants. This process required a full understanding of the research design and resources available.*
- *The content of instruments used to describe the study to participants was majorly revised to align with the intervention. The wording of some instruments used to capture study outcomes was slightly modified to align with the Family Check-Up Model Specialists' (FCMS) perception of how best to ask questions of participants. All instruments were translated to Spanish and Arabic.*

- *The majority of staff members were prepared for implementation as a result of the training provided by United Way, and confidence grew during the pilot.*
- *Staff were able to learn to use the Efforts to Outcomes (ETO) data management system to log information; however, ETO was still undergoing many changes at the end of the pilot and had not yet reached full functionality.*
- *Agencies used the trainings and pilot period to become familiar with how the intervention differed from their normal standards of care, how recruitment and randomization would work, and how measurements and protocols were related to the project goals.*

Fidelity to GOALS Program Design

GOALS utilized a variety of data points in the Efforts to Outcomes database to monitor fidelity in various aspects of the Family Check-Up model implementation. The components that were monitored on an on-going basis were the FCMS using light-touch intervention to work with families, completing assessments, setting goals, and making referrals to services.

Light-touch Intervention

GOALS was designed to be a light-touch intervention for families in need. In an effort to gauge how often FCMSs communicated with their families, United Way created a Communication Log. Knowing that different communities would require different communication strategies, United Way established a protocol to determine the volume and intensity of efforts to connect in-person and virtually with our participants. The process involved identifying the type of contact, meeting timeframe and type, time of the meeting, and robust note-taking procedures. Each time an FCMS contacted a participant, or was contacted by a participant, they recorded the communication as a "touchpoint" in the ETO database.

> *"It often seemed that sometimes what families needed most was just a caring ear, a warm heart, and the validation of their reality."*
>
> - Family Check-Up Model Specialist, Oakland Family Services

Partner agencies were responsive to their populations' communication styles, with unique experiences in terms of chosen communication mechanisms. Leveraging technology, FCMSs and DCSs were able to be responsive to the ways a participant needed to communicate.

Assessments

The assessment package varied slightly from family to family based on the age of the focus child. Specialists were instructed to select assessments based on the focus child age as outlined in Figure 3. ETO designation referred to which family member (parent or child) on which the assessment was based.

Figure 3: Assessment Matrix

Assessment	Age Range	ETO Designation
Family Profile Form / Arizona Self-Sufficiency Matrix	All ages	Parent
Feeding Your Child	2 and up	Parent
ASQ-3	All ages, select the appropriate questionnaire based on child's birthday	Focus Child
ASQ:SE-2	All ages, select the appropriate questionnaire based on child's birthday	Focus Child
Temperament Questionnaires (Select One): • Infant Behavior Questionnaire-R • Early Childhood Behavior Questionnaire • Childhood Behavior Questionnaire	• IBQ-R: 3 – 12 months • ECBQ: 13 – 36 months • CBQ: 3 and up	Focus Child
PICCOLO parent-child interaction script and age-appropriate materials	4 months and up	Parent

FCMSs were instructed to enter all the assessments described above into the Efforts to Outcomes database. Each entry included the date the assessment was taken, the timeframe of the assessment (baseline, six-month, or 12-month), as well as responses to each individual question. Scores for each assessment were automatically generated to reduce the possibility of errors in hand scoring. DCSs were required to use the auto-generated score. Data audits, which will be discussed later, were conducted throughout the study to ensure families received all applicable assessments and to maintain accurate records.

Goal Tracker

After feedback sessions were complete, FCMSs were required to upload the family's goals into the Efforts to Outcome database. Each goal entry in ETO included the goal set, the corresponding ASSM domain, resources given, and goal progress. As a monitoring procedure, United Way pulled a Goal Tracker report from ETO to determine how many goals had been set by families.

Referral Log

Regardless of the source, each referral was tracked in the Efforts to Outcomes database using the Family Check-Up Referral Log. A copy of this form can be found in Appendix S. This form captured the type of referral being made, the corresponding Arizona Self-Sufficiency Matrix category, as well as if the referral were made in relation to a set goal. Use of pathways were also

captured in this way, including if a family was participating in the pathway program at the time of enrollment into the study. Reports were pulled throughout the study to monitor the activity in the Referral Log to ensure referrals were properly made and recorded.

Program Exposure (Dosage)

GOALS families were supported using the study design of light-touch care coordination. This meant that families who needed intensive support and services were referred to such services instead of enrolled into the study. Families were able to receive check-ins more frequently if needed, or as the FCMS saw fit, depending on the families' goals and needs, but were not expected to occur on a frequent (e.g., weekly) basis. As it was designed, GOALS families typically received three (or more) total visits with their FCMS: two (or more) for initial interview and assessments and one feedback session. Families had baseline, 6-month and possibly 12-month sessions, depending on date of enrollment. Fidelity to this model was measured in a number of ways including communication logs, follow-up rates, and evaluation support reports.

Communication Logs

As mentioned earlier, all communication with participants was recorded in the Efforts to Outcomes database. Not only were these records used to ensure fidelity to the light touch intervention aspect of the Family Check-Up model, they were also used to measure the amount of exposure participants had to the program.

Follow-Up Rates

Follow-up rates were also used to measure a participant's exposure. Upon enrollment into the study, families were informed they would be participating in assessment sessions every six months for the duration of their enrollment. For families enrolled prior to June 30, 2019, this meant assessment sessions were conducted at baseline, six-months, and 12-months. Families enrolled after that date participated in assessments at baseline and six-months only.

Families were included in the follow-up counts if they had at least one follow-up session with an FCMS or a DCS and had completed at least one of the follow-up assessments. Six-month follow-up dates were calculated by adding six months to the date of intake, while 12-month follow-up dates were calculated by adding 12 months to the date of intake. By September 30, 2020 follow-up dates for all families had passed.

Evaluation Support Reports

Evaluation Support Reports were also designed to help measure exposure to the program. Families did not receive their evaluation support (initially $25 which was increased to $50) until a feedback session had been completed for the assessment time frame (baseline, 6- or 12-month). On rare occasions, families became unreachable between the assessment session and feedback session. As a result, a family missing the feedback would experience less exposure to

the program than those who completed the full set of sessions. The Evaluation Support Report reflected those families that may have lost touch with their agency.

Program Quality - Agency Level

Program quality was measured on two levels: the agency level and the specialist level. At the agency level, program quality was monitored using various monthly and quarterly tools. Data audits were used on an as-needed basis to monitor data entry quality as well.

Monthly Summaries

Multiple methods were used throughout the study to maintain a high level of program quality. Phillliber Research and Evaluation provided a Monthly Summary to United Way documenting how many participants had enrolled to date and how many follow-up assessments had been completed. The summary also reported on the characteristics of families enrolled as well as baseline scores for the various assessments described in previous sections. Separate monthly summaries were created for each partner agency as well that included agency-level enrollment information and combined assessment findings across agencies. These agency-level summaries helped agency program managers also keep track of their program's performance. United Way and the project evaluation team reviewed each monthly summary during one of their bi-weekly evaluation calls. During these calls, the evaluation team would discuss any ongoing implementation concerns or those that arose over the past few weeks.

Monthly Monitoring Tools

- Summaries from Phillliber
- All-Agencies Manager Meetings
- Agency Site Visits with United Way

Quarterly Monitoring Tools

- Evaluation Site Visits with Phillliber
- Agency Monitoring Reports
- Agency Progress Reports

Monthly Manager Meetings

United Way, Dr. Trentacosta, and all partner agency program managers met on a monthly basis. These meetings were used to provide updates from both agencies and United Way as well as to address any portfolio-wide concerns that arose in the last month. The group often worked collaboratively to address problems agencies were facing while implementing the study. Some of the topics that were addressed were recruitment struggles, attrition, follow-up rates, and staff retention.

Monthly Agency Site-Visits

Once per month the SIF Manager from United Way met with the program manager at each agency. These meetings were used to provide updates from both parties as well as to address

questions and/or concerns United Way or the agency had regarding implementation. Notes were taken and shared with both parties following the conclusion of the meeting.

Quarterly Evaluation Site Visits

Phillber conducted quarterly site visits with each agency. Most of these site visits occurred in person. However, weather conditions and the global health pandemic dictated that some of these site visits be conducted virtually. Detailed site visit guides were developed to facilitate a structured conversation about project implementation and evaluation. During these site visits, agencies were also provided with more detailed demographic and baseline assessment data about the families they served. The site visits were summarized in memos for United Way and discussed during monthly meetings with United Way.

Quarterly Monitoring Reports

The above Monthly Summaries were used to create individual quarterly monitoring reports for each agency. These reports documented compliance to program and study implementation. They reported data from the monthly summaries including enrollment, attrition, and follow-up rates; monthly meeting attendance; financial match obligations; and timely reporting. The Quarterly Monitoring Reports were color coded red, yellow, and green to coordinate with areas that needed improvement, were being monitored, or were on track with targets respectively. United Way provided a copy of the Quarterly Monitoring Report to partner agencies on a quarterly basis. The report was then reviewed and discussed with agency program managers during one of the monthly site visits. Strategies were developed to address any area of agency performance that needed improvement.

Quarterly Progress Reports

Partner agencies were required to submit progress reports on a quarterly basis. These reports were modeled after the bi-annual report required of United Way by CNCS. In these reports, agencies provided detailed descriptions of the progress made toward implementation goals, challenges and successes faced during implementation, and other notes related to agency performance. Through these reports partner agencies were also able to suggest additional trainings and relay success stories from families enrolled in the study. A blank copy of a Quarterly Progress Report can be found in Appendix T.

Data Audits

Data audits were performed to ensure all data entered into the Efforts to Outcomes database was up-to-date and accurate. Enrollment forms, which collected demographic data about the family, were checked for missing data. When items were found to be missing, specialists were asked to follow-up with the family when they were reassessed to obtain the information.

Assessments were also included in the data audits. Each assessment was checked for missing or inaccurate data. The most common errors found during data audits included missing question responses, missing or duplicate time frames, and assessments reported under the wrong family

member (i.e., ECBQ reported under parent instead of focus child). If an error was found, agencies were instructed to review their files and make any necessary corrections. Many of the assessments used multiple items to measure a single variable; therefore, overall scores for each variable were based on questions that were answered. Missing and duplicate assessment time frames were often found to be a result of human error selecting the wrong time frame in ETO. However, some assessments missed were due to the family opting out or the child aging out of the assessment. In these cases, the specialist was instructed to record the reason for the missing assessment in ETO.

Analytic Strategy

Consensus generating methods were used to analyze qualitative implementation data. An expert panel from the project team met bi-monthly over the course of the project period to review all implementation data. These experts included: Jeffrey D. Miles, MSW, Center for Early Childhood Excellence Executive Director; Melanie Gill, MPA, Social Innovation Fund Manager; Melissa Bowman, MPP, Data Analytics & Visualization Manager; and Maya Satterwhite, Data Specialist, from United Way; Dr. Randi Burlew, Senior Research Associate from Philliber Research and Evaluation; Dr. Robert Ty Partridge, Associate Professor of Psychology and Dr. Christopher Trentacosta, Associate Professor of Psychology from Wayne State University; and Dr. Alice Audie-Figueroa, Early Childhood Strategy Consultant from Here2There, LLC. Standing meeting agenda items included reviewing the monthly summary and presenting meeting minutes from monthly manager meetings and agency site visits (conducted by United Way), as well as summaries of quarterly progress reports, quarterly monitoring reports, and bi-annual data audits. At the end of the meetings, the panel worked to come to consensus on challenges and next steps.

The expert panel used a modified nominal group technique to collect and analyze quarterly evaluation site visit data. The evaluation team drafted the initial questions for each evaluation site visit which were then presented to the expert panel for feedback. The draft was then discussed during a bi-monthly panel meeting until consensus was reached on the final list of questions. The questions were then sent to agencies in advance of site visits so that appropriate staff could be invited to the site visit and needed data could be collected for discussion.

Dr. Burlew, the lead evaluator for the project led the site visits at each agency along with Heather Hirsch, MS, a data analyst on the project, who took detailed notes. Dr. Burlew and Ms. Hirsch were sometimes accompanied by other members of the expert panel during site visits. At the conclusion of the site visits, Dr. Burlew and Ms. Hirsch analyzed the site visit notes for themes. Themes from the site visits were then presented to the expert panel during a bi-monthly meeting. The themes were discussed until consensus was reached about conclusions and next steps. These conclusions and next steps were then summarized in a memo by the evaluation team and circulated to the expert panel for feedback, after which a final document was submitted.

Evaluators sought to confirm conclusions reached through the site visits through regular surveys and close out interviews with agency staff. In cases where conclusions drawn from evaluation site visits were in conflict with data collected through surveys and interviews with agency staff, discussions were held with agency staff during manager meetings to provide clarity.

Program Quality - Specialist Level

A combination of previously reported measures was used to assure program quality at a specialist level. Qualitatively, FCMSs went through extensive training on the Family Check-Up model and were highly encouraged to become certified in the model. FCMSs also participated in monthly hour-long "Learning Communities" where FCMSs presented challenging cases from their GOALS caseload. During Learning Communities, Dr. Trentacosta also provided training and support on specific aspects of the FCU such as goal setting. These Learning Communities gave United Way and Dr. Trentacosta an opportunity to gauge fidelity to the Family Check-Up model and to troubleshoot any problem areas that were observed.

Additional trainings were also offered throughout the study in response to challenges FCMSs reported facing during the Learning Communities. Some of these trainings included Motivational Interviewing, Home Visitor Safety, Recognizing and Supporting Human Trafficking Victims and Survivors, SMART Goal Setting, Domestic Abuse, and many others.

To monitor the quality of services provided by the FCMSs in a more quantitative way, a variety of reports were pulled from the Efforts to Outcomes database. The Goal Tracker and Referral Tracker (both described above) allowed managers to confirm that FCMSs helped families create goals and offered referrals to help the family reach them. Additionally, Communication Logs and Follow-Up Rates represented the quality of the services and the rapport specialists were able to build with the families they served.

Program Participant Responsiveness

Program Participant Responsiveness was measured using the Goal Setting Form and the Case Closure Form. Midway through the study, it was discovered that many families were not setting goals with their FCMS during the feedback sessions. This topic was discussed at a Learning Community where FCMSs reported that families were not comfortable setting goals they did not feel they could achieve. This issue was addressed through additional training and technical assistance and an increase in goals set was reflected in the following data audit.

As part of the Case Closure Form FCMSs were asked a variety of questions regarding the growth a family showed throughout their time in the study. They rated a family's growth from

"Participants became goal-oriented. The more goals participants were able to achieve, the more goals they wanted to set."

- Family Check-Up Model Specialist, ACCESS

"Regressed a lot" to "Grew a lot" and also evaluated the progress families made towards reaching their goals, from "Achieved none of their goals" to "Achieved all of their goals." Both FCMSs and DCSs were also asked to rate the amount of growth for each dimension assessed by the Arizona Self Sufficiency Matrix. It is of note that the study protocol did not require FCMSs and DCSs to provide support or resources in every area covered by the ASSM. Support provided to the GOALS families by FCMSs was driven by assessment results, goals set, and the needs expressed by the families. DCSs provided general resources to families in the comparison group based on their agency's referral protocols. Thus, FCMSs and DCSs were asked to rate families only in the areas in which they felt they had adequate information to make a clinical assessment.

Program Differentiation

The following partner agency descriptions are based on each organization's completed Request for Qualifications at the beginning of the study.

ACCESS

Arab Community Center for Economic and Social Services (ACCESS) is the largest Arab American community nonprofit in the United States, with their 11 locations and more than 120 programs offering social, economic, health and educational services to more than 70,000 people per year in metropolitan Detroit. Since 1971, ACCESS has worked to meet the needs of families and communities with a comprehensive system of programs and services that translate to a stronger society. Their programs include Even Start Family Literacy and Early On Program, Parents as Teachers, Great Parents/Great Start, 21st Century Community Learning Centers, and Early Learning Communities.

Having provided services to some of Metro Detroit's most vulnerable residents for almost 50 years, ACCESS has become a respected and trusted organization within their community. They have used their knowledge of the community, and content expertise, to modify programming to meet the needs and overcome barriers for the underserved communities of Southwest Detroit and South Dearborn. Demographically, Arab Americans make up 65% of ACCESS's clientele. However, while they were founded to serve the Arab American immigrant community, they provide service to anyone who walks through the doors of their multiple locations. Their programs and services are delivered in a culturally and linguistically appropriate manner, in more than 18 languages.

ACCESS had also been a partner agency for United Way's Social Innovation Fund 2011 grant. For more information, see: https://www.nationalservice.gov/impact-our-nation/evidence-exchange/united-way-southeastern-michigan-and-access-access-school

CARE of Southeast Michigan

CARE of Southeast Michigan's (CARE) mission is to strengthen resiliency in people and their communities through prevention, education and services that improve their quality of life. Founded in 1977 to provide free assessments and referrals for those experiencing difficulties because of problematic use of alcohol and/or other drugs, CARE has become an anchor agency in the community. Their programming still primarily focuses on substance abuse prevention and recovery, harm-reduction, co-occurring mental health challenges, and personal or workplace issues. They provide parenting, substance abuse, mental health, family support and employee assistance services to 20,000 people per year in Macomb County.

Having provided services and referrals to clients for over 40 years, CARE had developed strong partnerships with external agencies and organizations. As part of a continuum of care for families, CARE staff was knowledgeable about available community services and resources. Prior to participating in the SIF study, CARE had been utilizing the Arizona Self-Sufficiency Matrix in their programming and more than 20 staff members had already been training in motivational interviewing.

Leaps and Bounds Family Services

Leaps and Bounds Family Services (LBFS) was founded in 1988 with the mission: "to creatively and collaboratively address the educational, health and economic needs of children and families at risk." Since the beginning, the agency has provided services to high risk, low income families with children. While a relatively small agency, especially in comparison with other partner agencies, LBFS offers a variety of services to areas in the cities of Detroit and Hamtramck, as well as Macomb County. LBFS provides adult education, GED preparation classes, access to emergency food and baby needs, child care provider training and quality improvement, play and learn groups, home visiting and parent education workshops. Their small size allowed staff to work collaboratively and collectively to ensure agency clientele have information and access to all services.

Over the years LBFS has developed strong partnerships and connections with other agencies in the community. One of their partnerships included being a partner agency on United Way's Social Innovation Fund 2011 grant. For more information, see: https://www.nationalservice.gov/impact-our-nation/evidence-exchange/ready-children-ready-communities-final-report

National Kidney Foundation of Michigan

National Kidney Foundation of Michigan's (NKFM) mission is to prevent chronic kidney disease and improve the quality of life for those living with it. With offices throughout the state of Michigan (Ann Arbor, Detroit, Flint, and Grand Rapids) NKFM provides services to increase health education, improve health practices, and increase access to healthcare for families to increase self-sufficiency and resiliency. It was their vision of helping people increase their self-sufficiency that led them to United Way's SIF16 study. NKFM believed that the adoption of

healthy lifestyle behaviors through prevention efforts was an essential step in gaining self-sufficiency.

For the current study, NKFM was the only partner agency that did not provide direct early childhood services to clients. However, due to their early childhood nutrition program being offered in 108 Head Start and Early Head Starts throughout Southeast Michigan, NKFM had developed a network of early childhood relationships to draw upon for the SIF study.

Prior to participation in United Way's SIF16 study, NKFM had been a partner on United Way's Social Innovation Fund 2011 grant. For more information, see: https://www.nationalservice.gov/impact-our-nation/evidence-exchange/national-kidney-foundation-michigan-final-peach-implementation

Oakland Family Services

Oakland Family Services (OFS)'s mission is "Providing individuals and families the opportunity to build brighter futures." Founded in 1921, OFS has almost a century of experience in providing services to children and families with multiple risk factors including poverty, child abuse and neglect, and developmental delays. The organization provides prevention, education and treatment services to families from five locations in Oakland County. Some of the programming includes developmental assessments of children, free preschool, parent and child care provider workshops, playgroups, and in-home parent education and support.

OFS utilized a "no wrong door" approach similar to that of the current study prior to participation in SIF. Any client that came to OFS for services was assessed for other services needed and referred to internal and/or external resources. Prior to the SIF study, Oakland Family Services had already built a vast network of resources and participated in the Great Start Oakland Collaborative which included early childhood service providers, parents, and representatives from government and business.

Participant Satisfaction

The study did not rely exclusively on direct assessments of participant satisfaction with the GOALS project. This was an intentional decision as there are a number of difficulties with assessments of program satisfaction as an index of program success. Participant program satisfaction can be a useful proxy for program engagement and adherence, but it is often not a good index of program outcomes or impact. Further, self-report participant satisfaction assessments administered by program staff are susceptible to a false-positivity bias due to the lack of perceived anonymity and fears of losing services on the part of participants. As a result, we chose to also include more direct indicators of satisfaction via program engagement and retention. The retention rates for GOALS families were 78.5% and 75.1% for the 6-month and 12-month follow-up. This is comparatively high for multi-service programs for families with young children. A recent analysis of retention rates across 26 home visitation programs found

an average 12-month retention of only 58% (Janczewski et al., 2019). Program engagement was also very high with [consistency of contacts]

Service Participation Survey

A variety of both quantitative and qualitative measures were used to determine participant satisfaction with the study. A Service Participation Survey (see Appendix U) was conducted with participants at baseline, 6-month, and 12-month follow-ups. In this survey participants were asked about their experiences using services at the partner agency as well as the United Way 2-1-1 helpline. One of the questions asked participants to rate their satisfaction with their service experience from "Very Satisfied" to "Very Dissatisfied." At both six- and twelve-month follow-up, 99% of families enrolled in GOALS indicated that they were either very satisfied or satisfied with the assistance they were receiving from their agency. In addition, families reported a high level of satisfaction with the United Way 2-1-1 helpline. In particular, most families that used the service reported that they were provided with referrals that they were eligible for and that they actually received the services. Further, at both six- and twelve-month follow-up, nearly all of the families that had used the helpline indicated that they were satisfied or very satisfied with the help they received.

End of Study Surveys

At the conclusion of the study, 23 current staff completed End of Study Surveys (see Appendix V) regarding their experiences implementing the GOALS project and accompanying evaluation. The survey included questions that required staff to reflect on the client experience and included how well GOALS fit with families and what families found most beneficial. The overwhelming majority of staff surveyed indicated that they thought that the GOALS program was a good fit for the families their agency served, and they indicated that they believed most of the families felt helped by the GOALS program. One of the FCMS from CARE described her perception of the work she did with one of the families on her caseload as follows: *"I had a family in the intervention group that was homeless at the time of their initial assessment and living at a hotel. I was able to connect them with housing resources and they eventually worked with Salvation Army to help them find housing, as well as connecting them to resources for education, mental health, food, clothing and child development needs. The mother was also referred to my agency's in home parenting program where mom was able to set goals and a routine for her children once they had secured a home about a month after her initial assessment. I think just being a sense of emotional support, getting mom to set goals so that she would have something to work on and look forward to, as well as connecting her to resources to help her and*

> *"I feel that many of my clients appreciated the client-centered, strengths-based approach that the FCMS provides. I also feel that most of my clients appreciated the one-on-one support when in need of resources."*
>
> - Family Check-Up Model Specialist, Oakland Family Services

her family get back on their feet were the most helpful parts of the model, pertaining to her participation in the program."

Key Informant Interviews

Throughout the study conversations were had with FCMSs and agency Program Managers regarding how families were responding to the program. Multiple opportunities were provided to staff to participate in these discussions including the monthly Learning Communities, Manager Meetings, and agency site visits. Additionally, at the end of the study, Phillibert interviewed each current staff member including DCSs. United Way also used focus groups and open-ended essays to give staff members an opportunity to provide feedback on the overall project.

Staff indicated in close out interviews that they believed families felt helped by the GOALS program. FCMS indicated that families increased their motivation to set and reach goals and were excited to achieve the goals that they set for their families. The families seemed to feel helped by the positive, strengths-based approach that the model used.

> *"The study helped me to see that people need a lot of guidance and a hands on approach in order to meet there [sic] needs. They need goals set with them and to be followed up on, encouragement, and help along the way."*
>
> - Data Collection Specialist, CARE of Southeastern Michigan

Data Analysis Methods

DATA ANALYSIS METHODS

Changes Made for the Final SIF Evaluation Plan

As a result of funding restructuring reducing the timeline of the grant to run from 2016-2020 instead of 2016-2021, the focus of the SEP shifted from an outcome and impact evaluation to an implementation evaluation. In adding, the data collection period was reduced from 4 years to 3 years in length.

The initial SEP emphasized reducing missing data via the development of a protocol for following up with participants who missed a data collection; first through the partner agency and then by Philliber to keep attrition to a minimum. In the revised SEP it was further proposed to assess potential biases introduced into the data as a function of missing data and then using multiple imputation techniques to obtain complete data with unbiased estimates.

Also as a result of the reduced timeline, the data follow-up protocol removed 18-month assessments which were anticipated for participants that enrolled in the first six months of the project. Those without 18-month data would be treated as having data missing by design and thus it would not introduce bias into the sample statistics. However, once this fourth time point assessment was removed it became no longer necessary to use a missing-by-design approach.

Other changes made for the final SEP are as follows:

- Power analyses were adjusted to account for the shorter timeframe of the project.
- The final set of measures was selected and included:
    - The Family Profile Form
    - Ages & Stages Questionnaires, Third Edition
    - Ages & Stages Questionnaires: Social Emotional, Second Edition
    - Rothbart Temperament Negative Affect and Effortful Control subscales
    - Feeding Your Child Survey
- Randomization protocols were adapted to ensure that randomization did not take place until after the agency had secured an initial appointment for assessment with the family.
- Incentives were increased to $50 (from $25) in order to reduce attrition.

Lastly, major evaluation milestones included in the original SEP were shifted to reflect the greater focus on implementation rather than impact analysis. This also included the addition of regular monthly reports by Philliber, reporting on the status of program implementation. Additionally, quarterly interviews with program leads and staff were added to the evaluation protocols, as well as exit interviews for outgoing staff.

Database Usage

Data were entered by the FCMS or Data Collection Specialist into a platform created by Efforts to Outcomes and made available to Philliber Research for analysis by the United Way via download from a secure website. The data were monitored by a joint team from United Way and Philliber Research who regularly downloaded and screened the data to ensure data integrity.

Missing Data

If demographic variables were missing Philliber had the option of checking other sources of information or asking the agency to obtain the information at the next meeting with the participant. Both the enrollment form and the intake form obtain demographic information. If information was missing from one form, it was usually available on the other. Also, participants met with the FCMS or DCS at each assessment. Missing demographic information was sometimes obtained then. United Way conducted periodic data audits of the data in ETO and worked with agencies to ensure that all needed data were reported.

Missing data is ubiquitous in social science research and this is especially true in applied intervention/prevention studies. These studies often ask about sensitive information and are longitudinal in design which inevitably leads to missing data. Historically, missing data has been addressed by using listwise deletion (only using individuals in the study that have complete data) or some form of replacement, typically replacing the missing value with the sample mean for that variable. In the case of longitudinal missing data applied researchers would often take the last available data point for an individual participant and "move it forward" under the conservative assumption that the participant did not change. However, these methods are all problematic and lead to biased statistical estimates (Graham, 2012). Over the last 15 years there have been substantial advances in assessing and handling missing data and these techniques have been utilized in this study.

The first step in addressing missing data is to determine the type of missingness. This is a process for estimating the underlying reason for why the data is missing. There are three types of missingness; data that is missing-completely-at-random (MCAR), data that is missing-at-random (MAR), and missing-not-at-random (MNAR). The condition of MCAR is met when the missing data appears to be truly randomly distributed and unrelated to any other variables either measured or unmeasured (e.g., some people might have accidentally skipped a question). MAR data occurs when the missing data is systematically related to another variable, but it is a variable that is measured in the dataset and the reason the data is missing is unrelated to the value of the missing data point. For example, older adults might be more reticent to answer questions about income than younger adults, because the latter have more experience with being surveyed and being asked to disclose income information. As a result, missing income data might systematically be related to participant age, but not the actual income amount that was not reported. Missing data that meets the conditions of either MCAR or MAR can be reliably estimated from other data points and/or variables on which the participant did

provide data. If the missing data is determined to most likely be MNAR (there is no test for MNAR) then the pattern of missingness can be included in the statistical model and the bias introduced by non-random missing data can be statistically controlled for.

To test the level of missingness we used the MICE package in R (version 4.0.1). The MICE package (Multivariate Imputation via Chained Equations) is a comprehensive tool for both assessing patterns of missingness and imputing missing data for analysis. Figure 4. provides the proportion of missing data by variable, by assessment point, by intervention group. We first conducted a Little's MCAR chi-square test on all variables to determine whether or not the data satisfied the assumptions of MCAR. This test assumes the null hypothesis that the data is missing completely at random. The Little's MCAR test was conducted across all variables and across intervention groups at each assessment point. The table below provides the MCAR test results for each assessment point:

Figure 4: Little's MCAR Test Results

Baseline	6-month	12-month
χ^2 (1464) = 1383, p=.06	χ^2 (1464) = 1357, p=.02	χ^2 (1464) = 1391, p=.08

Non-significant results suggest that the data does not meet the criteria for MCAR, but in large samples (n>500), this test is overly sensitive. We then followed-up the Little's MCAR test with pairwise distributional comparisons to determine whether or not any missing data was systematically related to any of the variables in the dataset and found there were no conditional dependencies so we could assume the data was, at a minimum, missing at random (MAR). As a result, analyses can proceed under the assumption that missing data do not introduce statistical biases.

Baseline Equivalence

The study was designed as a randomized control trial of an intent-to-treat model. However, the response rates were not sufficient to make that possible. Randomized control trials are sensitive to cases lost to follow-up (people who enroll in a study, are randomized into treatment or comparison groups, but then fail for some reason to fully complete follow-up assessments). The percentage of people who are randomized and then complete follow-up assessments needs to be around 80%. When the percentage is lower than that there is an increased probability of bias introduced into the study because those who drop out are different in unknown ways from those who continue. However, a quasi-experimental design is a valid option.

Baseline equivalence is critically important in a quasi-experimental study. Its purpose is to demonstrate that the families who are in the treatment group (GOALS) are not significantly different from those in the comparison group in terms of demographic covariates or measures of outcomes at baseline.

Equivalence was examined for parent's age, child's age, parent's gender, child's gender, race/ethnicity, language spoken, family size, marital status, receiving assistance, education, and health insurance. Equivalence of outcomes at baseline were also examined for variables assessed using the Family Profile Form, Ages & Stages Questionnaires, Rothbart Temperament Scales, and the Feeding Your Child questionnaire.

Standard significance tests and effect sizes were used to assess baseline equivalence of each variable. P-values of each test of significance were examined as well as the means and standard deviations for both the intervention and comparison groups.

Analytic Samples

Two analytic samples were constructed for this study. The first sample was comprised of families that completed baseline assessments and six-month follow-up assessments. The second sample was made up of families that completed baseline assessments and 12-month follow-up assessments. Even if a family missed their six-month data collection, they were still contacted to participate in the 12-month data collection. For each outcome, the analytic sample was composed of those families who completed demographic data as well as data on the outcome being analyzed. Baseline equivalence was determined for each analytic sample.

A total of 992 families completed baseline assessments and were randomized to either GOALS (n=518) or to the Comparison group (n=474). All 992 families were eligible for a six-month follow-up and 577 families enrolled prior to June 30, 2019 were eligible for a 12-month follow-up. The Consort Diagram (Figure 5) illustrates how participants progressed through the study.

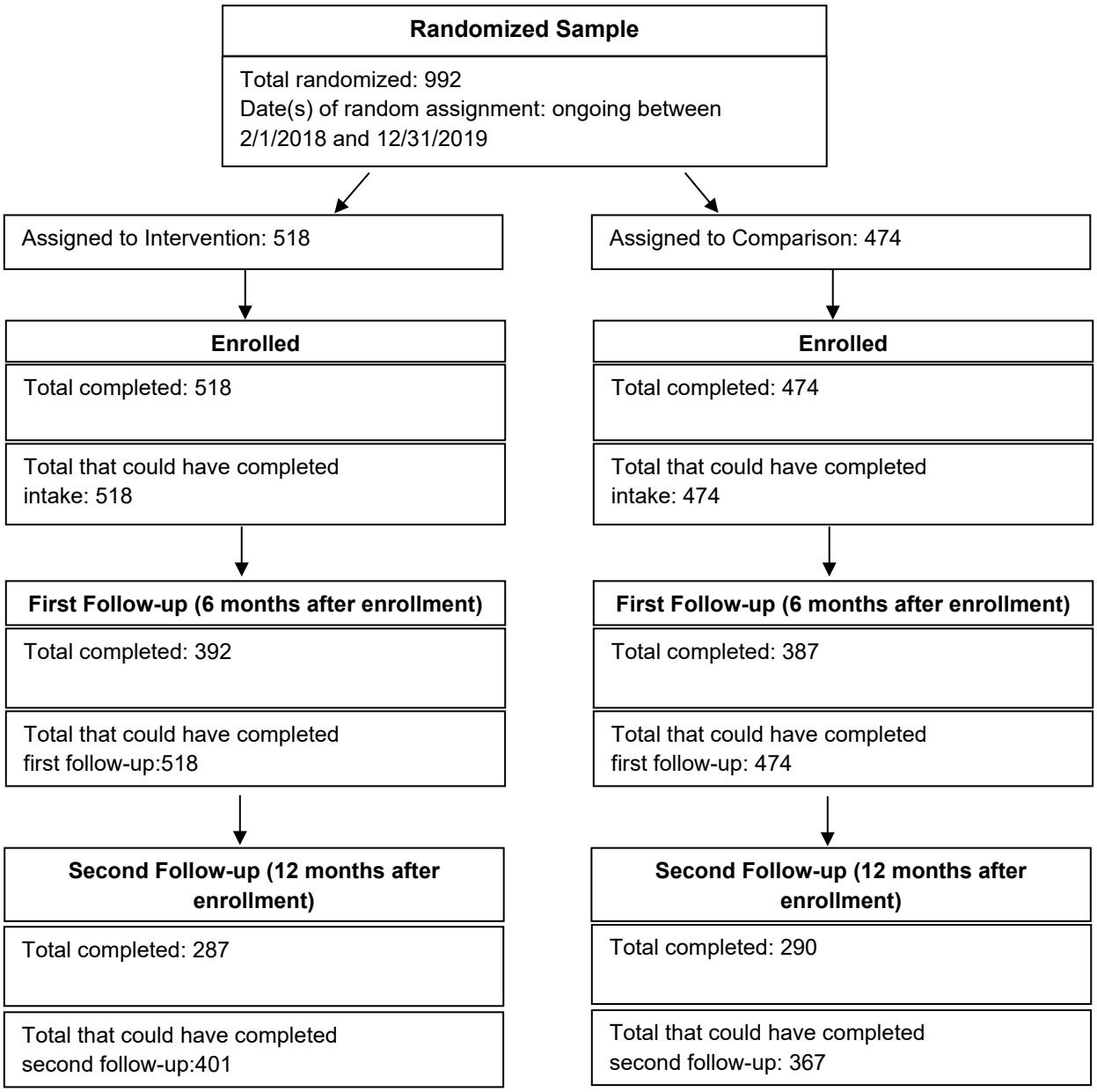
The six-month analytic sample had an overall attrition rate of 21.5% and a differential attrition rate of 5.9%. The 12-month analytic sample had an overall attrition rate of 24.9% and a differential attrition rate of 7.4%.

Figure 5: Consort Diagram

CONSORT Diagram

Data included in report are current as of: **December 15, 2020**

This is an individual-level RCT with families randomly assigned to Intervention or Comparison on a rolling basis between February 2018 and December 2019. The study collected baseline data, six-month follow-up data, and 12-month follow-up data. Only families enrolled prior to June 30, 2019 were eligible for a 12-month follow-up.



Analytic Strategy

Regression analysis was used to assess whether the outcomes among the GOALS participants were significantly different from the comparison participants. The outcome score at follow-up for each dimension was treated as a dependent variable.

Independent Variables Entered Into the Equations

- Participation in the GOALS or comparison group
- Baseline score on independent variable
- Parent's age
- Race/ethnicity (classified as African American, Other)
- Language spoken at home (English, Other)
- Living with spouse
- Receiving public assistance
- Parent's education
- Agency

T-tests were run to look at changes in GOALS families' scores on each of the outcome variables between baseline and six and 12-month follow-up in order to determine whether they demonstrated improvement in self-sufficiency and developmental readiness after participating in the program.

Findings, Lessons Learned, & Next Steps

FINDINGS, LESSONS LEARNED, AND NEXT STEPS

Introduction and Summary

Evaluation results indicate that the GOALS project was implemented successfully, and GOALS families showed significant gains in many areas. The project successfully enrolled 518 families into the intervention. More than three quarters (77%) of these families were receiving public assistance at the time of enrollment, and most were Families of Color (77%). Nearly all (97%) of the parents were female, and less than half were living with a spouse (45%). These families reported having a lot of needs at baseline. Most frequently they identified having needs with regards to housing, clothing, and food. Most (73% at six-month follow-up and 71% at 12-month follow-up) of these families stayed enrolled in the program.

GOALS families showed significant improvement at six- and 12-month follow-up in parenting skills, ability to meet basic needs, social supports, and behavior problems (parent). GOALS families also showed significant improvement on several protective factors to prevent child abuse and neglect at both six- and 12-month follow-up. At follow-up, GOALS families showed significant improvement in the practices they use to feed their children and a significant decrease in the areas of concern identified in their children.

In many areas, there were no differences between GOALS and comparison families. However, GOALS families outperformed comparison families in two important areas. At six-month follow-up, GOALS families scored higher than comparison families on social support, one of the protective factors to prevent child abuse and neglect. At both six- and 12-month follow-up, GOALS families scored higher than comparison families on an assessment of the practices that they use to feed their children.

Comparison families showed significantly better results than GOALS families on ability to meet basic needs and parenting skills on the Arizona Self Sufficiency Matrix at six-month follow-up and on parenting skills at 12-month follow-up. Comparison families also demonstrated significantly higher scores than GOALS families on the nurturing and attachment protective factor at six-month follow-up.

Key Findings

GOALS Families Showed Improvement In:

- Parenting Skills
- Ability to Meet Basic Needs
- Social Supports
- Behavior Problems (Parent)
- Protective Factors to Prevent Child Abuse and Neglect
- Practices Used to Feed Their Children

GOALS Families Outperformed the comparison group in:

- Social Support
- Practices Used to Feed Their Children

Communication

Sites used varying communication and recruitment strategies, with some engaging with a multi-part initial interview process and some using multiple assessment sessions to complete the process of enrollment and data collection. The study as a whole collected 14,602 individual points of contact during the program, an overwhelming majority of which were to establish or confirm meeting times and check in with participants as indicated in Figure 6. The difference between the number of communications to GOALS families versus the number to comparison families was expected when the study was designed. While GOALS was designed to be light-touch, FCMSs were still encouraged to check-in with participants between assessment timeframes. DCSs on the other hand were instructed not to initiate check-ins but were able to help participants that reached out to them between assessment timeframes.

Figure 6: Count of Types of Communication

Variable	Intervention N=518	Comparison N=474
Email	323	64
In Person (At Agency)	480	294
In Person (At Home of Participants Assessment Visits)	2028	1315
Phone (Left Voicemail)	732	395
Phone	2432	1386
Text	3711	990

Unable to Contact	188	133
Other	75	59
Total Contacts	9966	4636

Findings By Research Question

Implementation Questions - Confirmatory

How successful is GOALS (formerly Bib-to-Backpack) in enrolling families? i.e. How many families enroll?

GOALS Families

A total of 518 families were enrolled in the GOALS program. The number of families enrolled at each agency ranged from 86 to 131 families. At the beginning of the study, each agency had created their own enrollment goals ranging from 75 to 175 participants.

Figure 7: Enrollment in GOALS

	Number of Families	% of Total
ACCESS	86	17%
CARE	100	19%
LBFS	88	17%
NKFM	131	25%
OFS	113	22%
Total	518	

What are the characteristics of families who enroll? ***In addition to their demographic characteristics, what kinds of needs are identified at the time of enrollment?***

The average age of the parents enrolled in GOALS was 32.1 years. Nearly all (97%) of the parents enrolled were female. The average age of the focus child was 2.2 years, and nearly half (49%) of the focus children were female. Nearly half (47%) of the families identified as African American and just over three quarters (77%) of the families spoke English as their primary language. Just over three quarters (77%) of the families reported receiving Public Assistance. (See appendix W for a breakdown of demographics by agency.)

Figure 8: Characteristics of GOALS Families

Variable	N	%/ Average	SD
Parent's age (years)	511	32.1	7.397
18-25	110	22%	
26-34	240	47%	
35 and older	161	31%	
Child's age (years)	517	2.2	1.605
Parent's gender			
Female	514	97%	.163
Child's gender			
Female	517	49%	.500
Race/ethnicity[1]	514		
American Indian	18	4%	.184
Asian	14	3%	.163
African American	241	47%	.500
Hispanic	35	7%	.252
Middle Eastern/North African	116	23%	.418
Pacific Islander	0	0%	0
White	120	23%	.423
Other	21	4%	.198
Language Spoken	513		
English	394	77%	.423
Spanish	10	2%	.138
Arabic	99	19%	.395
Other	10	2%	.138
Household Composition			
Number in household	496	4.7	1.835
Living with spouse	516	45%	.498
Receiving public assistance	516	77%	.419
Less than high school education	494	23%	.423

[1]More than one option could be selected.

Families were asked to identify their immediate needs in order to help their FCMS provide them with appropriate referrals. GOALS families reported 743 needs at baseline, which is an average of 1.43 needs per family. Families were presented with a list of 22 potential needs that they might be experiencing. They were also given the option of listing any other needs they might be experiencing that were not captured by that list. The most frequently identified needs were housing, clothing, and food.

Figure 9: Needs of GOALS Families at Baseline

Need (N=518)	N	%
Housing	74	14.3%
Clothing	63	12.2%
Food	52	10.0%
Transportation	49	9.5%
Income/employment	48	9.3%
Child care	46	8.9%
Gas/Electric bill	45	8.7%
Dental/Eye care	41	7.9%
Furniture/Appliances	39	7.5%
Rent/Mortgage/Moving	36	6.9%
Baby	33	6.4%
Education (adult)	30	5.8%
Holiday	26	5.0%
Child development	22	4.2%
Counseling (Psych/Sub. Abuse)	22	4.2%
Health	21	4.1%
Home repair/Weatherization	21	4.1%
Water bill	21	4.1%
Education (children)	17	3.3%
Other	16	3.1%
Legal aid	9	1.7%
Property taxes	9	1.7%
Tax preparation	3	0.6%

How well is the Family Check-Up Model implemented? ***Do families move from assessment to services and continue engagement in services?***

GOALS families received payment to support their participation in their feedback sessions with a FCMS at each assessment time frame. This is also the session in which families are invited to set goals and are given referrals. Thus, a family is considered to have completed the required GOALS components at each assessment time frame if they received their support payment. All families enrolled in GOALS (518) were expected to complete six-month assessments with their FCMS. The payment data indicate that the project ended up with a 73% completion rate at six-month follow-up. Families that enrolled prior to June 30, 2019 were expected to also complete 12-month assessments with their FCMS. Enrollment data indicate that a total of 401 families were expected to complete 12-month assessments. The payment data indicate that 71% of these families completed their 12-month follow-up with their FCMS.

GOALS families are expected to set goals and receive referrals from their FCMS to help them meet those goals. Of those enrolled, 68% of GOALS families had at least one referral recorded

in ETO and 80% had at least one goal recorded in ETO. The percentage of families receiving referrals ranged from 34% to 93% by agency. The percentage of families at each agency setting at least one goal ranged from 59% to 98%.

What services do families receive? *Do families who receive the Family Check-Up Model participate in more services than families typically do?*

Families were asked at each data collection timeframe to report the number and types of programs that they had participated in at the agency which enrolled them in the GOALS study. The questions focus specifically on Child Development, Employment, Housing, and Parenting programs. It is of note that comparison families were eligible to participate in services as usual at the agencies after enrolling in the study. However, comparison families had to access agency services using existing entry pathways and protocols at the agencies.

At baseline, GOALS families reported participating in significantly more agency programs than comparison families (not shown). This may be an indication that GOALS families were already more connected to the programs prior to enrolling in the study.

Changes in Agency Program Participation Over Time

There was no significant difference in the number of agency programs that GOALS and comparison families reported participating in at six-month follow-up.

Figure 10: Number of Programs - 6-Month Follow-Up

Six Month	GOALS (N=296)		Comparison (N=256)	
Number of Programs	Number	Percent of Total	Number	Percent of Total
0	172	58%	154	60%
1	80	27%	69	27%
2	35	12%	23	9%
3	3	1%	7	3%
4	6	2%	3	1%

Figure 11: Average Number of Programs - 6-Month Follow-Up

	GOALS			Comparison			Regression		
	N	Unadjusted Average	SD	N	Unadjusted Average	SD	*Regression Coef.*	β	*p*
Six Month	296	.618	.883	256	.578	.855	-.063	-.036	.385

Adjusted using: Participation in the GOALS or the Comparison group, Baseline score on independent variable, Parent's age, Race/ethnicity (classified as African American, Other)
Language spoken at home (classified as English, Other), Living with spouse, Receiving public assistance, Parent's education, Agency.

Similarly, there were no significant differences in the number of programs that GOALS and comparison families participated in at 12-month follow-up.

Figure 12: Number of Programs - 12-Month Follow-Up

12 Month	GOALS (N=227)		Comparison (N=232)	
Number of Programs	Number	Percent of Total	Number	Percent of Total
0	148	65%	165	71%
1	54	24%	35	15%
2	24	11%	26	11%
3	0	0%	4	2%
4	1	<1%	2	1%

Figure 13: Average Number of Programs - 12-Month Follow-Up

	GOALS			Comparison			Regression		
	N	Unadjusted Average	SD	N	Unadjusted Average	SD	*Regression Coef.*	β	*p*
12 Month	227	.467	.718	232	.461	.826	-.099	-.064	.172

Adjusted using: Participation in the GOALS or the comparison group, Baseline score on independent variable, Parent's age, Race/ethnicity (classified as African American, Other)
Language spoken at home (classified as English, Other), Living with spouse, Receiving public assistance, Parent's education, Agency.

How long do families continue to participate in Bib to Backpack? *Do families who receive the Family Check-Up Model participate longer in services than families typically do?*

Completion rates at six- and 12-month follow-up were used as a proxy for how long families participated in services. Completion rates of comparison families were used as an indication of how long typical families stay engaged at the agencies. Although the completion rates for GOALS families at six- and 12-month follow-up were above 70%, they were significantly lower than completion rates for the comparison group.

Figure 14: Program Completion (GOALS and Comparison)

	% Completed (6 Month)		% Completed (12 Month)	
	GOALS	**Comparison**	**GOALS**	**Comparison**
Completion Rate	73%	81%**	71%	78%*

Difference based on t-test is statistically significant at *p<.05; ***p<.001.

Do families enrolled in the Family Check-Up Model improve levels of development and self-sufficiency?

Changes in scores on the PICCOLO, the ASSM, the Protective Factors Survey, and the Rothbart Temperament Scale between baseline and six- and 12-month follow-up were used to evaluate whether GOALS families demonstrated improvement in levels of development and self-sufficiency.

Parent interactions are scored on the PICCOLO using a scale of 0 (absent), 1 (barely demonstrated) or 2 (clearly demonstrated). GOALS families showed significant improvement on all four domains of the PICCOLO at both six- and 12-month follow-up.

Figure 15: PICCOLO Pre-post Scale Assessment - 6-Month Follow-Up

Domain	**Baseline Average N=220**	**6-Month Average N=220**	***Cohen's d***
Affection	1.73 (SD .290)	1.79** (SD .276)	.20
Responsiveness	1.68 (SD .301)	1.72* (SD .270)	.05
Encouragement	1.60 (SD .358)	1.68*** (SD .312)	.16
Teaching	1.24 (SD .403)	1.42*** (SD .352)	.24

*p<.05;**p<.01;***p<.001

Figure 16: PICCOLO Pre-post Scale Assessment - 12-Month Follow-Up

Domain	**Baseline Average N=157**	**12-Month Average N=157**	***Cohen's d***
Affection	1.73 (SD .300)	1.77* (SD .286)	.16
Responsiveness	1.65 (SD .293)	1.72** (SD .257)	.09
Encouragement	1.56 (SD .352)	1.68*** (SD .300)	.19
Teaching	1.16 (SD .381)	1.47*** (SD .327)	.48

*p<.05;**p<.01;***p<.001

GOALS families also showed significant improvement on all four domains of the Arizona Self Sufficiency Matrix at both six- and 12-month follow-up. Scores are based on a 1-5 Likert scale with 1 indicating a need and 5 indicating a strength.

Figure 17: Family's Ability to Meet Basic Needs, Parenting Skills, Social Supports, and Behavior Issues Pre-post Assessment - 6-Month Follow-Up

Domain	Baseline Average N=373	6-Month Average N=373	*Cohen's d*
Ability to meet basic needs	3.68 (SD .518)	3.74* (SD .493)	.11
Parenting skills	3.84 (SD .926)	4.01** (SD .926)	.17
Social supports	3.91 (SD .855)	4.08*** (SD .813)	.21
Behavior issues	4.77 (SD .412)	4.82** (SD .367)	.13

*p<.05;**p<.01;***p<.001

Figure 18: Family's Ability to Meet Basic Needs, Parenting Skills, Social Supports, and Behavior Issues Pre-post Assessment - 12-Month Follow-Up

Domain	Baseline Average N=271	12-Month Average N=271	*Cohen's d*
Ability to meet basic needs	3.67 (SD .512)	3.75** (SD .477)	.16
Parenting skills	3.84 (SD .925)	4.03** (SD .873)	.21
Social supports	3.88 (SD .859)	4.13*** (SD .760)	.30
Behavior issues	4.79 (SD .399)	4.86** (SD .349)	.18

p<.01;*p<.001

GOALS families showed significant improvement at six-month follow-up on two protective factors: "Concrete Support" and "Child Development/ Knowledge of Parenting." Scores can range from 1 to 7. A higher score reflects a higher level of the protective factors.

Figure 19: Protective Factors Pre-post Assessment - 6-Month Follow-Up

Domain	Baseline Average N=371	6-Month Average N=371	*Cohen's d*
Family Functioning/Resiliency	5.93 (SD 1.23)	6.00 (SD 1.20)	.06
Social Support	5.81 (SD 1.37)	5.93 (SD 1.31)	.09
Concrete Support	5.29 (SD 1.78)	5.75*** (SD 1.62)	.28
Nurturing and Attachment	6.76 (SD .386)	6.73 (SD .422)	-.09
Child Development/ Knowledge of Parenting	5.89 (SD .915)	6.01** (SD .919)	.14

p<.01;*p<.001

At 12-month follow-up, GOALS families showed significant improvement on three protective factors: "Social Support," "Concrete Support" and "Child Development/ Knowledge of Parenting".

Figure 20: Protective Factors Pre-post Assessment - 12-Month Follow-Up

Domain	**Baseline Average N=266**	**12-Month Average N=266**	***Cohen's d***
Family Functioning/Resiliency	5.96 (SD 1.24)	6.06 (SD 1.26)	.08
Social Support	5.78 (SD 1.38)	6.01* (SD 1.24)	.18
Concrete Support	5.07 (SD 1.88)	5.60*** (SD 1.85)	.27
Nurturing and Attachment	6.77 (SD .384)	6.72 (SD .657)	-.10
Child Development/ Knowledge of Parenting	5.90 (SD .892)	6.05**(SD .855)	.17

*p<.05;**p<.01;***p<.001

There was no significant change in GOALS families' scores on the child temperament scales at either six- or 12-month follow-up. Scores for the Rothbart Temperament Scales are based on a 7-point Likert scale.

Figure 21: Child Temperament Outcomes - 6-Month Follow-Up

Domain	**Baseline Average N=342**	**6 Month *Average* N=342**	***Cohen's d***
Negative Affect	3.53 (SD .995)	3.57 (SD 1.08)	-.04
Effortful Control	5.49 (SD .799)	5.50 (SD .781)	.01

Figure 22: Child Temperament Outcomes - 12-Month Follow-Up

Domain	**Baseline Average N=256**	**12 Month Average N=256**	***Cohen's d***
Negative Affect	3.56 (SD 1.02)	3.47 (SD .987)	.08
Effortful Control	5.47 (SD .825)	5.49 (SD .865)	.02

Do children whose families participate in the Family Check-Up Model improve levels of development as demonstrated by improved communication skills, problem solving skills, social development, social-emotional health, and eating practices?

Baseline, six-month, and 12-month scores on the Feeding Your Child questionnaire and ASQ-3 and ASQ:SE-2 surveys were used to assess whether GOALS families showed improvement in communication skills, problem solving skills, social development, social-emotional health, and eating practices.

GOALS families showed significant improvement on the Feeding Your Child scale at both six- and 12-month follow-up.

Figure 23: Feeding Your Child Outcomes - 6-Month Follow-Up

Outcome	Baseline Average N=183	6-Month Average N=183	*Cohen's d*
FYC Score	23.3 (SD 3.94)	24.3** (SD 3.94)	.27

p<.01;*p<.001

Figure 24: Feeding Your Child Outcomes - 12-Month Follow-Up

Outcome	Baseline Average N=144	12-Month Average N=144	*Cohen's d*
FYC Score	23.5 (SD 3.80)	24.8*** (SD 3.67)	.32

p<.01;*p<.001

GOALS families showed a significant decrease in the number of areas of concern on the ASQ at both six- and 12-month follow-up.

Figure 25: Pre-post Assessment for GOALS Families on Average Number of Categories of Concern - 6-Month Follow-Up

Outcome	Baseline Average N=358	6-Month Average N=358	*Cohen's d*
Areas of Concern	1.12 (SD 1.41)	.869*** (SD 1.33)	.19

*p<.05;***p<.001

Figure 26: Pre-post Assessment for GOALS Families on Average Number of Categories of Concern - 12-Month Follow-Up

Outcome	Baseline Average N=263	12-Month Average N=263	*Cohen's d*
Areas of Concern	1.17 (SD 1.50)	.932* (SD 1.52)	.19

*p<.05;***p<.001

Implementation Questions - Exploratory

Is the amount of improvement a family experiences increased by the number of services received?

The project initially planned to look at the relationship between the number of services received and outcomes demonstrated on the assessments given to families. As evaluators began examining the data, it became clear that this approach would not work. The original plan was to use the number of referrals received and number of programs enrolled in as proxy measures for the number of services received. However, as evaluators discussed the referral data with the United Way in monthly meetings, concerns began to arise that there were differences in the approaches that agencies were using to document referrals and that some referrals were not being recorded at all. These suspicions were confirmed during site visits with the agencies. The United Way responded by providing additional training to the agencies about how to document and record referrals. This training, though, happened after the project had been implemented for several months. Thus, the early referral data was determined to be an underestimate of the actual number of referrals provided to families. In addition, discussions with agencies revealed that one approach to helping families that had significant needs was to provide them with as many referrals as possible. Thus, more referrals might be more of a reflection of families' needs as opposed to an indicator of their likelihood to show improvement on their assessment scores.

Some of the agencies also explained to evaluators that many families were recruited out of their existing programs and that it was unlikely that the FCMS would recommend that the family repeat a program even if there was still room for progress to be made in areas such as parenting skills. In addition, agencies referred families out to other programs in the community if a needed program was not offered or space was not available in their own agency. These outside programs were not documented in ETO in the same way that internal programs were documented. As a result, evaluators felt that the number of programs was not a good indicator for predicting how much success a family might experience in the GOALS intervention.

An analysis of communication between FCMS and families also showed little correlation between growth and volume of communication. Initial communication tracking strategies were not identical across agencies, proven by an analysis of data entry and confirmed via site visits. After an intensive analysis of the data and training with input from FCMSs and DCSs, an evolved communication log tracking strategy was instigated with an in-depth analysis of data entered in a two-month period to evaluate any differences between sites. Analysis demonstrated that very 'light touch' communication like text messaging could be extremely frequent with some families but far less frequent in others, and that the number of contacts in general showed no connection to how those families scored on the ASQ-3 and Family Profile Form. Staff members reported that the amount of communication was largely driven by family preference rather than the need for referrals.

***Is the amount of improvement a family experiences increased by the length of time they participate in the program*?**

Scores on the PICCOLO, ASSM, Protective Factors Survey, and Rothbart Temperament Scale were examined to evaluate whether GOALS families demonstrated better outcomes after twelve months of participation in GOALS than they demonstrated after six months of participation in GOALS.

GOALS families showed significant improvement on three of four domains of the PICCOLO between six- and 12-month follow-up.

Figure 27: PICCOLO Pre-post Assessment - 6 and 12 Month

Domain	**6-Month Average N=160**	**12-Month Average N=160**	***Cohen's d***
Affection	1.76 (SD .320)	1.78 (SD .299)	.04
Responsiveness	1.67 (SD .287)	1.73* (SD .255)	.04
Encouragement	1.63 (SD .337)	1.68* (SD .302)	.03
Teaching	1.34 (SD .383)	1.47*** (SD .326)	.24

*p<.05;***p<.001

There were no significant changes in GOALS families between six- and 12-month follow-up on any of the domains of the ASSM.

Figure 28: Family's Ability to Meet Basic Needs, Parenting Skills, Social Supports, and Behavior Issues Pre-post Assessment - 6 and 12 Month

Domain	**6-Month Average N=270**	**12-Month Average N=270**	***Cohen's d***
Ability to meet basic needs	3.72 (SD .485)	3.75 (SD .476)	.07
Parenting skills	4.04 (SD .840)	4.00 (SD .881)	-.04
Social supports	4.11 (SD .747)	4.12 (SD .763)	.01
Behavior issues	4.84 (SD .325)	4.86 (SD .341)	-.04

Similarly, there were no significant changes for GOALS families on any of the five Protective Factors domains between six- and 12-month follow-up.

Figure 29: Protective Factors - 6 and 12 Month

Domain	6-Month Average N=270	12-Month Average N=270	*Cohen's d*
Family Functioning/Resiliency	6.05 (SD 1.13)	6.06 (SD 1.26)	.02
Social Support	5.96 (SD 1.25)	6.02 (SD 1.23)	.04
Concrete Support	5.62 (SD 1.73)	5.59 (SD 1.87)	-.09
Nurturing and Attachment	6.75 (SD .398)	6.72 (SD .654)	-.02
Child Development/ Knowledge of Parenting	6.00 (SD .927)	6.06 (SD .849)	.06

There was a significant decrease in GOALS families' scores on the negative affect domain of the child temperament scales between six- and 12-month follow-up. That is an indication of improvement on this domain.

Figure 30: Child Temperament Outcomes - 6 and 12 Month

Domain	6-Month Average N=262	12-Month Average N=262	*Cohen's d*
Negative Affect	3.59 (SD 1.08)	3.44* (SD .986)	-.13
Effortful Control	5.46 (SD .788)	5.51 (SD .870)	.05

*p<.05

GOALS families showed no significant improvement on the Feeding Your Child scale between six- and 12-month follow-up.

Figure 31: Feeding Your Child - 6 and 12 Month

Outcome	6-Month Average N=160	12-Month Average N=160	*Cohen's d*
FYC Score	24.2 (SD 3.99)	24.7 (SD 3.64)	.05

GOALS families did not show any significant change in the number of areas of concern identified on the ASQ-3 and ASQ:SE-2 between six- and 12-month follow-up.

Figure 32: Pre-post Assessment for GOALS Families on Average Number of Categories of Concern - 6 and 12 Month

Outcome	6-Month Average N=254	12-Month Average N=254	*Cohen's d*
Areas of Concern	.909 (SD 1.40)	.858 (SD 1.41)	-.036

Impact Questions

A total of 992 families completed baseline assessments and participated in GOALS (n=518) or in the comparison group (n=474).

The final sample for the six-month analyses was equally distributed between GOALS (50%) and comparison (50%) families. The two groups were similar on most characteristics at baseline. However, at baseline, GOALS families reported a significantly higher average number of people living in their households, they were more likely to be living with a spouse, and were more likely to be receiving public assistance than comparison families. Almost all of the parents that enrolled in the study were women and about half were between the ages of 26 to 34. They were most often African American or of Middle Eastern/North African or White origin. Most families reported that the primary language their family used at home was English.

The What Works Clearinghouse™ (WWC) standards determine if baseline equivalence is met for individual characteristics by calculating the effect size (the difference between the GOALS group and comparison group average divided by the pooled standard deviation). If the effect size has an absolute value ≤ 0.05, then baseline equivalence is satisfied (represented as ↑ in Figure 33). If the effect size has an absolute value > 0.05 and ≤ 0.25, then statistical adjustment is required to satisfy baseline equivalence (→), and if an effect size has an absolute value > 0.25, then baseline equivalence is not met (↓). Figure 33 below also outlines the baseline equivalence of GOALS and comparison families that completed six-month follow-up data. All of the individual characteristics either met the standard or could be adjusted statistically.

Figure 33: Baseline Equivalence of Individual Characteristics - 6-Month Follow-Up Sample

Variable	GOALS			Comparison			Difference in % or Average	Pooled SD	Effect Size	WWC Standard Met
	N	% / Average	SD	N	% / Average	SD				
Assigned group	392	50%		387	50%		0%			
Parent's age	390	32.6	7.269	381	33.4	8.474	.8 yr	7.887	.101	→
Child's age	392	2.2	1.576	387	2.3	1.513	.1 yr	1.545	.065	→
Parent's gender										
Female	391	97%	.158	385	98%	.151	1%	.155	.065	→
Child's gender										
Female	392	48%	.500	387	52%	.500	4%	.500	.08	→

Race/ethnicity[1]	391			385						
American Indian	14	4%	.186	7	2%	.134	2%	.162	.123	→
Asian	11	3%	.166	12	3%	.174	0%	.170	0	↑
African American	173	44%	.497	171	44%	.498	0%	.497	0	↑
Hispanic	22	6%	.231	14	4%	.187	2%	.210	.095	→
Middle Eastern /North African	103	26%	.441	105	27%	.446	1%	.443	.023	↑
Pacific Islander	0	0%	0	0	0%	0	0%	0	0	↑
White	92	24%	.425	86	22%	.417	2%	.421	.048	↑
Other	14	4%	.186	16	4%	.200	0%	.193	0	↑
Language Spoken	391			385						
English	275	70%	.457	282	73%	.443	3%	.450	.067	→
Spanish	8	2%	.142	4	1%	.102	1%	.124	.080	→
Arabic	99	26%	.435	91	24%	.425	2%	.430	.047	↑
Other	9	2%	.150	8	2%	.143	0%	.147	0	↑
Household Composition										
Number in household	391	4.8	1.851	384	4.6	1.982	0.2*	1.917	.104	→
Living with spouse	391	50%	.501	386	40%	.490	10%**	.496	.202	→
Receiving public assistance	391	79%	.406	386	70%	.458	9%**	.433	.208	→
Less than high school education	389	23%	.424	374	27%	.443	4%	.433	.092	→

[1] More than one option could be selected.

Difference based on t-test is statistically significant at *p<.05; **p<.01; ***p<.001.

Figure 34 outlines baseline equivalence for families that completed 12-month follow-up data. The sample was equally distributed between GOALS (50%) and comparison (50%) families. All but one of the individual characteristics either met the WWC standards or could be adjusted statistically to satisfy baseline equivalence. Receiving public assistance did not meet the WWC standard for baseline equivalence. At baseline, GOALS families who completed the 12-month follow-up were more likely to report receiving public assistance than comparison families.

Figure 34: Baseline Equivalence of Individual Characteristics - 12-Month Follow-Up Sample

Variable	GOALS			Comparison			Difference in % or Average	Pooled SD	Effect Size	WWC Standard Met
	N	% / Average	SD	N	% / Average	SD				
Assigned group	287	50%		290	50%		0%			
Parent's age	286	32.4	7.417	287	33.4	8.539	1.0 yr	8.000	.125	→
Child's age	287	2.2	1.559	290	2.3	1.548	.1 yr	1.553	.064	→
Parent's gender										
Female	286	98%	.144	289	98%	.131	0%	.138	0	↑
Child's gender										
Female	287	49%	.501	290	48%	.501	1%	.501	.020	↑
Race/ ethnicity[1]	286			289						
American Indian	11	4%	.193	6	2%	.143	2%	.170	.118	→
Asian	7	2%	.155	10	3%	.183	1%	.170	.059	→
African American	104	36%	.482	117	40%	.492	4%	.487	.082	→
Hispanic	21	7%	.261	12	4%	.200	3%	.232	.129	→
Middle Eastern / North African	91	32%	.467	91	32%	.465	0%	.466	0	↑
Pacific Islander	0	0%	0	0	0%	0	0%	0	0	↑
White	65	23%	.420	60	21%	.406	2%	.413	.048	↑
Other	12	4%	.201	16	6%	.229	2%	.216	.093	→
Language Spoken	286			289						
English	182	63%	.482	201	69%	.461	6%	.472	.127	→
Spanish	8	3%	.165	2	1%	.083	2%	.130	.154	→
Arabic	88	31%	.462	78	27%	.445	4%	.454	.088	→
Other	8	3%	.165	8	3%	.164	0%	.164	0	↑
Household Composition										
Number in household	286	4.9	1.787	289	4.7	1.926	0.2	1.858	.108	→
Live w/spouse	286	51%	.501	290	45%	.499	6%	.500	.120	→
Receiving public assist.	286	82%	.386	290	69%	.463	13%***	.427	.304	↓

Less than High School education	285	24%	.429	280	31%	.462	7%	.446	.157	→

[1] More than one option could be selected.
Difference based on t-test is statistically significant at *p<.05; **p<.01; ***p<.001.

Do families who receive the Family Check-Up model make significantly greater improvements in self-sufficiency compared to families who only receive standard services as evidenced by improved parenting skills, ability to meet basic needs, increased social supports, and reduced risk behaviors?

At six-month follow-up, the comparison families showed significantly higher scores on their ability to meet basic needs and on parenting skills on the Arizona Self-Sufficiency Matrix. At 12-month follow-up, comparison families scored significantly higher than GOALS families on parenting skills.

Figure 35: Family's Ability to Meet Basic Needs, Parenting Skills, Social Supports, and Behavior Issues Pre-post Assessment - GOALS and Comparison Families - 6-Month Follow-Up

Six Months	GOALS			Comparison			Regression		
	N	Unadjusted Average	SD	N	Unadjusted Average	SD	*Regression Coef.*	β	*p*
Ability to meet basic needs	377	3.74	.492	380	3.84	.512	-.085	-.084	.005
Parenting skills	376	4.00	.926	372	4.20	.858	-.146	-.081	.020
Social supports	377	4.08	.809	378	4.12	.685	-.027	-.018	.578
Behavior issues	377	4.82	.366	379	4.90	.295	-.028	-.041	.167

Adjusted using: Participation in the GOALS or the comparison group, Baseline score on independent variable, Parent's age, Race/ethnicity (classified as African American, Other)
Language spoken at home (classified as English, Other), Living with spouse, Receiving public assistance, Parent's education, Agency.

Figure 36: Family's Ability to Meet Basic Needs, Parenting Skills, Social Supports, and Behavior Issues Pre-post Assessment - GOALS and Comparison Families - 12-Month Follow-Up

12 Months	GOALS			Comparison			Regression		
	N	Unadjusted Average	SD	N	Unadjusted Average	SD	Regression Coef.	β	p
Ability to meet basic needs	291	3.76	.480	291	3.85	.514	-.054	-.054	.133
Parenting skills	290	4.00	.882	286	4.22	.918	-.206	-.117	.005
Social supports	291	4.11	.774	288	4.01	.809	.031	.020	.617
Behavior issues	291	4.85	.353	290	4.89	.325	-.020	-.032	.388

Adjusted using: Participation in the GOALS or the comparison group, Baseline score on independent variable, Parent's age, Race/ethnicity (classified as African American, Other)
Language spoken at home (classified as English, Other), Living with spouse, Receiving public assistance, Parent's education, Agency.

Protective Factors

At six-month follow-up, the GOALS participants scored significantly higher on the social support dimension and the comparison group scored significantly higher on the nurturing and attachment dimension. At 12-month follow-up there were no statistically significant differences.

While we did calculate Cohen's *f* for these analyses, we did not include them in these tables because the standardized regression weights are provided and can be squared to obtain a percentage of variance accounted for by treatment group status. This is a more intuitive effect size for most readers and is more robust to the deviations from normality and heteroscedasticity of the variables, which is to be expected for risk variables in a vulnerable population.

Figure 37: Protective Factors - 6-Month Follow-Up

Six Months	GOALS			Comparison			Regression		
	N	Unadjusted Average	SD	N	Unadjusted Average	SD	*Regression Coef.*	β	*p*
Family Functioning/ Resiliency	376	6.00	1.21	375	6.03	1.17	-.005	-.002	.953
Social Support	376	5.93	1.30	375	5.74	1.40	.170	.064	.047
Concrete Support	376	5.76	1.63	376	5.60	1.62	.199	.061	.067
Nurturing and Attachment	375	6.73	.427	375	6.77	.540	-.073	-.077	.032
Child Development / Knowledge of Parenting	374	6.02	.914	375	6.19	.883	-.074	-.041	.214

Adjusted using: Participation in the GOALS or the comparison group, Baseline score on independent variable, Parent's age, Race/ethnicity (classified as African American, Other)
Language spoken at home (classified as English, Other), Living with spouse, Receiving public assistance, Parent's education, Agency.

Figure 38: Protective Factors - 12-Month Follow-Up

12 Month	GOALS			Comparison			Regression		
	N	Unadjusted Average	SD	N	Unadjusted Average	SD	*Regression Coef.*	β	*p*
Family Functioning/ Resiliency	291	6.02	1.29	289	6.12	.109	-.084	-.038	.325
Social Support	290	5.95	1.30	289	5.94	1.21	.040	.017	.670
Concrete Support	290	5.61	1.84	289	5.52	1.75	.159	.045	.237

Nurturing and Attachment	290	6.72	.641	289	6.78	.419	-.070	-.063	.139
Child Development / Knowledge of Parenting	290	6.07	.842	289	6.24	.781	-.127	-.076	.060

Adjusted using: Participation in the GOALS or the comparison group, Baseline score on independent variable, Parent's age, Race/ethnicity (classified as African American, Other)
Language spoken at home (classified as English, Other), Living with spouse, Receiving public assistance, Parent's education, Agency.

Do children in families who receive the Family Check-Up model make significantly greater improvements in development compared to children in families who only receive standard services as evidenced by improved communication skills, problem solving skills, social development, social emotional health, and eating practice?

Child Development Outcomes

As indicated in figures 39 and 40, few children scored at risk on each of the areas assessed by the Ages & Stages Questionnaires at baseline, six months and at 12 months.

Figure 39: Change in Child's Development - 6-Month Follow-Up

	Baseline		Six Month	
Communication	**GOALS N=341**	**Comparison N=353**	**GOALS N=341**	**Comparison N=353**
At Risk	7.9%	8.8%	7.6%	4.3%
Monitor	12.3%	10.2%	8.5%	9.9%
No Risk	79.8%	81.0%	83.9%	85.8%
Gross Motor Skills	**N=340**	**N=351**	**N=340**	**N=351**
At Risk	7.9%	6.5%	4.1%	4.6%
Monitor	6.2%	7.7%	8.2%	4.6%
No Risk	85.9%	85.8%	87.7%	90.8%
Fine Motor Skills	**N=338**	**N=347**	**N=338**	**N=347***
At Risk	6.8%	9.2%	3.6%	8.1%
Monitor	14.2%	19.0%	14.2%	11.5%
No Risk	79.0%	71.8%	82.2%	80.4%
Problem Solving	**N=338**	**N=349**	**N=333**	**N=349**
At Risk	6.5%	8.0%	3.2%	5.7%
Monitor	11.0%	9.2%	9.5%	6.9%
No Risk	82.5%	82.8%	87.3%	87.4%
Personal Social	**N=341**	**N=350**	**N=341**	**N=350**

At Risk	7.0%	6.3%	5.9%	4.9%
Monitor	12.0%	8.6%	7.3%	8.6%
No Risk	81.0%	85.1%	86.8%	86.5%
ASQ:SE-2	**N=350**	**N=358**	**N=350**	**N=358**
At Risk	8.9%	8.7%	8.9%	8.9%
Monitor	11.1%	10.9%	9.1%	9.2%
No Risk	80.0%	80.4%	82.0%	81.9%

* p<.05 (CHI2)

Figure 40: Change in Child's Development - 12-Month Follow-Up

	Baseline		**12 Month**	
Communication	**GOALS N=248**	**Comparison N=253**	**GOALS N=248**	**Comparison N=253**
At Risk	8.5%	9.9%	7.2%	8.3%
Monitor	14.5%	9.9%	8.5%	5.5%
No Risk	77.0%	80.2%	84.3%	86.2%
Gross Motor Skills	**N=248**	**N=250**	**N=248**	**N=250**
At Risk	10.1%	7.2%	4.0%	2.8%
Monitor	6.4%	8.0%	6.5%	6.0%
No Risk	83.5%	84.8%	89.5%	91.2%
Fine Motor Skills	**N=246**	**N=250***	**N=246**	**N=250**
At Risk	6.5%	7.6%	9.8%	8.0%
Monitor	12.6%	21.2%	11.8%	12.8%
No Risk	80.9%	71.2%	78.4%	79.2%
Problem Solving	**N=246**	**N=250**	**N=246**	**N=250**
At Risk	8.1%	8.0%	5.3%	3.2%
Monitor	11.0%	10.0%	9.8%	6.4%
No Risk	80.9%	82.0%	84.9%	90.4%
Personal Social	**N=249**	**N=250**	**N=249**	**N=250**
At Risk	7.6%	5.6%	6.8%	4.8%
Monitor	13.7%	11.2%	10.9%	9.2%
No Risk	78.7%	83.2%	82.3%	86.0%
ASQ:SE-2	**N=254**	**N=256**	**N=254**	**N=256**
At Risk	9.8%	7.8%	9.8%	11.3%
Monitor	9.8%	9.8%	7.9%	8.2%
No Risk	80.4%	82.4%	82.3%	80.5%

* p<.05 (CHI2)

Figure 41 presents a summary of the total number of ASQ-3 and ASQ:SE-2 domains in which children were assessed to be in the "at risk" or "monitoring" category at six-month follow-up.

Fifty-six percent of the GOALS children and 59% of the comparison children scored in the "no risk" category on all of the ASQ-3 and ASQ:SE-2 domains at six-month follow-up. The remaining 44% of GOALS and 41% of comparison children had at least one category of concern.

Figure 41: Number of Categories of Concern - 6-Month Follow-Up

Six Month	GOALS (N=370)		Comparison (N=373)	
Number of At Risk or Monitoring Categories[1]	**Number of Children**	**Percent of Total**	**Number of Children**	**Percent of Total**
0	206	56%	221	59%
1	86	23%	79	21%
2	35	9%	26	7%
3	18	5%	25	7%
4	14	4%	12	3%
5	5	1%	7	2%
6	6	2%	3	1%

There was no significant difference between the GOALS and comparison groups in the percentage of families in which children scored in the "at risk" or "monitoring" categories on at least one domain at six-month follow-up.

Figure 42: Percent of Participants with at Least One Category of Concern 6-Month Follow-Up

Six Month	GOALS		Comparison		Logistic Regression		
	N	**Unadjusted Percentage**	**N**	**Unadjusted Percentage**	**Adjusted Difference**	***Regression Coef.***	***p***
Percent of families with one or more categories of concern	370	44.32%	373	40.75%	3.01%	.165	.358

Adjusted using: Participation in the GOALS or the comparison group, Baseline score on independent variable, Parent's age, Race/ethnicity (classified as African American, Other)
Language spoken at home (classified as English, Other), Living with spouse, Receiving public assistance, Parent's education, Agency.

Figure 43 presents similar data at 12-month follow-up. Fifty-nine percent of the GOALS children and 56% of the comparison children scored in the "no risk" category on all of the ASQ-3 and ASQ:SE-2 domains at 12-month follow-up. The remaining 41% of GOALS and 44% of comparison children had at least one category of concern.

Figure 43: Number of Categories of Concern - 12-Month Follow-Up

12 Month	GOALS (N=273)		Comparison (N=270)	
Number of Refer or Monitoring Categories[1]	**Number of Children**	**Percent of Total**	**Number of Children**	**Percent of Total**
0	161	59%	150	56%
1	52	19%	69	25%
2	23	8%	20	7%
3	16	6%	19	7%
4	5	2%	5	2%
5	8	3%	5	2%
6	8	3%	2	1%

There was no significant difference between the GOALS and comparison groups in the percentage of families that scored in the "at risk" or "monitoring" categories for at least one domain at 12-month follow-up.

Figure 44: Percent of Participants with at Least One Category of Concern - 12-Month Follow-Up

12 Month	GOALS		Comparison		Logistic Regression		
	N	**Unadjusted Percentage**	**N**	**Unadjusted Percentage**	**Adjusted Difference**	***Regression Coef.***	***p***
Percent of families with one or more categories of concern	273	41.03%	270	44.44%	3.05%	-.175	.383

Adjusted using: Participation in the GOALS or the comparison group, Baseline score on independent variable, Parent's age, Race/ethnicity (classified as African American, Other)
Language spoken at home (classified as English, Other), Living with spouse, Receiving public assistance, Parent's education, Agency.

Temperament Outcomes

It is of note that comparisons of the current study participants' temperament scores across time should be interpreted with caution since some children aged into different versions of the temperament measures between data collections.

The differences between the groups were not significant at six- or 12-month follow-up for negative affect or effortful control.

Figure 45: Child's Temperament Outcomes - 6-Month Follow-Up

Six Month	GOALS			Comparison			Regression		
	N	Unadjusted *Average*	SD	N	Unadjusted *Average*	SD	*Regression Coef.*	β	*p*
Negative Affect	373	3.60	1.08	366	3.63	1.08	-.017	-.008	.822
Effortful Control	373	5.52	.786	366	5.51	.773	.035	.022	.517

Adjusted using: Participation in the GOALS or the comparison group, Baseline score on independent variable, Parent's age, Race/ethnicity (classified as African American, Other)
Language spoken at home (classified as English, Other), Living with spouse, Receiving public assistance, Parent's education, Agency.

Figure 46: Child's Temperament Outcomes - 12-Month Follow-Up

12 Month	GOALS			Comparison			Regression		
	N	Unadjusted *Average*	SD	N	Unadjusted *Average*	SD	*Regression Coef.*	β	*p*
Negative Affect	279	3.46	.984	292	3.51	1.02	-.052	-.026	.540
Effortful Control	279	5.48	.864	292	5.50	.760	.012	.007	.858

Adjusted using: Participation in the GOALS or the comparison group, Baseline score on independent variable, Parent's age, Race/ethnicity (classified as African American, Other)
Language spoken at home (classified as English, Other), Living with spouse, Receiving public assistance, Parent's education, Agency.

Feeding Your Child Assessment Outcomes

GOALS families had significantly higher scores on the Feeding Your Child survey than the Comparison group at both six- and 12-month follow-up.

Figure 47: Child's Feeding Practices Outcomes - 6-Month Follow-Up

Six Month	GOALS			Comparison			Regression		
	N	Unadjusted *Average*	SD	N	Unadjusted *Average*	SD	*Regression Coef.*	β	*p*
Feeding Your Child	221	24.07	3.87	243	22.81	4.19	.827	.102	.039

Adjusted using: Participation in the GOALS or the comparison group, Baseline score on independent variable, Parent's age, Race/ethnicity (classified as African American, Other)
Language spoken at home (classified as English, Other), Living with spouse, Receiving public assistance, Parent's education, Agency.

Figure 48: Child's Feeding Practices Outcomes - 12-Month Follow-Up

12 Month	GOALS			Comparison			Regression		
	N	Unadjusted *Average*	SD	N	Unadjusted *Average*	SD	*Regression Coef.*	β	*p*
Feeding Your Child	211	24.26	3.70	221	22.12	4.32	1.92	.226	.000

Adjusted using: Participation in the GOALS or the comparison group, Baseline score on independent variable, Parent's age, Race/ethnicity (classified as African American, Other)
Language spoken at home (classified as English, Other), Living with spouse, Receiving public assistance, Parent's education, Agency.

Discussion

GOALS families showed significant improvement in many areas between pre and post-test. However, the results indicate that they only outperformed the comparison group in two areas. Several factors likely contribute to the fact that the two groups looked similar in many ways at follow-up. First, the recruitment strategy used to enroll families into the study included recruiting families out of high quality, evidence-based programs in areas like parenting at four of the five agencies. In addition, these families were sometimes still participating in these high-quality programs while they were enrolled in either the intervention or comparison group. Thus, some families in the comparison group were receiving interventions that have been shown in previous research to have positive impacts on some of the same areas assessed in this study. A plan to look at the data generated by these programs for GOALS and comparison families was unable to be implemented due to the shortened period.

Another factor that likely contributed to the similarity in the two groups is the fact that the comparison group received a higher level of care than standard care in these agencies. Comparison families received all but one of the assessments that the intervention group received – assessments that are not typically given to families in these agencies. In addition, comparison families received feedback about the results of these assessments along with a list of community resources, even though the feedback was not as comprehensive as the feedback provided to the GOALS families. Along the same lines, GOALS families received on average 19.2 contacts with staff compared to 9.7 contacts per family on average for control families. While that is a substantial difference, it does highlight the extent of communications between agency staff and control group families.

Additionally, the needs of both GOALS families and control group families were quite heterogeneous. Aggregating group outcomes might be masking more substantial differences if needs at baseline were disaggregated. This would, in many cases, result in small samples and reduced power, but subsequent studies may focus on these disaggregated samples in an exploratory fashion.

> *"The greatest need was found to be the need for belonging and self-actualization."*
>
> - Program Manager, CARE of Southeastern Michigan

Future study of the GOALS intervention might include a comparison of families that receive GOALS to families who are not receiving services from the agencies. This might provide a clearer picture of the true impact of this intervention.

Finally, some of the assessments involved in the GOALS intervention and evaluation are not designed to detect marginal gains, such that might be experienced by some of the families targeted by this intervention. For example, moving to a higher category on the Arizona Self Sufficiency Matrix often requires a large change in a family's level of functioning. The FCMSs who worked on this project reported on their Case Closure Forms that they saw progress in these families that might not have been detectible by some of the assessments used. Future studies should involve more sensitive assessments that detect smaller steps towards self-sufficiency.

Lessons Learned

In addition to the successes and challenges this study has discussed, this section highlights substantive challenges the project experienced throughout its implementation and includes a discussion of the modifications and/or recommendations for future implementers. It is organized by category, challenge, and modification/recommendation.

Category: Conducting Assessments
Challenge: Many families seemed to have difficulty with the Likert scales on the assessments.
Modifications/Recommendations: A staff member developed a visual depiction of the Likert scale for each assessment that she brought to the assessment session. She shared this approach with other FCMSs and DCSs.

Category: Assessments
Challenge: The overall assessment package was quite long, typically taking multiple hours for families to complete.
Modifications/Recommendations: The assessment package could be trimmed to the most essential components that were most readily understood by families and closely linked to families' most common goals. The trimmed down assessment package could include direct observation of parenting, assessment of child developmental competence, and assessment of the most relevant family self-sufficiency domains (e.g., access to health care and child care).

Category: Assessments
Challenge: Some assessments, particularly the assessments of temperament and nutrition, were reported to be more problematic by the FCMSs and DCSs.
Modifications/Recommendations: Assessments seen as less valuable for feedback or more confusing to families could be dropped in future implementations of the GOALS program. Continually review the salience of assessments and how they are connected to work with families.

Category: Assessments - Temperament scales
Challenge: The Strengths and Difficulties Questionnaire (SDQ) is recommended for use with the Family Check-Up, but the SDQ is recommended for ages 3-16 and the GOALS program targets families with children between newborn and 5.
Modifications/Recommendations: The Rothbart temperament assessments (IBQ-R, ECBQ, CBQ) were added to the assessment protocol as a replacement for the SDQ.
The Rothbart temperament assessments were selected because they have item overlap with the SDQ but have been validated on infants and toddlers. The SDQ provides 5 subscale scores: Emotion Symptoms, Conduct Problems, Hyperactivity/Inattention, Peer Relationship Problems, and Social Problems.

Category: Assessments - Temperament scales
Challenge: The Rothbart scales provide 3 subscales: Negative Affect, Effortful Control, and Surgency. The Surgency dimension was challenging to interpret for FCMSs and they also found it hard to incorporate the temperament dimensions into caregiver feedback.
Modifications/Recommendations: To address these challenges the Surgency subscale was dropped from the scoring and training was provided to FCMS to frame Negative Affect and Effortful Control temperament traits as aspects of their child that might lead to additional parenting challenges / stress and require adaptive parenting strategies, rather than something of concern with the child that needed to be addressed.

Category: Assessments - Feeding Your Child Survey
Challenge: The Feeding Your Child Survey (FYCS) was included in the GOALS assessment protocol because the UWSEM FEAST program was a core pathway for the program. The FYCS is a relatively new measure and focuses on attitudes, norms, and behaviors around food rather than specific nutritional behaviors. This measure was challenging on a number of fronts. Parents expected more information regarding incorporating healthy foods into their children's diets instead of broader approaches to food in general. Some of the items were also confusing (e.g., "I am comfortable with providing meals for my family").
Modifications/Recommendations: Training was provided to FCMSs related to how to communicate to caregivers about this scale and how to frame results in feedback sessions.

Category: Automatic Data Scoring and Feedback Forms

Challenge: There were a number of challenges related to incorporating the ETO system into the data utilization process for the GOALS program. ETO was to be utilized in two different capacities: 1) Automated scoring of assessments and generating family feedback forms, 2) the primary data management system for the evaluation of the GOALS program. The overarching challenge presented by ETO is that it is designed for case management and agency performance outcomes rather than a traditional relational database, and the assessment heavy nature of the GOALS program stretched the capabilities of the ETO system. Specifically, the scoring of the ASSM from the Family Profile Form required a complex scoring algorithm (see assessments section of the report) that was extremely challenging for the logical operator-based queries in ETO. A missing item or inconsistent response would prevent the scoring algorithm from executing and resulted in large amounts of missing data that would have to be checked against hand scored ASSMs. This was true of other measures as well but was most pronounced in the ASSM scoring. Additionally, the relational structure of ETO made it challenging to link Family IDs with Child IDs often resulting in inaccurate counts and orphaned data. Similarly, the linkage of Family ID and Child ID made it difficult to pull information from different database tables and this resulted in widespread missing data on variables such as child age, sex, etc.
Modifications/Recommendations: A subgroup met on a bi-weekly basis for approximately 18-months, beginning in March of 2018, to review and address ETO data challenges. This involved an item-by-item review of scoring algorithms. FCMSs also, in many cases as issues were being addressed, continued to hand score the assessments to confirm accuracy. Data audits were also conducted to ensure accuracy of the data in ETO.

It should also be noted that despite extensive technical expertise on the project team, United Way had to rely on Social Solutions for some of the more technically complex reporting builds and projects should be sure to budget for this type of technical assistance. This also impacted project timelines and the possibility for this type of external delay should be discussed and planned for during the design and pilot phases of the project.

Additionally, work with a data management system that is an open relational database (e.g., SQL) that gives more control and flexibility to agencies implementing this program. Additionally, develop a formal process for transferring data from the data management system to data analysis and reporting systems to ensure more efficiency.

A shortened pilot period also impacted the team's ability to address these issues prior to full launch. Every effort should be made to test all data systems and associated protocols prior to launch.

Category: Communications Regarding Implementation
Challenge: FCMSs and DCSs had concerns or questions about the delivery of the assessments and feedback. They also encountered challenges unique to specific cases in their caseload.
Modifications/Recommendations: Monthly "Learning Communities" were set up for FCMSs to present challenging cases and to discuss broader concerns and receive additional training on

specific topics (e.g., goal setting). DCSs also had monthly meetings to discuss assessment delivery and other concerns.

Category: Sharing Feedback with Families
Challenge: FCMSs expressed concerns about sharing areas of weakness that may need attention with families during feedback sessions.
Modifications/Recommendations: The initial Family Check-Up training emphasized that the program uses a strengths-focused approach. FCMSs were encouraged during training and in subsequent Learning Communities to share feedback in a way that was consistent with the data and results while highlighting families' strengths and adjusting feedback in response to caregivers' perspectives.

Category: Goal Setting
Challenge: Initially, many families did not set goals, and FCMSs sometimes struggled helping families to set goals.
Modifications/Recommendations: In subsequent training sessions during monthly Learning Communities, the importance of goal setting was emphasized and barriers to goal setting were discussed. Regular check-ins with all staff, especially on key components of the project, should be conducted to ensure understanding. It may be helpful to have multiple teams or individuals conduct these to capture different perspectives, as some individuals may have difficulty discussing some issues with the funding agency.

Category: Pathways
Challenge: It is difficult to anticipate every need that project participants will have and to pre-identify quality interventions for every referral. Projects that rely on external resources want to remain nimble around their ability to activate around new opportunities.
Modifications/Recommendations: Pathways were added through a mix of opportunities from the community as long as it met the spirit of, and complied with, the intervention and project requirements and need expressed by the participants and program staff (e.g. Citizenship Pathway and Literacy Pathway).

Category: Pathways
Challenge: FCMSs indicated during site visits that there were some areas of confusion regarding how to use pathways and the services associated with the pathways.
Modifications/Recommendations: FCMSs indicated that it would be helpful to have documentation outlining concrete steps for enrolling families in pathways and providing the associated services. In order to detect gaps in understanding and use of pathways quickly, more early and intense monitoring of pathway data along with coaching for FCMSs specifically aimed at supporting families enrolled in various pathways might be beneficial.

Category: Blurring of Conditions
Challenge: The GOALS and comparison conditions may have been more similar than intended. Specifically, even though DCS were named "Data Collection Specialists" they also provided

feedback to families (albeit more limited) and assisted with referrals, likely to varying degrees across agencies. It is difficult to know how similar this comparison condition was relative to care "as usual" at these agencies.
Modifications/Recommendations: Small samples stratified by level of engagement might be able to tease this apart.
Additionally, because there remains an obligation to treat, more monitoring of the communication and referral data specifically for the comparison condition to ensure that all services received are controlled for in the analysis.

Category: Randomization of Participants
Challenge: Randomization protocols instructed agencies to begin the randomization process for families recruited via word of mouth or at large recruitment events as soon as they expressed interest in the project. Families who expressed interest in the study were immediately randomly assigned to either the intervention or comparison group by the agencies. The agencies would then follow up with families to set up the initial assessment appointment. There was often a gap of days or weeks between when a family initially expressed interest and when they were contacted by the agency to set up an appointment. Agencies found that some families lost interest during that time and never actually enrolled in the study. Other families, particularly those recruited at large community events, may have never been interested or may not have understood what enrollment in the study entailed. As a result, a large number of families who were randomized early in the study never actually enrolled in the study. This led to high baseline attrition numbers.
Modifications/Recommendations: Under the new protocols, agencies did not immediately randomize families that expressed interest in the study. Instead, the agencies recorded contact information from these families and let the families know that they would receive a call from the agency when there was room to immediately enroll new families into the study.
If the families expressed both that they remained interested in enrolling and that they were prepared to set up an appointment immediately, they were offered a spot in the study. After the phone call, the agency would randomly assign the family to the intervention or comparison group using the updated randomization protocol. If a family was randomly assigned to the intervention group, a Family Check-Up Model Specialist immediately contacted them to set up the first appointment. If a family was randomly assigned to the comparison group, a Data Collection Specialist immediately contacted them to set up a first appointment.

Category: Staff Turnover
Challenge: There was a high level of turnover in FCMSs and DCSs, although the rate of turnover varied considerably across agencies and across time. United Way as the project lead also experienced a high-level turnover among its executive staff who oversee overall strategy for the organization.
Modifications/Recommendations: The project team anticipated this turnover and one of the first major documents pulled together following the pilot phase of the project when most processes had been codified was to create a comprehensive implementation manual. This manual pulled together overviews, process flows, job aides, and other materials related to the

project to assist in onboarding and to serve as a reference for issues that came up. United Way also instituted a "Help Ticket" model to support staff with technical issues.

Another recommendation from project partners that could not be implemented due to compliance issues around how these funds could be used was to create a retention bonus for staff that stayed through the full project period to help ensure full staffing through the final months of the project.

For future efforts and communicating with executive staff members this study would recommend creating high-level overviews, infographics, and presentations that can help key decision makers quickly understand a project this complex.

Next Steps

The goal of all Social Innovation Fund projects is to "figure out what works and make it work for more people" United Way intends to support this effort in three ways.

First, United Way will continue to review the data generated by this project and deepen its analysis, as is practicable and funding allows. Additional articles, infographics, and presentations to the field will continue to support the knowledge sharing efforts around this work. The COVID-19 impact data is of particular interest as United Way serves as a local hub for pandemic relief efforts in Southeast Michigan and this data will help deepen the organization's understanding as it continues to support crisis relief and community resilience efforts.

Second, United Way is planning to continue to support key GOALS pathways and components of the assessment in its Center for Early Childhood Excellence. This will include the ASQ-3 and ASQ-SE screening tools and READY4K texting platform. United Way has also modified the READY4K texting pathway to respond to ASQ-3 screening data creating a tailored experience for parents. Under this new partnership, a parent or childcare provider will enter the screening responses and the data is then sent through an API to a proprietary algorithm created by ParentPowered Public Benefit Corporation specifically to support this pathway expansion. The algorithm then selects texts based on the caregiver's answers and delivers messages and activities that respond directly to the child's needs. This is repeated every time an ASQ is conducted.

Additionally, FCMSs repeatedly cited the difficulty families had in finding childcare in their communities. Leveraging funds from this project and others in service of our scaling and sustainability efforts, United Way has been able to create a new one-stop-shop to digitally house several GOALS pathways and support families in finding childcare called www.Connect4CareKids.org. In a pilot with the City of Detroit, this new platform expands the texting pathway to allow parents to determine their eligibility for subsidized childcare, locate childcare settings, and begin the enrollment process all from the texting app on their phones or through the website. Text prompts through the same system will also help United Way staff begin to proactively ascertain other needs families may have and direct them to services using processes adapted from GOALS.

> *"The biggest commonality no matter the culture, was that children's learning seemed to most often be families' highest area of interest, and this topic would frequently take precedence over resources, regardless of level of need."*
>
> - Data Collection Specialist, Oakland Family Services

Lastly, United Way is embarking on the work to create a Community Information Exchange, or CIE, to help bridge the data divide between social services and healthcare partners and move from reactive information and referral to proactive social service navigation supports. GOALS staff have been part of the planning efforts around this work and will continue to support on implementation with the goal being to infuse the learnings generated from GOALS into this new system of care. Of particular interest is the work around the Family Profile Form and using motivational interviewing to support family goal setting. This has the potential to greatly enhance the 2-1-1 model and change United Way's service delivery model in ways that empower families, bolster systems, and leverage data to drive positive outcomes.

COVID-19 Pandemic Effects

COVID-19 PANDEMIC EFFECTS

COVID-19 Timeline

December of 2019: The first reported cases of a novel Corona virus (Corona Virus ID 2019 or COVID-19) emerged in Wuhan, China.

December 31, 2019: Last date of program enrollment for the GOALS project.

January 21, 2020: The first case of COVID-19 was reported in the United States.

March 11, 2020: Michigan had its first reported case; this case was identified in Oakland County.

March 18, 2020: GOALS project began development of remote service delivery and evaluation protocols.

March 23, 2020: Michigan Governor issued an executive order requiring residents to shelter-in-place and all non-essential business along with schools to close.

April 2, 2020: Michigan reported the 3rd highest number of cases in in the U.S. with 10,791 cases, 79.5% of the cases occurring in the Metro-Detroit region with Detroit accounting for 33% of the Metro cases. Furthermore, the mortality rate was disproportionately impacting the African American community (https://www.michigan.gov/coronavirus/0,9753,7-406-98163_98173---,00.html) which accounted for 40% of COVID-19 deaths in Michigan, nearly double the rate of Caucasian deaths (26%).

April 28, 2020: GOALS IRB amendment was approved to include two COVID-19 impact measures that were administered remotely beginning with currently enrolled families, followed by reaching out to previously enrolled families.

August 31, 2020: Data collection on the GOALS project was completed. Michigan had reported 102,468 cases of COVID-19 and 6,480 deaths. The Metro-Detroit area which is the catchment area for the GOALS project accounted for 54% of all COVID-19 cases in Michigan and 72% of COVID-19 deaths. City of Detroit residents alone accounted for 23% of deaths and had a death rate of 10.2%, more than twice the Michigan average of 4.9%.

COVID-19 Impact and Implications

The COVID-19 pandemic had a tremendous negative impact on the families being served by the GOALS project. African Americans, which comprise 47% of our sample, in Michigan are 1.9 times more likely to contract the virus and 3.6 times more likely to die from COVID-19 than any other racial demographic group. Long standing health disparities put African Americans at much greater risk because of disproportional rates within the African American community of

the risk factors with the highest COVID-19 death rates (https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e2.htm) cardiovascular disease (10.5% death rate), diabetes (7.3% death rate), chronic respiratory disease (6.3% death rate), and hypertension (6.0% death rate). This is further complicated by increased immunosuppression in the African American community resulting from chronic exposure to stressors (Black, Johnson, & VanHoose, 2015). This is particularly true for African American women (Lewis, et al., 2017).

In addition to the direct impact of COVID-19 on vulnerable families, they are also the most severely impacted by societal ramifications of the virus.

The cumulative impact of COVID-19 on an asymmetrical and inequitable social infrastructure is that the most vulnerable families will be hit earliest, hardest, and have the most difficult time recovering from this public health crises. This will likely have a generational impact due to the ripple effects of lost economic and educational opportunity and straining public social services for decades, ultimately leading to further societal disparities and injustices.

Societal Ramifications of COVID-19 on Vulnerable Populations

Families are more likely to:

- Have low income, hourly-wage jobs with no paid sick leave
- Be laid off indefinitely
- Have unstable housing and higher likelihood of eviction
- Lack adequate health care coverage and access to health care services
- Rely on public transportation
- Limited access to food and other household necessities
- Be more negatively impacted by the need for childcare and school closings
- At higher risk for legal and judicial actions resulting from crimes of poverty
- Lack of social capital
- Long-term family disruption due to illness and or death
- Barriers to obtaining social and economic supports

COVID-19 Impact on GOALS participants

As noted in the timeline above, current and former study participants were contacted by partner agency staff via phone and asked to complete two COVID-19 impact questionnaires (see appendices X and Y). One questionnaire asked about exposure to COVID-19 by the participant and within the participants family and friends, as well as COVID-19 symptoms. The other questionnaire was focused on the ways in which COVID-19 directly and indirectly, via stay-at-home orders, etc., impacted participants' daily life. Participants who were currently active in the GOALS program were contacted first followed by families who had completed the GOALS program in reverse order of enrollment date. Thus, families with the most recent involvement in the program were contacted first in order to maximize recruitment. The final sample consisted of 380 participants.

To administer the COVID-19 surveys partner agency staff were instructed to begin with study participants who had been recently in contact with an FCMS or DCS as these were the people

more likely to have up-to-date contact information. After completing those calls, staff was then instructed to call participants that had not had recent contact. Additionally, in an effort to maintain case closure, staff members were asked not to contact participants that had previously been assigned to their caseload except in extenuating circumstances (ex: a language barrier).

Public health reports across the United States have shown that individuals from marginalized populations are at much higher risk of COVID-19 exposure and risk of dying from COVID-19. The GOALS families reported COVID-19 exposure rates that were consistent with these National findings.

Reported COVID-19 Exposure in Study Participants

- 4% reported testing positive for COVID-19
- 11% reported that one or more immediate family members had tested positive for COVID-19
- 40% reported that one or more members of their extended family and/or close friends had tested positive for COVID-19.
- 18% reported that they have had a family member or close friend die from COVID-19

These findings illustrate the substantial and disproportional exposure to the virus that GOALS families experience. Compared to the general population GOALS families, like most members of marginalized communities are bearing the brunt of the pandemic. Perhaps because GOALS families have such widespread exposure to the virus, they report a very high compliance with masking. Approximately 94% of respondents reported wearing a mask when outside their own home. However, social and economic inequities often prevent GOALS families from a "shelter-in-place" approach putting them at greater risk for contracting COVID-19 despite high mask compliance. On average GOALS families left home between 3-4 days per week. 20% of respondents reported leaving home for work and 55% reported leaving home in order to get groceries. While leaving home for groceries is common across demographic groups, it appears from our data that GOALS families are leaving home more frequently which may be due to economic and transportation barriers that restrict the ability to buy in sufficient bulk to reduce the frequency of leaving home. Moreover, when leaving the home, GOALS families reported having close contact with 7-8 people when they left the home. In addition to the direct impact of experiencing COVID-19, GOALS families reported substantial negative indirect effects as well. 72% of participants reported that they had a significant decrease in income as a result of the pandemic, with one-third (31%) reporting that they lost their income completely. More than one-fifth of families reported a moderate to severe negative impact on food access and 45% of respondents reported a moderate to severe increase in stress as a result of the pandemic.

GOALS Mitigation of COVID-19 Effects

While the GOALS project had stopped enrolling new participants on December 31, 2019, families that had enrolled in the program as early as April 2019 (n=374) had a baseline

assessment prior to the onset of COVID-19 and either a 6-month or 12-month assessment after COVID-19. This natural experiment allowed for a direct test of the impact of COVID-19 on families in two ways. First, it allowed for the comparison of rates of change in outcomes between GOALS families and control families across the onset of the pandemic. It also allows for comparisons of rates of change pre-COVID-19 to post-COVID-19. Focusing on the first comparisons allowed for the assessment of the differential impact of COVID-19 between GOALS families and control group families. The ASSM outcome domains were dichotomized into high-risk (scores of 1,2, or 3) and low risk (scores of 4 or 5). Multilevel logistic regression with assessment occasion (baseline, 6-months, 12-months) as the level 1 factor and intervention v. control as the level 2 factor was then used. Analyses were further stratified by COVID-19 phase, with Phase 1 defined as the period from 3/13/20 (one week before the Michigan Shelter-In-Place Order) to 4/30/20 (the first curve flattening in Michigan), and Phase 2 extended from 5/1/20 thru 8/30/20.

It was found that there was a significant increase in the likelihood of either staying in or moving into the high-risk category for both the intervention and control groups during the COVID-19 Phase 1 period across multiple ASSM domains: Health Care, Employment, Family Social Connections, Community Engagement, Parenting, and Mental Health. However, during Phase 2, the families enrolled in the GOALS program were significantly more likely to move to the low-risk category in areas of Mental Health, Parenting, Family Connection, and Health Care. The odds ratios for these analyses ranged from 1.8 to 3.5 indicating a nearly two-fold decrease in risk across these domains at a minimum. It is reasonably speculated that this positive buffering effect is at least in part related to the GOALS program providing an established and trusted support system to help navigate the needs of families in the face of the COVID-19 pandemic.

"From the start, the SIF [GOALS] program was an incredible experience. I thought in the beginning [it was] only doing surveys and giving the results to the clients. In fact, after each term or session, my spiritual growth grew a lot due to reflecting on my lifestyle. It changed my outlook on life such as my negative thoughts turned into positive, more patient. I am more open minded and laid back, I learned to give my kids more chances and time to make the change, be more independent, and build trust. I am proud to be part of SIF program due to how it changed my perspective. I am proud of being able to help myself, my children, and the people/clients that I worked with."

- Family Check-Up Model Specialist, ACCESS

References

Arizona State University Research and Education Advancing Children's Health Institute. (2016). *Family Check-Up Overview,* 17.

Black, L. L., Johnson, R., & VanHoose, L. (2015). The relationship between perceived racism/discrimination and health among black American women: a review of the literature from 2003 to 2013. *Journal of racial and ethnic health disparities*, 2(1), 11-20.

Centers for Disease Control and Prevention. (2020, April 02). *Preliminary Estimates of the Prevalence of Selected Underlying Health Conditions Among Patients with Coronavirus Disease 2019 - United States, February 12–March 28, 2020*. https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e2.htm

Dishion, T. J., Shaw, D., Connell, A., Gardner, F., Weaver, C., & Wilson, M. (2008). The family check-up with high-risk indigent families: Preventing problem behavior by increasing parents' positive behavior support in early childhood. *Child development*, 79(5), 1395-1414.

Graham, J. W. (2012). *Missing Data: Analysis and Design*. Springer Science & Business Media.

Janczewski, C.E., Mersky, J.P., & Brondino, M.J. (2019). Those Who Disappear and Those Who Say Goodbye: Patterns of Attrition in Long-Term Home Visiting. *Prevention Science,* 20, 609-619.

Lewis, J. A., Williams, M. G., Peppers, E. J., & Gadson, C. A. (2017). Applying intersectionality to explore the relations between gendered racism and health among Black women. *Journal of counseling psychology*, 64(5), 475.

Michigan.gov. (n.d.). *Michigan Coronavirus Data*. https://www.michigan.gov/coronavirus/0,9753,7-406-98163_98173---,00.html

Shaw, D. S., Dishion, T. J., Supplee, L., Gardner, F., & Arnds, K. (2006). Randomized trial of a family-centered approach to the prevention of early conduct problems: 2-year effects of the family check-up in early childhood. *Journal of consulting and clinical psychology*, 74(1), 1.

Appendices

APPENDICES

Appendix A: Glossary

2-1-1	United Way's call-based information and referral system.
ALICE	**A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed – a construct used by United Way and its partners to describe families that are above the technical poverty line, but financially vulnerable.
ASU REACH Institute	Arizona State University's Research and Education Advancing Children's Health Institute is the home of the FCU.
Bib-to-Backpack	The name of the United Way for Southeastern Michigan's (United Way) SIF2016 proposal that was awarded a 5-year, $6 million grant to implement a study testing the ability to implement the Family Check-Up model in five Greater Detroit agencies to increase the engagement of families in services through an integrated Service Delivery system thereby strengthening the developmental readiness and well being of their children.
DCS	Data Collection Specialists were staff trained to serve the control-group families.
ETO	Efforts to Outcomes by Social Solutions, the data platform used in the study.
FCMS	Family Check-Up Model Specialists were staffed trained in the model and who served GOALS (intervention) families.
FCU	As described by REACH, the Family Check-Up is a brief, strengths-based intervention model for children ages 2 through 17. It promotes positive child outcomes by improving parenting and family management practices. The Family Check-Up has more than 30 years of evidence demonstrating strong intervention effects.
GOALS	GOALS (Gain Opportunities to Achieve Lasting Success) is a connected continuum of evidence-based services which recruit, engage, and empower parents and parents of children age 5 and under.

Pathways	A portfolio of evidence-based programming available to GOALS families through various partnering agencies. These previously established programs were adapted to support a "no wrong door" approach to offering services.
Philliber	Philliber Research and Evaluation an independent research and evaluation firm, specializing in outcome-based evaluation and planning services was awarded the role of lead evaluator after a rigorous bid process.
SIF	The Social Innovation Fund was a federally funded program through the Corporation for National and Community Service (CNCS) that united public, private and nonprofit organizations to identify and support sustainable evidence-based programs.
Partner Agencies	Through two rigorous Request for Qualifications processes, United Way for Southeastern Michigan (United Way) identified five community partners to be subrecipients of the SIF grant and work with United Way to implement this program model within their agencies. They included Arab Community Center for Economic and Social Services (ACCESS), Community Assessment Referral and Education (CARE) of Southeastern Michigan, Leaps and Bounds Family Services (LBFS), National Kidney Foundation of Michigan (NKFM), and Oakland Family Services (OFS).
United Way	United Way for Southeastern Michigan works to create positive, measurable and sustainable change in the community and was awarded a Social Innovation Fund (SIF) grant in 2016 to implement Bib-to-Backpack, making it the lead investigator of the project. This was the second SIF grant awarded United Way for Southeastern Michigan.
WSU	Wayne State University, a premier research-tiered university located in Detroit, long-time partner with United Way, and home to two project consultants.

Appendix B: Sample Recruitment Flyer (for July - December 2019)

ACCESS

HOW CAN WE BETTER SERVE CHILDREN AND FAMILIES?

- Are you a parent or guardian of a child 5 years old or younger?
- Do you live in Detroit or Dearborn?
- Do you want to learn about resources available to you and your family?

If you answered yes to all of these questions, then you may qualify to participate in a new study and earn up to $150

Participate today and help us understand how we can better serve you and your family.

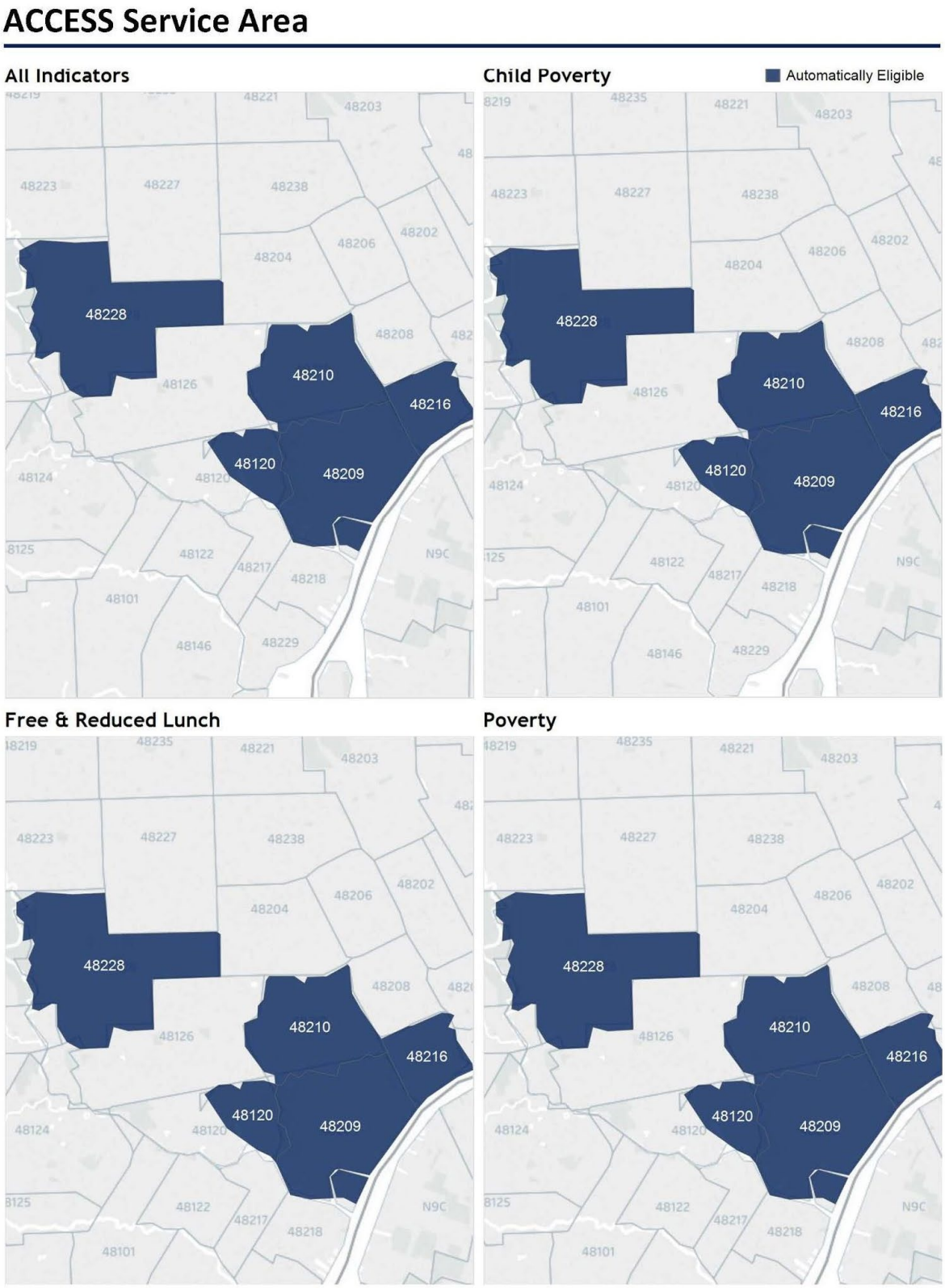
For more information, please contact us at: 313-842-4765

Appendix C: Agency Recruitment Strategies

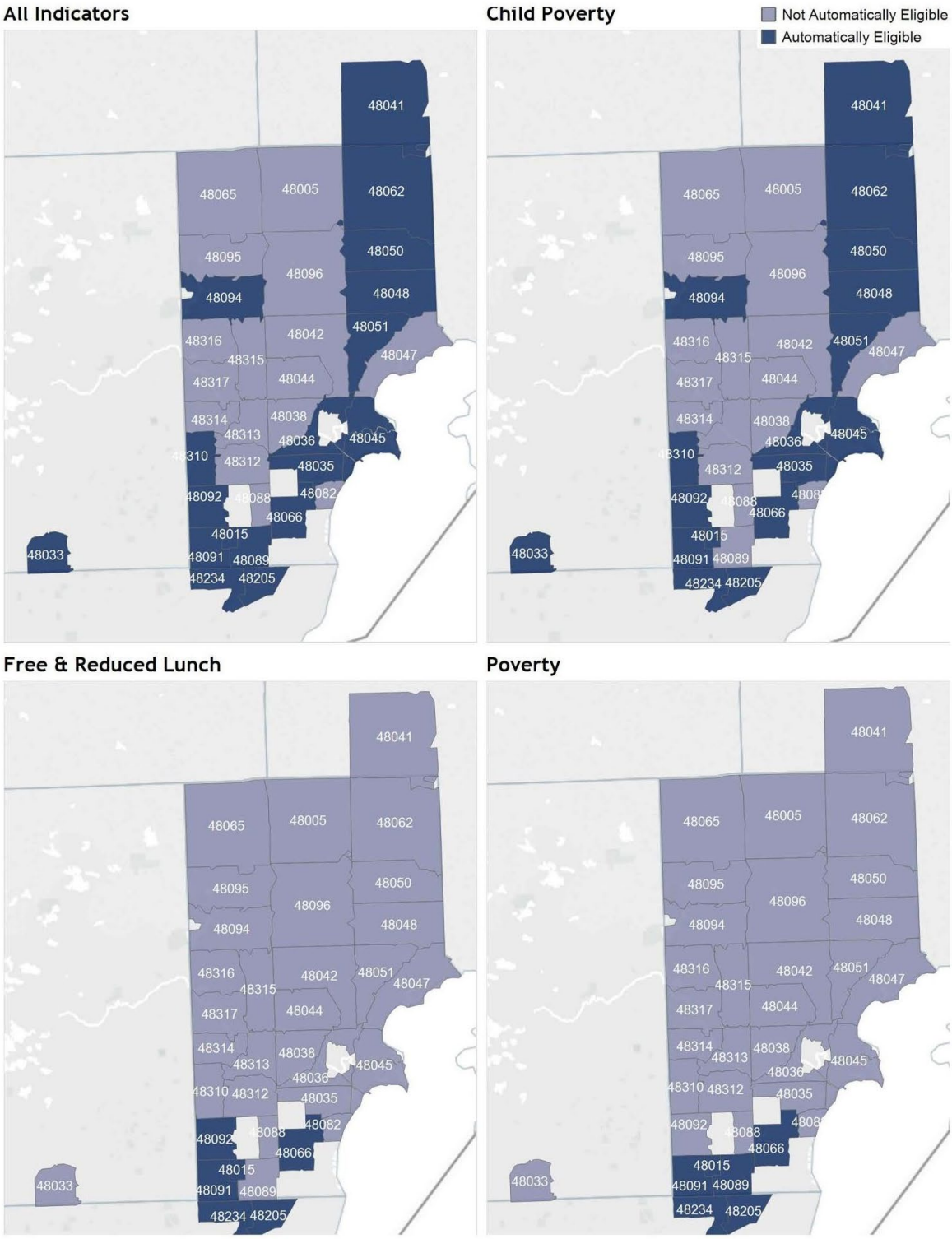
Agency	Recruitment Strategies
ACCESS	Agency Programs ACCESS to School program (Dearborn and Detroit) ACCESS WIC Clinic (Dearborn and Detroit) ACCESS Social Services (Dearborn) ACCESS Clinic (Dearborn) Community Programs Reading Works (Metro Detroit) Wayne Metro Head Start Walk-in Families (ex: people who call or come in after seeing the flyer or through word of mouth) Community Events
CARE	Agency Programs Supportive Opportunities for Families Nurturing Parents Active Parenting Community Programs Brilliant Detroit Walk-in Families (ex: people who call or come in after seeing the flyer or through word of mouth) Community Events
LBFS	Agency Programs Home Visiting Play Groups Early On Early Learning Community Walk-in Families (ex: people who call or come in after seeing the flyer or through word of mouth) Community Events
NKFM	Agency Programs PE-Nut Elementary Program Community Programs Reggie's Rainbow Adventures NAP SACC Enhance Fitness DPP PATH

	WIC Federally Qualified Health Centers Walk-in Families (ex: people who call or come in after seeing the flyer or through word of mouth) Community Events
OFS	Agency Programs Parents As Teachers Play Groups Community Programs Libraries The Department of Health and Human Services Walk-in Families (ex: people who call or come in after seeing the flyer or through word of mouth) Community Events

Appendix D: Service Areas and Recruitment Zones by Agency

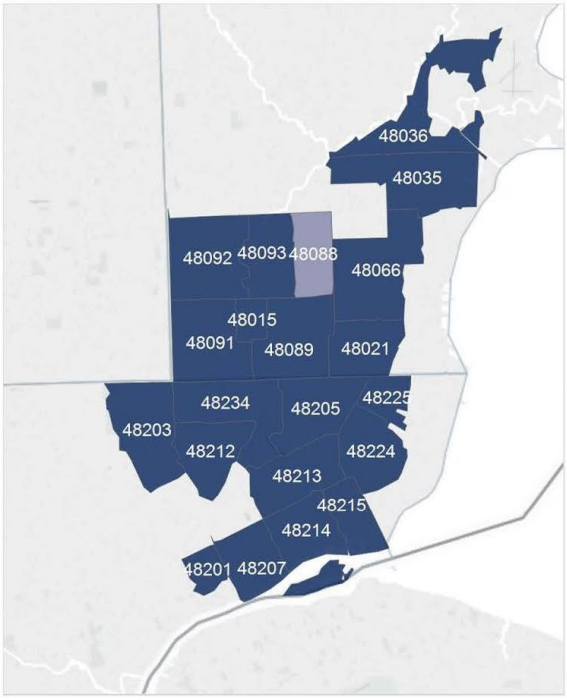


CARE Service Area

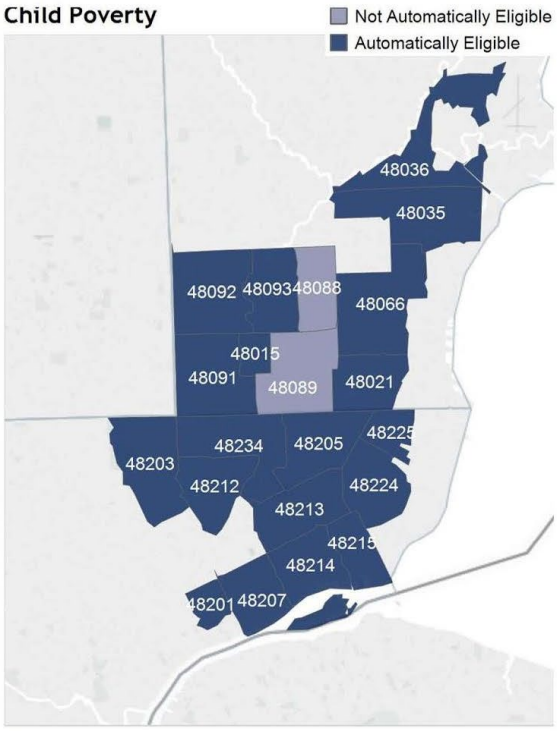


LBFS Service Area

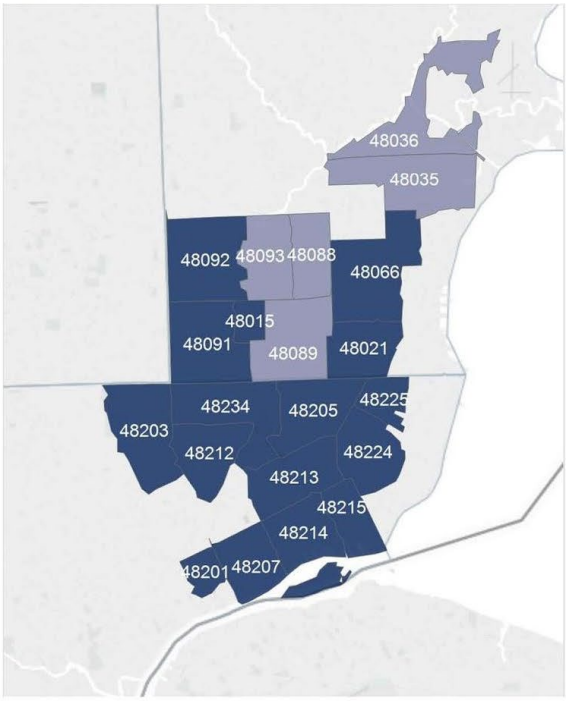
All Indicators



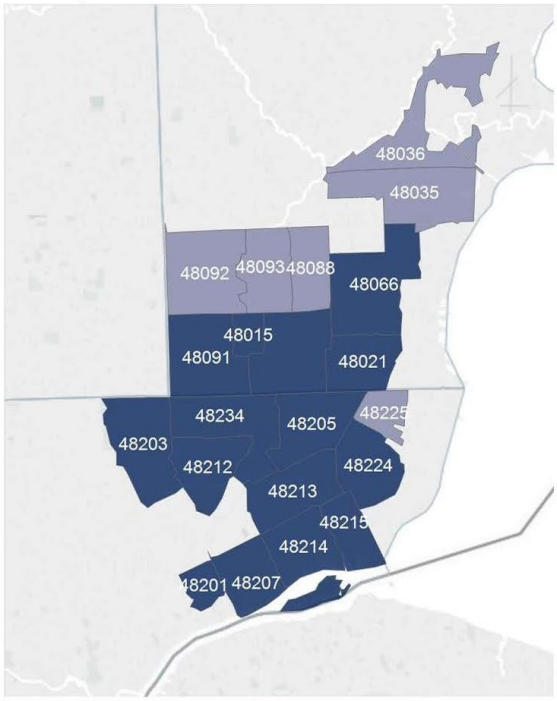
Child Poverty



Free & Reduced Lunch

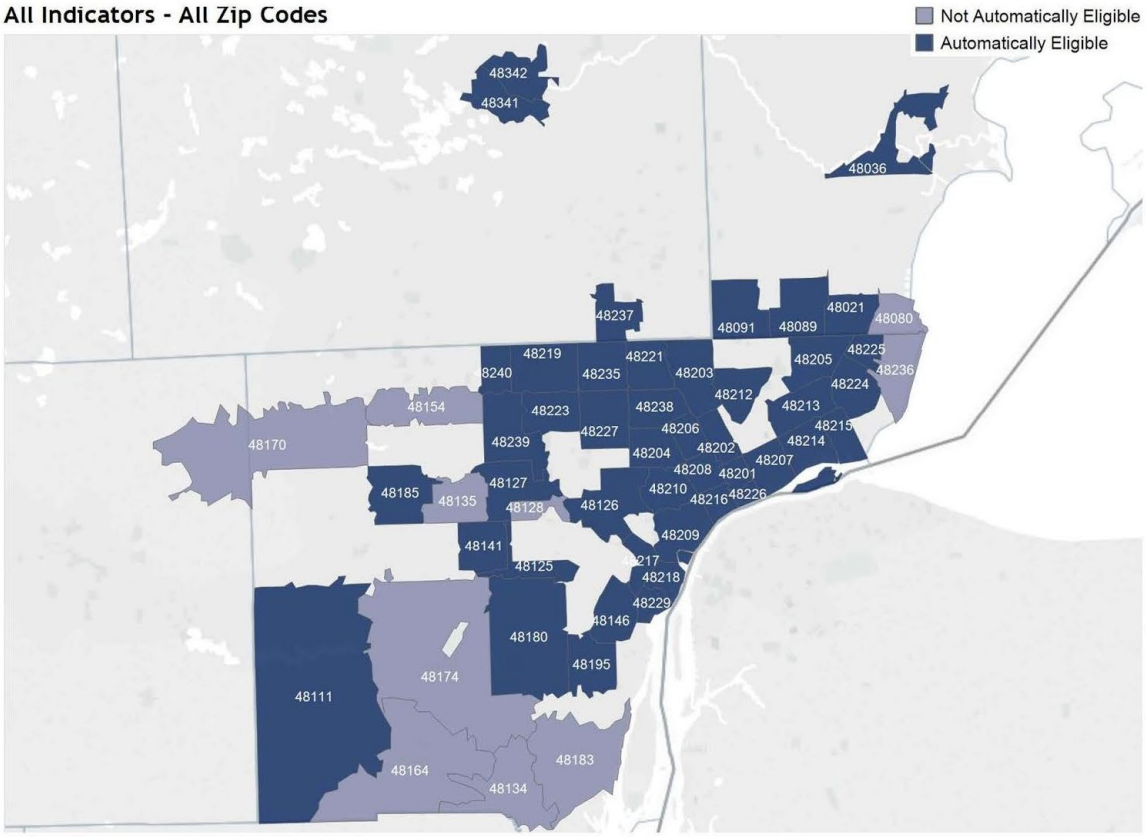


Poverty

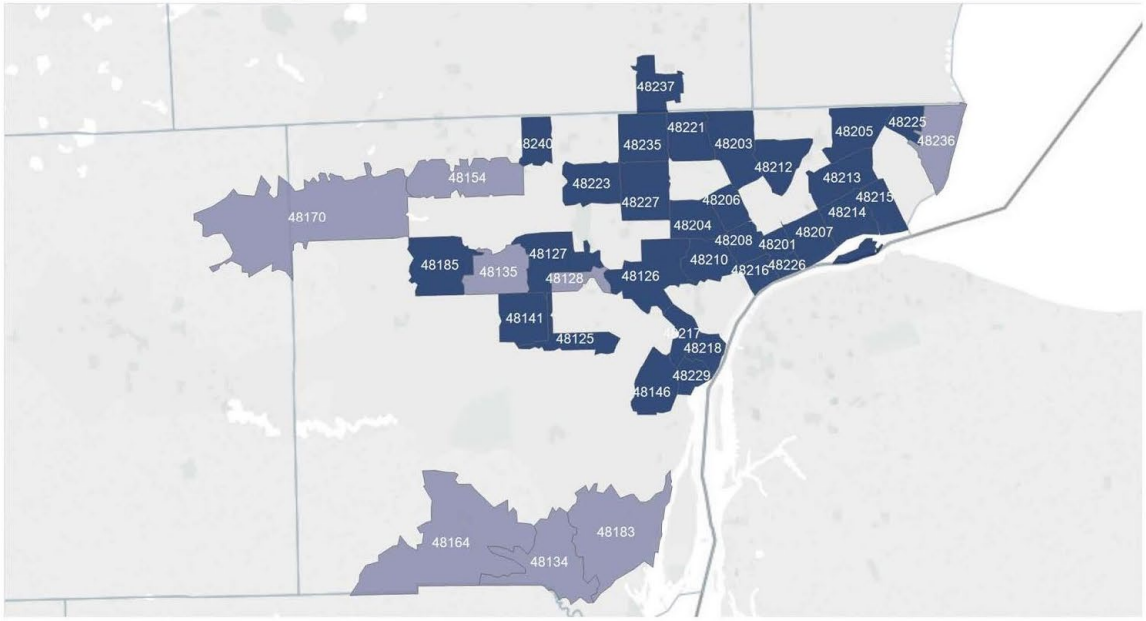


NKFM Service Area

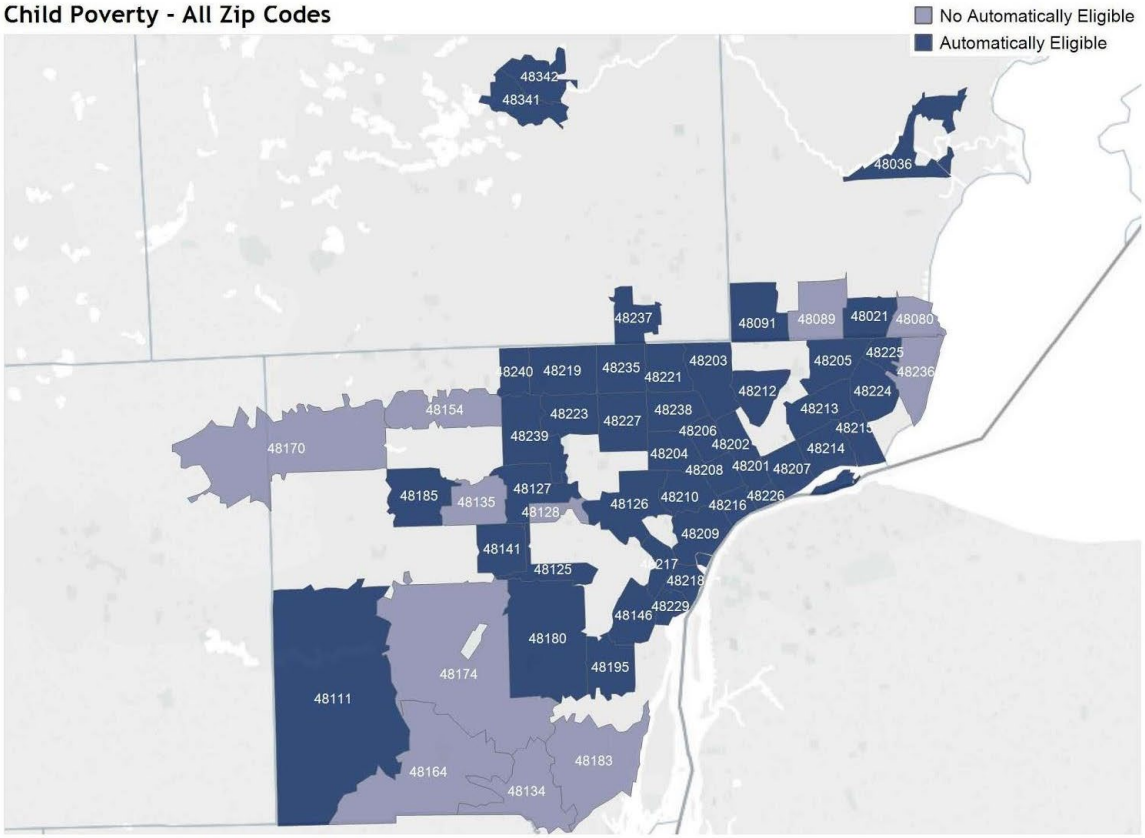
All Indicators - All Zip Codes



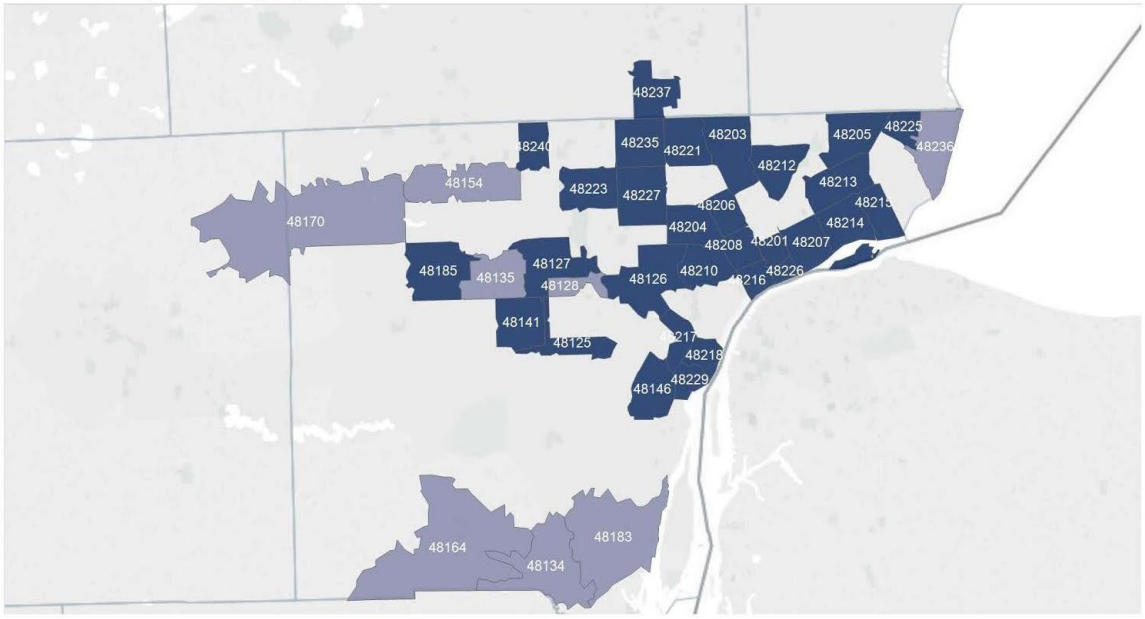
All Indicators - Priority Zip Codes



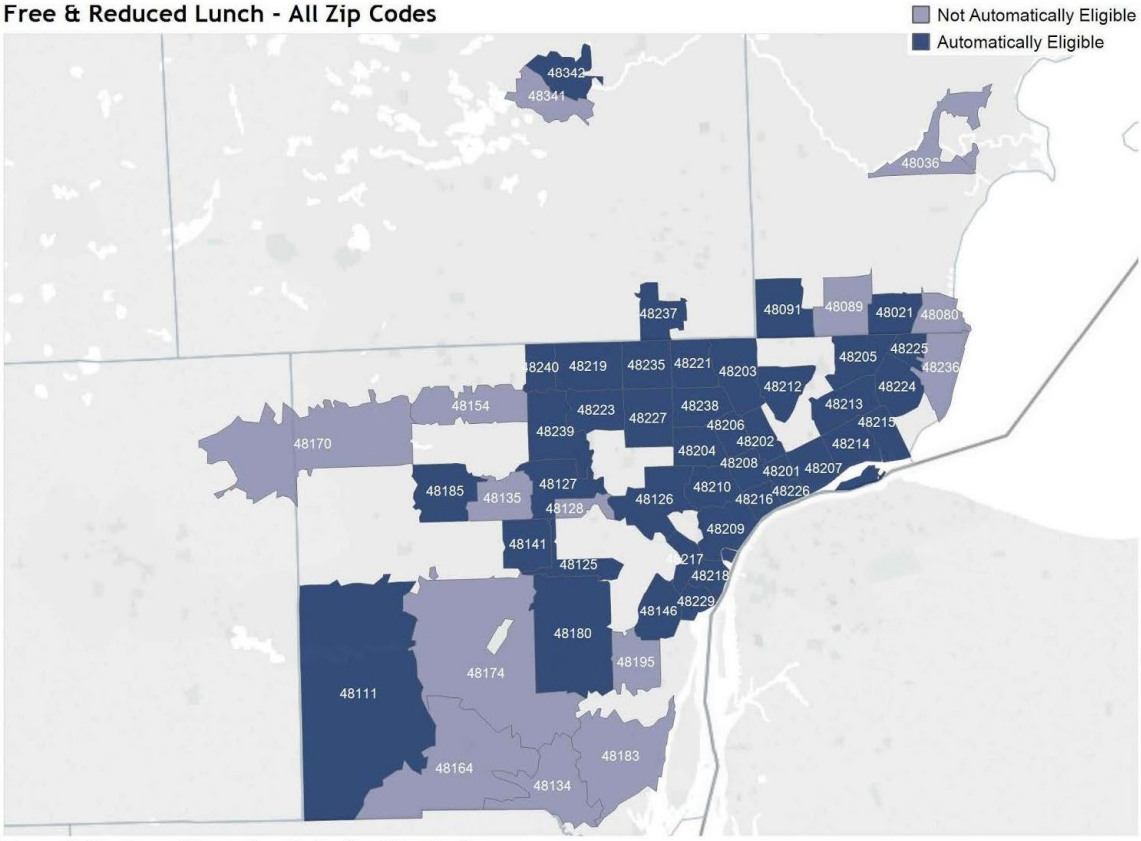
Child Poverty - All Zip Codes



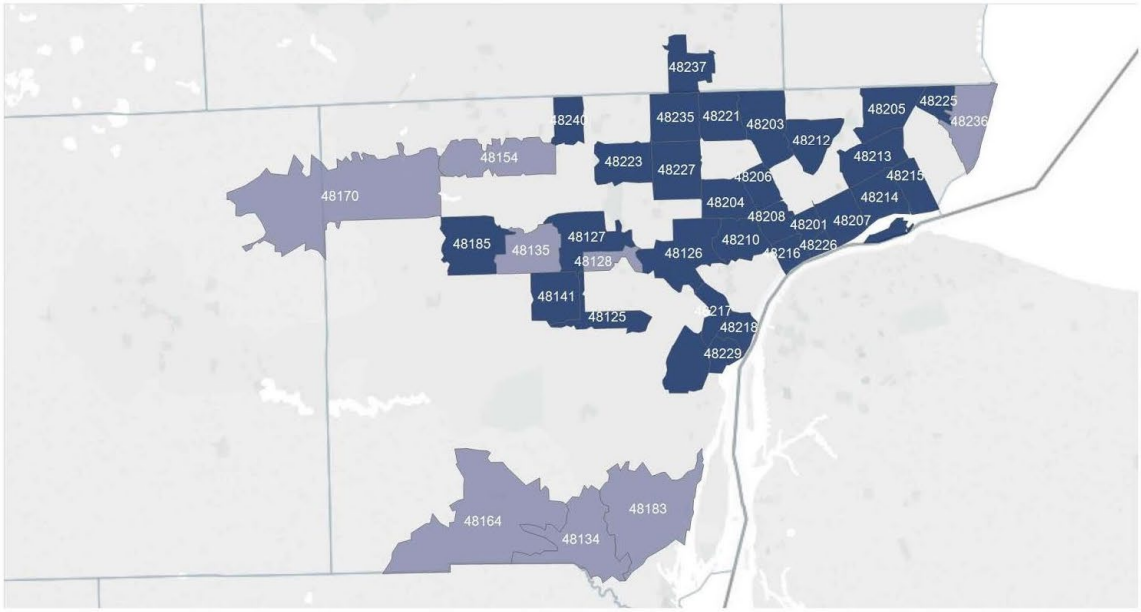
Child Poverty - Priority Zip Codes



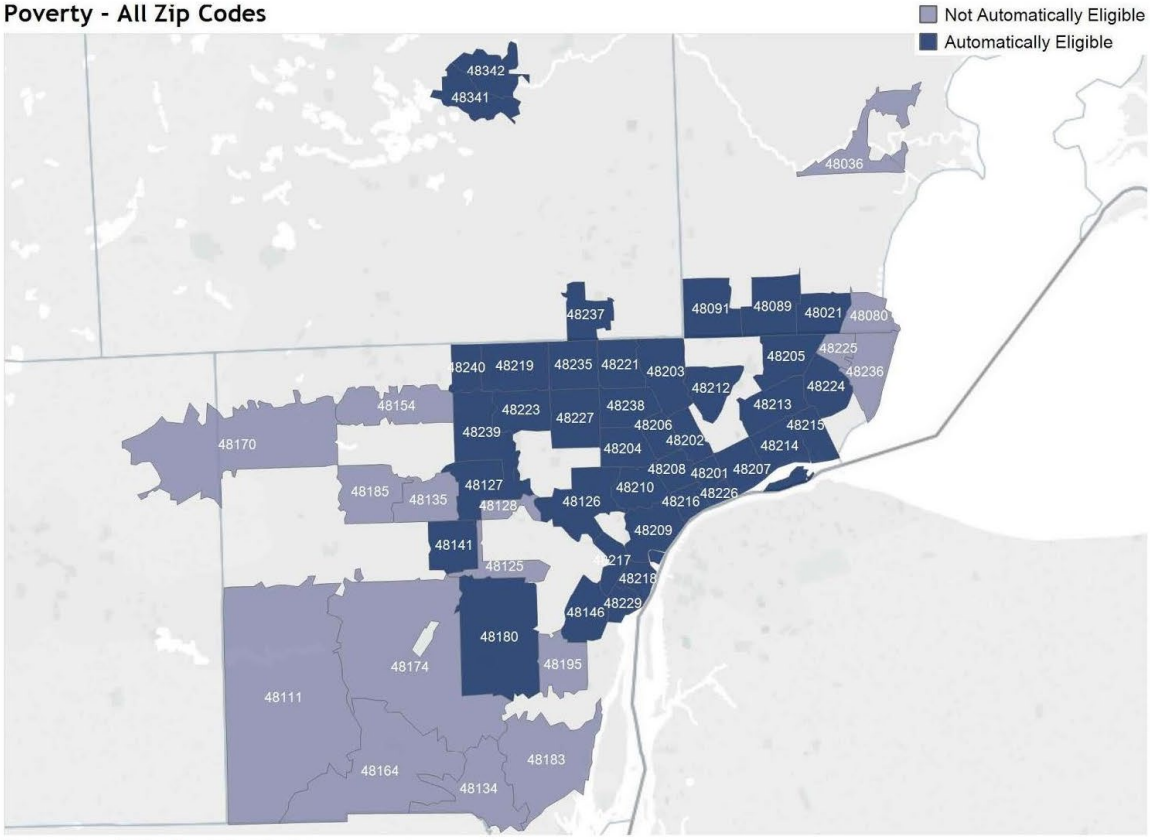
Free & Reduced Lunch - All Zip Codes



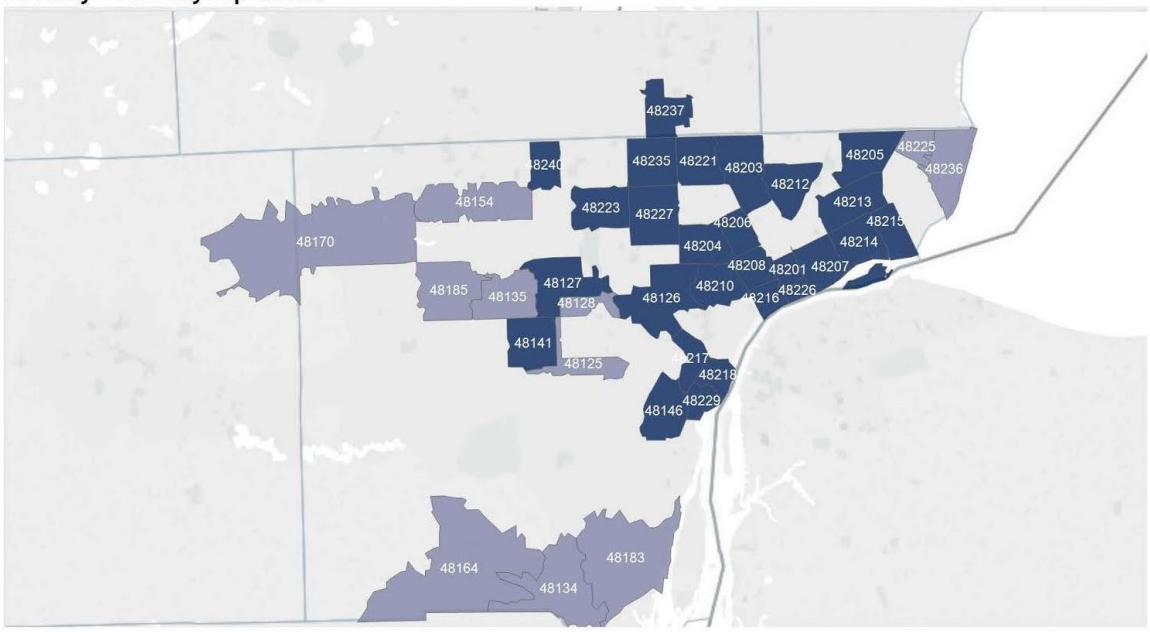
Free & Reduced Lunch - Priority Zip Codes



Poverty - All Zip Codes

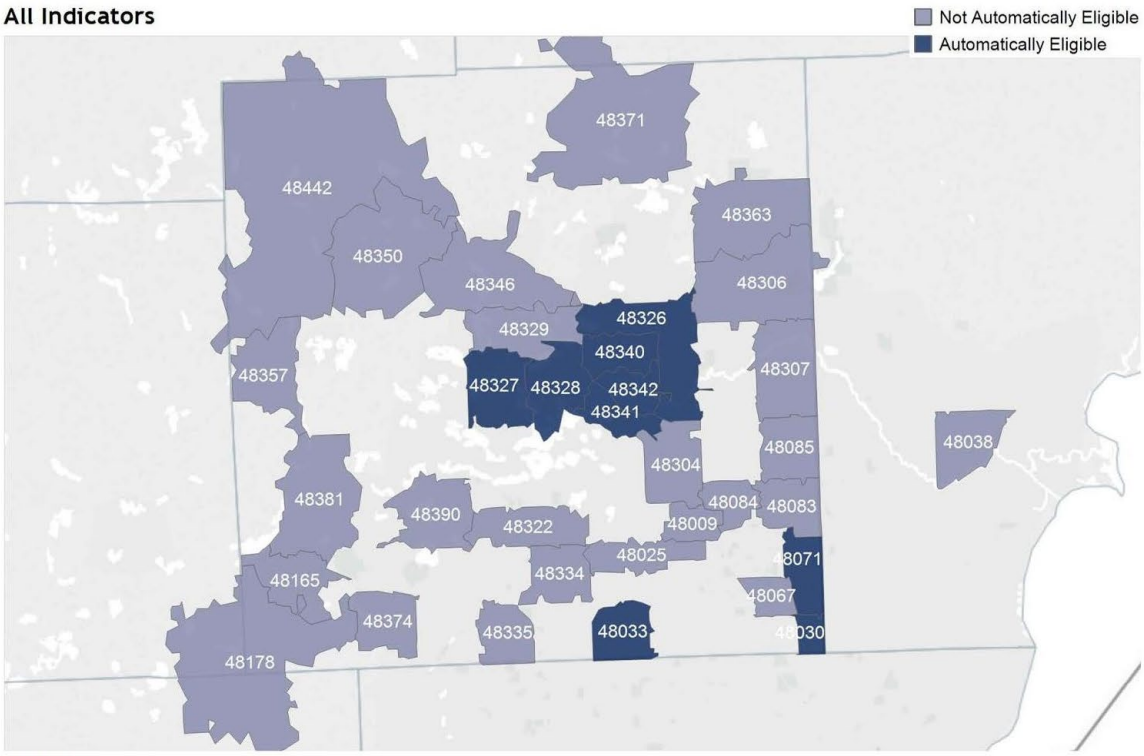


Poverty - Priority Zip Codes

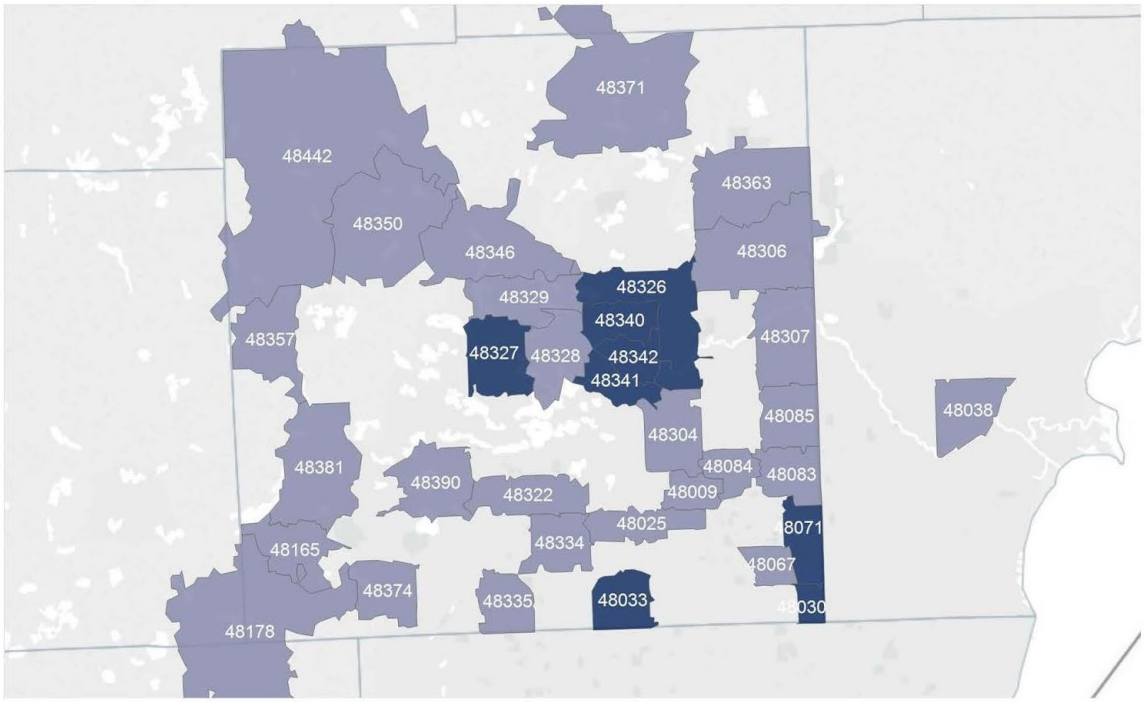


OFS Service Area

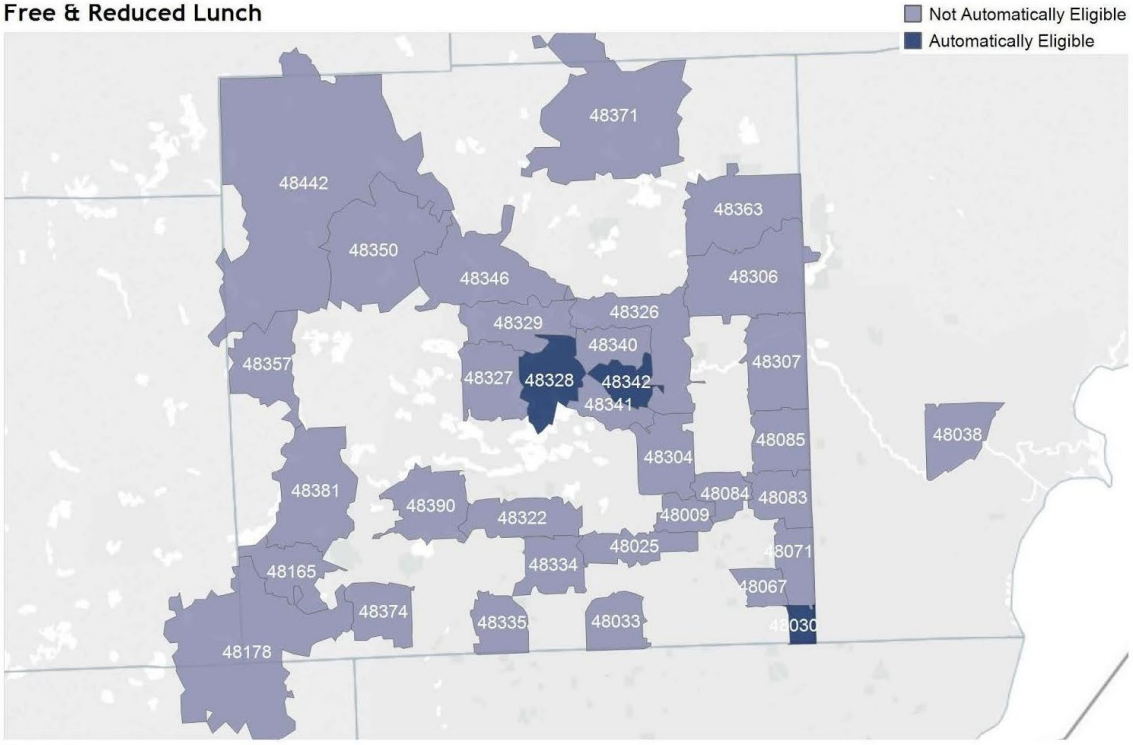
All Indicators



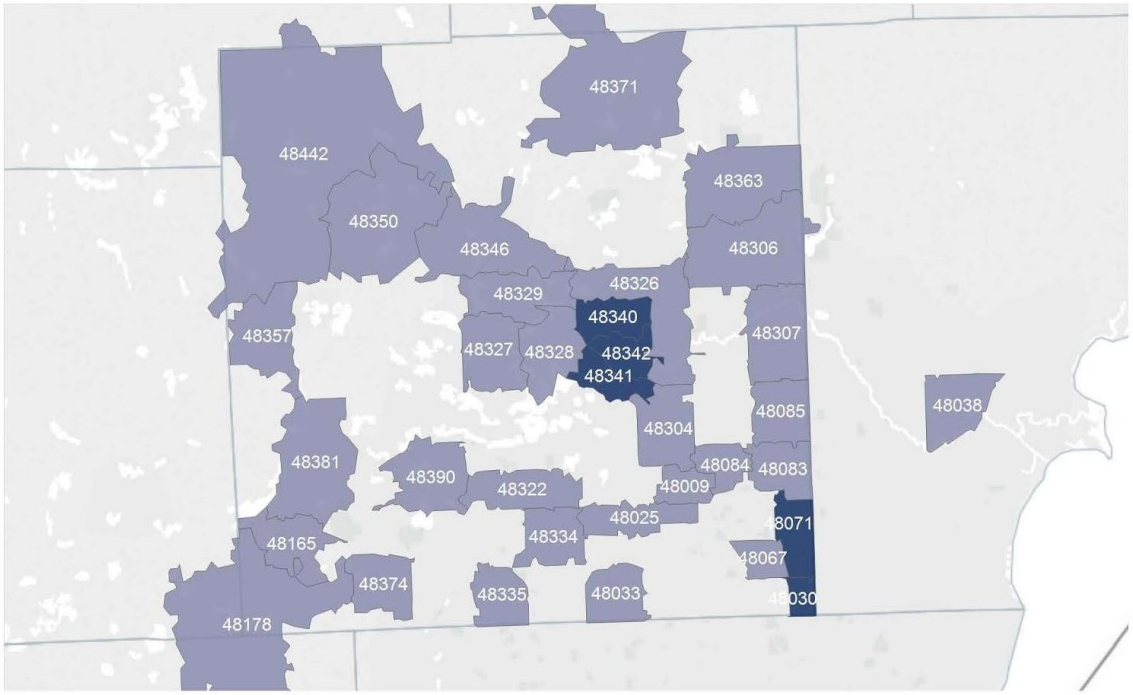
Child Poverty



Free & Reduced Lunch



Poverty



Appendix E: Baby Bundle Distribution Form

BABY BUNDLE
DISTRIBUTION FORM

Please fill out this form for every person who receives a Baby Bundle.
All fields are mandatory.

First/Last Name _____

Email _____

Street Address _____

City _____ State _____ ZIP _____

Recipient's age _____

Child's age _____

Recipient's relationship to child _____

Date bundle was or will be received _____

Phone _____

Distribution agency _____

How did you learn about Baby Bundles? _____

_____

Would you like to receive information on your child's development via text, email or phone call? ❑ Yes ❑ No

United Way
United Way for Southeastern Michigan

Appendix F: Recruitment Form

Agency logo can go here

Form #: _____

Family Check-Up Model Recruitment Form

Date of Referral: _____ **Agency Name:** _____

Referred By: _____

Program from which person is being referred: _____

Full Name of Client Referred: _____

Date of Birth: (MM/DD/YY): _____ **Gender:** _____

Directions:

Step 1: Read the following description of the Family Check-Up Model project to the client:

"Our agency is working with the United Way on a project to determine whether a new way of providing services is helpful to families. The new way of providing services is called the Family Check-Up Model. In the Family Check-Up Model, families are linked to a Family Check-Up Model Specialist who works with the family to set goals, identify services that the family thinks will be helpful, and follows up with the family to ensure the services have been helpful. We are currently recruiting families to be a part of this project. If you participate in the program:

- *Our research partners will assign you to one of two groups. One group of families will receive services the way that we currently provide them. The other group of families will receive services through the Family Check-Up Model. You will not get to choose which group you are in.*
- *No matter which group you are assigned to, you will be asked to complete a set of assessments when you join the program, six months later, and then 12 months later.*
- *Every time you complete a set of assessments you will receive $50. That is a minimum of $150 over the course of one year. You will get this money no matter which group you are assigned to. Payments will come through the mail after assessments are completed."*

Step 2: Ask: *"Would you be interested in participating in this project?"* **and record response below.**

☐ **No** (Please ask the family why they are not interested, record their response below, and thank them for their time.)

_____

_____

☐ **Yes**

V2_01/2019

This form continues on the other side.

Step 3: If the person is interested, read the following and fill out information below.

"I will give your information to the Family Check-Up Model manager and he/she will be in contact with you soon about participating if you're eligible. When he/she contacts you, he/she will give you more information about the project, answer any questions you have, and set up a time to meet with you. To make sure you are eligible can you provide me with a few facts about yourself and give me the best contact information for the Family Check-Up Model Specialist to reach you?"

Are you over 18?____Yes____No

Address: ____

____

Phone Number: ____

List Child(ren) Youngest to Oldest:

Name:________________________ **Date of Birth (MM/DD/YY):** ________________________ **Gender:**________________

Name:________________________ **Date of Birth (MM/DD/YY):** ________________________ **Gender:**________________

Name:________________________ **Date of Birth (MM/DD/YY):** ________________________ **Gender:**________________

Name:________________________ **Date of Birth (MM/DD/YY):** ________________________ **Gender:**________________

Name:________________________ **Date of Birth (MM/DD/YY):** ________________________ **Gender:**________________

Are you pregnant?___Yes___No____N/A Due Date (MM/YY): ____________

Eligibility Screen: (FOR SIF STAFF USE ONLY)

- ☐ Over 18
- ☐ At least 1 child between ages 0 and 5
  - ☐ Focus Child Name: ________________________
- ☐ Resides in SIF-eligible zip code
  - ☐ If no, income range verified during follow-up call to family.
- ☐ Verified no duplicate clients in ETO
- ☐ Date client entered into ETO: ________________________
- ☐ Family ID Number:

Appendix G: Sample Individualized Randomization

Randomization Protocol for NKFM

This document outlines the recruitment and randomization protocol for your agency. At the end of this document, we have listed the steps for randomization.

Program	Brief Description	Are you still planning to recruit from this program?	Randomization Strategy
Regie's Rainbow Adventure and NAP SACC (Head start/preschool locations)	NKFM will utilize existing partnerships to recruit families that currently participate in our early childhood programs. We will work with center directors/teachers to identify families to participate.	☐ Yes ☐ No	Randomization by numbered recruitment forms
Health Pathways (Enhance Fitness, DPP, PATH)	NKFM will utilize existing partnerships to recruit families that currently participate in our health pathway programs.	☐ Yes ☐ No	Randomization by numbered recruitment forms
WIC/ FQHC	NKFM will work with new and existing partnerships with WIC/FQHC to identify families interested in the program.	☐ Yes ☐ No	Randomization by numbered recruitment forms
PE-Nut elementary program (SNAP-Ed)	NKFM will utilize existing partnerships to recruit families that currently participate in our PE-Nut programs.	☐ Yes ☐ No	Randomization by numbered recruitment forms

SIF 2016 Recruitment Form Instructions

These are general guidelines for using the recruitment form to enter families into the SIF 2016 evaluation. It is important that each agency review all of their programs with Philliber to determine which randomization strategy to use for each program.

Randomization by Recruitment Form

The manager of the Family Checkup Model program at your agency should give a stack of blank recruitment forms to whomever is leading the event (or handling intake calls or handling referrals through the clinic). That person should then do the following:

- **Step 1:** Bring an appropriate number of **blank forms** to each event (or keep an appropriate number of forms at a desk).
- **Step 2:** Give a **blank form** to every family that you approach about participating in the study. This can be done one-on-one (e.g., during home visiting programs) or in big groups (e.g., play group, parenting program). Use the language on the form to explain the project to the family.
- **Step 3:** Have (or help) each family complete a form- even if they are not interested in participating. This will help us monitor the percentage of the refusals we get as well as programs that are hardest/easiest to recruit from. If the family says no, mark that on the form and write down the reason the family declined the invitation.
- **Step 4:** Give the completed forms to the manager of the Family Checkup Model program at your agency.

The manager of the Family Checkup Model program at the agency should take the following steps:

- **Step 5:** Review the forms as quickly as possible.
- **Step 6:** Separate out all forms for families who decline the invitation and enter those forms into the appropriate section of ETO.
- **Step 7:** Review the forms from families who have accepted the invitation and screen for eligibility. If a family is ineligible, remove them from the pile and enter them into ETO indicating why they are not eligible.
- **Step 8:** Gather all of the forms for families who are eligible to participate and who agreed to participate. Call or text these families to ensure that they are still interested in participating. If they are not still interested, remove them and enter them into ETO as declined. Place all remaining forms in a pile. One at a time, take a form from the pile and give it a number. The form at the top of the pile would get a "1". The next form would get a "2", and so on. Make sure you number every form. Forms that have an odd number should be put into one pile. Forms that have an even number should be put into another pile. We will tell you which pile is randomized to the intervention group and which pile is randomized to the control group. Please note that you will undergo this process several times throughout the project and numbering should be sequential over time. So, if the first time you number forms, you assign them the numbers 1 through 5, the next time you undergo the process you should start with the number 6. At the end of the project, each of your families should have their own unique randomization number.
- **Step 9:** Give the intervention pile to the Family Checkup Model Specialist (FCMS) and instruct the FCMS to review the form to confirm eligibility and make contact with the family to set up the introductory session.
- **Step 10:** Give the control pile to the staff member that will be collecting data for the control group and instruct them to review the form to confirm eligibility and make contact with the family to set up the introductory session.

Appendix H: Onsite Randomization Protocols Update

SIF 2016 Onsite Randomization Instructions- CARE

These are general guidelines for onsite randomization for the SIF 2016 evaluation. Onsite randomization should be used if a family presents themselves to the agency and is ready to enroll in the study and complete their data collection ***immediately onsite***.

Onsite Randomization

Prior to beginning the randomization, confirm that both an FCMS and a DCS are present onsite and available to collect data from the family, if they are eligible. Remember, families may be randomized to either the intervention or control group so the appropriate staff member needs to be available to meet with the family as soon as randomization is complete.

- **Step 1:** Thank the family for their interest in participating and confirm that they are available for the next two hours to conduct the first assessment.
    - If the family is not available to stay for the next two hours to complete their first assessment **DO NOT USE THIS PROTOCOL TO RANDOMIZE THEM.** Instead have them complete a recruitment form and either be randomized using your normal protocol or come back when they are available to stay for two hours to be randomized and complete the initial assessment.
- **Step 2:** Review the recruitment form and confirm that the family is eligible.
- **Step 3:** Use the language on the recruitment form to explain the study to the family.
- **Step 4:** Answer any questions that the family has about the study. Confirm that the family is still interested and is willing to stay onsite for the next two hours to complete the initial assessments.
- **Step 5:** Add the family to the first available row in the onsite random assignment list. If the group listed on the family's row is "A" that family gets assigned to the intervention group (Family Checkup Model group). If the group listed on the family's row is "B" that family gets assigned to the control group.
- **Step 6:** Walk the family to the appropriate staff person (an FCMS for families assigned to group A, a DCS for families assigned to group B) so that they can immediately begin their assessments.
- **Step 7:** Upload an updated version of the onsite randomization list to your evaluation folder in Sharepoint each week when you upload your updated enrollment list.
- **Step 8:** Let Heather Hirsch at Philliber (hhirsch@philliberresearch.com) know when you reach participant number 30 so that we can send you a new onsite randomization list to be used once the current list is full.

Onsite Random Assignment List
Agency Name:

Participant Number	Group A= Intervention B=Control	Date	Participant Name
1	A		
2	B		
3	A		
4	A		
5	B		
6	B		
7	A		
8	B		
9	A		
10	B		
11	A		
12	B		
13	B		
14	A		
15	B		
16	A		
17	A		
18	B		
19	B		
20	B		
21	B		
22	A		
23	A		
24	A		
25	A		
26	B		
27	B		
28	A		
29	A		
30	A		
31	A		
32	B		
33	B		
34	B		
35	A		
36	A		
37	B		

38	B		
39	B		
40	A		

Randomization generated on 02/19/19 by https://www.graphpad.com/quickcalcs/randomize1.cfm

Appendix I: Family Profile Form: Development and Assessment

Background

One of the central tenants of the GOALS project was that through the Family Check-Up Model's comprehensive assessment, use of motivational interviewing techniques, goal setting and supports linked to the expansive referral capacity of United Way, families would become more empowered and less vulnerable to societal marginalization. This is one of the hallmark features of the GOALS programs that sets it apart from the majority of family prevention programs. Rather than being focused on a singular domain of family functioning (e.g., education, housing, employment) the GOALS program recognizes the interconnectedness of all domains of family functioning and that to achieve sustainable and transformational outcomes a prevention intervention must have the capacity to engage the family holistically.

One of the most well-developed and widely used instruments for assessing individuals and families in a holistic manner is the Arizona Self-Sufficiency Matrix (ASSM). The ASSM is derived from work examining the true impact of poverty on families and extending the notion of poverty beyond the federally established poverty line, which does not take into account economic and social context (Pierce & Brooks, 1999). This initial work in the late 1990's culminated in a methodological approach in which core domains impacted by poverty were identified and an ordinal rating scale was used to assess the level of risk for each domain. The initial Sufficiency Matrix identified 25 potential domains; however, the framework was always intended to be adapted to include any domains that were salient to a particular population and/or community. This approach to assessing vulnerabilities to self-sufficiency was quickly adopted by researchers, practitioners, and policy makers working in the area of homelessness and the ASSM was formally developed in that context and became widely used and well validated (Cummings, 2018).

One of the most useful features of the Self-Sufficiency Matrix[1] approach is the level of flexibility in identifying domains most salient to a community and the program(s) serving that community. These measures are extremely flexible. The other key feature is the scoring / rating process which uses functionally defined anchors for each of the response categories. These ratings use a decision tree logic in which each response anchor must be satisfied before considering the next in an hierarchical fashion. For example, figure 1 below provides an example of this process for income assessment with scores ranging from 1 "client is in crisis" to 5 "client is self-sufficient"

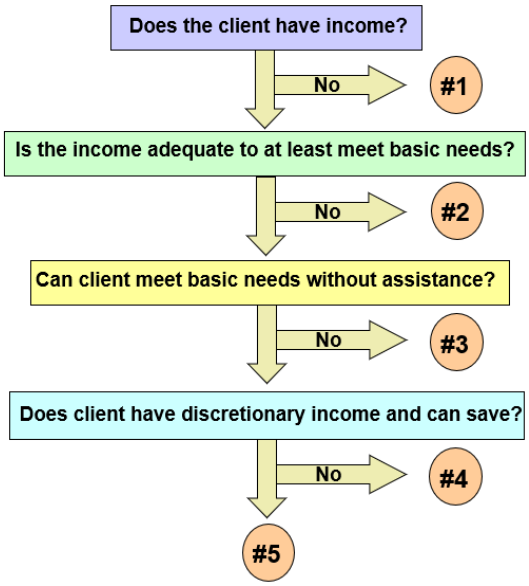


Figure 1. Decision logic for scoring income self-sufficiency

For use in the GOALS project we adapted the ASSM to assess 17 key domains: Housing, Income, Food, Adult Education, Employment, Transportation, Health Care Access, Mental Health, Substance Abuse, Disability, Child Care, Child Education, Parenting Skills, Family Social Supports, Community Involvement, Safety, Life Skills, and Judicial System Involvement (labeled Legal in the ASSM).

Development of the FPF

Beginning in May of 2017, a committee comprised of UNITED WAY staff, Phillliber Research and Evaluation staff, site managers from ACCESS, Leaps and Bounds Family Services, CARE of Southeast Michigan Macomb County, and Oakland Family Services[2], and three consultants from two Wayne State University and Here2There, LLC Consultants convened a work group that met 6 times from May 2017 to August 2017 to identify questions that could be used to provide responses to the ASSM in a consistent manner. Traditionally the ASSM is filled out by a frontline staff member based on interview and case notes. This leaves open the possibility for differences in ratings between staff members or across agencies because of the type of information and the nature of the questions are not uniform across interviewers. Using a uniform questionnaire that is completed by the staff member through a structured interview with the participant normalizes the responses and ensures that all participants were asked about the same domains of family functioning and in the same manner. One of the guiding principles of this process was to use existing sources of data wherever possible. While no single agency regularly collected intake data that could be used for the entire ASSM, across the partner agencies there were enough existing assessments that approximately 80% of the items on the Family Profile Form were already being collected by at least one of the partner agencies. An iterative process of discussion and consensus building was conducted by the assessment work group across several meetings resulting in the final Family Profile Form tool.

Use of FPF for ASSM Scoring

Following the development of the FPF instrument a smaller workgroup comprised of 6-8 members representing all stakeholder groups met on a regular basis through August and September to establish a scoring rubric through which responses on the FPF were converted to standardized criteria defining each of the categories in the ASSM. These scoring criteria start with the lowest risk category (5) and work down to the highest risk category (1) using a flow chart decision tree method. For example, on the FPF questions 4-8 ask about housing. To get a score of 5, the participant has to indicate that they either own, rent, or share a house, consider that housing permanent, pay for or contribute to the rent/mortgage themselves, that the rent/mortgage is 30% or less of their income, and that the housing is adequate for them and their family. If all of these are not satisfied the scoring moves to a category of 4 and must satisfy all of those criteria which include all of the items for a score of 5 with the exception that the housing is subsidized formally or by family members and the monthly housing cost is greater than 30% of their income. If all of those criteria are not satisfied the scoring moves to a 3 and another set of criteria are assessed. This process continues until all of the criteria for a score are met or the process reaches category 1. The full scoring rubric is presented in appendix B.

During the pilot phase of the project ASSM scoring was completed by hand using the FPF and scoring rubric by the data specialists. From October of 2017 – July of 2018 a small workgroup worked to develop automatic scoring of the ASSM directly from the FPF scores through the data management software for the project (ETO). This was an iterative process with scoring algorithms being developed, tested on client data, checked against hand scored ASSM values, and data auditing. Through this process the scoring protocols were adjusted to remove logical inconsistencies which caused ETO to produce missing scores. By July of 2018 the ETO scores were reliably reproducing hand scored ASSM values and were no longer generating missing values.

Reliability and Concurrent Validity

During the pilot phase of the project we evaluated the inter-rater reliability and concurrent validity of the ASSM scoring via the FPF.

A sample of 10 families were recruited for this study from the population of families being served by the four service agency partners participating in the SIF 16 grant. Families were identified by the FCMS and asked to participate in this validation study. Once the study details were explained to the family by the FCMS and the family agreed to participate, they were provided with a consent form (See Appendix Z). Each family was interviewed by two FCMS and interviews were scheduled within two-weeks of each other to ensure that the information obtained by each interviewer remained the same. Each FCMS conducted four interviews in total such that each FCMS was paired with the other four FCMS such that all-pairwise comparisons between FCMS on the same family could be assessed. The assignment design is illustrated in Figure 2 below.

For the purpose of assessing the concurrent validity, each interview was audio recorded and uploaded to a cloud-based server at United Way. The audio recordings of the interviews were

then labeled and put on a thumb-drive to be provided to ASSM expert raters. Each interview was rated by two ASSM experts. The ASSM experts listened to the audio recordings of the interview and used the ASSM to make ratings according to standards of practice in the field.

Two of the expert ASSM raters were advanced Ph.D. students programs in the clinical psychology program at Wayne State University. Both students were experienced with the ASSM and have had multiple years of training in clinical assessment with urban populations similar to the families participating in this validation study. In addition, they were provided with approximately 6 hours of in-person training across two 3-hour long sessions. They were also provided with the official training materials developed by 1) the State of Michigan Homelessness Management Information System; 2) the National Homeless Management Information System; 3) the Snohomish County Self-Sufficiency Task force in Washington State.

Two additional ASSM raters were recruited from Oakland Family Services. These two raters have been using the ASSM as a part of their case management services for several years.

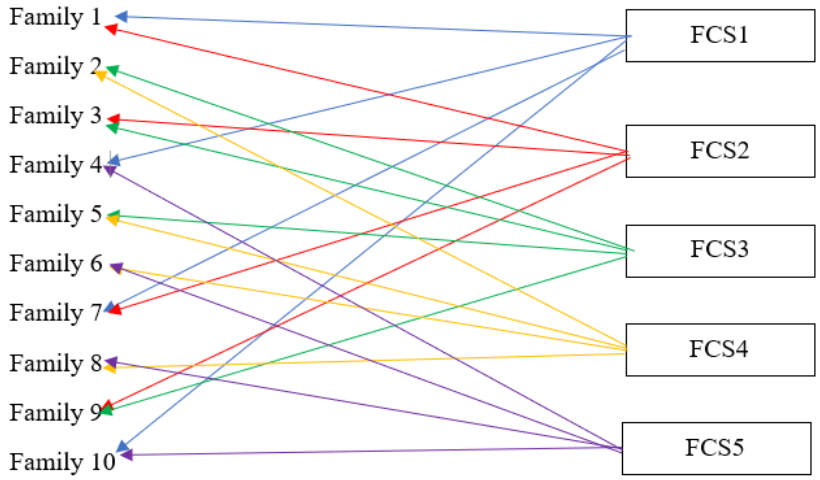


Figure 2. Graphical display of rater assignments across families.

Results

In order to test the inter-rater reliability across the five FCS raters cross-tabulation contingency tables were constructed and an index of percent agreement was calculated across all families. **The average percent agreement across all sample families was 92%.** The range of agreements ranged from 68% (parenting skills) to perfect agreement. Examination of the contingency tables indicated that the majority of disagreements were cases in which one rater scored the family a 4 and the other rater scored the family a 5. In one instance, one rater scored the family a 4 on child care and the other scored the family as a 2. In another instance (safety) there was a disagreement where one rater had scored the family as a 1 and the other scored the family as a 5. Closer examination revealed that there had been a shooting at a public event in which the family had been attending. According to the notes, the child was unaware that anything had even occurred. A strict interpretation of the scoring guidelines would indicate a 1, but the score was not at all reflective of the family's overall functioning. In the notes, the FCMS

that rated the family a 1 put a 5 in parentheses with a question mark. As such, this level of disagreement is not reflective of the overall agreement for the tool and was a circumstantial outlier. The percent agreement for each of the ASSM domains is provided in table 1 below.

Table 1. Average percent agreement across all FCMS raters

Domain	Percent Agreement	Percent Agreement when 4 & 5 are considered a match
Housing	90%	100%
Income	90%	100%
Food	90%	100%
Adult Education	100%	100%
Employment	90%	100%
Transportation	90%	100%
Health Care Access	90%	100%
Mental Health	90%	100%
Substance Abuse	100%	100%
Disability	100%	100%
Child Care	90%	90%
Child Education	100%	100%
Parenting Skills	70%	90%
Family Social Supports	80%	100%
Community Involvement	100%	100%
Safety	90%	90%
Life Skills	100%	100%
Legal	90%	100%

To test the concurrent validity the same analyses as described above for inter-rater reliability were conducted comparing FCMS raters to expert raters. Each FCMS rater's scores were compared to two expert rater scores and then the percent agreement was averaged across the two comparisons. These average agreement ratings were then pooled across all families to yield an overall average percent agreement. **The overall agreement was 88%.** The level of agreement ranged from 70% for income and safety to 100% for disability, community involvement, and life skills. As was the case for the former set of analyses, when disagreements comprised of 4 v. 5 ratings were considered a match the degree of agreement approaches near perfect agreement. The domain specific ratings are provided in Table 2 below.

Table 2. Average percent agreement between FCMS and expert raters on ASSM

Domain	Percent Agreement	Percent Agreement when 4 & 5 are considered a match
Housing	94%	100%
Income	70%	80%
Food	85%	100%
Adult Education	82%	100%
Employment	90%	100%
Transportation	95%	100%
Health Care Access	80%	100%
Mental Health	95%	100%
Substance Abuse	95%	100%
Disability	100%	100%
Child Care	90%	100%
Child Education	90%	90%
Parenting Skills	80%	95%
Family Social Supports	80%	90%
Community Involvement	100%	100%
Safety	72%	100%
Life Skills	100%	100%
Legal	90%	100%

Conclusion

Overall, these results suggest that the use of the FPF as a semi-structured interview produces high levels of inter-rater reliability in ASSM assessments. This, as noted above, is critical for the evaluation as it rules out "rater effects" as a possible confound to impact analyses relating to the ASSM domains. It is recommended that periodically throughout the course of the evaluation a subset of family assessments are audio-recorded using the methodology used for the expert rater validation assessment, and cross-rated by all five FCMS in order to avoid rater "drift" over time.

The findings also suggest that the ASSM ratings provided by the FCMS are consistent with ASSM ratings obtained from independent expert raters. This provides evidence of concurrent validity which suggests that the ASSM ratings of the project are not only reliable among FCMS staff but are valid assessments of the ASSM.

Family Profile Form: Scoring

The Family Profile Form was created to help systematize the scoring of the ASSM. As families began completing the Family Profile Form, testing began to determine how well the initial

scoring guide was able to convert responses on the Family Profile Form to scores on the ASSM. Initial results indicated that the scoring left many families without ASSM scores on multiple domains. The project then formed a working group to examine the initial scoring guidance and develop a revised scoring protocol.

The Family Profile Form working group consisted of members of the evaluation team, members from the United Way for Southeast Michigan's SIF 2016 leadership team, and Dr. Robert Ty Partridge. The group met bimonthly over a period of several months to develop a scoring protocol for each ASSM domain. The focus of these discussions was to:

1. Identify the most common situations that led to a family not receiving a score on a given ASSM domain;
2. Come to a consensus on the information needed to accurately score each ASSM domain;
3. Determine which questions on the Family Profile Form provided relevant information for the scoring of each ASSM domain; and,
4. Create a logical scoring convention for each ASSM domain based on relevant responses from the Family Profile Form.

Once a scoring convention for a given domain was agreed upon by members of the working group, the evaluation team:

1. Scored each family using the new scoring protocol;
2. Reviewed the results of the new scoring protocol with the working group; and,
3. Made any needed additional changes before finalizing the scoring protocol for the ASSM domain.

The final scoring protocol was shared widely throughout the project. The ASSM, like other assessments used in the study, is autoscored once data are entered into the project's Efforts To Outcomes database. Once the new scoring protocol was finalized, the auto scoring procedures were also updated.

Appendix J: Family Profile Form

United Way for Southeastern Michigan

Agency logo can go here

Date Completed: _____
Participant Name: _____
Case Number: _____
Survey Start Time: _____

Family Profile Form

HOUSING

1. What is your current marital status? ***(Check one option.)***
   - ☐ Married, living with Spouse
   - ☐ Married, not living with Spouse
   - ☐ Cohabitating (living with significant other, not married)
   - ☐ Divorced
   - ☐ Single
   - ☐ Widowed
   - ☐ Other: _____

2. Who lives in your household? ***(Check all that apply.)***
   - ☐ All of my children
   - ☐ Some of my children
   - ☐ Mother
   - ☐ Father
   - ☐ Spouse/Partner
   - ☐ Your child's other parent (and who is not your current Spouse/Partner)
   - ☐ Niece/Nephews
   - ☐ Siblings
   - ☐ Aunt/Uncle
   - ☐ Cousins
   - ☐ Other: _____

3. Total number of adult household members (including yourself):_____

   Total number of children living in your home: _____

4. Current family housing arrangement:
   - ☐ Own
   - ☐ Rent
   - ☐ Shared housing (with relatives or roommates)
   - ☐ Temporary (shelter, staying with friends or family)
   - ☐ Homeless or currently threatened with eviction

5. Do you consider this arrangement to be permanent? (Meaning that housing will stay the same for at least the next 90 days.)
   - ☐ Yes
   - ☐ No

6. Who pays for your rent or mortgage on a regular basis? (If you pay your rent every month using one or more options, check all that apply.)
   - ☐ Myself and/or my partner/spouse
   - ☐ Family members who do live with me
   - ☐ Family members who do not live with me
   - ☐ Subsidy (Section 8 or Low-Income Housing)
   - ☐ I am not currently paying to live where I am.
   - ☐ Other: _____

   How much is your rent/mortgage monthly?_____

7. Is your current housing adequate to meet the needs of you and your family?
   - ☐ Yes
   - ☐ No
   - ☐ Sometimes

   If no or sometimes, what could be different about your housing so it does meet your needs?

   _____

   _____

INCOME

For the questions in this section, "household" refers to you and those impacted by the income.

8. What is your household's current weekly take-home income? _____

   or what is your household's current monthly take-home income? _____

9. What is your household's estimated gross (or total before taxes) annual income?
   - ☐ No income
   - ☐ Less than $9,999
   - ☐ $10,000 - $19,999
   - ☐ $20,000 - $29,999
   - ☐ $30,000 - $39,999
   - ☐ $40,000 - $49,999
   - ☐ $50,000 - $59,999
   - ☐ $60,000 - $69,999
   - ☐ $70,000 - $79,999
   - ☐ $80,000 or more

10. Are you or others in your household currently receiving any forms of financial assistance? ***(Check all that apply.)***

	You	Your Child/Children	Other Household Member
Food Stamps (Bridge Card)	☐	☐	☐
Cash assistance (such as TANF)	☐	☐	☐
WIC	☐	☐	☐
SSI (Social Security)	☐	☐	☐
Financial help from family and/or friends	☐	☐	☐
Alimony/Child Support	☐	☐	☐
Free/Reduced Lunch Eligible	☐	☐	☐
Subsidy for Childcare	☐	☐	☐
Other:	☐	☐	☐

_____

11. Is your current household income, plus any financial assistance you receive, enough to meet your household needs?
    - ☐ Yes
    - ☐ No

12. Does your current household income cover enough to make minimum payments on any debt/mortgage/loan payments on most months?
    - ☐ Yes
    - ☐ No

13. Do you have extra funds at the end of most months, after meeting your household's basic needs, to save or spend in discretionary items? (Discretionary items are things that are not needs and that your household could live without, such as entertainment, toys, electronics, extra clothing, travel, etc.)
    - ☐ Yes
    - ☐ No

FOOD

14. If you are receiving food stamps, is it enough to cover your family's food expenses for the whole month?
    - ☐ Yes
    - ☐ No
    - ☐ N/A (Not receiving food stamps because I don't qualify.)
    - ☐ N/A (Not receiving food stamps because I haven't applied.)

15. In the last 6 months, how many times have you had to rely on other sources, such as family or friends, food banks, or churches, to get food for your family?
    - ☐ None
    - ☐ 1 – 2 times
    - ☐ 3 – 4 times
    - ☐ 5 or more times

16. My family can choose to eat/purchase any food we desire.
    - ☐ Yes
    - ☐ No

EDUCATION

17. What is the primary language you and your family use at home?
    - ☐ English
    - ☐ Arabic
    - ☐ Spanish
    - ☐ Other: _____

18. How well do you *speak* English?
    - ☐ Very well
    - ☐ Well
    - ☐ Not well
    - ☐ Not well at all

19. How well do you *read* English?
    - ☐ Very well
    - ☐ Well
    - ☐ Not well
    - ☐ Not well at all

20. Are your English skills ever a barrier for employment?
    - ☐ Yes
    - ☐ No

    If yes, are you enrolled in an ESL/Literacy program?
    - ☐ Yes
    - ☐ No

21. Select your highest level of education:
    - ☐ Less than high school
    - ☐ High school diploma/GED
    - ☐ Some college
    - ☐ 2 year Associate's degree
    - ☐ 4 year Bachelor's degree
    - ☐ Graduate Degree (Masters/Doctorate)

- ☐ Any other type of vocational training or certification *(for example: Licensed Practical Nurse (LPN), Child Development Associate, medical assistant, master electrician, etc.)*

22. Are you currently enrolled in GED program?
    - ☐ Yes
    - ☐ No

23. Are you currently enrolled in a secondary education program? *(Such as college, vocational training or certification.)*
    - ☐ Yes
    - ☐ No

24. With your current education level and skill set are you able to get a job that meets your financial needs?
    - ☐ Yes
    - ☐ No

EMPLOYMENT

25. Are you employed? **(If you select N/A, skip to question 30).**
    - ☐ Yes
    - ☐ No
    - ☐ N/A (Not currently seeking employment)

    If yes:

    What is your occupation? _____

    Have you been at your job(s) for 3 months or more?
    - ☐ Yes
    - ☐ No

26. Considering your hours across any/all jobs that you currently have; do you work:
    - ☐ Full-time (More than 32 hours)
    - ☐ Part-time (Less than 32 hours)

27. Considering any/all jobs, are you employed:
    - ☐ Long-term
    - ☐ Temporary/Seasonal

28. Are your wages sufficient to cover your share of the financial responsibilities for your household (such as your half of the rent), without public assistance?
    - ☐ Yes
    - ☐ No

29. Does your employer provide you any of the following benefits? ***(Check all that apply.)***
    - ☐ Healthcare
    - ☐ Sick time
    - ☐ Paid vacation/ holidays
    - ☐ Contributions to a retirement plan
    - ☐ Other: _____

30. Is anyone else in the household employed?
    - ☐ Yes
    - ☐ No

TRANSPORTATION

31. Do you have adequate transportation to meet the needs of you and your family?
    - ☐ Yes
    - ☐ No

32. How do you primarily get around? **(Check that one that mostly applies.)**
    - ☐ I have and drive my own car.
    - ☐ I borrow a car that is mostly available to me when I need it.
    - ☐ I use rideshare options (Uber, Lyft) or a taxi when I need it.
    - ☐ I use public transportation, such as the bus.
    - ☐ I have friends or family who can drive me around when I need it.
    - ☐ I have no regular access to transportation.
    - ☐ Other: _____

33. If you have and drive your own car, check all that apply:
    - ☐ I am a licensed driver.
    - ☐ My car is currently insured.
    - ☐ I consider my car to be reliable.

HEALTHCARE

34. Do you and/or your significant other or spouse have health insurance?
    - ☐ Yes, just me
    - ☐ Yes, just my significant other/spouse
    - ☐ Yes, both of us
    - ☐ No, neither of us have health insurance.

35. Does your child/children have health insurance?
    - ☐ Yes
    - ☐ No

If yes to 34 or 35, do you receive insurance through:

- ☐ Medicaid
- ☐ Medicare
- ☐ Children's Health Insurance Program (CHIP)

Are there any medical needs that you or members of your household have that are not being addressed because your insurance does not cover treatment?

- ☐ Yes
- ☐ No

Do you consider your health care coverage to be affordable, meaning the cost of your coverage doesn't strain or limit spending on other necessities?

- ☐ Yes
- ☐ No

If no to 34 or 35:

Do you have an immediate need for healthcare coverage for you or members of your household?

- ☐ Yes
- ☐ No

Are there any medical needs that you or members of your household have that are not being addressed because you do not have medical coverage?

- ☐ Yes
- ☐ No

36. Do you have a doctor that you see regularly?
    - ☐ Yes
    - ☐ No

37. Do you have a pediatrician/doctor that your child sees regularly?
    - ☐ Yes
    - ☐ No

38. Have you ever been told by a health care provider that you had gestational diabetes?
    - ☐ Yes
    - ☐ No
    - ☐ N/A

39. Has a health care provider ever told you that you have a health condition that can continue from year to year?
    Some examples of these health conditions include: asthma, diabetes, cancer, migraines, or mental health condition (e.g., depression, anxiety, stress disorder), etc.
    - ☐ Yes
    - ☐ No

    If **yes**, which health condition? _____

40. Are you a caregiver for someone, such as a friend or family member, that has an ongoing health condition such as those in the previous question? (Do not answer yes if caregiving is your job.)
    - ☐ Yes
    - ☐ No

    If answered yes to questions 39 or 40, thinking back over the last year, how often did having this health condition or being a caregiver for someone with an ongoing health condition make it hard for you to keep up with your work or social / family life?
        - ☐ Never/Almost Never
        - ☐ Not Very Often
        - ☐ Fairly Often
        - ☐ Very Often
        - ☐ Always

MENTAL HEALTH

41. Do you have a mental health condition that interferes with your day to day life? ***(If you answer no, skip to question 46.)***
    - ☐ Yes
    - ☐ No

42. How difficult has this condition made it for you to do your work?
    - ☐ Not difficult at all
    - ☐ Only rarely
    - ☐ Somewhat difficult
    - ☐ Very difficult
    - ☐ Extremely difficult

43. How difficult has this condition made it for you to get along with other people?
    - ☐ Not difficult at all
    - ☐ Only rarely
    - ☐ Somewhat difficult
    - ☐ Very difficult
    - ☐ Extremely difficult

44. How difficult has this condition made it for you to take care of things at home?
    - ☐ Not difficult at all
    - ☐ Only rarely
    - ☐ Somewhat difficult
    - ☐ Very difficult
    - ☐ Extremely difficult

45. Over the last two weeks, have you had thoughts that you would be better off dead or of hurting yourself in some way?
    - ☐ Yes
    - ☐ No

If yes, how often have you had these thoughts?

- ☐ Once
- ☐ A few times
- ☐ More than half of the days
- ☐ Nearly everyday

SUBSTANCE ABUSE

46. Has there ever been a time in your life when using alcohol or other drugs affected your personal relationship, school, work, or overall well-being? **(If you answer no, skip to question 51.)**
    - ☐ Yes
    - ☐ No

47. Have you ever felt you should cut down on your drinking or drug use?
    - ☐ Yes
    - ☐ No

    How many times in the last 6 months?
    - ☐ 1
    - ☐ 2
    - ☐ 3
    - ☐ 4
    - ☐ 5 or more

48. Have people ever annoyed you by criticizing your drinking or drug use?
    - ☐ Yes
    - ☐ No

    How many times in the last 6 months?
    - ☐ 1
    - ☐ 2
    - ☐ 3
    - ☐ 4
    - ☐ 5 or more

49. Have you ever felt bad or guilty about your drinking or drug use?
    - ☐ Yes
    - ☐ No

How many times in the last 6 months?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 or more

50. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (as an “eye opener”)?
    - ☐ Yes
    - ☐ No

    How many times in the last 6 months?
    - ☐ 1
    - ☐ 2
    - ☐ 3
    - ☐ 4
    - ☐ 5 or more

DISABILITIES

51. Do you have a physical, developmental, or learning disability? ***(If you answer no, skip to question 56.)***
    - ☐ Yes
    - ☐ No

52. What are you doing to manage your condition?
    - ☐ Medication
    - ☐ Treatment
    - ☐ Physical therapy
    - ☐ Assistive equipment
    - ☐ Other: _____

53. How difficult has this condition made it for you to do your work?
    - ☐ Not difficult at all
    - ☐ Only rarely
    - ☐ Somewhat difficult
    - ☐ Very difficult
    - ☐ Extremely difficult

54. How difficult has this condition made it for you to get along with other people?
    - ☐ Not difficult at all
    - ☐ Only rarely
    - ☐ Somewhat difficult
    - ☐ Very difficult
    - ☐ Extremely difficult

55. How difficult has this condition made it for you to take care of things at home?
    - ☐ Not difficult at all
    - ☐ Only rarely
    - ☐ Somewhat difficult
    - ☐ Very difficult
    - ☐ Extremely difficult

CHILDCARE

56. Are there times during the day or evening when you need to do things without your child and you use/need childcare? Reasons for needing childcare could include: work, school, errands, appointments, meetings, etc. Examples of childcare could include: childcare centers, friends or neighbors, babysitters, family members, etc.
    (If you answer no, skip to question 62.)
    - ☐ Yes
    - ☐ No

57. Is your childcare *available*? (Childcare is considered available when you can use it at the time of day you need it, the center is not full/on a waitlist, and when your child is eligible to attend the childcare.)
    - ☐ Yes
    - ☐ No

58. Is your childcare *accessible*? (Childcare is considered accessible if you are able to get there or they are able to get to you in a reasonable amount of time and they have a spot available for your child)
    - ☐ Yes
    - ☐ No

59. Is your childcare *reliable*? (Childcare is reliable if they are consistently available when needed and rarely cancels.)
    - ☐ Yes
    - ☐ No

60. Is your childcare *affordable*? (Childcare is affordable if your household spends no more than 15% of income on childcare and/or the cost of this childcare has not forced you to reduce your work hours due to disproportionate cost.)
    - ☐ Yes
    - ☐ No

61. Check all that apply about your childcare:
    - ☐ My child's teacher/caregiver knows and cares about my child and responds to her/his individual needs.
    - ☐ I feel comfortable and at ease leaving my child at childcare each day.
    - ☐ My child is happy and safe at their childcare.
    - ☐ The meals and snacks served are nutritious and varied.
    - ☐ The curriculum meets my child's needs and is fun for my child.

CHILDREN'S EDUCATION

62. Have you established a reading habit (20 minutes or more most days of the week) with your child(ren)? Examples include reading a book, telling a story, practicing letter sounds or words, or other activities to help your child learn to read.
    - ☐ Yes
    - ☐ No

63. Do you have any children aged 5 or older? ***(If no, skip remaining questions in this category.)***
    - ☐ Yes
    - ☐ No

64. Are all of your children aged 5-18 enrolled in school?
    - ☐ Yes
    - ☐ No

    If no, please describe why your child(ren) may not be enrolled: _____
    _____

65. How often do your school-aged children attend classes?
    - ☐ None of the time
    - ☐ Less than half the time
    - ☐ More than half the time
    - ☐ Most or all of the time

66. Have you ever been notified by the school that any of your children is considered truant?
    - ☐ Yes
    - ☐ No

PARENTING SKILLS

Select one option for how much you agree with each of the following statements:

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
67. There are many times when I don't know what to do as a parent.	1	2	3	4	5	6	7
68. I know how to help my child learn.	1	2	3	4	5	6	7
69. My child misbehaves just to upset me.	1	2	3	4	5	6	7
70. I praise my child when he/she behaves well.	1	2	3	4	5	6	7
71. When I discipline my child, I lose control.	1	2	3	4	5	6	7

72. I am happy being with my child.	1	2	3	4	5	6	7
73. My child and I are very close to each other.	1	2	3	4	5	6	7
74. I am able to soothe my child when he/she is upset.	1	2	3	4	5	6	7
75. I spend time with my child doing what he/she likes to do.	1	2	3	4	5	6	7

FAMILY/SOCIAL RELATIONS

76. Who do you feel that you can rely on when you need support? ***(check all that apply)***
    - ☐ Church/Religious Community
    - ☐ Spouse/Partner
    - ☐ Relatives or family mentor
    - ☐ Friends/Neighbors
    - ☐ Coach, Mentor, or Teacher
    - ☐ Service Provider (Home visitor, case manager, doctor, nurse)
    - ☐ Other: _____

77. Have you had any contact with Child Protective Services (CPS) for your child(ren) in the last 6 months?
    - ☐ Yes
    - ☐ No

    If yes, was the claim substantiated by CPS?
    - ☐ Yes, and the case is ongoing
    - ☐ Yes, and the case is resolved
    - ☐ No

Select one option for how much you agree with each of the following statements:

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
78. In my family, we talk about problems.	1	2	3	4	5	6	7
79. When we argue, my family listens to "both sides of the story."	1	2	3	4	5	6	7
80. In my family, we take time to listen to each other.	1	2	3	4	5	6	7
81. My family pulls together when things are stressful.	1	2	3	4	5	6	7
82. My family is able to solve our problems.	1	2	3	4	5	6	7

83. I have others who will listen when I need to talk about my problems.	1	2	3	4	5	6	7
84. When I am lonely, there are several people I can talk to.	1	2	3	4	5	6	7
85. I would have no idea where to turn if my family needed food or housing.	1	2	3	4	5	6	7
86. I wouldn't know where to go for help if I had trouble making ends meet.	1	2	3	4	5	6	7
87. If there is a crisis, I have others I can talk to.	1	2	3	4	5	6	7
88. If I needed help finding a job, I wouldn't know where to go for help.	1	2	3	4	5	6	7

COMMUNITY INVOLVEMENT

89. How would you rate your involvement in the community?
    - ☐ Very Involved
    - ☐ Involved
    - ☐ Somewhat Involved
    - ☐ Not Involved

90. In what ways are you involved in the community? ***(Check all that apply.)***
    - ☐ School Programs (either your school or your child's school)
    - ☐ Church/Religious Activities
    - ☐ Support Groups
    - ☐ Volunteering
    - ☐ Sports Leagues
    - ☐ Political Activities
    - ☐ Other: _____

91. Do you find that you have experienced any of these barriers to being involved in your community? ***(Check the one that mostly applies.)***
    - ☐ I am too concerned about meeting my family's basic needs (such as food and housing) to worry about getting involved right now.
    - ☐ I'd like to be more involved, but I am not sure how.
    - ☐ I have a language barrier.
    - ☐ I can't find the childcare or transportation that I need to get involved.
    - ☐ I am not involved because I don't like to be involved.
    - ☐ I don't have any regular barriers to being involved.
    - ☐ Other: _____

SAFETY

92. Do you generally feel safe in your home?
    - ☐ Yes
    - ☐ No

93. Do you generally feel safe in your neighborhood?
    - ☐ Yes
    - ☐ No

94. Are you currently concerned about your child(ren)'s safety?
    - ☐ Yes
    - ☐ No

95. Are you currently concerned about the safety of you and/or your child(ren)'s safety in the next 6 months?
    - ☐ Yes
    - ☐ No

96. Are there changes you make to your routine on a regular basis to adapt or cope with your safety concerns?
    - ☐ Yes
    - ☐ No

97. Have you and/or your child(ren) witnessed or experienced dangerous behavior or a crime in the past 6 months?
    - ☐ Yes
    - ☐ No

98. Are you and/or your child(ren) currently experiencing threats to your safety?
    - ☐ Yes
    - ☐ No

LIFE SKILLS

Review this list of activities you may do every day:

Bathing	**Climbing Stairs**
Dressing	**Eating**
Oral Care (Brushing teeth)	**Shopping**
Toileting	**Cooking**
Transferring from sitting to standing	**Using phone**
Walking	**Housework**

Laundry	**Driving**
Managing Medication	**Managing Finances**

99. Are you able to regularly complete the activities listed above for yourself and your family? **(If you answer yes, skip to question 101.)**
- ☐ Yes
- ☐ No
- ☐ Sometimes

100. Do you have any challenges on a regular basis completing any of the activities listed above?
- ☐ Yes
- ☐ No
- ☐ Sometimes

If yes or sometimes, is there anyone that comes over and helps you with completing these activities on regular basis?
- ☐ Yes
- ☐ No
- ☐ Sometimes

LEGAL

101. Have you **ever** been charged with a misdemeanor or felony?
- ☐ Yes
- ☐ No

102. In which ways have you been involved with the criminal justice system within the last 12 months?
- ☐ Have not been involved with the criminal justice system
- ☐ Current unresolved ticket
- ☐ Current open warrant
- ☐ Current pending charges, not yet been to court
- ☐ Currently involved with trial/court proceedings for pending charges
- ☐ An arrest within the last 12 months (whether or not charged)
- ☐ A felony conviction within the last 12 months
- ☐ Other: _____

103. Are you currently on probation or parole?
- ☐ Yes
- ☐ No

If yes, are you currently compliant with the terms of your probation or parole?
- ☐ Yes

☐ No

If **no**, have you successfully completed a probation or parole in the last 12 months?

☐ Yes
☐ No

104. Does your legal situation (past or present) interfere with your ability to provide for your family (such as getting a job, finding a place to live, etc.)?

☐ Yes
☐ No

Staff Use Only:
Survey Start Time: _____Survey End Time:_____

Appendix K: Family Profile Form Scoring Worksheet

Family Profile Form Scoring Worksheet

ASSM DOMAIN: HOUSING

Score Summary:

5	A score of 5 is received when a family lives in an own, rent, or shared situation that they report as adequate to meet their needs and they are paying for their own rent using income. Question 4: Own, Rent, or Shared Housing + Question 5: Yes + Question 6a: Myself and/or my partner/spouse + Question 7a: Yes + Rent or Mortgage is no more than 30% of monthly income: 6b/8b = ASSM 5
4	A score of 4 is received when a family lives in an own, rent, or shared situation that they report as adequate to meet their needs and they are having their rent or mortgage paid by others or a subsidy. Question 4: Own, Rent, or Shared Housing + Question 5: Yes + Question 6a: Family Members, Subsidy, or Not Paying + Question 7a: Yes + Rent or Mortgage is more than 30% of monthly income: 6b/8b = ASSM 4
3	A score of 3 is received when a family lives in an own, rent, or shared situation that they report is not adequate to meet their needs and they are having their rent or mortgage paid by others or a subsidy. Question 4: Own, Rent, or Shared Housing + Question 5: Yes + Question 6a: Family Members, Subsidy, or Not Paying + Question 7a: No + Rent or Mortgage is more than 30% of monthly income: 6b/8b = ASSM 3
2	A score of 2 is automatically received when a family is living in a temporary situation as reported by selecting temporary or reporting that they don't foresee their current situation lasting more than 90 days. Question 4: Temporary (shelter, staying with friends or family) and/or Question 5: No = ASSM 2
1	A score of 1 is automatically received when a family is homeless or currently threatened with eviction. Question 4: Homeless or currently threatened with eviction

	= ASSM 1

ASSM DOMAIN: INCOME

Score Summary:

5	A score of 5 is received when a family's income is sufficient to meet basic needs without assistance, pay off debt/save, has appropriate spending habits, and has discretionary funds. Question 8a and 8b + Question 9 ≠ 0 +Question 10: none +Question 11: Yes +Question 12: Yes +Question 13: Yes = ASSM 5
4	A score of 4 is received when a family's income is sufficient to meet basic needs without assistance, pays off debt most months, and has appropriate spending habits but is not able to save much nor have many discretionary funds. Question 8a and 8b + Question 9 ≠ 0 +Question 10: none +Question 11: Yes +Question 12: Yes +Question 13: No = ASSM 4
3	A score of 3 is received when a family's income is sufficient to meet basic needs with assistance and has appropriate spending, but is not be able to save/ pay off debts most months nor have discretionary funds. Question 8a and 8b + Question 9 ≠ 0 Question 11: Yes Question 12: No =ASSM 3
2	A score of 2 is received when a family's income is insufficient to meet basic needs with assistance and/or has inappropriate spending habits. These families are unable to manage debts nor save and have no discretionary funds. Question 8a and 8b + Question 9 ≠ 0 +Question 11: No = ASSM 2
1	A score of 1 is received when a family has no income and no financial assistance. Question 8a and 8b: $0 + Question 9: No Income + Question 10: None

	= ASSM 1

ASSM DOMAIN: FOOD

Score Summary:

5	A score of 5 is received when a family is not on food stamps, has not sought out other sources of food to feed their family beyond their income in the last 6 months, and can purchase any food desired. Question 14: N/A +Question 15: None + Question 16: Yes = ASSM 5
4	A score of 4 is received when a family is not on food stamps, has not sought out other sources of food to feed their family beyond their income in the last 6 months, but cannot purchase any food desired. Question 14: N/A + Question 15: None + Question 16: No = ASSM 4
3	A score of 3 is received when a family is not on food stamps, has sought out other sources of food to feed their family beyond their income 1 or more times in the last 6 months, and cannot purchase any food desired. Question 14: N/A + Question 15: 1-2 or higher + Question 16: No = ASSM 3
2	A score of 2 is received when a family is on food stamps and it is enough to cover the cost of food to feed their family for the month. Question 14: Yes + Question 15: None = ASSM 2
1	A score of 1 is received when a family is on food stamps and it is not enough to cover the cost of food to feed their family for the month, and has sought out other sources of food to feed their family beyond their income 1 or more times in the last 6 months. Question 14: No + Question 15: 1-2 or higher = ASSM 1

ASSM DOMAIN: ADULT EDUCATION

Score Summary:

5	A score of 5 is received when an individual's language proficiency and literacy is not a barrier to employment and their current education level/skills provide them the opportunity for adequate employment that fits their needs. Question 20a: No + Question 24: Yes = ASSM 5
4	A score of 4 is received when an individual's language proficiency and literacy is not a barrier to employment and they *are currently enrolled* in a secondary education/training/certification program that is needed in order to get adequate employment that fits their needs. Question 20a: No + Question 24: No + Question 23: Yes = ASSM 4
3	A score of 3 is received when an individual's language proficiency and literacy is not a barrier to employment, but they need a secondary education/training/certification program in order to get adequate employment that fits their needs and are *not currently enrolled.* Question 20a: No + Question 24: No + Question 23: No = ASSM 3
2	A score of 2 is received when an individual's language proficiency and literacy *is a barrier* to employment, and they *are currently* enrolled in an ESL and/or Literacy program. Question 20a: Yes + Question 20b: Yes = ASSM 2
1	A score of 1 is received when an individual's language proficiency and literacy *is a barrier* to employment, and they are *not currently* enrolled in an ESL and/or Literacy program Question 20a: Yes + Question 20b: No = ASSM 1

ASSM DOMAIN: EMPLOYMENT

Score Summary:

5	A score of 5 is received when an individual's combined employment is full-time, long-term and also provides adequate pay and benefits. Question 25a: Yes + Question 26: Full-time + Question 27: Long-term

	+ Question 28: Yes + Question 29: 2 or more + Question 25c: yes OR Question 25a: Yes + Question 26: Part-time + Question 27: Long-term + Question 28: Yes = ASSM 5
4	A score of 4 is received when an individual's combined employment is full-time and provides adequate pay and benefits; but isn't considered long-term. Question 25a: Yes + Question 26: Full-time + Question 27: Long-term + Question 28: Yes + Question 29: 2 or more + Question 25c: no =ASSM 4
3	A score of 3 is received when an individual's combined employment is full-time, but pay is inadequate and/or there are few to no benefits. Question 25a: Yes + Question 26: Full-time + Question 27: Long-term + Question 28: No OR Question 25a: Yes + Question 26: Full-time + Question 27: Long-term + Question 28: Yes + Question 29: 1 or less = ASSM 3
2	A score of 2 is received when an individual's combined employment is part-time, temporary or seasonal, and pay is inadequate with no benefits. Question 25a: Yes + Question 26: Part-time + Question 27: Temporary/Seasonal OR

	Question 25a: Yes + Question 26: Part-time + Question 27: Long-term + Question 28: No OR Question 25a: Yes + Question 26: Full-time + Question 27: Temporary/Seasonal = ASSM 2
1	A score of 1 is received when an individual is not currently employed and wants/needs employment. Question 25a: No = ASSM 1
N/A	A score of N/A is received when an individual is not currently employed, but is not currently seeking employment. Question 25a: N/A = ASSM N/A

ASSM DOMAIN: MOBILITY (TRANSPORTATION)

Score Summary:

5	A score of 5 is received when a participant has their own car which is considered reliable and they report that they are licensed and insured. Question 31: Yes + Question 32: 1 + Question 33: All selected = ASSM 5
4	A score of 4 is received when a participant reports that their transportation options are adequate to meet their needs and relies on borrowing a car, using rideshare or taxis, or public transportation. Question 31: Yes + Question 32: 2, 3, or 4 = ASSM 4
3	A score of 3 is received when a participant reports that their transportation is not adequate to meet their needs, but reports having access to one of the transportation options available. Question 31: No + Question 32: 2, 3, or 4 = ASSM 3

2	A score of 2 is received when a participant reports that their transportation is not adequate to meet their needs and they have their own car, yet that car is not insured or reliable or the participant reports not being licensed. Question 31: No + Question 32: 1 + Question 33: 2 or less selected = ASSM 2
1	A score of 1 is received when a participant reports that their transportation is not adequate to meet their needs and that they have no access to transportation. Question 31: No + Question 32: 5 = ASSM 1

ASSM DOMAIN: HEALTH CARE COVERAGE

Scoring Summary:

5	A score of 5 is received when a participant reports that all members are covered by affordable, adequate health insurance. Question 34a: Yes, both of us + Question 35a: Yes + Affordable + Question 34/35b: No (Adequate) = ASSM: 5
4	A score of 4 is received when a participant reports that all members can get medical care when needed, but may strain budget Question 34a: Yes, both of us or Yes, just me (for single-parent households only) + Question 35a: Yes + Not affordable and/or not adequate (Question 34/35b: No) = ASSM: 4
3	A score of 3 is received when a participant reports that only some family members (i.e. Children or Partner only) have health insurance Question 34a: Yes, just me (when there are two adults in the family) OR Yes, just my significant other/spouse AND/OR Question 35a: Yes = ASSM: 3
2	A score of 2 is received when a participant reports that Question 34a: No, neither of us + Question 35a: No

	+ Question 34/35c: No + Question 34/35d: No = ASSM: 2
1	A score of 1 is received when a participant reports that Question 34a: No, neither of us + Question 35a: No + Question 34/35c: Yes AND/OR Question 34/35d: Yes = ASSM: 1

ASSM DOMAIN: MENTAL HEALTH

Scoring Summary:

5	A score of 5 is received when a participant reports that they do not have a mental health condition that interferes with daily life. Question 41: No = ASSM: 5
4	A score of 4 is received when a participant reports that reports that they do have a mental health condition that interferes with daily life and makes work, social life, and self-care rarely difficult or not difficult at all. Also, participant does not have suicidal or self-harm thoughts. Question 41: Yes + Question 42-44: All rarely or not difficult at all + Question 45: No = ASSM: 4
3	A score of 3 is received when a participant reports that reports that they do have a mental health condition that interferes with daily life and makes work, social life, and self-care only somewhat difficult. Also, participant does not have suicidal or self-harm thoughts. Question 41: Yes + Question 42-44: All somewhat difficult or higher + Question 45: No = ASSM: 3
2	A score of 2 is received when a participant reports that reports that they do have a mental health condition that interferes with daily life and makes work, social life, and self-care rarely difficult or not difficult at all. Also, participant does not have suicidal or self-harm thoughts. Question 41: Yes + Question 42-44: All very difficult or higher +Question 45: No = ASSM: 2
1	A score of 1 is received when a participant reports that reports that they do have a mental health condition that interferes with daily life and makes work, social life, and self-care rarely difficult or not difficult at all. Participant does not have suicidal or self-harm thoughts, regardless of how other questions were answered.

	Question 41: Yes + Question 42-44: At least one question rated extremely difficult OR Question 45: Yes = ASSM: 1

ASSM DOMAIN: SUBSTANCE ABUSE

Scoring Summary:

5	A score of 5 is received when a participant reports there has not been a time in their life when using alcohol or other drugs affected their personal relationship, school, work, or overall well-being Question 46: No = ASSM: 5
4	A score of 4 is received when a participant reports there has been a time in their life when using alcohol or other drugs affected their personal relationship, school, work, or overall well-being. The Participant also reports thinking about changing their drinking or drug habits, been criticized for their drinking or drug habits, and/or felt guilty about their drinking or drug habits 1-2 time in the last 6 months. Question 46: Yes + Question 47-50: 1-2 times in the last 6 months for any question = ASSM: 4
3	A score of 3 is received when a participant reports there has been a time in their life when using alcohol or other drugs affected their personal relationship, school, work, or overall well-being. The Participant also reports thinking about changing their drinking or drug habits, been criticized for their drinking or drug habits, and/or felt guilty about their drinking or drug habits 3 times in the last 6 months. Question 46: Yes + Question 47-50: 3 times in last 6 months for any question = ASSM: 3
2	A score of 2 is received when a participant reports there has been a time in their life when using alcohol or other drugs affected their personal relationship, school, work, or overall well-being. The Participant also reports thinking about changing their drinking or drug habits, been criticized for their drinking or drug habits, and/or felt guilty about their drinking or drug habits 4 times in the last 6 months. Question 46: Yes + Question 47-50: 4 times in last 6 months for any question = ASSM: 2
1	A score of 1 is received when a participant reports there has been a time in their life when using alcohol or other drugs affected their personal relationship, school, work, or overall well-being. The Participant also reports thinking about changing their drinking or drug habits, been criticized for their

	drinking or drug habits, and/or felt guilty about their drinking or drug habits 5 or more times in the last 6 months. Question 1: Yes + Question 2-5: 5 or more times in last 6 months for any question = ASSM: 1

ASSM DOMAIN: DISABILITIES

Scoring Summary:

5	A score of 5 is received when a participant reports they do not have physical, developmental, or learning disability Question 51: No = ASSM: 5
4	A score of 4 is received when a participant reports that do have a physical, developmental, or learning disability, but they are taking steps to manage the disability, so it rarely makes work, social life, and self-care difficult. Question 51: Yes + Question 52: At least one selected + Question 53-55: All Rarely or Not difficult at all = ASSM: 4
3	A score of 3 is received when a participant reports that do have a physical, developmental, or learning disability, but they are taking steps to manage the disability so it sometimes makes work, social life, and/or self-care difficult. Question 51: Yes + Question 52: At least one selected + Question 53-55: All somewhat difficult or higher = ASSM: 3
2	A score of 2 is received when a participant reports that do have a physical, developmental, or learning disability, but they are taking steps to manage the disability, so it makes work, social life, and/or self-care very difficult. Question 51: Yes + Question 53-55: All very difficult or higher = ASSM: 2
1	A score of 1 is received when a participant reports that do have a physical, developmental, or learning disability, but they are taking steps to manage the disability, so it makes work, social life, and/or self-care extremely difficult. Question 51: Yes + Question 53-55: Extremely difficult or higher for at least one question = ASSM: 1

ASSM DOMAIN: CHILDCARE

Score Summary:

5	A score of 5 is received when childcare is accessible, reliable, affordable, and is of the parent's quality standard. Question 56: Yes + Question 57: Yes + Question 58-60 (combined): 3 Yes + Question 61: 4 or more = ASSM 5
4	A score of 4 is received when childcare is accessible, reliable, and affordable; but is not ideal choice per parent's quality standard. Question 56: Yes + Question 57: Yes + Question 58-60 (combined): 3 Yes + Question 61: 3 or less = ASSM 4
3	A score of 3 is received when childcare is 2 out of 3: inaccessible, unreliable, and unaffordable. Question 56: Yes + Question 57: Yes + Question 58-60 (combined): 2 Yes = ASSM 3
2	A score of 2 is received when childcare is inaccessible, unreliable, and unaffordable. Question 56: Yes + Question 57: Yes + Question 58-60 (combined): 1 Yes = ASSM 2
1	A score of 1 is received when childcare is needed but not available nor accessible. Question 56: Yes + Question 57: No OR Question 56: Yes + Question 57: Yes + Question 58-60 (combined): 0 Yes = ASSM 1
N/A	A score of N/A is received when there is no childcare needed. Question 56: No = ASSM N/A

ASSM DOMAIN: CHILDREN'S EDUCATION

Score Summary:

5	A score of 5 is received when the household's school-aged children are all enrolled in school and attending classes most or all of the time. Question 63: Yes + Question 64: Yes + Question 65: Most or All of the time = ASSM 5
4	A score of 4 is received when the household's school-aged children are all enrolled in school and attending classes more than half the time, but not consistently. Question 63: Yes + Question 64: Yes + Question 65: More than half the time = ASSM 4
3	A score of 3 is received when the household's school-aged children are all enrolled in school, but one or more children are attending classes less than half the time. (50% or less) Question 63: Yes + Question 64: Yes + Question 65: Less than half of the time = ASSM 3
2	A score of 2 is received when all of the household's school-aged children are all enrolled in school, but one or more children are not attending classes. Question 63: Yes + Question 64: Yes + Question 65: None of the time = ASSM 2
1	A score of 1 is received when one or more of the household's school-aged children are not enrolled in school. Question 63: Yes + Question 64: No = ASSM 1
N/A	A score of N/A is received when a household does not have any school aged-children Question 63: No = ASSM N/A

ASSM DOMAIN: PARENTING SKILLS

Scoring Summary

Note: Questions 67, 69, and 71 require reverse coding. For example, an answer of 1, strongly disagree, for Question 88 would be scored a 7.

Questions 67-75 come from the Protective Factors Survey and comprise one factor and one subscale within that tool. To assign an ASSM score for the Parenting Skills Domain, a score must be calculated for each subscale:

Child Development/Knowledge of Parenting: Questions 67-71 make up the Child Development/Knowledge of Parenting factor. Due to the nature of these questions, they will be considered individually, not as a scale. Keep in mind that questions 67, 69, and 71 need to be reverse coded.

Nurturing and Attachment: Questions 72-75 make up the Nurturing and Attachment subscale. If at least 3 items are complete, take the average of scores to questions 72-75 as the overall score for this subscale.

5	A score of 5 is received when a participant reports no CPS involvement and well-developed parenting skills. Question 77a: No +Questions 67-71: all rated ≥ 6 +Questions72-75: Subscale ≥ 6 = ASSM 5
4	A score of 4 is received when a participant reports no CPS involvement and adequate parenting skills. Question 77a: No +Questions 67-71: all rate ≥ 5 +Questions 72-75: Subscale ≥ 5 = ASSM 4
3	A score of 3 is received when a participant reports no CPS involvement and apparent but inadequate parenting skills. Question 77a: No +Questions 67-71: all rated > 4 OR Question 77a: No +Questions 72-75: Subscale > 4 = ASSM 3
2	A score of 2 is received when a participant reports no CPS involvement and minimal parenting skills. Question 77a: No + Questions 67-71: At least one question ≤ 4 + Questions 72-75: Subscale ≤ 4 = ASSM 2
1	A score of 1 is automatically received when a participant reports any CPS involvement (Question 77 which can be found in the Family/Social Relations Domain). Question 77a: Yes + Question 77b: any response

	= ASSM 1

ASSM DOMAIN: FAMILY/SOCIAL RELATIONS

Score Summary:
Note: Questions 85, 86, and 88 require reverse coding. For example, an answer of 1, strongly disagree, for Question 88 would be scored a 7.

Questions 78-88 come from the Protective Factors Survey and comprise three separate subscales within that tool. To assign an ASSM score for the Family Social Relations Domain, a score must be calculated for each subscale:

Family Functioning/Resiliency: Questions 78-82 make up the Family Functioning/Resiliency subscale. If at least 4 items are complete, take the average of scores to questions 78-82 as the overall score for this subscale.

Social Support: Questions 83, 84, and 87 make up the Social Support subscale. If at least 2 items are complete, take the average of scores to these questions as the overall score for this subscale.

Concrete Support: Questions 85, 86, and 88 make up the Concrete Support subscale. If at least 2 items are complete, take the average of scores to questions 78-82 as the overall score for this subscale. Keep in mind that these questions need to be reverse coded.

5	A score of 5 is received when a participant reports supports in all three subscales and no abuse/neglect. Question 77a: No +Questions 78-88: All three subscales ≥ 4.5 OR Question 77a: Yes +Question 77b: No +Questions 78-88: All Three subscales ≥ 4.5 = ASSM 5
4	A score of 4 is received when a participant reports support in two subscales and no abuse/neglect. Question 77a: No +Questions 78-88: Two subscales ≥ 4.5 OR Question 77a: Yes +Question 77b: No +Questions 78-88: Two subscales ≥ 4.5 = ASSM 4

3	A score of 3 is received when a participant reports support in one subscale and no abuse/neglect Question 77a: No +Questions 78-88: One subscale ≥ 4.5 OR Question 77a: Yes +Question 77b: No +Questions 78-88: One subscale ≥ 4.5 = ASSM 3
2	A score of 2 is automatically received when a participant reports limited family/social support or that CPS has been involved, but the case is resolved Question 77a: No +Questions 78-88: All three subscales < 4.5 OR Question 77a: Yes +Question 77b: No +Questions 78-88: All three subscales < 4.5 OR Question 77a: Yes + Question 77b: Yes, but resolved = ASSM 2
1	A score of 1 is automatically received when a participant reports there is current, active CPS involvement. Question 77a: Yes + Question 77b: Yes, and ongoing = ASSM 1

ASSM DOMAIN: COMMUNITY INVOLVEMENT

Score Summary:

5	A score of 5 is received a participant reports that they are very involved or involved in their community and they offer examples of their involvement. Question 89: Very Involved or Involved + Question 90: At least one selection = ASSM 5

4	A score of 4 is received when a participant reports that they are involved or somewhat involved in their community, but they also report that there are logistical barriers to their involvement, such as language, childcare, or transportation. Question 89: Involved or Somewhat Involved + Question 91: Language barrier AND/OR Can't find the childcare or transportation I need = ASSM 4
3	A score of 3 is received when a participant reports that they don't know how to get involved. Question 91: I'd like to be more involved, but I am not sure how = ASSM 3
2	A score of 2 is automatically received when a participant reports that they are not involved and also reports that they are not involved because they do not want to be. Question 89: Not Involved + Question 91: I am not involved because I don't like to be involved = ASSM 2
1	A score of 1 is automatically received when a participant reports that their barrier to involvement is basic needs. Question 91: Too concerned about meeting my family's basic needs = ASSM 1

ASSM DOMAIN: SAFETY

Score Summary:

5	A score of 5 is received a participant reports that they generally feel safe in their home and neighborhood and have no current or future concerns about their safety. Question 92: Yes + Question 93: Yes + Question 94: No + Question 95: No = ASSM 5
4	A score of 4 is received when a participant reports that they currently feel safe in their home and neighborhood, but they have concerns about their safety in the next 6 months. Question 92: Yes + Question 93: Yes + Question 94: no +Q95: Yes = ASSM 4
3	A score of 3 is received when a participant reports that they are not currently feeling safe in their home and/or neighborhood and/or they are concerned about their child's safety and they are making changes to their regular routine to cope with any safety concerns they have.

	Question 92: No OR Question 93: No AND/OR Question 94: No + Question 96: Yes = ASSM 3
2	A score of 2 is automatically received when a participant reports that they or their child(ren) are currently receiving threats to their safety. Question 98: Yes = ASSM 2
1	A score of 1 is automatically received when a participant reports they or their child(ren) have witnessed or experienced a crime. Question 97: Yes = ASSM 1

ASSM DOMAIN: LIFE SKILLS

5	A score of 5 is received a participant reports that they are able to provide beyond basic needs of daily living for self and family. Question 99: Yes = ASSM 5
4	A score of 4 is received when a participant reports that they are able to meet basic needs of living sometimes and have assistance when needed. Question 99: No Question 100a: No OR Question 99: No Question 100a: Sometimes + Question 100b: Yes = ASSM 4
3	A score of 3 is received when a participant reports that they are able to meet basic needs of living and have access to assistance sometimes. Question 99: No Question 100a: Sometimes

	+ Question 100b: Sometimes OR Question 99: No Question 100a: Yes + Question 100b: Yes = ASSM 3
2	A score of 2 is automatically received when a participant reports that they are not able to meet basic needs of living but have access to help sometimes OR they are able to meet basic needs of living sometimes but do not have access to help when need. Question 99: No Question 100a: Yes + Question 100b: Sometimes Or Question 99: No Question 100a: Sometimes + Question 100b: No = ASSM 2
1	A score of 1 is automatically received when a participant reports they are not able to meet basic needs of living and does not have access to help. Question 99: No Question 100a: Yes + Question 100b: No = ASSM 1

ASSM DOMAIN: LEGAL

5	A score of 5 is received when an individual doesn't have any criminal justice history, occurring in the last 12 months and no history of felony/misdemeanor. Question 102: No + Question 103: Option #1 + Question 104: No + Question 104b: No + Question 105: No =ASSM 5
4	A score of 4 is received when an individual has no current charges within the last 12 months and has successfully completed parole or probation in the last 12 months. Question 103: Option #1

	+ Question 104: No + Question 104b: Yes + Question 105: No = ASSM 4
3	A score of 3 is received when an individual is currently on parole or probation but is fully compliant. Question 104: Yes + Question 104a: Yes + Question 105: Yes = ASSM 3
2	A score of 2 is received when an individual has been arrested but not yet been to court, or if they are currently in trial or court proceedings, or is not compliant with probation or parole. Question 103: Option #4 and/or #5 AND/OR Question 104: Yes +Question 104a: No =ASSM 2
1	A score of 1 is automatically received when an individual has current unresolved ticket or open warrant. Question 103: Options #2 and/or #3 (regardless of all other answers) = ASSM 1

Appendix L: Feeding Your Child Survey

Date Completed: _____

FEEDING YOUR CHILD SURVEY
(ages 2 to 6)

Parent Case Number:_____

Child's Name: _____

Child's Age: _____ Years _____Months

Sex of Child (circle one): M / F

Relationship Between Child and Person Completing Survey:_____

INSTRUCTIONS:

Facilitators: Please review the instructions and practice question with the parent, making sure the parent understands the scale. Please assist the parent in completing the question below.

Parents: The purpose of this survey is to learn more about feeding your preschool child 2 to 6 years old, asking what you do with feeding your child and how you think and feel about it. Please answer the practice question with help from the interviewer to understand the scale.

I prepare the same meal for my child every day.	Always	Often	Sometimes	Rarely	Never

How did you complete the practice question (please check one):

- ☐ Yes, the practice question was completed **with** help from the Interviewer
- ☐ Yes, the practice question was completed **without** help from the Interviewer
- ☐ No, the practice question was **not** completed

After you have completed the practice question, decide how you wish to complete the rest of the survey.

Before you begin, would you like to (please check one):

- ☐ Continue the survey on your own?
- ☐ Have the survey read to you while you circle your responses?
- ☐ Have the survey read to you and responses circled by the Interviewer?

Please answer all of the questions, based on the child whose name is written on page 1.

This is a survey about feeding your preschool child 2 to 6 years old, asking what you do with feeding your child and how you think and feel about it. Please choose ONE response for each item.

		Always	Often	Sometimes	Rarely	Never
1.	My family has meals at about the same times every day					
2.	I let my child eat whenever s/he feels like eating.					
3.	If I think my child hasn't had enough, I try to get him or her to eat a few more bites.					
4.	When I am home at mealtimes, I sit down and eat with my child.					
5.	I struggle to get my child to eat.					
6.	I decide what foods to buy based on what my child eats.					
7.	I let my child feed him/herself.					
8.	I let my child eat until s/he stops eating and doesn't want more.					
9.	I am comfortable with providing meals for my family.					
10.	I make something special for my child when s/he won't eat.					
11.	I let my child have drinks (other than water) whenever s/he wants them.					
12.	We have food leftover after meals.					

Appendix M: Case Closure Form

Date Completed: _____
Agency: _____
Family ID: _____
Participant ID: _____

Case Closure Form

Name: _____

1. Are you an: ☐ FCMS ☐ DCS	**2. Is this family in the:** ☐ Intervention group ☐ Comparison group
3. Were you the only FCMS or DCS that this family worked with? ☐ Yes ☐ No	**4. Did this family enroll in the program for 6 months or 12 months?** ☐ 6 months ☐ 12 months
5. Overall, did you observe growth in this family over the course of their involvement in the study? ☐ No- this family regressed a lot ☐ No- this family regressed a little ☐ This family stayed the same ☐ Yes- this family experienced a little growth ☐ Yes- this family grew a lot	

6. Please rate how much improvement you saw in this family in the following areas:	**None**	**A little**	**Some**	**A lot**
a) Housing (stability)	☐	☐	☐	☐
b) Employment	☐	☐	☐	☐
c) Income	☐	☐	☐	☐
d) Food (security)	☐	☐	☐	☐
e) Childcare	☐	☐	☐	☐
f) Children's Education	☐	☐	☐	☐
g) Adult Education	☐	☐	☐	☐
h) Healthcare Coverage	☐	☐	☐	☐
i) Life Skills	☐	☐	☐	☐
j) Family/Social Relations	☐	☐	☐	☐
k) Mobility (transportation)	☐	☐	☐	☐
l) Community Involvement	☐	☐	☐	☐
m) Parenting Skills	☐	☐	☐	☐
n) Legal	☐	☐	☐	☐
o) Mental Health	☐	☐	☐	☐
p) Substance Abuse	☐	☐	☐	☐
q) Safety	☐	☐	☐	☐
r) Disabilities	☐	☐	☐	☐

For intervention group only:

7. **How much progress did this family make in achieving the goals they set while in the program?**
   - ☐ This family achieved all of their goals
   - ☐ This family achieved some of their goals
   - ☐ This family achieved a few of their goals
   - ☐ This family did not achieve any of their goals

8. **Please let us know what, if anything, you thought about the Family Checkup Model was most helpful for this family.**

_____
_____
_____
_____
_____

9. **Do you think this family was a good fit for the Family Checkup Model?**
   - ☐ Yes
   - ☐ No, why not?_____

Appendix N: GOALS Family Feedback Form

Profile for:_____ Child's Age:_____ Date:_____

GOALS: Family Feedback Form

Child Well-being and Development

Behavior	
Social & Emotional Wellbeing	
Language and Communication	
Physical Development	
Other:	

Strength — Needs Attention

Family Well-being and Support

Basic Needs	
Family & Community Relations	
Employment/Education	
Behavioral Health	
Health Support	
Nutrition	
Other:	

Strength — Needs Attention

Parenting

Parenting Skills	
Affection	
Responsiveness	
Encouragement	
Teaching	
Other:	

Appendix O: Comparison Family Feedback Form

Profile for:_____ Child's Age:_____ Date:_____

Family Feedback Form

Based on the results of your family assessment, resources have been identified to support your family's growth potential. Areas in need of attention are checked below.

If you have any questions, please contact:

_____

_____

☐ **Child Well-being and Development**

Resources to support **Child Well-being and Development:**

_____

_____

_____

☐ **Family Well-being and Support**

Resources to support **Family Well-being and Support**:

_____

_____

_____

☐ **Parenting**

Resources to support **Parenting**:

_____

_____

_____

☐ **NO areas in need of attention at this time**

V1_01/2018

Appendix P: Family Goal Setting Form

Family Goals

Family Name: _____

If we need help, we should contact:_____

Goal #1

Steps to reach our goal

Resources we need

Accomplish Date ____ /____/____

Goal #2

Steps to reach our goal

Resources we need

Accomplish Date ____ /____/____

Goal #3

Steps to reach our goal

Resources we need

Accomplish Date ____ /____/____

V2_01/2018

Appendix Q: Pathway Programs

GOALS Pathway Programs

Parenting Education

ACCESS: Systematic Training for Effective Parenting (STEP)

STEP is a classroom-based parenting program for parents with children ages 0 to 5. It focuses on child development, discipline, communication strategies, and how to build child self-esteem. The materials are adapted to be suited for ELLs (English Language Learners). The classes are facilitated in three languages simultaneously: English, Arabic, and Spanish.

ACCESS: Citizenship Program

The Citizenship Program is a classroom-based environment for individuals who desire to become naturalized citizens of the United States and have already applied for their citizenship. The classes are designed to prepare participants for the US Citizenship Naturalization Test. Participants in the Citizenship Program learn about US history, government, and English as a Second Language (ESL) skills. The ESL portion of the class provides participants with the skills necessary to talk about themselves, understand the information on their application, and pass the English portion of the US Citizenship Naturalization Test.

While citizenship classes are open to everyone, they are designed for low-level English speakers. GOALS participants who are native or high-level English speakers are provided the study literature to review at their own pace. Workshop style events are also offered for participants who cannot commit to weekly classes.

Black Family Development: LENA Start

LENA Start is a United Way funded program offered through a partner agency. The program uses wearable LENA technology to record speech and language environments at home a day after each LENA Start class. LENA Technology is research-based technology used worldwide to measure early talk for research, intervention, and clinical use. LENA Start classes address the early talk gap, using feedback from LENA Technology and through curriculum that teaches parents simple strategies to improve talk. LENA Start is a free 13-week program with entertaining lessons which included videos and hands-on activities where parents are coached on speaking and reading more to their child. Parents are also given take home material and easy to use Talking Tips to build conversations, along with receiving a book at each session.

CARE of Southeastern Michigan: Active Parenting

Active Parenting is a 4-week parenting course for parents with children birth to age 5, focused on discipline techniques, cooperation, responsibility, and self-esteem in children.

CARE of Southeastern Michigan: Nurturing Families

Nurturing Families is a classroom-based parenting class for non-custodial parents of children age birth to 17 years who have an open Child Protective Services case and are required to take parenting courses.

CARE of Southeastern Michigan: Supportive Opportunities for Families (SOF)

SOF is an intensive home visiting program using the Nurturing Families parenting curriculum for parents with children age birth to five. It consists of 12 visits which are spaced out based on the family's level of need for support.

Leaps & Bounds Family Services and **Oakland Family Services: Parents as Teachers (PAT)**

Parents as Teachers is a home visiting program for parents of children birth to age 3½ years focused on teaching parents to be their child's first teacher and getting them ready to learn. It covers topics such as child development, parenting skills, and general family well-being.

United Way for Southeastern Michigan: ABCMouse

ABCMouse is an online program that is a step-by-step research driven curriculum with more than 850 lessons in ten levels. As the child completes each lesson it guides them to the next lesson, motivated by a ticket and reward system. A progress tracker is also available so parents are able to view the learning activities completed and progress by academic level and subject. The system promotes literacy from early literacy to reading paragraphs. There are more than 450 books and beginning readers in the program, along with writing and language skills that include sentence structure, punctuation, parts of speech and more.

United Way for Southeastern Michigan: Earned Income Tax Credit Program

Every year the residents of Metro-Detroit leave millions of dollars in tax credits unclaimed. United Way for Southeastern Michigan, along with its partners work to combat that with their Earned Income Tax Credit Program. Volunteers for this program provide free tax preparation services for low to moderate income individuals. These trained volunteers help individuals

maximize their return and claim the Earned Income Tax Credit (EITC). The EITC is a refundable tax credit for low to moderate income working individuals and couples.

United Way for Southeastern Michigan: Reading is Fundamental

Reading is Fundamental (RIF) has developed content and resources that produce measurable results. Through RIF's various programs and partnerships, they provide opportunities for children and their families to experience the life-changing impact of reading. Reading is the fundamental building block to all life's essential skills. The program invites parents to explore the program by bringing books and literacy resources to children at home. The GOALS program provided all intervention families with 6 books at each baseline, 6-month, and 12-month assessment visit.

Additionally, FCMS' share approved print materials about the online resources available at www.rif.org. These resources supported parents with the literacy programming in conjunction with the books.

United Way for Southeastern Michigan: Ready4K

Ready4K is an evidence-based text messaging program that sends age appropriate facts, tips, and growth opportunities directly to parents of children ages newborn-8 years old. Developed by educational researchers, these text messages are based on a curriculum that aligns with the educational standards set by the State of Michigan. Parents receive three text messages each week that help them maximize already established family routines to help build their child's skills. Some examples included:

1. FACT: The grocery store is great for building literacy skills. On the way to the store, ask: If you could only eat one food forever, what would it be? Why?
2. TIP: When you're at the store, go on a letter hunt. Can your child find an "A" on a sign, box, or food label? What about "B"? Can s/he go all the way to "Z"?
3. GROWTH: Keep preparing 4K at the grocery store! As you walk by the eggs, ask: What rhymes with egg? Leg, peg, beg. Try it with cheese. Bees, knees, please!

These messages help parents take on more of an active role in their child's learning.

Health Care Access & Support

National Kidney Foundation of Michigan: Diabetes Prevention Program

Diabetes Prevention Program participants are part of a small, supportive group lead by a trained lifestyle coach. This lifestyle change program helps people with prediabetes eat healthier, become more physically active, and lose weight with the goal to delay or even prevent the onset of Type 2 Diabetes. Participants learn about healthier eating habits, ways to be more physically

active, and other behavior changes over the course of 16 weekly one-hour sessions. The group continues to meet monthly, completing a full year of the Diabetes Prevention Program. Participants work towards losing 5-7% of their starting body weight and being physically active for 150 minutes per week.

National Kidney Foundation of Michigan: Enhance Fitness

Enhance Fitness is a physical activity program for adults that is designed to improve functional fitness and well-being. Functional fitness means keeping strong, balanced, and flexible to retain the ability to do the daily activities of life that you normally would do. They give people an opportunity to exercise and socialize with their friends. The classes focus on balance, strength, endurance, and flexibility exercises and are adjustable to all levels of fitness. Classes are taught by certified fitness instructors who are specifically trained in Enhance Fitness procedures and the exercise program.

National Kidney Foundation of Michigan: PATH

The Stanford Chronic Disease Self-Management Program (PATH in Michigan) was developed and tested by Stanford University to help people learn to better manage their long-term health conditions. It is a six-week workshop conducted in 2½ hour sessions each week. PATH is designed to benefit adults with chronic or ongoing health conditions including arthritis, heart disease, diabetes, emphysema, asthma, bronchitis, and depression. Family members, friends, and parents are also encouraged to attend.

There are a variety of PATH workshops to choose from for those people with specific health challenges such as diabetes, kidney disease, and chronic pain. These workshops are similar to the traditional PATH but offer additional information and support for people with those conditions:

- General PATH is for anyone with a chronic health condition such as arthritis, hypertension, cancer, and other long-term health problems.
- Diabetes PATH is for people who are living with Type 2 Diabetes.
- Chronic Pain PATH is for people living with chronic pain.
- Kidney PATH is for people living with chronic kidney disease.
- Cancer Thriving & Surviving is for cancer patients, cancer survivors and their loved ones.

United Way for Southeastern Michigan: Asthma Program

A pathway for all families that have children on Medicaid and uncontrolled asthma. The Michigan MATCH program was developed by the Asthma Network of West Michigan in the Grand Rapids area, and is implemented in greater Flint, Ann Arbor, Ingram and Wayne County

areas. Anyone can refer clients to the MATCH program. The premise for the program is for each client and family to work with a case manager to improve their asthma self-management.

WCHAP provides asthma education to families whose child(ren) may have uncontrolled asthma that are on Medicaid. They talk with the families, help to educate the families on proper usage of medication, and to identify triggers in and out of the home. They do six or more home visits, visits to school or work, and/or the physician's office. They will help to create or update an asthma action plan for that child.

United Way for Southeastern Michigan: MI Bridges Navigator

The MI Bridges Navigator assists community residents to identify their needs and connects them to community resources through community programs and organizations through partnership with 2-1-1. The MI Bridges Navigator helps to improve community residents' experiences making the Michigan Department of Health and Human Services (MDHHS) process of accessing benefits easier for them. Through one-on-one sessions the Mi Bridges Navigator helps to answer questions, complete a needs survey, find local resources, or apply online for benefits. In addition, the MI Bridges Navigator helps community partners play a significant role by assisting them if needed to access benefits and support for their families.

United Way for Southeastern Michigan: WCHAP (FQHC, PCP, and Health Plans)

Wayne Children's Healthcare Access Program (WCHAP) is a not-for-profit organization located in downtown Detroit, Michigan. WCHAP staff works with primary care physicians, health plans, parents, and other community agencies in a collective effort to improve the healthcare outcomes of all children throughout the City of Detroit and Wayne County.

WCHAP promotes the health of children by helping parents and their children get the most out of their relationship with their pediatrician or family physician. WCHAP provides health education to families, helps doctors improve the quality of their care, and acts as a voice for issues affecting children's health.

United Way for Southeastern Michigan: Virtual Children's Healthcare Access Program

Born out of Kent County, Michigan, CHAP is an evidence-based model that improves the quality of care and health outcomes for children with Medicaid while reducing the cost of care. When families have sufficient access to quality pediatric patient centered medical homes, they are significantly more likely to use their medical home for primary care, ultimately leading to healthier children and reduced costs.

Virtual CHAP provides education, care coordination, accessing transportation and other necessary services to address social determinants of health and barriers to medical access for children on Medicaid. Services are provided over the phone by a trained VCHAP specialist.

Nutrition/Family Feeding Practices

United Way for Southeastern Michigan: FEAST

FEAST (Feeding, Eating, and Succeeding Together) is a four-class series that teaches parents strategies to help their children grow into healthy, happy eaters. Learning is done through dialogue and group discussion rather than lectures. Each class is 1 hour and 15 minutes long, and they are taken one per week over four weeks.

The topics of the four classes are:

- Reducing stress around feeding
- Roles and responsibilities at mealtime
- Family meals and routines
- Learning to like new foods

Appendix R: Pilot Survey Summary

Training Area	Responses
Understanding of SIF grant purpose and goals	Most participants agreed (65%) or strongly agreed (25%) that they understood the project. The two who disagreed did not attend this session.
Understanding of project evaluation and goals	Most participants agreed (60%) or strongly agreed (20%) that they understood the evaluation. 55% agreed and 25% strongly agreed that they understood their agency's pilot recruitment plan. Twenty percent have had previous experience with random assignment studies. All but two (90%) understood procedures for obtaining informed consent.
Preparation for implementation of the Family Check-Up model	All participants were new to the Family Check-Up model at the beginning of the training series. By the end, three quarters of participants agreed (70%) or strongly agreed (5%) that they felt prepared to administer it. Most understood how the FCU differed from the normal standard of care at their agency (65% agreed, 20% strongly agreed) and almost all (90%) understood their role in the project. Open ended feedback included two comments that the FCU training could have been more helpful if it was more tailored to how the SIF project will be using the model. Although only 10% of the group had experience with 211 before the trainings, almost all (90%) felt they understood the role of 211 in the Family Check-Up model. Slightly less (75%) felt they understood the role of text messaging. Only 40% felt prepared to use the Family Check-Up model with families who are not fluent in English. We note that the agencies vary in terms of what percentage of their clients is not fluent in English.
Preparation for administration of measurement tools	ASQ-3 and ASQ:SE-2: 60% of the group had experience with ASQs before the training. After, 90% felt prepared to administer them and 85% felt prepared to score and interpret them.

	ASSM: 35% of the group had experience with the ASSM before the training. After, 80% felt prepared to administer it and 75% felt prepared to score and interpret it. Two open ended responses requested more training on scoring and interpretation. We did not ask if participants had previous experience with the following three assessments. Feeding Your Child: After the training, 80% felt prepared to administer it and 75% felt prepared to score and interpret it. Child Temperament: After the training, 75% felt prepared to administer it and only 65% felt prepared to score and interpret it. One open ended response requested more training on scoring and interpretation. All FCMS indicated they felt prepared to administer, score, and interpret the ASQ-3 and ASQ:SE-2. All but one felt prepared to administer, score, and interpret the ASSM and Feeding Your Child Questionnaire. All but one felt prepared to administer the Child Temperament Questionnaire and two did not feel prepared to score and interpret it.
Preparation to give feedback and set goals	Motivational interviewing: 35% of the group had experience with motivational interviewing prior to participation (5 of 11 FCMS had experience). One open ended response requested more practice on this and more information about how control visits would differ. Providing feedback on assessments: after the training, 60% agreed and 15% strongly agreed they were prepared to give feedback based on the assessments. One open ended response requested training on how to provide research to go along with results during feedback sessions. Another requested more practice on delivering difficult results or having hard conversations. Another open ended response indicated a need to better understand the purpose behind many of the questions in the assessments. Sixty percent of participants agreed and 20% strongly agreed they were prepared to help families set goals based on assessments.
Preparation for implementation of	No participants indicated they had experience with ETO before the training. One open ended response expressed a preference to hold

administrative processes (ETO, payments, etc.)	off on ETO training until the database was complete. Access client information in ETO: 70% agreed they were prepared, 15% strongly agreed. Understand evaluation support payments: 65% agreed they were prepared, 15% strongly agreed. Enter enrollment data in ETO: 60% agreed they were prepared, 15% strongly agreed. Enter assessment data in ETO: 55% agreed they were prepared, 10% strongly agreed.
Overall assessment of training	The majority agreed (60%) or strongly agreed (25%) that the training met their needs for information and skill development at this time. Open ended responses included a preference for task-based training, rather than lecture-based training, although others felt the format and context were appropriate. One participant suggested that the lead for each agency could have created a sample case for the assessments before working with the practice families. Another requested a checklist for completion of forms and two participants requested a model of someone going through the entire intervention. One simply requested more practice for the group to ensure consistent results. Additional requests included a clear outline for the process for the FCU and referral processes for the pathways outside of 211.

Appendix S: Referral Log Form

Date Completed: _____
Participant Name: _____
Family ID: _____

Family Check-Up Referral Log

Instructions: Fill this form out for each referral individually. This form is not intended to be given to the participant – it is for tracking purposes only. If a family is participating in your pathway program, you will need to refer them into that program. Use this form to fill out the Referral touch point in ETO.

Category: (Aligned with ASSM domains)

- ☐ Housing
- ☐ Employment
- ☐ Income
- ☐ Food
- ☐ Child Care
- ☐ Children's Education
- ☐ Adult Education
- ☐ Health Care Coverage
- ☐ Life Skills
- ☐ Family/Social Relations
- ☐ Mobility
- ☐ Community Involvement
- ☐ Parenting Skills
- ☐ Legal
- ☐ Mental Health
- ☐ Substance Abuse
- ☐ Safety
- ☐ Disabilities
- ☐ Other: _____

Is this referral to meet an identified family goal?

- ☐ Yes
- ☐ No

If yes, which goal?

Goal Number: _____

Referral type:

- ☐ 2-1-1 Referral
- ☐ Nutrition Pathway Referral (FEAST)
  - Date Started: _____
- ☐ Parenting Pathway Referral: _____
  - Date Started: _____
- ☐ Health Pathway Referral: _____
  - Date Started: _____

☐ Other: _____

If 2-1-1 referral, list the referral information:

_____

_____

_____

Note: *If a referral is made utilizing 2-1-1, participants will get a follow-up call from a 2-1-1 Care Advocate in one week to determine if the participant was successful in accessing the service. If they were not due to a barrier (i.e. full waitlist), the 2-1-1 Care Advocate will make additional referrals and log into ETO.*

If referral to another source, list the referral information:

_____

_____

_____

Referral made at:

- ☐ Baseline Feedback Session
- ☐ 6-month Feedback Session
- ☐ 12-month Feedback Session
- ☐ 18-month Feedback Session
- ☐ Other contact point: _____ Date: _____

Follow-up Date: _____

Appendix T: Partner Agency Quarterly Progress Report

Social Innovation Fund
Subgrantee Progress Report

Report through September 30, 2020; due October 15, 2020 via upload to SharePoint.

Organization:

Person completing this report:

Instructions: Fill out each of the following sections. There is no required minimum or limit to the length of responses. Each response should adequately address each component of the question. If there is a question that is not yet applicable, you may notate this in your response. If you have any questions, please contact Melanie Gill at Melanie.Gill@liveunitedsem.org.

I. Overview:
Brief narrative description of the progress you made towards major program implementation goals during this reporting period.

Social Innovation Fund
Subgrantee Progress Report

Report through September 30, 2020; due October 15, 2020 via upload to SharePoint.

II. Challenges and Successes:

- What SIF-related challenges has your organization encountered during this reporting period, and how have you dealt with them?
- Highlight noteworthy successes your organization achieved.

III. Performance and Progress:

Describe your organization's performance on established requirements or goals of the SIF program.

Social Innovation Fund
Subgrantee Progress Report

Report through September 30, 2020; due October 15, 2020 via upload to SharePoint.

IV. Training and Technical Assistance:

Please describe any training or technical assistance your agency received as a part of SIF during this reporting period. Describe any future training or technical assistance opportunities from which your agency would benefit.

V. Match Leveraged:

Please describe any progress towards securing any new match sources or strategic funding partnerships during this reporting period. Describe any major changes or shifts in your organization's match plan for year three.

Social Innovation Fund
Subgrantee Progress Report

Report through September 30, 2020; due October 15, 2020 via upload to SharePoint.

VI. Sustainability:

Please describe any specific developments or steps your organization has taken to strengthen its longer-term financial stability to support the work under SIF beyond grant funding.

VII. Communication:

Please describe any instances of press coverage of any key activities and accomplishments during this reporting period. Please discuss any plans and updates for communicating key activities and accomplishments during year three.

Social Innovation Fund
Subgrantee Progress Report

Report through September 30, 2020; due October 15, 2020 via upload to SharePoint.

VIII. Share Your Great Stories:

Highlight one or two successful activities during this reporting period that reflect the impact the program has in the community or on individual beneficiaries. This can include interesting or inspiring stories and anecdotes from programming that you feel reflect the value of your program and capture the spirit of how your award is making a difference.

IX. Other Updates:

Please describe any other SIF-related updates not previously covered in this report.

X. COVID-19 Surveys

Please indicate how many of each COVID survey your agency completed in total. This number should include any surveys completed prior to the beginning of the quarter if applicable.

Assessment Title	Number Completed
Coronavirus Impact Scale	
COVID-19 Symptoms and Social Distancing Survey	

Appendix U: Service Participation Report

Agency Logo

Date Completed: _____
Participant Name: _____
Case Number: _____
Follow-Up:
- ☐ 6-month Follow-Up
- ☐ 12-month Follow-Up
- ☐ 18-month Follow-Up

Service Participation Report Survey (Follow-Up)

1. United Way for Southeastern Michigan operates a 24/7 call-center called 2-1-1 where people can get information about services that may be helpful to them. Since you last completed these assessments (six months ago), have you called 2-1-1 to find out about services that may be helpful for you?
   - ☐ Yes
   - ☐ No

2. Was 2-1-1 able to provide you with referrals that you qualified for?
   - ☐ Yes
   - ☐ No

3. If yes, were you able to receive services from the agencies 2-1-1 referred you to?
   - ☐ Yes
   - ☐ No
   - ☐ Did not contact

If no, what was the main reason you were not able to receive the services?

☐ Pending appointment	☐ No response from agency/Phone not in service
☐ Agency determination pending	☐ Program full/Waitlist
☐ Left message waiting call back	☐ Inaccessible (no transp./online app/days or times)
☐ No or not enough income	☐ Can't afford service/Co-payment
☐ Over income	☐ Caller states it's a work in progress
☐ Outside of target pop/Service area	☐ Services no longer needed
☐ No documentation (ID, eviction, shut-off)	☐ Not available in the time frame needed
☐ Previously assisted/funding cap reached	☐ Specific resource was not available
☐ Exceeds the funds available	☐ Don't know
☐ No funding available	☐ Other:_____

If you did not contact, is there any particular reason why you have not contact the agencies?

☐ Haven't had the time	☐ No longer needed the services
☐ Didn't receive the email/text	☐ Inaccessible to me (due to transportation, internet access or other barrier)
☐ Lost the information	☐ Was not the resource I needed (resource was given for diversion)
☐ Other: ______________	

4. How satisfied were you with the assistance you received from 2-1-1?
   - ☐ Very Satisfied
   - ☐ Satisfied
   - ☐ Dissatisfied
   - ☐ Very dissatisfied
   - ☐ N/A – Did not contact 2-1-1

5. Please indicate whether you have participated in each of the following programs at (INSERT AGENCY NAME) since you last completed these assessments. If you have participated, please also tell us when you started the program and whether you have completed the program.

	Have you participated in this program?	If you participated, did you complete the program?
(INSERT PROGRAM NAME)	☐ Yes ☐ No When did you begin program? ______________	☐ Yes, I completed the program ☐ I am still enrolled in the program ☐ No, I did not complete the program
(INSERT PROGRAM NAME)	☐ Yes ☐ No When did you begin program? ______________	☐ Yes, I completed the program ☐ I am still enrolled in the program ☐ No, I did not complete the program
(INSERT PROGRAM NAME)	☐ Yes ☐ No When did you begin program? ______________	☐ Yes, I completed the program ☐ I am still enrolled in the program ☐ No, I did not complete the program
(INSERT PROGRAM NAME)	☐ Yes ☐ No When did you begin program? ______________	☐ Yes, I completed the program ☐ I am still enrolled in the program ☐ No, I did not complete the program

6. How satisfied were you with the assistance you received from the agency?
   - ☐ Very Satisfied
   - ☐ Satisfied
   - ☐ Dissatisfied
   - ☐ Very dissatisfied

7. Since you last completed these assessments, have you received services from an agency in your community to help you with things like housing, financial/employment assistance, food, child care or other family needs?
   - ☐ Yes
   - ☐ No

8. Do you have any immediate needs for you or your family that are currently not being addressed?
   - ☐ Yes
   - ☐ No

   If yes, please tell us what your immediate needs are. (Select all that apply)

☐ Housing	☐ Dental/Eye care
☐ Food	☐ Counseling (Psych/Sub. Abuse)
☐ Income/employment	☐ Home repair/Weatherization
☐ Child care	☐ Rent/Mortgage/Moving
☐ Child development	☐ Gas/Electric bill
☐ Health	☐ Water bill
☐ Education (children)	☐ Property taxes
☐ Baby	☐ Tax prep
☐ Clothing	☐ Legal aid
☐ Education (adult)	☐ Furniture/Appliances
☐ Transportation	☐ Holiday
☐ Other: _____	

9. If your family has needs in the future, how likely are you to call 2-1-1 or call the agency for assistance?
   - ☐ Very Likely
   - ☐ Likely
   - ☐ Somewhat Likely
   - ☐ Not Very Likely

Appendix V: End of Study Survey with Results

SIF 2016 End of Study Survey – Responses
(updated 8/26/2020 with surveys completed through 8/5/2020)

1. What is your agency?

What is your agency?	Manager (N=7)	FCMS (N=13)	DCS (N=5)
ACCESS	2 (29%)	3 (23%)	1 (20%)
CARE	1 (14%)	4 (31%)	1 (20%)
LBFS	1 (14%)	2 (15%)	1 (20%)
NKFM	2 (29%)	1 (8%)	1 (20%)
OFS	1 (14%)	3 (23%)	1 (20%)

2. What is your current role on the SIF 2016 project? (check all that apply)

What is your current role on the SIF 2016 project? (check all that apply)	Manager (N=7)	FCMS (N=13)	DCS (N=5)
FCMS	0 (0%)	11 (85%)	1 (20%)
DCS	0 (0%)	2 (15%)	5 (100%)
Manager	4 (57%)	1 (8%)	0 (0%)
Other	3 (43%)	1 (8%)	0 (0%)

Notes: Other (Manager): Previous Manager (1), FCMS Manager (1), Director overseeing Manager (1); Other (FCMS): No longer on the project (1)

3. What previous roles have you had in the SIF 2016 project? (check all that apply)

What previous roles have you had in the SIF 2016 project? (check all that apply)	Manager (N=7)	FCMS (N=13)	DCS (N=5)
No previous SIF 2016 role	2 (29%)	8 (62%)	4 (80%)
FCMS	1 (14%)	5 (38%)	0 (0%)
DCS	0 (0%)	0 (0%)	0 (0%)
Manager	0 (0%)	0 (0%)	0 (0%)
Other	0 (0%)	1 (8%)	0 (0%)

Notes Other (FCMS): ESL instructor/work with female adults and Childcare monitor (1)

Family Checkup Model (FCMS and Managers)

4. How good of a fit do you think the Family Checkup Model was for the families your agency served?

How good of a fit do you think the Family Checkup Model was for the families your agency served?	Manager (N=7)	FCMS (N=13)
Very good fit	1 (14%)	5 (38%)
Good fit	5 (72%)	7 (54%)
Not a good fit	1 (14%)	1 (8%)
Not a fit at all	0 (0%)	0 (0%)

4a.Please explain your answer:

Manager

- Families seemed to respond positively to having a supportive person in their life helping guide them to achieve their goals.
- Most families really seemed to enjoy the working with their FCMS and the goal setting process. We saw some families make really significant progress on the goals that they set & the overall well-being of their family. We had a few families really struggle with the concept of goal setting and it was difficult to motivate them to take steps towards goals or improving their family's well-being.
- The families at our agency are often afflicted with a number of needs.
- The overall goal and purpose of the FCU fit very well with our families. There were certain aspects of the evaluation and study that needed to be tailored for our target community, but we were able to make those changes as needed. A lot of what the FCU provided was information and support that families didn't know they needed until they started in the program.
- While most intervention families needed extra help to create their own goals (because that is farther outside their cultural context than for English-speaking Americans), overall they had a positive experience in the program.
- The Family Checkup Model was a great addition to our services offered. Some other aspects of the GOALS program were not as beneficial (poor database for data entry, research evaluation that was not consistent across agencies.)
- We don't provide in house services, or work directly with families. most of our recruitment was through other partners that do have those types of services.

FCMS

- I feel that many of my clients appreciated the client-centered, strengths based approach that the FCMS provides. I also feel that most of my clients appreciated the one-on-one support when in need of resources.
- I think it was a great fit because of the clientele that our agency works with. A lot of the families that ended up joining this program were referred to us by other programs in the agency.
- I've been able to link and refer families to resources and services that have been helpful to them
- Many of the families we work with were looking for slightly more intense services.
- Many participants appeared to find value in the model and appreciated the strength based and reflective approach. Some participants preferred for a quicker, more direct feedback. Our team believes the most beneficial approach for the families we have served in an on-going model would be to provide a feedback even more tailored to the participants than what the model is. We could do this by providing the Family Check-Up Model to those fully interested in the full conversation, but to others who like a direct approach, the case manager could use their discretion to provide a DCS model of feedback, while perhaps adding a few reflective questions.
- My response to this question varies drastically depending on the client. Many clients began the project scoring highly, these clients seemed to enjoy learning about their children's development but would have been a-okay without the intervention. Other clients who scored in the "needs attention" range at the beginning of the project seemed to be helped more by having a listening ear than anything. More times than not, they had needs much greater than our resources. Needs like childcare and housing that are near impossible to solve. However, having someone to listen and support seemed to be a great emotional help.
- Our agency works with many low-income families that need additional community support so I thought that it was a good fit for those purposes.

- Some of the families seemed to be doing very well without assistance and didn't really need resources, but most of them benefited
- The idea of focusing on a families strengths and looking at areas that may need improvement still in a more positive light really benefits families.
- With my previous experience of working and teaching adults ESL and childcare areas. These factors were a good opportunity to start as A FCMS, allows me to work with participants confidently, and truly respect their background and culture, working hard to make families fitting well and living safely in this community.

Training of FCMS (FCMS)

5. How prepared did you feel to implement the Family Checkup Model after taking the training provided by UWSEM?
☐ Very prepared **6 (46%)**
☐ Prepared **5 (39%)**
☐ Not very prepared **2 (15%)**
☐ Not prepared at all **0 (0)%)**

5a.What additional training would have been useful?

- After taking the training and watching the clips provided, I felt very comfortable implementing the Family checkup model. Coming into the program later than it had started, I also had coworkers that had been implementing this program for awhile and that also was a huge help with starting to implement it on my own.
- All training provided me with what I needed in order to allow the hands on experience to further my understanding of the model.
- Although both trainings were great, I felt that there was a lack of consistency in the training I received for this role. The training I received from Chris at UW was different from the training I received from my supervisor at my agency. It overall left me confused.
- How to find different resources and communicate with referrals appropriate for families' various needs
- I was a part of the original, very intensive training. From those trainings, yes it was very helpful. Myself and the CARE SIF team has always felt that a training on how to complete DHHS forms would have been incredibly helpful. Also, the training Delonda mentioned that allows case managers to navigate DHHS benefit pages (for free) would have been an incredible asset to the program and I believe would have assisted significantly in our enrollment numbers. https://www.michigan.gov/mdhhs/0,5885,7-339-71551_82637_82640---,00.html
- I was really just filling in until a new case manager was hired, so there was a LONG period of time between my training from UWSEM and my actual implementation of the program.
- I wished we had a thorough training on the temperament questionnaire at the beginning of the GOALS implementation to know what the indicators behind each question are. In the beginning, I had to research and study each question and what lies behind each question then later during the implementation we obtained some information in the learning community.
- I would have loved more motivational interviewing training. Additionally, because I do not yet have a clinical background, any training in that aspect would have been much appreciated. I pride myself in my ability to be empathetic and kind. These traits definitely helped in situations where conversations with my clients became very similar to those a psychologist may have with a patient, however, often times I wish I had more training/than these traits to fall back on.

- It's something that definitely takes practice and experience to feel proficient, but I think the trainings helped prepare us as much as they could; really the Learning Communities helped contribute to my preparedness immensely.
- all training that I attended in the past was so excellent to upgrade my knowledge, feed up my learning skills, moved up my work in the right pathway. What it could help me as FCMS due to COVID10 have more resource of Basic Need, not only apply for food stamp but also have easy contact with social service, I would like to train more of childcare development programs (mental health, and speaking difficulties)

FCMS Certification (FCMS)

6. Did you complete FCMS Certification? 6a. Please explain your answer. If yes, why? *or* If no, why not?

☐ Yes **8 (62%)**, why?

- Because I thought it was a requirement of the project, and also it seemed like a good idea.
- I felt becoming certified could only benefit me.
- I thought it was important to become certified as a reminder to myself and others that I am competent enough to carry out the FCU Model
- It was requested of us in the program.
- Its a part of my job to be a FCMS specialist, it allows me to do my work efficiently because it gives me the resources and knowledge to do so.
- One of the great outcomes of this study that I personally benefited although I wished that we had the motivational interviewing skill training early in the study. My credentials background is education. I did not come from the social work or psychology background which motivational interviewing skills is the foundation of their work. But I am an educator. I am always searching, learning, and educating myself to provide high quality performance.
- To make it right
- it is part of my job requirement

☐ No **5 (38%)**, why not?

- I was busy with workload at first and then it was nearing the end of the study
- I was going to complete the certification process, but the Coronavirus got in the way of me being able to finally do the video certification process.
- I went through all of the training but at that time the priority was to get the assigned FCMS case managers certified before additional staff.
- To complete the certification, you must record your feedback session with two families. I completed this recording with one and got feedback from Chris; however, I was unable to record a second session due to COVID-19.
- Was going to, however, Covid and no in person visits has prevented this

6b. Please explain any challenges that made obtaining certification difficult.

- Families are less than willing to have interactions video taped in their home. It takes sometimes more than three visits to gain trust of the family.
- I almost wish clients were randomly selected to be part of the certification (with our right to veto if a client was in severe crisis). I admire that we were trusted to pick a family ourselves, but I struggled to decide which family to choose. Some families were doing great, so I felt recording feedbacks with them would not show all my skills. Some families had children too young or too old for some assessments (i.e. PICCOLO, IBQ and ASQs) so they could not be selected. Some families were in crisis mode and I would not have felt comfortable choosing them. My overthinking/indecisiveness along with being very, very busy at the time of certification made it difficult to "keep the ball rolling".
- It takes too long

- It was not a challenge as mush as seeking more information on how to use the motivational interviewing skills with the community we work with. Trying to make participants be in charge and see what best for them coming from themselves, changing some core beliefs embedded in them without lecturing.
- N/A
- None that I can think of.
- The only challenges I faced were the feedback session steps because it took me some time to understand how to do them properly.
- The only challenges I felt, were the personal ones I put on myself. I never feel I can prepare enough.
- The pandemic caused this program to change to virtual and because of this I was not able to do the home visits in person and do the video certification process.
- There were minor challenges for me determining my certification families and some technical difficulties with the ASU website; but they were resolved.
- Video technology.
- distractions during recording, I had to attempt my second certification video twice due to distractions out of my control.
- n/a

Project support (FCMS, DCS, Managers)

7. How much technical support did your agency receive for using ETO?

How much technical support did your agency receive for using ETO?	Manager (N=7)	FCMS (N=13)	DCS (N=5)
More than enough support	2 (29%)	4 (31%)	1 (20%)
Just the right amount of support	3 (42%)	8 (61%)	4 (80%)
Not enough support	2 (29%)	1 (8%)	0 (0%)

7a. Please explain your answer and provide any comments about any additional support that would have been helpful.

Manager

- ETO consistently had issues throughout the course of SIF. The support staff for ETO was spread across multiple programs and not always available to assist in a timely manner.
- ETO was very hard to work with at the beginning of the project, but once it was up and running any questions/issues were handled in a timely manner. However, if given the choice, I would not use ETO as a platform in the future due to the number of issues over the years.
- I can only speak for the past year or so (2019-mid 2020), but to me, the support has been great. I know some issues remain that the caseworkers have grappled with more than I have, so I'll leave that to them.
- I think support for ETO came in waves. When information was needed at a higher level, then the focus was brought back to ETO and its shortcomings. At the end of the project there were still a lot of redundancies in the system and the flow in entering information was never streamlined. There were a lot of changes in the beginning as ETO was being built out that lead to inconsistencies in data entry between staff. I feel that the ETO team at United Way was trying their best to work out all the kinks, but there were a lot of kinks. I do not believe that we didn't get enough support because if we had questions about ETO, they were usually answered in a timely fashion. I do believe that ETO and data entry should have been better planned out prior to us starting the project in full. I still believe that some of the scores in ETO may be incorrect based on the automatic scoring. While this did get better as the project went on, it is almost impossible to account for everything.

- Our data entry staff had a fairly easy time with ETO, so we did not need much support. I think the fact that we had limited staff entering data into ETO played a role in not requiring much support. When we did have questions or run into problems, support was readily available.
- Professional development provided was just the right amount. Technical support in the traditional sense as help desk support was not enough. It was often completed later than expected. Additional help desk support with administrator capabilities would have been helpful on this project.
- Its actually a mixed answer, the 1st half of the study I feel we didn't get the support and direction we needed. after staffing changes I feel this improved greatly and was happy with the TA we received.

FCMS

- All assistance needed with ETO was provided.
- I was involved for such a short time that I am not really sure.
- I'm not a personal fan of the ETO software but I do feel that we received quick responses from UW when we had technical difficulties with it.
- It was difficult to get the amount of support we all needed for a system that has so very many issues and is so not user-friendly.
- Maya has been very helpful with troubleshooting difficulties and updates with ETO.
- Maya was extremely helpful with ETO updates and technical support. I know ETO had many issues during the duration of this program and Maya helped try and mend some of those issues. Unfortunately I think there were too many issues with ETO for Maya to always be able to fix, but she helped endlessly with updates.
- This question is also difficult to answer. Honestly, I do not feel that ETO was set up to handle the information we put in it. ETO was constantly having issues- scoring incorrectly, missing questions, adding questions and even taking data entered for one client and randomly placing it in another client's touchpoint. These inconsistencies along with ETO being far from user friendly concern me in terms of the validity of our project. However, Maya has always been receptive and helpful with our ETO issues. Maya is hardworking, a genius when it comes to ETO and very easy to talk with. She is the best we could have hoped for and yet still not enough to handle all the issues ETO has to offer (which has me convinced that no one is).
- We got more than enough support for using ETO. Data was saved in easy and accessible steps, it backed up information, and updated data entry. We were able to contact technical support, record E-Ticket, email team leaders for problem-solving, or delete incorrect data
- We have always had support for ETO available to us. The issue was that there have been on-going changes and issues with ETO throughout the course of the study, which has taken a lot of time to adjust. There have been several times when a ticket and/or email for tech support was requested and not answered until asked several times. This was more prevalent during the transition of UW staff and early in the study, however it has occurred in more recent months as well. While it is known that we can ask for support, and it is provided, there are delays which can impact our work as we move on with our other participants, having the simular ETO issues.

DCS

- When there was a problem during our usage of ETO and additional technical problems we were able to get it figured out.
- Our issues were always acknowledged and support and assistance was always provided.

(FCMS, Managers)

8. How much clinical support did your agency receive for implementing the Family Checkup Model and working with clients?

How much clinical support did your agency receive for implementing the Family Checkup Model and working with clients?	Manager (N=7)	FCMS (N=13)
More than enough support	2 (29%)	3 (23%)
Just the right amount of support	4 (57%)	8 (62%)
Not enough support	1 (14%)	2 (15%)

8a. Please explain your answer and provide any comments about any additional support that would have been helpful.

Manager

- Both FCMS's felt very supported by Chris. Whenever we had questions, he was quick to respond and very helpful. I had a difficult time with uploading the staff's videos during the certification process, and Chris & the tech support at ASU were very supportive in resolving the problem.
- Chris was a good support to staff.
- More than enough in person and virtual training was provided for this project. Additionally, clinical support was available whenever needed - whether by phone, email or in person.
- The Learning Communities were helpful. Being able to discuss a case was helpful for a lot of our staff, but because we worked with a very specific community, some of the cases didn't relate as well to who we may have been working with at the time. That doesn't mean that the information and working with the rest of the network wasn't helpful and beneficial. I remember us having to do some of our own detective work to come up with resources and materials that fit our clients specific needs. While I feel that the FCMS did get enough support, I do not feel as though the DCS were supported as well as they should've been. I know there was a lot of discussion around how the DCS should interact with clients and what resources they should be providing families. I believe that the DCS should've been more involved in our learning communities from the very beginning as they were still supposed to give appropriate resources and referrals, just without the follow-up using the FCM model. Many times our DCS would end up connecting with our FCMS on a needed resource.
- Trainings on the clinical side of things came very late in the game. Attending for example the motivational interviewing training only in the third year of the project seems really late. In order to make it a robust part of the routine interactions with the clients, trainings such as these should've been implemented before the start of the project or at least before starting to work with clients.
- Chris was great

FCMS

- Additional clinical support is always something I would never say would hurt a program. I think between other agencies and our learning communities, we had a lot of support during this program.
- All assistance needed was provided
- I was involved for such a short time that I am not really sure.
- I would implement the family checkup model by following the steps it showed, during interviews, I would use it, and then I would enter the data in ETO. By doing so it would give me a graph that shows me which areas I needed to focus the most on.
- My supervisor has been very helpful in working with me during preparation of case conceptualizations and finding resources for clients, and giving me tips for doing feedbacks with intervention participants.
- Our SIF meetings once a month are very beneficial and Chris has been more than open to answer questions (and continue to check for our understanding) of the model. I feel that we

were appropriately prepared and taught about any changes prior to them occurring. Kim has been great at helping trickle this information to us as well.

- Our agency's main focus is substance abuse prevention services. Our Early Learning Communities (ELC) department makes up less than 5% of our entire staff. Although there was plenty of support WITHIN the department, I feel that there was very minimal support from the agency in general.
- Sometimes I was made to feel that nothing I ever did for my families was the correct thing. That I should have done better. In my heart I know I worked hard for all of my families.
- Though our team had the benefit of getting support through monthly learning communities and our own agency's monthly Reflective Supervision meetings; I felt that my team and I could've used one-on-one clinical support with our more difficult clients. I found that my colleagues and I often ended up turning to each other for support, which was fine enough, but having a trained clinical professional available would have been very helpful. For future programs like this, it would be helpful to have a larger focus on discussing, training, and supporting the clinical nature of our work to prepare home visitors.
- We had many learning opportunities during the learning community meetings and outside of them that supported our work such as the mental health first aid, motivational interviewing skills, ASQ-training and attending many infants toddlers conferences.

9. How much evaluation support did your agency receive?

How much evaluation support did your agency receive?	Manager (N=7)	FCMS (N=13)
More than enough support	0 (0%)	3 (23%)
Just the right amount of support	7 (100%)	9 (69%)
Not enough support	0 (0%)	1 (8%)

9a. Please explain your answer and provide any comments about any additional support that would have been helpful.

Manager

- Evaluation support available quarterly and when needed by email was just enough. The team appreciated being included in discussions with evaluators.
- I didn't quite understand the need for the reports with agency data removed, but maybe that was helpful more in the beginning or middle of the study, before I came on board?
- I'm not exactly sure as to what "evaluation support" entails, but I do believe that support was provided if it was really needed. More support was needed at the beginning of the project than at the end. If we had questions about a specific survey, the question sometimes was put off until we could meet together as a network to discuss it. That wasn't always helpful right away. Towards the end of the project we still weren't clear on if certain touchpoints in ETO were needed to be completed by FCMS, DCS, or both.
- The Phillliber team was available as needed to answer questions.
- The evaluation team has always been quick to respond to questions and concerns. During our periodic calls or meetings the staff has always felt heard & understood by everyone. The reports that we get are very helpful for monitoring. When we experienced the situation where we needed to use the Certificate of Confidentiality, the evaluation team & UWSEM staff were incredibly supportive and provided us with the answers we needed within a short amount of time.
- We did not have many issues, and most circled around miss communication

FCMS

- All assistance needed was provided.

- During this period we would have evaluators from Phillibers come and evaluate our work and give us the result and number of our work and see where our weaknesses and strengths are.
- I think a manager would be able to better answer this question, but I do know that we would receive updates on how we were doing and where we needed to work within this program.
- I was involved for such a short time that I am not really sure.
- It's been a while, but I don't remember having inadequate support in learning how to evaluate.
- See response to 8a. (Our agency's main focus is substance abuse prevention services. Our Early Learning Communities (ELC) department makes up less than 5% of our entire staff. Although there was plenty of support WITHIN the department, I feel that there was very minimal support from the agency in general.)
- no comment.

ETO (FCMS, DCS (add N/A to Q 10 for DCS only), and Managers)

10. Rate how useful ETO was for:

Rate how useful ETO was for preparing feedback	**Manager (N=7)**	**FCMS (N=13)**	**DCS (N=5)**
Very useful	0 (0%)	2 (15%)	0 (0%)
Somewhat useful	3 (43%)	2 (15%)	2 (40%)
Not very useful	3 (43%)	4 (31%)	0 (0%)
Not at all useful	1 (14%)	5 (39%)	3 (60%)
Rate how useful ETO was for monitoring progress of families	**Manager (N=7)**	**FCMS (N=13)**	**DCS (N=5)**
Very useful	0 (0%)	2 (15%)	0 (0%)
Somewhat useful	4 (57%)	4 (31%)	3 (60%)
Not very useful	3 (43%)	3 (23%)	1 (20%)
Not at all useful	0 (0%)	4 (31%)	1 (20%)
Rate how useful ETO was for looking at agency level data	**Manager (N=7)**	**FCMS (N=13)**	**DCS (N=5)**
Very useful	0 (0%)	2 (15%)	1 (20%)
Somewhat useful	2 (29%)	4 (31%)	2 (40%)
Not very useful	4 (57%)	3 (23%)	1 (20%)
Not at all useful	1 (14%)	4 (31%)	1 (20%)
Rate how useful ETO was for tracking follow-up dates	**Manager (N=7)**	**FCMS (N=13)**	**DCS (N=5)**
Very useful	0 (0%)	3 (23%)	1 (20%)
Somewhat useful	2 (29%)	2 (15%)	2 (40%)
Not very useful	5 (71%)	3 (23%)	1 (20%)
Not at all useful	0 (0%)	5 (39%)	1 (20%)

10e. What were your agency's biggest challenges with ETO?

Manager

- As a manager, I didn't prepare feedback, monitor progress of families, or track follow-up dates so those answers (above) are based on what I heard from our team. In the beginning, the scores were oftentimes incorrect on the feedback form, so handscoring was essential and therefore ETO was basically useless. This was probably our biggest challenge as it

added time spent on each case. I personally never looked at agency level-data from ETO because of the way it ended-up being formatted in Excel and half the time it never downloaded correctly anyways. I had created my own spread sheet before the information was available on ETO, so I just kept using my own personal spreadsheet to type in notes, collect dates and check incentive information.

- ETO entries would disappear or show up connected with other families. Various mixing up of results and family members. Incorrect results based on answers (caseworkers will I'm sure speak more to this). We didn't really use it for any data analysis or tracking; we kept a separate excel internally that was much more user-friendly.
- ETO had many issues over the years, but not being able to see data that had been entered or easily run reports would be two of the bigger issues.
- Our biggest challenge was with utilizing the feedback forms in ETO. We continuously had difficulties with be able to run them, and when we could they were frequently wrong. Our FCMS's switched to hand scoring very early on in the project, which took a great deal of time away from their work with families.
- Reports did not adequately produce the intended data.
- Reports not populating meaningful data.
- Inaccurate data.

FCMS

- Always found that hand scoring was most beneficial due to ETO having issues with scoring correctly in the beginning.
- As a DCS, I've often run into the issue of ETO running blank feedback forms for comparison participants.
- Everything
- I know there were issues with information not saving in ETO, there were assessment counting issues, feedback preparation form issues, and issues with needing to skip assessments but not being able to.
- I rated not at all useful because I did not count on ETO. I used ETO only to enter assessments. the ETO was not able to generate a feedback form for FCMS. I used an excel sheet that I created in the beginning of the study that helped me tracking my families timelines.
- It was not user friendly at all. It was not useful for preparing feedbacks, monitoring progress, nor looking at data because I never found the scoring to be accurate. All prep and progress monitoring has had to be by hand to ensure accuracy, which makes ETO essentially useless. And it was never useful for tracking follow-up dates because you have to sign on and search where those were listed anyway- my calendar was much more useful for that. The way that many of the touch-points were built in, there was a big lack of ease-of-entry which encourages human error; repeated incorrect numbering, missing options, repeated questions. Also, the lack of ability to edit touch-points myself has been a major hassle in correcting errors correctly. The frequent glitching has of course, added to the challenges we've been facing; error messages, swapping client data, and showing our data entry pages so differently than those built so our ETO support is unable to help us without screenshots provided to them so they know what we're talking about. And these are just the few I can think of now.
- It wasn't accurate. Everything had to be hand scored too, so I thought it was useless.
- Our agency's biggest challenge with ETO was the issue of deleting mistakes. It would take time to delete as you have to go to supervisors or team leaders for it to be deleted.
- Preparing Feedback: For DCS there were several issues with generating the feedback which was crucial for preparation and delivery of the information. Maya has helped us with this, but it has occurred often. For FCMS, we did not use the ETO feedback form because the answers did not appear accurate compared to the hand scored version.

- The time-outs while entering data, the fact that we couldn't enter assessments directly into the software (we had to write in on a hard copy and then transfer it at another time), the fact that it only operates on Internet Explorer (which is slow on most newer computers)
- We never used it to prepare for feedbacks because it either did not work or was incorrect. We never trusted the scoring in ETO and did it on our own. I think I can remember three or four times ETO scored correctly on one of my client's assessments. ETO had glitches like taking the emergency contact on one client's participant intake and putting it on other client's participant intakes after they had previously been entered correctly (that terrifies me- not only could a lot of our data be incorrect after it was entered correctly, but also in terms of client confidentiality). ETO was not user friendly- often very slow and unable to handle our big assessments in one touchpoint. For example, there is a lot of extra room for error for the ASQ-3s because we have to enter the date, month of ASQ and interval for each section instead of just once. Also, having to enter the date multiple times for each touchpoint has left more room for error.

DCS

- How it often changes. The forms sometimes can be complicated with information that is not needed.
- Preparing feedbacks
- The data has been switching- the program is creating internal validity issues.
- The efficiency of the site as far as entering in data and making changes, there were multiple steps and access points to do one task.
- We didn’t really have any.

11. How often did you use the reports in ETO to better understand the families being served by your agency?

How often did you use the reports in ETO to better understand the families being served by your agency?	Manager (N=7)	FCMS (N=13)	DCS (N=5)
Very often	0 (0%)	2 (15%)	2 (40%)
Often	0 (0%)	0 (0%)	1 (20%)
Occasionally	4 (57%)	4 (31%)	1 (20%)
Never	3 (43%)	7 (54%)	1 (20%)

11a. Please explain your answer:

Manager

- I personally never used this information and liked to manually check each touch point in ETO because I would have to go in and check the touch points any way to ensure that the scores were correct and that the questions were all entered correctly. I relied heavily on my team to keep my up-to-date on our families and any trends we saw in family needs.
- I tried occasionally.
- I would talk to my caseworkers to better understand the families.
- We had difficulty with running reports and getting accurate data, so this is not something I chose to utilize.
- We only pulled reports when looking for a very specific piece or when requested

FCMS

- Don't recall how to use this function
- I appreciated the data being reviewed and sent to us by Phillibber for a condensed understanding of the needs. I relayed more on these reports more than ETO itself.
- I have personally not utilized these reports and obtain my data by hand scoring.
- I only used ETO reports for comparison participants in completing their feedbacks.
- I work with many clients and need to gain data and reports from ETO which shows me the family's progress, issues, and where to approach their goals. This means I use it a lot in order to fully understand where my clients are so I can help them the best I can.
- The reports almost never generated an accurate score so I never bothered to use it.
- The scoring isn't consistently accurate, so running reports seems like a waste of time.

DCS

- Due to being a DCS worker I was not able to access specifics of the families and interpret there results I was more so involved with the basics.
- I am not sure about the question- I never generated reports using any special functions. I just would go back and look at previous family profiles and assessments to see what changes had occurred between visits and to anticipate needs for upcoming visits.
- It was not an easy process to learn and navigate and understand the data inputted.

Assessments

(FCMS, DCS (take g. PICCOLO off Q12 for DCS only), and Managers)

12. Rate how useful each assessment was in understanding the needs of the families you served:

Rate how useful each assessment was in understanding the needs of the families you served: Family Profile Form	Manager (N=7)	FCMS (N=13)	DCS (N=5)
Very useful	3 (43%)	12 (92%)	4 (80%)
Somewhat useful	4 (57%)	1 (8%)	1 (20%)
Not very useful	0 (0%)	0 (0%)	0 (0%)
Not at all useful	0 (0%)	0 (0%)	0 (0%)
ASSM	**Manager (N=7)**	**FCMS (N=13)**	**DCS (N=5)**
Very useful	3 (43%)	7 (54%)	1 (20%)
Somewhat useful	4 (57%)	2 (15%)	2 (40%)
Not very useful	0 (0%)	3 (23%)	0 (0%)
Not at all useful	0 (0%)	1 (8%)	2 (40%)
Temperament	**Manager (N=7)**	**FCMS (N=13)**	**DCS (N=5)**
Very useful	0 (0%)	3 (23%)	2 (40%)
Somewhat useful	1 (14%)	3 (23%)	1 (20%)
Not very useful	5 (72%)	5 (39%)	2 (40%)
Not at all useful	1 (14%)	2 (15%)	0 (0%)
ASQ-3	**Manager (N=7)**	**FCMS (N=13)**	**DCS (N=5)**
Very useful	4 (57%)	12 (92%)	3 (60%)
Somewhat useful	3 (43%)	1 (8%)	2 (40%)
Not very useful	0 (0%)	0 (0%)	0 (0%)
Not at all useful	0 (0%)	0 (0%)	0 (0%)
ASQ: Social Emotional	**Manager (N=7)**	**FCMS (N=13)**	**DCS (N=5)**
Very useful	4 (57%)	11 (85%)	3 (60%)
Somewhat useful	2 (29%)	2 (15%)	2 (40%)
Not very useful	1 (14%)	0 (0%)	0 (0%)
Not at all useful	0 (0%)	0 (0%)	0 (0%)
Feeding Your Child	**Manager (N=7)**	**FCMS (N=13)**	**DCS (N=5)**
Very useful	1 (14%)	4 (31%)	2 (40%)
Somewhat useful	1 (14%)	3 (23%)	1 (20%)
Not very useful	5 (72%)	3 (23%)	2 (40%)
Not at all useful	0 (0%)	3 (23%)	0 (0%)
PICCOLO	**Manager (N=7)**	**FCMS (N=13)**	--
Very useful	1 (14%)	8 (61%)	--
Somewhat useful	6 (86%)	4 (31%)	--
Not very useful	0 (0%)	1 (8%)	--
Not at all useful	0 (0%)	0 (0%)	--

13. Are there areas of family functioning or child development that were not assessed that you think should have been assessed? (FCMS and Managers)

Are there areas of family functioning or child development that were not assessed that you think should have been assessed?	Manager (N=7)	FCMS (N=13)
No	6 (86%)	6 (46%)
Yes	1 (14%)	7 (54%)

13a. If yes, please elaborate:

Manager

- I believe that we captured a lot of good data using the surveys listed above. The FPF was redundant most of the time for follow-ups.

FCMS

- Although I think the ASQ's were a great resources, I do not think it went in depth enough to truly evaluate the child development in sections such as communication or personal social.
- If there were multiple children under age 5, it was almost as if their needs were ignored. Quite often the youngest child wasn't the one the parents were struggling with (in all areas, child development, social emotional skills, eating habits, physical or mental health concerns, etc).
- More in depth assessments on parent mental health and stress levels and its impact on child development.
- Safe Sleep and Car Seat Safety
- Self care of parents. I know many of the families I worked with were single-parent households. I think that adding a brief questionnaire about self care may be useful because it allows that conversation to naturally flow. Many single parents are just burned out because they don't do anything for themselves. I would also have liked to see a topic on credit history. One of the barriers I saw for some families was the inability to get better housing and/or transportation due to poor credit. Asking these questions may be able to allow the FCMS to explore some credit counseling with them.
- Some sort of past trauma history could've been helpful; but of course there can be major limitations in asking someone to discuss such topics with a stranger. Maybe in future programs, that could be done after a handful of visits, just to help the provider get a better idea of their clients' life experience.
- There are tons of aspects of family life that are not addressed in the family profile. Often times explanations from families about why they answered a certain way (outside factors in their lives) totally changed my scoring. However, the family profile covers a lot of bases and easily opens the conversation with clients to talk about some of these situations that are often very specific to them and their family.

14. How would you describe the length of the assessment process? (FCMS, DCS, and Managers)

How would you describe the length of the assessment process?	Manager (N=7)	FCMS (N=13)	DCS (N=5)
Too long	5 (71%)	8 (62%)	3 (60%)
About right	2 (29%)	5 (38%)	2 (40%)
Too short	0 (0%)	0 (0%)	0 (0%)

Implementation of the Family Checkup Model

15. How often did you use the motivational interviewing techniques that were taught in training? (FCMS)

☐ Very often **3 (23%)**
☐ Often **10 (77%)**
☐ Occasionally **0 (0%)**
☐ Never **0 (0%)**

15a. Please give an example of how you used them:

- Emphasis on families' strengths
- Everytime I would talk to parents about potential help needed with child development or tips on parenting skills.
- In helping clients explore setting their goals and during goals check-ins, in addition to using some MI during many other interactions.
- It was very hard in the beginning to elicit some change talk but with practice and understanding the characteristics of the community we work with gave us some insights how we want to use the MI. for example, some parents believe it's normal for a child to sleep at midnight, why not, the child does not go school. So, using MI helped them acknowledge how important to change and made feel they empowered, supported, understood, and respected.
- Many of the parents I worked with were resistant to change or didn't believe they were capable of changing. I used many of the MI techniques in these two scenarios specifically.
- Motivational interviewing occurred most frequently for me with clients when they made opposing statements about their want to achieve something. Motivational interviewing was also very beneficial to gage a client's motivation that I may not have otherwise gaged correctly (and I definitely think it helped to make their motivations or lack of more clear to themselves)
- The Motivational Interviewing training was extremely helpful for our team! We used them in every FCMS feedback and I use them in supervision with staff.
- Using Empathy and Reflective Listening through my visits.
- When parents have an area of need that they are not ready to change (i.e. such as getting help for a health-related issue, making repairs in the home, continuing education, etc.) I use reflective listening and open ended questions taught during the MI Training in order to engage parents and talk about needed areas of change, and then set goals with them.
- When talking to my clients in interviews in order for them to be more comfortable I would use motivational techniques. One I would use most is expressing empathy when listening to my clients, rather than imposing and joining the conversation, I would allow my clients to speak and I would listen. This encouraged them to speak more in the interview and thus, would allow me to work better towards them.

16. How often did families set goals during the feedback session? (FCMS)

☐ Very often **10 (77%)**
☐ Often **2 (15%)**
☐ Occasionally **1 (8%)**
☐ Never **0 (0%)**

17. How often did families make progress towards reaching those goals? (FCMS)

☐ Very often **0 (0%)**
☐ Often **9 (69%)**

☐ Occasionally **4 (31%)**
☐ Never **0 (0%)**

17a. What were the biggest barriers that families experienced in trying to reach their goals?

- Creating goals that are too broad and not specific enough to be able to complete in that period of time.
- Finances, income, lack of transportation and stress.
- I think many of them set too high of a goal that was just impossible to complete in such a short period of time. For instance, I had one parent that set a goal of getting her PhD and she didn't even have a high school diploma or GED....
- Lack of time, support, transportation, confidence, etc. Also, sometimes the goals that they had thought were attainable turned into something that felt intimidating and unrealistic; or they just lost steam or changed their mind.
- Not being motivated to do so. More often than not, clients who did not complete their goals did not seem very interested in setting them from the start.
- Some of the goals were too broad. It got better once we did the SMART goal training and changed the goals to be done in steps, counting progress in the goal as steps verses the entire goal itself. An example is: Enroll in a CNA program. The step would be to call, talk to an advisor, and apply. They were more likely to reach a step that the entire enrollment in 6 months when they have several other commitments. The biggest barrier is a lack of transportation, child care, and confidence. When participants met their goals, they were very proud of themselves. When unable, they felt like they needed to provide a reason for it, though not requested by the FCMS. I believe that the majority of the barrier is a lack of confidence in their own support network, that others are willing to help them, and that they can do what it takes to accomplish their goals. Perhaps having a bit more follow up from the FMCS would have been beneficial, however with the caseload, it was near impossible to provide that type of case management.
- The biggest barriers that families experienced in trying to reach their goals were time management on their goals, such as how long does it take to potty train, how long should one nurse a child.
- Transportation English language
- Transportation, financial difficulty, lack of support
- Transportation, motivation, education

18. How difficult was it to find referrals for families in the following categories? (FCMS)

How difficult was it to find referrals for families in the following categories?	Very difficult	Somewhat difficult	Not very difficult	Not at all difficult
a. Housing	6 (46%)	5 (39%)	2 (15%)	0 (0%)
b. Income	4 (31%)	7 (54%)	2 (15%)	0 (0%)
c. Food	0 (0%)	2 (15%)	4 (31%)	7 (54%)
d. Adult Education	0 (0%)	6 (46%)	2 (15%)	5 (39%)
e. Employment	0 (0%)	0 (77%)	2 (15%)	1 (8%)
f. Transportation	9 (69%)	2 (15%)	1 (8%)	1 (8%)
g. Healthcare	1 (8%)	3 (23%)	5 (38%)	4 (31%)
h. Safety	2 (15%)	4 (31%)	3 (23%)	4 (31%)
i. Life skills	2(15%)	2 (15%)	2 (15%)	7 (55%)
j. Childcare	4 (31%)	6 (46%)	1 (8%)	2 (15%)
k. Parenting skills	0 (0%)	2 (15%)	4 (31%)	7 (54%)

l. Children's education	0 (0%)	1 (8%)	6 (46%)	6 (46%)
m. Family/social relations	1 (8%)	5 (38%)	6 (46%)	1 (8%)
n. Community involvement	1 (8%)	2 (15%)	6 (46%)	4 (31%)
o. Mental health	0 (0%)	1 (8%)	8 (62%)	4 (30%)
p. Substance abuse	0 (0%)	1 (8%)	4 (30%)	8 (62%)
q. Disabilities	1 (8%)	2 (15%)	6 (46%)	4 (31%)
r. Legal	0 (0%)	4 (31%)	6 (46%)	3 (23%)

19. Were there any services that families needed for which you did not have a referral source? (FCMS)

☐ No **7(54%)**

☐ Yes **6 (46%)**

19a. If yes, please describe:

- Car insurance/car repair
- Childcare, health care, and transportation were the hardest sections to find referrals for.
- Free or discounted dental referral. Even if I find a referral for them the copay is very expensive for participants. Car seats, we encountered that even if there's a training about car seats and they will distribute a car seat for parents, our parents were not allowed to attend those meeting because of their English language. They were allowed to bring an interpreter with them although our organization offered to provide interpretation services so parents can get a car seat. Transportation: They don't have problem with obtaining the permit, we gave them the materials to study, they apply, and then they obtain the permit but then they face the challenge that cannot afford to pay the fee $35 per hour to practice driving in the road. They need at least 12 hours to practice so, some permits end up expired.
- There is some help out there for housing, transportation, income, employment, childcare, etc- BUT many of those resources are very limited or very difficult to navigate and therefore not useful to many of my clients.
- Transportation and immigration

20. What do you think families liked most about the program?(FCMS and Managers)

Manager

- I believe families liked the relationships aspect of the program the best. They trusted someone enough to divulge their family's information and their worries. The majority of our families reached out to their FCMS between the scheduled 6 month assessment time period to ask questions and get additional resources and referrals. Without that relationship, families wouldn't have felt comfortable doing so.
- I'm not the best person to answer this, but I would think they liked learning about the features of their family and child and then getting resources and referrals to address anything necessary. Everyone has a general understanding of their family and kids, I'm sure, but I doubt anyone delves this deep into it independently. Having that outside perspective and support to make changes I would think was nice.
- It seemed to be that families really enjoyed the relationships that they were able to develop with staff. We frequently had families calling staff to check in and even stopping in the office just to say hello. Families also seemed to take pride in showing the progress they made on their goals. Even the little accomplishments were shared between assessment sessions.
- The feedback we received from families was that they felt very supported by their specialists and appreciated the help in finding resources that met their needs.
- The incentive and having an engaged FCMS.
- The interaction with a service provider.
- Money, useful items, and useful and accessible resources

FCMS

- Being able to track their progress in terms of self-sufficiency and goals they have set from their initial feedback to their 6 month (and sometimes 12 month), as well as learning about helpful resources in their community that they otherwise not would have known about.

Additionally, I think setting goals for families that were in the intervention group gave them a sense of something to look forward to and increased their motivation to become more self-sufficient.
- Compensation for some. Others enjoyed the support provided by the worker
- Getting their gift cards, definitely. But many families also expressed appreciation for the one-on-one support provided by having a FCMS focused on your needs. Many parents expressed that they enjoyed just having someone to talk to for a bit, as well.
- Having a supportive, listening ear and a $50 gift card.
- Having someone come in and provide the family with tips, tricks, and resources to help the family in a variety of ways. Families also liked to see the child development changes from the baseline to the 6 months.
- I think families liked most about the program is that they became more aware of themselves and their position in their own lives, whether that be as parents, sisters, brother, or more. Allowing them to see their weaknesses, or where they need to pay more attention to themselves and everyone around them. They understandably became better and more educated versions of themselves thanks to this program.
- Of course, the gift card. But other than that, most of my families said that they enjoyed having me as their worker. They said that I "opened their eyes" to a lot of different things in regards to their child's development and their parenting skills. Most families found the resources and referrals I provided to them very helpful.
- Resources
- Resources
- Setting goals and seeing their progress
- The gift card.
- The reflective and strength based approach.
- The relationship we built in this project with them . The open communication. The referral to go to ask for help, to raise a concern, or share a success.

21. What do you think families liked least about the program?(FCMS and Managers)

Manager

- Hearing some results if they weren't so great, especially about their child. Sometimes parents tend to be in denial. Also another thing that was always tricky was the culturally sensitive questions like about addiction and mental illness. Those are taboo in the community, so asking and answering those was probably uncomfortable.
- I believe the families felt that a lot of the information was rather personal. This was the most difficult part about the 1st session - having parents understand the need for ALL of the information in order to help their child. It was also a long process. Assessment sessions happened over multiple periods some of the time.
- Length between check ins. FCMS not having much time to support family. During the recruitment and enrollment period the focus was on meeting numbers more than anything.
- The length of assessments.
- The length of the surveys.
- The most common complaint that we received about the program was the frequency of assessment sessions and duration of the program. The majority of our families wanted to see their FCMS in person more often. Almost all of our families were sad to have to stop working with their FCMS once they completed their final session.
- The time commitment, length of feedback

FCMS

- Depends on the family. Some families were doing well and were over talking about assessments (and completing them). Other families were merely participating for the $50 and did not like spending the time to honestly complete assessments. I would assume a lot of "not liking the program" came from the length of assessments and the inability for us to always provide a helpful resource for their needs.
- Having to answer questions about sensitive/personal topics
- I think some families would have benefitted from completing their feedback the same way participants in the comparison group receive feedback, while some parents liked the thoroughness of the FCMS model, I felt like there were families that disliked it and found it to be too time-consuming.
- If they reached out for a referral and there were not very many that we could provide or referrals that were just not helpful enough in that section. Also during the 6 months of not as much contact, I had families who would have rathered keep physical in person check in visits to keep them on track and keep it easier to not lose contact.
- Length/amount of assessments
- Nothing
- Takings with family
- The length of the questions for sure. Some families also didn't like the time frame between the visits. I've also had a few participants say that the questions are sort of annoying because they're repetitive.
- The time commitment, definitely. For many parents, it seemed that scheduling and completing visits was sometimes very burdensome to their already full schedule and it was also the most common reason provided for those clients who dropped out. Also, some families expressed being uneasy with the personal nature of some of the assessments.
- There were situations where they had to be uncomfortable in order to give us answers, such as problems with abuse, their income, and more. Although we did not press them for these answers they are in a situation where they are uncomfortable and awkward, that is what I think they did not like about this program
- They were promised services they would never receive. Each case manager was so busy trying to meet their deadlines and recruiting participants in order to meet their numbers that they were unable to provide any case management services. The initial assessment took way too long. We were basically harassing anyone who didn't answer their phone for 6 or 12 month check ups. People told us they no longer wanted to participate but we were told to still call them.
- Time Commitment
- When they have the referral but still they cannot benefit from it because other challenges arise such transportation or extra fee to pay.

Lessons learned about the FCU and its usefulness for families

22. What do you think were the three biggest needs of the families that your agency served through this project? (FCMS and Managers) (Check the top three)

What do you think were the three biggest needs of the families that your agency served through this project?	Manager (N=7)	FCMS (N=13)
Housing	3 (43%)	6 (46%)
Income	4 (57%)	7 (54%)

Food	3 (43%)	4 (31%)
Adult Education	1 (14%)	5 (38%)
Employment	1 (14%)	1 (8%)
Transportation	2 (29%)	6 (46%)
Healthcare	0 (0%)	0 (0%)
Safety	0 (0%)	0 (0%)
Life skills	0 (0%)	0 (0%)
Childcare	1 (14%)	6 (46%)
Parenting skills	4 (57%)	2 (15%)
Children's education	1 (14%)	1 (8%)
Family/social relations	1 (14%)	1 (8%)
Community involvement	0 (0%)	0 (0%)
Mental health	0 (0%)	0 (0%)
Substance abuse	0 (0%)	0 (0%)
Disabilities	0 (0%)	0 (0%)
Legal	0 (0%)	0 (0%)

23. What were the most beneficial things from the Manager/FCMS/DCS meetings? (FCMS, DCS, and Managers)

(check all that apply)

What were the most beneficial things from the Manager/FCMS/DCS meetings?	Manager (N=7)	FCMS (N=13)	DCS (N=5)
Clinical support and guidance	3 (43%)	9 (69%)	3 (60%)
Training	1 (14%)	8 (62%)	3 (60%)
Case Presentations	3 (43%)	10 (77%)	1 (20%)
Technical Assistance	2 (29%)	4 (31%)	2 (40%)
Hearing from other agencies	7 (100%)	8 (62%)	4 (80%)
Updates from UWSEM	5 (71%)	6 (46%)	4 (80%)
Other	0 (0%)	0 (0%)	1 (20%)

Note: Other - Always willing to listen and find better alternatives, easier solutions, find a plan.

23a. Please list specific trainings or other specific meeting activities that were especially helpful and explain why they were helpful.

Manager

- I think that the discussions in general during the Manager's Meetings were incredibly helpful. The staff & clients at each agency are so diverse, so being able to hear what was successful or not at different agencies was beneficial.
- Managers meetings were beneficial to check in with partnering agencies to ensure all agencies were delivering programming consistently, and if not, it would be highlighted at these meetings.
- Motivational Interviewing
- Motivational Interviewing training because of the direct impact it had on the caseworkers' ability to engage participants. It should've been done earlier in the study. Also the case presentations were really helpful for sharing ideas and resources. Talking through what different assessments and questions really are getting a was also helpful.
- Motivational interviewing training at U of M was very helpful.

- The case presentations were very helpful for the team as explained previously. I wish the DCS were also a part of this process.
- motivational interviewing

FCMS

- All case presentations I believe were helpful because it allowed for many different perspectives to come together to help someone in that case. It also almost always ended with resources given to one another that someone else might not have had before that presentation. Trainings on human trafficking, car seat safety, and many others allowed for me not only to learn more about the topic, but get specific resources given to me that I could keep and know of for future situations. All trauma trainings that were done were always helpful as well because of the clientele that we work with.
- All the training
- Being able to reflect on the challenges of the program and how others phrase certain topics was very helpful. For example, how to explain when someone is in RED because of their CPS involvement, but scored well in their other answers surrounding parenting. Topics of MI and SMART Goals were very beneficial.
- Case presentations- ideas for resources/referrals for issues which some of my families might be facing too
- FCMS community learning meeting each month with the entire SIF team. During these meetings, we were able to listen to others and we come together to solve an issue and give feedback and resources in order to be ready for feedback.
- I do not remember the specific trainings.
- I found the MI training to be helpful and I felt that the case presentations done at the meetings were helpful in learning about new resources for families as well as how to approach certain topics with families. I also felt that the FCMS and DCS meetings had good discussions for things that we may have had issues with during the course of the study.
- I think the case presentations were extremely helpful. When I presented my case, I was honestly lost and confused about what to do. But the whole team had so many additional support and resources available. It was really nice to be able to put our heads together and come up with solutions for families. I also loved hearing about other people's case presentations and helping out when I could.
- I took a mental health first aid training and it was fantastic. Would help anyone that works with people be more aware of mental health and questions to ask.
- Motivational Interviewing
- One of the most beneficial training that I got is the Motivational interviewing skills. it was very useful to me as I mentioned before, my credential background is education and I don't use MI skills in depth like in therapy sessions or social work meetings, so MI skills helped me identify ambivalence and elicit change talk.
- The child abuse and neglect conference was very interesting and I feel that I learned a great deal.
- The motivational Interviewing trainings were helpful in providing useful clinical skills; it would've been more helpful to continue with the other MI trainings provided by U of M. The FCU trainings were of course helpful in setting a blue print for the FCU.

DCS

- Professional Development trainings that were applicable to the work we do, that we attended were very helpful. For example, the motivational interviewing trainings were very beneficial.
- The car seat training had a lot of information that I didn't know and had wondered about for a long time, and had actually searched for and wasn't able to find the answers.
- The trainings that were geared towards professional development such as the mental health first aid training were helpful.

- N/A
- N/A

23b. What could have made the Manager/FCMS/DCS meetings more useful?

Manager

- DCS meetings were never really useful. Putting the DCS with the FCMS would've been a much better use of time and more growth would've occurred as well.
- For awhile it felt like we were discussing the same issues repeatedly during the Manager's Meetings. It got discouraging that a decision was not being made and we were going in circles about the issues during the meetings. It would have been much more beneficial if there could have been a clear process on how to resolve certian issues and been given clear answers.
- Perhaps ask managers to complete a running list of items that are discussed during the month at there agency and share out in advance of the monthly SIF meeting.
- The manager meetings could have been more helpful if there was more concise direction.
- Less focus on case presentation towards the end, more focus on whats next, maybe more talk about proper methods of termination or transition for clients
- N/A

FCMS

- Cannot think of anything.
- I don't know
- I enjoyed when the Manager Meetings were after the FCMS and DCS meetings, as those two meetings often gave us more to talk about. If there were big changes to announce to all FCMS/DCS, United Way could have sent out a quick email to managers to notify them prior to the meeting, allowing us to think through questions ahead of time. I believe the FCMS meetings should have been extended to 1 1/2 hour, as we were often short on time and had to rush through. For some, it takes an entire hour to get to the site of meeting, so to have a meeting the same length as a one way drive feels a bit wasteful of time. The DCS did not need to meet monthly, perhaps every other month, DCS often did not much to discuss and it often seemed unorganized, which allowed the meetings to revisit the same issues every time, causing confusion, which led to the DCS feeling unsupported. I appreciated the combination of groups when appropriate.
- I think more trainings would have been more helpful. I came towards the end of the project though so I could have missed a good amount of trainings. I also think that case presentations are super helpful, but when we do not have a case to present focusing on trainings or things going on in the world right now would have been helpful.
- I was not part of them.
- In my opinion, FCMS meetings were great and Chris always was a resourceful professional in those meetings.
- Maybe incorporating more "re-training" about topics that were taught about at the beginning of the project. Maybe a 10 mins discussion each meeting as a refresher about topics like setting goals, presenting feedbacks and correctly administering assessments. Tasks as simple as how to correctly determine whether a client has achieved a goal or is in progress at follow-ups would be beneficial. For example, as a project is it our protocol to continuing checking up on goals that are already achieved? If a client sets a goal to do something weekly and they do so at the first check-in is that considered achieved or in progress? These topics can seem relatively simple, but I think it is always great to continue checking in as a project to insure data is being obtained and entered the same across agencies.
- More efficient training could have made the Manager/FCMS/DCS meetings more useful.
- No comment.
- Not having separate meetings for FCMS and DCS

- Nothing
- The Learning communities are already very helpful, but maybe adding in some more reflective, clinical support could be make them even better.
- Timing. I always thought it was weird that the FCMS meeting was only one hour long. 1.5-2 hours would have been a little better in order to feel a little less rushed. Also, why do DCS have their own meeting????

DCS

- Faster solutions to technology problems. Felt like we circled around similar problems a lot at meetings.
- For a couple of meetings, we spent some time going over the same issues, and the group had a difficult time moving on to the next topic for too long.
- Having one on one training with each other.
- Having the meetings more specific to the tasks at hand. I believe because every agency was handling the study in a slightly different manner the meetings often became repetitive and confusing because issues and concerns would be brought up and discussed at great length but without any solution.
- N/A

24. What were the major challenges of the project?(FCMS, DCS, Managers)

Manager

- ETO was a challenge and all the changes that were made along the way to the project. Every couple of months I feel that there was something new we had to complete, or a different way of completing our tasks. The project was never consistent. It was definitely good to tailor the project as we see need to do so, but maybe those changes could've taken place in stages instead of making changes and adding tasks all the time. An example of this is staff training. It changed from the beginning of the project to the end (And I'm not sure why). Another challenge was dealing with the staff turnover. While this wasn't as big of a challenge for our agency in particular, as a network, it made the success of the project more difficult. Especially when trying to reach numbers, attrition rates, etc.
- Formatting of assessments in ETO and paper copies not aligned. Feedback forms and reports did not populate correctly.
- Recruitment was challenging at the beginning of the project. I think that because myself & the staff weren't comfortable with how to describe the program to families or how to highlight the benefits of participating, it really caused us to have slow recruitment for awhile. As we all came to have a better understanding of the project, this became less of a challenge. Another challenge we dealt with throughout the project was working with participants who spoke little or no English and not always having the staff to support that need. Translating some of the forms was difficult and assessment & feedback sessions were quite lengthy. It was very challenging with some families to gain their trust & get them to feel comfortable with letting us into their homes when we didn't speak their language.
- Retention for most agencies; ACCESS is lucky to have such a tightly knit community and thus not much attrition. In the assessments, there was a lot of repetition and assessments took a long time, and I feel that reducing the repetition would've helped participants remain more easily engaged through the assessments at each round. Something specific for our clientele is that many of the goals of this study (engaging in kids' development and being an agent in one's life) are culturally foreign or removed for many immigrants in our area compared to the typical white American mindset. Changing that mindset for our clients was a lot of work.

- There were too many moving pieces and guidance was constantly changing, which made it difficult to implement with fidelity.
- Timeline changes ETO database
- Building the frame work as we ran it was particularly difficult. poor communication in the beginning. lack to UWSEM team members with clinical or front line experience.

FCMS

- Keeping clients engaged who have walls up or are feeling overburdened by the time commitment. - ETO. - The very large caseloads were not always manageable. Balancing our very large caseloads with the large amounts of paperwork, resource research, and data entry that was needed to support our very large caseloads was very difficult and at times overwhelming. - The lack of clinical training and support.
- ETO
- Employee turn over rate, participants dropping out of the program.
- Helping families
- Losing contact with clients
- Mainly just getting in touch with participants, either to schedule 6 and 12 month follow ups or having them keep appointments. Many participants were difficult to get ahold of, especially as people change their address and phone number in the program quite often.
- Motivating some families to take action for their own independence (only a few of them though)
- Not having enough resources to meet the needs of clients. ETO. Feeling defeated when the only thing I could provide to a client is a listening ear.
- Overall, having direct answers would have been appreciated. Often, in any of the meetings held, our opinion on next steps of preference was requested, and then direction on a decision was not provided for at least another month. This caused a lot of frustrations by our staff. We appreciate that the study valued our opinions, but when there was such a variety of opinions, we just needed an answer on what the expectation was in order to proceed in a way that would be beneficial for our participants, and for the purpose of consistency of the study.
- Scheduling appointments, making first interviews, and signing the consent form were the major challenges of the project
- The project became so much about numbers that there wasn't time or energy left to put into actual services. The supervisor provided training in a different manner than was required for certification so it was difficult for people to know which way to do things. Participants and potential participants were essentially being harassed with phone calls from their assigned case manager. During the brief period I worked on the project, I felt more like a survey-taker than a case manager. I lost motivation to even do the surveys because all I was doing was collecting data. I didn't have the time to provide actual services to the people on my caseload because I had to try tracking down participants that weren't answering and going to recruiting events.
- Trying to schedule participants that live in the same area was difficult. Driving most of the day to see 3 or 4 people doesn't seem efficient. Maybe the county could have been broken up into areas so drive time could be less?
- With the project being broken up in 6 month intervals, it made it very easy for clients to fall out of contact with the worker. Something that myself and my clients thought would be a good idea is to still schedule in person check ins during those 6 months of not doing assessments. This keeps a good rapport with clients, as well as making it easier to keep in

contact and not lose touch. Another challenge was some of the assessments either asking too specific questions, or not having enough that would depict the true level of development for the child. I had families that the child was lacking in a certain aspect of child development, but because of the small amount of questions scored in the strength area.

DCS

- ETO was so inefficient that it put a lot of stress on me because of course, I spent a lot of time driving and seeing clients, and that program added so much time to the data entry that I didn't have enough time to complete my work. Another thing that added too much time too the workload was the detail of the communication logs requested at one point. I realize there was a study of those logs, but if I remember correctly I was having to document number of texts at each exchange, number of minutes each text took, what was said, amount of time driven to each home, number of miles, how long it took, both written and entered into ETO, and it was too much on top of what a DCS has to do.
- Having a better understanding of the population we was serving. Not enough resources to provide for families. Dividing the incentive payments. The ages of the children.
- Keeping a hold of some families.
- The comfort level of the parents responding to the Family Profile Form.
- The constant changes and inconsistency of the project towards the end, the difficultly it took to get ahold of the participants due to the longevity of the project.

25. What were the major successes of the project? (FCMS, DCS, Managers)

Manager

- All the families we met with were positively impacted in some way. Our team also learned a new and more beneficial way of completing case work and encouraging families. We learned how to work as a team.
- I think the biggest success of the project was the relationships that were developed between participants and staff. The project really allowed staff to take on a new role with the families in our community and develop more meaningful relationships with them. Watching the relationships develop over time and then seeing how that often translated into the families taking steps towards their goals or making improvements in their family well-being was so really exciting and said a lot about the importance of the project and the work we were doing.
- Meeting our enrollment goals and follow up completion, and seeing clients make real gains in progress towards life changing, beneficial advancements, providing a better of quality of life for their family.
- Supporting the families we served.
- Serving high number of families. Growth within families served.
- Witnessing increasing engagement from the clients and families in their kids' education and the family's personal goals. We were able to widen the world-view of many of our clients who took more control in their lives and were empowered to make their own decisions.
- Helping families and seeing them grow.

FCMS

- When clients were able to utilize a resource that I provided. - When clients expressed they're enjoyment/appreciation of the support provided by the FCU. - Providing clients with useful things that actually made a positive impact on their lives: gift cards, books, etc.
- A lot of data was collected.

- Being able to connect families with resources in their community that were able to help them; resources that they may have otherwise not known about. Also just being a listening ear and support for families dealing with a lot of stress and that had a lot of needs.
- Being able to provide these clients with a wide range of resource options. Also seeing the differences between baseline to 6 months for the families was really helpful to allow them to see where they needed to work or where needed more resources to help make that a strength.
- Enrollment, it has been very exciting to work with so many different families throughout Wayne County. The experience gained is invaluable.
- Gaining good relationships with the families and follow up appointments were the major successes of the project.
- Give family resources
- Participants feeling supported and able to identify their own strengths when going through the Family Check Up Model.
- Seeing families set goals and reach them
- The awareness of referrals and resources available in the community for them when they need. Participants are advocating for children's learning and more involved in children's school activities. The great relationship between FCMS and participants. The relationship that never phased out even when they phased out the study, the connection stayed to share other successes participants make. Our retention rates. Participants trusted us to the extent that they helped us in recruiting their relatives and friends.
- The resources we provide to the families (the books and gift card especially).
- Watching clients become self-sufficient in obtaining their own resources. Breaking through boundaries and having clients open up to me. Feeling like a great support for clients. Watching clients find the motivation or opportunity to make small changes in their lives (i.e. getting a new job, going to see a counselor) and how these small changes affected them and the development of their children greatly.
- Watching clients grow.

DCS

- Completing assessments and meeting with families.
- Getting to know families and connect them with resources and having what I felt were a large number of families finishing and being happy with the project.
- Helping families, understanding the dynamic of the family, learning and educating yourself on the assessments, being able to go all the way through the program and the end process.
- Seeing the families flourish throughout and benefit from community resources.
- The resources, connections and aid we were able to provide with people in the community.

26. Please give us an example of a family you felt was really helped by the program. Please provide details about what needs the family had, how you worked with the family to meet those needs, and how the Family Checkup Model in particular was well suited to the family: (FCMS)

- A family I worked with during the beginning of the Pandemic, needed food, food delivery, home medication delivery, assistance with obtaining food as the single parent was immunocompromised. I was able to assist her with all of the above needs. She was very thankful and grateful for the assistance and as far as I know is still receiving the assistance that I assisted in setting up.

- A family that really benefited from the program was Client S. The reason why we dismissed the client S was due to the fact that she quit ELA due to not having any transportation which led to quitting SIF. Last week, I was calling all my clients dismissed or not due to Covid-19 and me asking for their well-being and wanted to remind them of Access and how we are always there willing to help them during this hard time. This is when it all began- during the middle of the night, she called on WhatsApp and left me a voicemail which I only saw the next morning. Upon hearing her message I realized that Client S was in a terrible situation. Her husband lost her job, she has no bridge card that currently working since March. She was unable to pay rent and all other expenses. So right away after hearing this, I called her to try to fully understand the situation and how to help her. Right away I told her to reupload all the documents Social Services was asking for online and to call her caseworker right away. I also sent her the link to the unemployment resources so her husband could apply for unemployment and receive its benefits. I also reminded her to call United Way at 211 to get more resources or help in order so she could manage her monthly expenses more cordially. The reason why I helped her even though she was dismissed from SIF is that as a community I believe it is our duty to help everyone and anyone- especially during the pandemic crisis right now. So on Friday morning I received news that her food stamp is reopened and that her husband called the unemployment facilities and applied. I am very happy that I helped my client to the best of my abilities.
- A huge contribution of this project is the empowerment outcomes. Throughout feedback sessions, open communication, sharing success stories of other participants in the same community. Some participants took as if they can do, why I can't do it despite the old-fashioned beliefs that are embedded in them. One of my participants saw success starts with determination. She was very determined to be self-sufficient by setting goals that lead to it. She was clear what exactly she wants despite of some beliefs and old-fashioneded thoughts towards work, driving, and be self-sufficiency. Participant is a mom, married, lives with her family because her husband is still overseas. In her baseline feedback, participant set a goal to study the driving materials and obtain the permit. I provided the study materials. She studied them, took the test and passed it. This was her first goal that she accomplished. Within the first six months, she kept practicing driving with her permit any time her father's car was available. Six months feedback session, she set another goal to obtain a driving license, she applied, took the road test, and passed it. Now that she has her driver license, which was the first barrier to self-sufficiency, she set a third goal to work to be able to save money and buy a car. I referred her to ACCESS employment and training to find a job but one of the our participants told her about a bakery business that is hiring. she went, applied and, got hired. Now, she's working and started saving money to buy her own car.
- Help family to CPS for her kids
- Honestly, not one specific family comes to mind when thinking about how the Family Checkup Model was particularly helpful. In many ways, I felt that providing support was more helpful to most families than the Model itself. I had many families that make great strides throughout the program but of all of those families I am thinking of right now, I strongly believe they would have made these strides without the program. However, this may be specific to me as I came onto the project late and had only a few clients that I started the project with.
- I do not think any of the families I worked with felt like they were helped. I do think the pilot families benefited. I worked with some of them in a different program and these families received services as they were intended.

- I had a family in the intervention group that was homeless at the time of their initial assessment and living at a hotel. I was able to connect them with housing resources and they eventually worked with Salvation Army to help them find housing, as well as connecting them to resources for education, mental health, food, clothing and child development needs. The mother was also referred to my agencies in home parenting program where mom was able to set goals and a routine for her children once they had secured a home about a month after her initial assessment. I think just being a sense of emotional support, getting mom to set goals so that she would have something to work on and look forward to, as well as connecting her to resources to help her and her family get back on their feet were the most helpful parts of the model, pertaining to her participation in the program.
- I had a family that I presented in our FCMS team meeting. Mother was a 42 year old single mother with 6 children. The focus child was 2 years old. Mom was relatively self sufficient. Although she reported receiving financial assistance such as food stamps and reduced lunch for her children, she claimed that she was able to meet her family's basic needs. The parent's biggest barrier was poor parent/child interaction evident by her low parenting survey score and her low PICCOLO scores. During the feedback session, the parent admitted that she's heard all of these things before and felt as if people were personally attacking her and telling her everything she was doing wrong as a parent. Overall, the model allowed me to highlight her strengths as a parent (i.e. being a great provider to her kids even as a single parent) and briefly explore some of the challenges she faced. I think this model was specifically helpful to this family because it looks at the bigger picture instead of just focusing on the negatives, which many programs do. I was able to connect the parent with resources in her community such as parenting classes, mental health counseling for postpartum depression, and play and learn groups. One of the things I liked most was being able to talk about this family to the group because other agencies were able to relate and offer different perspectives to me. This family was able to achieve most of their goals (mainly the barriers had to do with COVID19) and mom expressed that she really liked the program overall.
- I have a client that was able to make a goal of getting her high school diploma and with the resource I provided her she was able to sign up for online classes and obtained her high school diploma last month.
- Many of my families benefited from this program in very different ways, but one family sticks out because of all of the different ways this program was able to help her and her family. When I first came into the home, the focus child was very very silent and shy. She had struggled with using her words because she always depended on her older sisters to talk for her. She also was very clingy to the mom, almost baby like even though she was around 5 years old. After talking with the mom a few times we started to build a really good relationship where she was able to open up more about the past. We talked through the past and figured out some reasons of why her daughter could have been acting these way and having these developmental delays. After working with this family I was able to get not only the focus child in counseling, but all of the daughters and the mother herself. There were many other resources and areas that we worked on together to help, but getting the mom to discuss the past and really see how that could have shaped the way the girls act was a huge step. This family was a fantastic family to be involved in a program like this, and also pushed her to get more involved in other programs similar to be able to continue to help the family and hold her accountable.

- One mom had all the tools she needed to succeed but was in a bad relationship and lived with her mother who is very controlling, and when we chatted at length about her strengths, she took it to heart and became more confident to do what she needed to do for herself and her kids
- One mother I worked with had some big mental health issues that she's been struggling with her whole life, as well as her child having some development delays. After several months of working with Mom and Dad's concerns about getting help, we were able to get their son enrolled in Early On and then connected with the school district for support to get him back on track. He he began to show improvements within the first month of services. And then, after completing all of their timepoints and finishing her 12m feedback, I got an update from Mom that our conversations about counseling helped motivate her to connect with a therapist. This step toward addressing her mental health needs is very likely to have a positive impact on her parenting, her family's wellbeing, and of course her own wellbeing. The one-on-one support provided by the FCU was essential for helping this family become comfortable in seeking help for things they were not able to address on their own.
- One particular family had children with special needs and was in the process of a divorce out of a domestically violent marriage, when she enrolled in the program. She was very self-sufficient, carrying two jobs, doing online school, and supporting the needs of her kids. Through SIF, we were able to connect her to another parenting home visiting program at CARE for further support of her and her kids. Through the support of both SIF and SOF, she got connected to early intervention services for her children and connected support groups for parents of special needs. These programs were also able to assist her with holiday needs by connecting her to resources to financially help during troubling times. The Family Checkup Model was well suited for her because she was very open to reflect on her responsibilities and emotions, and took pride in being able to make progress towards goals pertaining to the development of her children and to improve herself I ways that would benefit her family long-term.

27. Do you feel that participating in SIF 2016 benefitted you professionally ? (FCMS)
☐ No **1 (8%)**
☐ Yes **12 (92%)**
27a. If yes, please explain:

- Because we can help the family
- Being part of a study
- Coming into this position, I had very limited professional experience. The only relative experience that I had was with case management. I loved that that this position didn't require too much experience and the on-the-job training I received was really helpful in my professional development because I've always wanted to work with children and families.
- Home visiting has been a hugely beneficial experience for me.
- I already knew how to do assessments and motivational interviewing.
- I am more comfortable working and communicating effectively with all different types of clients after my experience with these families
- I feel I grew professionally in this project, using MI skills not just at work but even at the personal level especially that I had a teen in the house tremendously helped me.
- I feel more competent in my clinical skills based on the experiences I've had doing SIF as well as the trainings and meetings that I have attended and participated in.
- I had no idea of what resources were available for Wayne County and now I have a much better idea of the resources out there and how to go about finding them. Also working with

families in Wayne County has given me a much better perspective of what the needs are in Wayne County. Being able to gain the trust of the family and have them welcome me into there home is humbling.

- I learned a lot personally and professionally. This project was a wonderful opportunity to practice my clinical skills and home-visit without a Master's degree. I was recently accepted to Wayne State to pursue a MSW and I feel that my learning throughout this program will be much different/more personal due to my experiences and knowledge from working in SIF 2016.
- Motivational Interviewing as been a blessing to my professional development.
- Within the social services field, I think any home visiting work is beneficial. For me personally, working with younger kids was very beneficial because it was an age range I had not worked a ton with and really wanted to work more with. Also this program allowed for me to find and hear about resources that I never knew existed. I also enjoyed all of the trainings that we were able to do during this project especially based on how to deal with trauma within families and children.
- Yes, it allowed me to know the rules, how to manage clients, how to efficiently solve their problems, how to solve hard cases.

28. Did you communicate with families in languages other than English? (FCMS, DCS)

Did you communicate with families in languages other than English?	FCMS (N=13)	DCS (N=5)
No	8 (62%)	3 (60%)
Yes	5 (38%)	2 (40%)

28a. If so, what language(s)? (check all that apply)

If so, what language(s)? (check all that apply)	FCMS (N=5)	DCS (N=2)
Arabic	4 (80%)	2 (100%)
Bengali	1 (20%)	1 (50%)
Spanish	1 (20%)	0 (0%)
Other	0 (0%)	0 (0%)

If yes to question 28:

29. How difficult was it to conduct the assessments in a language other than English? (FCMS, DCS)

How difficult was it to conduct the assessments in a language other than English?	FCMS (N=5)	DCS (N=2)
Very difficult	1 (20%)	0 (0%)
Difficult	0 (0%)	0 (0%)
Not very difficult	1 (20%)	2 (100%)
Not difficult at all	3 (60%)	0 (0%)

29a. Please explain your answer:

FCMS

- I am bilingual, I speak Arabic and English fluently.
- I know how to read and write Arabic
- It depends on the level of the other language. Arabic is my mother tongue and I understand most of the dialects of the Arabic language.

- Motivational interviewing in the feedback sessions required more conscious effort, but assessment sessions were easy
- Since I only speak English myself I had to utilize a translator which I found very difficult at times.

DCS

- Having experience, and Arabic language background, being a native speaking in Arabic, reading and writing the language, it was very helpful.

30. How difficult was it to find appropriate referrals for families who spoke languages other than English? (FCMS)

☐ Very difficult **0 (0%)**
☐ Difficult **1 (20%)**
☐ Not very difficult **2 (40%)**
☐ Not difficult at all **2 (40%)**

30a. Please explain your answer:

- I am bilingual, I read and write Arabic and English fluently.
- I read for them and translate
- It just sometimes that they don't benefit from the referral because the language. when the make the call, there's no one speak their language.
- Making sure the referrals they could utilize given language barriers.
- There are so many organizations nearby that serve Spanish-speakers, since we're so close to SW Detroit

31. How good of a fit do you think the GOALS project was for families who spoke languages other than English? (FCMS)

☐ Very good fit **3 (60%)**
☐ Good fit **2 (40%)**
☐ Not a good fit **0 (0%)**
☐ Not a fit at all **0 (0%)**

31a. Please explain your answer:_____

32. What suggestions would you make for adapting the GOALS project so that it works better for families that speak languages other than English? (FCMS)

- Allow more resources and referrals to have language translations, not only Arabic and Spanish.
- I will get rid of the temperament questionnaire, unless I change the phrases into simple sentences not including a clause phrase because it confuses participants and it affected their answers. In the family profile form, I will add more questions related to child's education because this a priority for participants. The scale in the assessments, make it simple, visual not more than 5-points scale. Assessments, referrals and resources should be available in Arabic and Spanish from the beginning of the study. 2-1-1 should imidiatly take participants to languages selections when they call. They were many times where I had to be with participants when they called 2-1-1. Provide books in different language to promote reading skill.
- N/A- I think it worked well
- Not really sure.
- Nothing

Thank you!

Appendix W: Characteristics of GOALS Families by Agency

Table 1: Characteristics of GOALS Families – ACCESS (N=86)

Variable	N	%/ Average	SD
Parent's age	86	31.2	6.336
18-25	17	20%	
26-34	50	58%	
35 and older	19	22%	
Child's age	86	2.3	1.420
Parent's gender			
Female	86	100%	0
Child's gender			
Female	86	40%	.492
Race/ethnicity[1]	86		
American Indian	2	2%	.152
Asian	1	1%	.108
African American	11	13%	.336
Hispanic	6	7%	.256
Middle Eastern/North African	64	74%	.439
Pacific Islander	0	0%	0
White	3	3%	.185
Other	1	1%	.108
Language Spoken	86		
English	12	14%	.349
Spanish	6	7%	.256
Arabic	67	78%	.417
Other	1	1%	.108
Household Composition			
Number in household	86	6	1.988
Living with spouse	86	80%	.401
Receiving public assistance	86	79%	.409
Less than high school education	86	63%	.486

[1] More than one option could be selected.

Table 2: Characteristics of GOALS Families - CARE (N=100)

Variable	N	%/ Average	SD
Parent's age	99	31.4	7.547
18-25	23	23%	
26-34	50	51%	
35 and older	26	26%	
Child's age	99	2.0	1.605
Parent's gender			

Female	99	96%	.198
Child's gender			
Female	99	51%	.503
Race/ethnicity[1]	99		
American Indian	4	4%	.198
Asian	4	4%	.198
African American	47	47%	.502
Hispanic	6	6%	.240
Middle Eastern/North African	10	10%	.303
Pacific Islander	0	0%	0
White	33	33%	.474
Other	4	4%	.198
Language Spoken	99		
English	93	94%	.240
Spanish	1	1%	.101
Arabic	1	1%	.101
Other	4	4%	.198
Household Composition			
Number in household	93	4.5	1.632
Living with spouse	99	45%	.500
Receiving public assistance	99	83%	.379
Less than high school education	93	13%	.337

[1] More than one option could be selected.

Table 3: Characteristics of GOALS Families – LBFS (N=88)

Variable	N	%/ Average	SD
Parent's age	88	32.0	6.931
18-25	20	23%	
26-34	37	42%	
35 and older	31	35%	
Child's age	88	2.0	1.436
Parent's gender			
Female	88	97%	.183
Child's gender			
Female	88	58%	.496
Race/ethnicity[1]	88		
American Indian	1	1%	.107
Asian	1	1%	.107
African American	39	44%	.500
Hispanic	88	2%	.150
Middle Eastern/North African	32	36%	.484
Pacific Islander	0	0%	0
White	14	16%	.368

Other	4	5%	.209
Language Spoken	88		
English	55	63%	.487
Spanish	0	0%	0
Arabic	29	33%	.473
Other	4	4%	.209
Household Composition			
Number in household	82	4.6	1.601
Living with spouse	88	51%	.503
Receiving public assistance	88	86%	.345
Less than high school education	81	14%	.345

[1] More than one option could be selected.

Table 4: Characteristics of GOALS Families - NKFM (N=131)

Variable	N	%/Average	SD
Parent's age	125	31.5	7.791
18-25	31	25%	
26-34	57	45%	
35 and older	37	30%	
Child's age	131	2.3	1.750
Parent's gender			
Female	128	98%	.152
Child's gender			
Female	131	50%	.502
Race/ethnicity[1]	128		
American Indian	4	3%	.175
Asian	2	2%	.125
African American	90	70%	.459
Hispanic	9	7%	.257
Middle Eastern/North African	7	5%	.228
Pacific Islander	0	0%	0
White	23	18%	.385
Other	5	4%	.195
Language Spoken	127		
English	125	98%	.125
Spanish	1	1%	.089
Arabic	1	1%	.089
Other	0	0%	0
Household Composition			
Number in household	128	4.5	1.874
Living with spouse	130	20%	.402
Receiving public assistance	130	77%	.423
Less than high school education	128	20%	.398

[1] More than one option could be selected.

Table 5: Characteristics of GOALS Families - OFS (N=113)

Variable	N	%/Average	SD
Parent's age	113	34.0	7.704
18-25	19	17%	
26-34	46	41%	
35 and older	48	42%	
Child's age	113	2.5	1.655
Parent's gender			
Female	113	96%	.186
Child's gender			
Female	113	46%	.501
Race/ethnicity[1]	113		
American Indian	7	6%	.242
Asian	6	5%	.225
African American	54	48%	.502
Hispanic	12	11%	.309
Middle Eastern/North African	3	3%	.161
Pacific Islander	0	0%	0
White	47	42%	.495
Other	7	6%	.242
Language Spoken	113		
English	109	96%	.186
Spanish	2	2%	.132
Arabic	1	1%	.094
Other	1	1%	.094
Household Composition			
Number in household	107	4.1	1.513
Living with spouse	113	42%	.497
Receiving public assistance	113	65%	.480
Less than high school education	106	12%	.330

[1] More than one option could be selected.

Appendix X: Coronavirus Impact Scale

Date Completed: _____
Agency:_____
Family ID: _____
Participant ID: _____

Coronavirus Impact Scale

People around the world are adjusting to changes in their lives due to the coronavirus. These next questions ask you for information about how the coronavirus may have changed your life. Some of the things that we ask about may have been hard even before the coronavirus came to your community or may have changed for other reasons. When you answer, we would like you to think about whether these things are even harder or have changed because of the coronavirus.

1. **Routines:**
   - ☐ No change.
   - ☐ Mild. Change in only one area (e.g. work, education, social life, hobbies, religious activities).
   - ☐ Moderate. Change in two areas (e.g. work, education, social life, hobbies, religious activities).
   - ☐ Severe. Change in three or more areas (e.g. work, education, social life, hobbies, religious activities).

2. **Family Income/Employment:**
   - ☐ No change.
   - ☐ Mild. Small change; able to meet all needs and pay bills.
   - ☐ Moderate. Having to make cuts but able to meet basic needs and pay bills.
   - ☐ Severe. Unable to meet basic needs and/or pay bills.

3. **Food Access:**
   - ☐ No change.
   - ☐ Mild. Enough food but difficulty getting to stores and/or finding needed items.
   - ☐ Moderate. Occasionally without enough food and/or good quality (e.g., healthy) foods.
   - ☐ Severe. Frequently without enough food and/or good quality (e.g., healthy) foods.

4. **Medical health care access:**
   - ☐ No change.
   - ☐ Mild. Appointments moved to telehealth.
   - ☐ Moderate. Delays or cancellations in appointments and/or delays in getting prescriptions; changes have minimal impact on health.
   - ☐ Severe. Unable to access needed care resulting in moderate to severe impact on health.

5. **Mental health treatment access:**
   - ☐ Not Applicable
   - ☐ No change.
   - ☐ Mild. Appointments moved to telehealth.
   - ☐ Moderate. Delays or cancellations in appointments and/or delays in getting prescriptions; changes have minimal impact.
   - ☐ Severe. Unable to access needed care resulting in severe risk and/or significant impact.

6. **Access to extended family and non-family social supports:**
   - ☐ No change.
   - ☐ Mild. Continued visits with social distancing and/or regular phone calls and/or televideo or social media contacts.
   - ☐ Moderate. Loss of in person and remote contact with a few people, but not all supports.
   - ☐ Severe. Loss of in person and remote contact with all supports.

7. **Experiences of stress related to coronavirus pandemic:**
   - ☐ None.
   - ☐ Mild. Occasional worries and/or minor stress-related symptoms (e.g., feel a little anxious, sad, and/or angry; mild/rare trouble sleeping).
   - ☐ Moderate. Frequent worries and/or moderate stress-related symptoms (e.g., feel moderately anxious, sad, and/or angry; moderate/occasional trouble sleeping).
   - ☐ Severe. Persistent worries and/or severe stress-related symptoms (e.g., feel extremely anxious, sad, and/or angry; severe/frequent trouble sleeping).

8. **Stress and discord in the family:**
   - ☐ None.
   - ☐ Mild. Family members occasionally short-tempered with one another; no physical violence.
   - ☐ Moderate. Family members frequently short-tempered with one another; and/or children in the home getting in physical fights with one another.
   - ☐ Severe. Family members frequently short-tempered with one another and adults in the home throwing things at one another, and/or knocking over furniture, and/or hitting and/or harming one another.

9. **Personal diagnosis of coronavirus.** ***(By personal diagnosis we mean that you have been diagnosed with coronavirus by a medical professional after taking a coronavirus test.)***
   - ☐ None.
   - ☐ Mild. Symptoms effectively managed at home.
   - ☐ Moderate. Symptoms severe and required brief hospitalization.
   - ☐ Severe. Symptoms severe and required ventilation.

10. **Number of immediate family members diagnosed with coronavirus:** ***(By diagnosed, we mean immediate family members that have been diagnosed with coronavirus by a medical professional after taking a coronavirus test.)***

    _____ # of immediate family members

    If one or more of your immediate family members have been diagnosed with coronavirus, please rate the symptoms of the person who was most sick:
    - ☐ Mild. Symptoms effectively managed at home.
    - ☐ Moderate. Symptoms severe and required brief hospitalization.
    - ☐ Severe. Symptoms severe and required ventilation.
    - ☐ Immediate family member died from coronavirus.

11. **Number of extended family member(s) and/or close friends diagnosed with coronavirus:** ***(By diagnosed, we mean extended family members and/or close friends that have been diagnosed with coronavirus by a medical professional after taking a coronavirus test.)***

_____ # of extended family members

If one or more of your extended family members and/or close friends have been diagnosed with coronavirus, please rate the symptoms of the person who was most sick:

- ☐ Mild. Symptoms effectively managed at home.
- ☐ Moderate. Symptoms severe and required brief hospitalization.
- ☐ Severe. Symptoms severe and required ventilation.
- ☐ Extended family member and/or close friend died of coronavirus.

12. **What resources do you think would be most helpful to you and your family while managing changes in your life related to COVID-19?**

_____

_____

_____

_____

13. **Other. Please tell us about any other ways the coronavirus pandemic has impacted your life:**

_____

_____

_____

_____

Thank you for completing our survey!

Appendix Y: COVID-19 Symptoms and Social Distancing Web Survey

Date Completed: _____
Agency:_____
Family ID: _____
Participant ID: _____

COVID- 19 Symptoms and Social Distancing Web Survey

1. How many people currently live in your household (include yourself, other family members, roommates, and temporary visitors)?

_____ #of people

We are now going to ask you some questions about your health and the health of other members of your household.

2. Have you experienced any of the following symptoms in the past two weeks?	**Yes**	**No**	**Don't Know**
a) Fever	☐	☐	☐
b) Dry cough	☐	☐	☐
c) Tiredness	☐	☐	☐
d) Shortness of breath	☐	☐	☐
e) Other flu like symptoms	☐	☐	☐
3. Has anyone else in your household besides yourself experienced any of these five symptoms in the past two weeks?	**Yes**	**No**	**Don't Know**
a) Fever	☐	☐	☐
b) Dry cough	☐	☐	☐
c) Tiredness	☐	☐	☐
d) Shortness of breath	☐	☐	☐
e) Other flu like symptoms	☐	☐	☐

4. Have you ever been tested for coronavirus (COVID-19)?

- ☐ No – I have not tried to get tested
- ☐ No- I tried to get tested but could not get access to a test
- ☐ Yes
- ☐ Don't know

5. Did you receive a flu vaccine anytime between September 2019 and today?

- ☐ Yes
- ☐ No
- ☐ Don't know

6. Did anyone else in your household receive a flu vaccine anytime between September 2019 and today?

- ☐ Yes
- ☐ No
- ☐ Don't know

7. Were you working for pay in February 2020?

- ☐ Yes
- ☐ No

8. Since March 1, 2020 have you seen a decrease in income from paid work?

- ☐ no decrease
- ☐ some decrease
- ☐ I no longer have any income from work

9. What is your current employment status?

- ☐ Employed full time ***(skip to Question 11)***
- ☐ Employed part time ***(skip to Question 11)***
- ☐ Furloughed
- ☐ Unemployed

10. If furloughed or unemployed, do you plan to return to work after the coronavirus?

- ☐ Yes
- ☐ No

11. During the past 7 days have you done any paid work?

- ☐ Yes
- ☐ No

12. During the past 7 days, how many days did you leave your home for paid work?

- ☐ 1 ☐ 2 ☐ 3 ☐ 4
- ☐ 5 ☐ 6 ☐ 7

13. Prior to the current coronavirus (COVID-19) outbreak, did you regularly work outside the home?

- ☐ Yes
- ☐ No

Now we would like to ask you some questions about social distancing

14. During the past 7 days, how many days did you leave your home?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

15. Did you leave your home yesterday?

- ☐ Yes
- ☐ No ***(skip to Question 20)***

16. How many hours were you outside of your home yesterday?

_____ hours

17. What were your reasons for going out yesterday? *(Select all that apply.)*

- ☐ Work
- ☐ Groceries/shopping
- ☐ Bank/ATM
- ☐ Exercise/walk/recreation
- ☐ Health care/visit to doctor or pharmacy
- ☐ Meeting friends or relatives
- ☐ Getting tired/bored of being inside the house
- ☐ Education
- ☐ Religious services/church
- ☐ Volunteering
- ☐ Other _____

18. Did you wear gloves when you left your home yesterday?

- ☐ Yes
- ☐ No

19. Did you wear a mask when you left your home yesterday?

- ☐ Yes
- ☐ No

20. Excluding members of your household, how many people in total did you come into close contact with (within six feet) yesterday? INCLUDE any co-workers, relatives, neighbors, delivery workers, other shoppers, etc. that you might have met.

_____ #of people

21. Did anyone else in your household leave the home yesterday?

- ☐ Yes
- ☐ No

Thank you for completing our survey!

Appendix Z: Participant Consent Form

United Way
United Way for Southeastern Michigan

Date Completed: _____
Participant Name: _____
Parent Case Number:_____

Family Check-Up Model Participant Consent Form

Sponsor / Study Title:	**Phillliber Research and Evaluation / "Evaluation of the impact of the Family Checkup Model on Parenting and Child Development Outcomes"**
Principal Investigator:	**Randi Burlew, Ph.D.**
Telephone:	**(845) 626-2126 (24 Hours)**
Addresses:	**CARE of Southeastern Michigan** **31900 Utica Rd** **Fraser, MI 48026** **Leaps and Bounds Family Services** **8129 Packard Ave** **Warren, MI 48089** **Oakland Family Services** **114 Orchard Lake Rd** **Pontiac, MI 48341** **National Kidney Foundation of Michigan** **7800 West Outer Drive, Suite 203** **Detroit, MI 48203** **Arab Community Center for Economic and Social Services (ACCESS)** **2651 Saulino Ct** **Dearborn, MI 48120**

Dear Parent/Caregiver,

Our agency is working with the United Way for Southeastern Michigan on a project to determine whether a new way of providing services is helpful to families. The new way of providing services is called the Family Check-up Model. In the Family Check-up Model, families are linked to a Specialist who works with the family to set goals, identify services that the family thinks will be helpful, and follows up with the family to ensure the services have been helpful. You have been selected as a possible participant because you have a child(ren) age 5 or younger

living in your home and have met our other eligibility requirements. Take time to ask the investigator or study staff as many questions about the study as you would like.

What do I need to do?

- Our research partners will randomly assign you to one of two groups. One group of families will receive services the way that we currently provide them. The other group of families will receive services through the Family Check-up Model. You will not get to choose which group you are in.
- No matter which group you are assigned to, you will be asked to complete a set of assessments when you join the program, six months later, then 12 months later, and possibly 18 months after you enroll. It is expected that these assessments will take approximately 90 minutes.
- Every time you complete a new set of assessments you will receive a $50 gift card. You will get this money no matter which group you are assigned to.
- Keep the agency up to date about how to contact you.

What are the potential benefits?

- You will have the opportunity to participate in programs at the agency that you think will benefit you, including (possibly) the new Family Check-up Model that is being tested through this evaluation, if you are assigned to that group.
- You will receive a $50 gift card for each new round of Family Check-up Model assessments that you complete.

What are the potential risks?

- By taking part in this study, you may experience some emotional discomfort in answering some of the questions on our survey. If at any time, you are comfortable with a question you do not have to answer that question.
- We must notify the appropriate authorities if at any time during the study there is concern that child abuse has possibly occurred.

How will my confidentiality be protected?

- All information collected for this project will be kept strictly confidential to the maximum extent allowable by law. To help us protect your privacy, we have obtained a Certificate of Confidentiality from the National Institutes of Health. Our team can use this Certificate to legally refuse to disclose information that may identify you in any federal, state, or local civil, criminal, or other proceedings. The researchers will use the Certificate to resist any demands for information that would identify you.
- The Certificate cannot be used to resist a demand for information from the Corporation for National and Community Service, the agency sponsoring the project, that will be used for auditing or program evaluation of agency funded projects.
- You should understand that a Certificate of Confidentiality does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research.
- The Certificate of Confidentiality will not be used to prevent disclosure to state or local authorities of child abuse and neglect.

- The results of this project will not be released in any individually identifiable form. A code will be used instead of your name. All results will be reported in combination with others and no single individual's data will be included in any reporting.
- All information collected for this project will be stored in password protected computers. Paper forms will be kept in secure areas or locked file cabinets.
- The sponsor, the Department of Health and Human Services, and Advarra IRB may have access to the study data.

Am I required to participate?

- No, participation is voluntary.
- This study is for research purposes only. The only alternative is to not take part in this study.
- You will not be penalized or lose any benefits if you refuse to participate.
- You may change your mind and decide not to participate at any time. Tell the study staff in person or at the telephone number listed on the first page of this form. There will be no penalty or loss of benefits to which you are otherwise entitled.
- Your investigator may end your participation in the program if he/she thinks it is in your best interest or if the study is stopped.
- You will be told about any new information found during the study that may affect whether you want to continue to take part.

Are there any costs or compensation for being in the study?

- There are no costs associated with participation.
- You will be given a $50 gift card each time you complete a new set of Family Check-up Model assessments.

Who do I contact if I have questions?

- If you have any concerns or feelings of distress as a result of one or more of the questions asked during the assessment, please tell the person who gave you this consent form or contact one of the following agencies: CARE of Southeastern Michigan, Leaps and Bounds Family Services, Oakland Family Services, National Kidney Foundation of Michigan, or Arab Community Center for Economic and Social Services (ACCESS).
- During the study, if you have questions, concerns or complaints about the study, please contact the Investigator at the telephone number listed on the first page of this consent document. If you seek emergency care, or hospitalization is required, alert the treating physician that you are participating in this research study.

An institutional review board (IRB) is an independent committee established to help protect the rights of research subjects. If you have any questions about your rights as a research subject, and/or concerns or complaints regarding this research study, contact:

- By mail:
  Study Subject Adviser
  Advarra IRB

6940 Columbia Gateway Drive, Suite 110
Columbia, MD 21046

- or call **toll free**: 877-992-4724
- or by **email**: adviser@advarra.com

Please reference the following number when contacting the Study Subject Adviser: Pro00023107.

Do you wish to participate in this study?

☐ Yes *(Please sign on next page)*
☐ No *(Do not sign this form)*

Your signature below means that you voluntarily agree to participate in this evaluation project. *

_____ _____
Signature of Participant Date

Please print your name: _____

WITNESS STATEMENT (if applicable)

My signature indicates that I was present when the subject signed this form and initialed the Supplemental Consents.

_____ ___/___/___
Signature of Witness Date

_____
Printed Name of Witness

*Use when participant has had this consent form read to them (for example, illiterate, legally blind, translated into foreign language).

_____ _____
*Signature of translator/reader *Date

_____
*Printed name of translator/reader

SUPPLEMENTAL CONSENTS

Please indicate your consent to each section by initialing next to each area you agree to, or signing where indicated.

Text Messaging Consent

One of the tests of the Bib to Backpack Pathway Program will to better understand the role that text messaging can play in supporting families. This program will mainly use one-way texting for things like meeting reminders and other program notifications. However, you and your Family Check-up Model Specialist may also choose to use two-way text-messaging to communicate back and forth.

_____ I acknowledge I would like to receive **one-way** text message notifications. This will allow my Family Check-up Specialist to communicate meeting reminders and other notifications via text messaging. I understand that message and data rates may apply.

You may also choose to communicate with your Family Check-up Model Specialist using two-way text messages.

_____ I acknowledge I am agreeing to receiving **two-way** text message communications. This will allow me and my Family Check-up Specialist to communicate via text messaging **if we both decide this is a good option**. I understand that message and data rates may apply.

OR

_____ I choose to NOT receive any text messaging and understand that my Family Check-up Specialist will primarily contact me using the information I provide on the Participant Contact Form.

Social Media Consent

As part of this project, we are asking to stay in contact with you for a prolonged period of time and we understand that phone numbers and addresses can change. We also understand that many people keep the same social media contacts even when they move or change phone numbers. We would like to be able to contact you privately through your social media channels in the event that we cannot reach you through the primary methods of the phone and email.

_____ I acknowledge I would like to receive communication via social media private messaging platforms, in the event I cannot be reached through phone or email.

AND

_____ I understand that private messaging will be used **solely for notification** and is NOT for communicating back and forth with my Family Check-up Specialist.

OR

_____ I choose NOT to receive private messaging via social media and understand that my Family Check-up Specialist will primarily contact me using the information I provide on the Participant Contact Form.

Release of Contact Information Consent

_____ I authorize the release of my contact information to the evaluator for the purpose of mailing my compensation following the completion of each set of Family Check-up Model assessments and locating me for follow-up surveys should my current contact information become invalid. I understand that the evaluator will receive my contact information separately from my assessment data to protect my privacy and anonymity of my assessment results.

Videotaping or Recording Family Interactions Consent

The Family Check-up Model Specialist may videotape sessions for the purposes of better understanding how you and your child interact. This will allow you to receive the maximum benefit from the Family Check-up Model. If you choose not to be videotaped, alternative methods to understand how you interact with your child to help inform programming suggestions can be used.

Statement of Consent:

- I give my consent for me and my child to be videotaped during my participation in the Family Check-up sessions.
- I understand that access to these videotapes will be restricted to my Family Check-up Model Specialist and their supervisors.
- The purpose of videotaping is to optimize the effectiveness of Family Check-up session so that I receive maximum benefit from my participation in the Family Check-up Model.
- I understand that all videotaped or recorded information will be kept confidential to the fullest extent of the law.
- I understand that videos will only be kept until my FCMS has shared their observations with me, after which they will be permanently deleted or destroyed.
- I understand the contents of this section of the consent form and have been encouraged to ask questions. All my questions have been answered.
- I further understand that I may withdraw my consent at any time.

☐ I am this child's parent and/or legal guardian.

_____ Date: _____

Signature of Participant

_____

Printed name of Participant

I choose to not participate in any videotaping or recording and understand that my Family Check-up Model Specialist will use alternative methods to understand how I interact with my child to help inform programming suggestions that can be used by my family.

_____ Date: _____

Signature of Participant

_____

Printed name of Participant

Appendix AA: Study Logistics and Updates

Protection of Human Subjects

The study protocol was submitted to Advarra IRB for review and approval. Evaluation staff maintained regular communication with the IRB to obtain updated approvals as the pilot unfolded, implementation forms were updated and/or translated, instruments were revised and/or translated, protocols were updated, and other changes, such as adding the six-month cohort and the COVID-19 measures, were made to the study.

Participants were asked to sign a consent form to participate during their first session with an FCMS or DCS (see Appendix Z). The consent form was available in English, Spanish, and Arabic. The study enrollment period was extended from April 30, 2019 to December 31, 2019 in order to enroll more families. A revised version of the consent form was approved by the IRB in December of 2018 to reflect the increase of the evaluation support from $25 to $50. Families enrolled after December 31, 2019 received only one follow up assessment after six months in the program. A revised consent form, available in English, Spanish, and Arabic, was developed for this group of families and approved by the IRB to account for this change.

The consent form provided an overview of the study including a description of what would be asked of participants, the potential risks and benefits, a description of how confidentiality would be protected, and information about the evaluation support payment. In addition, families were presented with a set of supplemental consents that requested permission to contact them via text messaging, reach out to them through social media, release their contact information to the evaluation team in order to monitor evaluation support payments, and to video tape some portions of the assessment process. Families were still able to participate if they did not agree to any or all of the items in the supplemental consents.

In June of 2020, the project team decided to add two new assessments that asked questions about families' experiences related to COVID-19. At that time, face to face visits with families had been suspended in order to prevent both staff and participants from being exposed to COVID-19. The study team developed a verbal consent form to be read to families (in English, Spanish or Arabic) seeking their consent to complete these new measures over the phone and receive an additional $10 evaluation support. The verbal consent form was reviewed and approved by the IRB.

The project team also obtained a Certificate of Confidentiality from the National Institutes of Health. The Certificate of Confidentiality provided an additional layer of protection for participants by enabling the project team to withhold the identities of participants from all persons not connected to the research. The project team believed the Certificate of Confidentiality was necessary due to the sensitive nature of some of the assessments included in the project.

Budget and Timeline

This project began at the now closed Corporation for National and Community Service

(CNCS) and is now housed with AmeriCorps. It was part of the 2016 Social Innovation Fund portfolio and was United Way's second Social Innovation Fund Award (also awarded in 2011, for detail on that project see: https://www.nationalservice.gov/impact-our-nation/evidence-exchange/uwsem-portfolio-evaluation-implementation-and-outcomes-united). In 2016, United Way was awarded $6 million with a required one to one match on every dollar. There was also a majority pass through stipulation meaning that at least 51% of the federal award had to go to subgrantees (referred to in this report as partner agencies) who were also required to match their awards dollar for dollar. With the shortened period of performance, United Way's total budget was just over $4 million with a pass-through rate of approximately 76 percent.

United Way was awarded the SIF grant for this project in September 2016. Between then and the April 1, 2017 start date, the United Way team worked to hire staff and conduct a Request for Qualifications process to identify partner agencies for subgrants as well as a Request for Proposals process to identify the external evaluator. Partners were brought under contract beginning April 1, 2017. When the timeframe for the study was reduced by a year, a second RFP process was employed to award a fifth agency. And the 18-month visit with families was eliminated. Data collection was originally to end April 30, 2020 but continued until August 2020. The final evaluation report was to be completed in the Fall of 2020. United Way's contract with CNCS ends December 31, 2020.

Evaluation and Program Staff Involvement

United Way for Southeastern Michigan

This is the final project team from United Way:

- Chief Impact Officer: Tonya Adair
- Senior Director: Jeffrey D. Miles, MSW
- Project Manager: Melanie Gill, MPA
- Data Specialist: Maya Satterwhite

Philliber Research and Evaluation

Upon embarking on the GOALS evaluation with United Way, Philliber established a five-member team to manage the evaluation. These team members included:

- Lead Evaluator: Randi Burlew, PhD
- Senior Evaluator: Stacie Powers, PhD
- Senior Advisor: William Philliber, PhD
- Data Analyst: Ed Parker, MA
- Evaluation Coordinator: Heather Hirsch, MS

Drs. Burlew and Powers provided general oversight of the project, managed all evaluation activities, and supervised the Data Analyst and Evaluation Coordinator. Dr. Philliber provided technical assistance and consultation at all stages of the project. The Data Analyst cleaned and analyzed all data associated with the project and conducted routine reporting for the Monthly Summaries provided to United Way. The Evaluation Coordinator managed communication with and provided evaluation technical assistance and support to the five partners implementing the project.

The Philliber evaluation team remained consistent over the course of the project which helped with retaining institutional memory. Midway through the project, Philliber underwent organizational restructuring which included shifting of projects and responsibilities throughout the company. As a result, Dr. Powers transitioned off of the GOALS project. However, she remained available throughout the course of the project for consultation and often reviewed documents and reports associated with the GOALS project deliverables.

Partner Agencies

At the start of the GOALS program each partner agency was staffed with one Program Manager and at least two Family Check-Up Model Specialists. Due to a language barrier, one agency was allowed to have a third FCMS who worked with Spanish speaking families and eventually moved into a dual capacity of both FCMS and DCS. After the extensive FCMS training had been completed, each agency added one Data Collection Specialist to work with comparison families.

Throughout the course of the GOALS program the ability to maintain a consistent staff varied drastically between the agencies. While one agency replaced one FCMS early in the program and maintained staffing thereafter, another went through a plethora of staffing changes including three managers, nine FCMS's, and two DCS staff.

While turnover at any position was difficult, losing an FCMS had the most impact on the program. This can partially be connected with the difference in training FCM specialists received throughout the program. Original members of the FCMS staff received training on the Family Check-Up Model (directly from Arizona State University), conducting assessments, connecting families with resources, using the pathways, and utilizing the Efforts to Outcomes database. New FCMSs coming in after the start of implementation participated in a Family Check-Up training with a certified FCU trainer and were educated by their agencies on conducting assessments, community resources and pathways, and entering data into ETO. Since newer staff members did not have consistent training across agencies, slight variations in implementation as well as data entry occurred. Differences were often addressed during monthly Learning Communities.

The loss of either an FCMS or a DCS was also felt among the participating families. Specialists were able to build trusting relationships with their clients throughout the program. When a specialist left, it was often difficult for families to recreate that relationship with a new case worker. Partner agencies suggested this was due to the deeply personal nature of the

assessments. This was especially true for participants that had more than one change in FCMS or DCS. It is hypothesized that some families dropped out of the program due to inconsistent staffing.