Wisconsin Promising Practices Program

Supporting Teen Families

Program Summary

August 2010

WISCONSIN PROMISING PRACTICES

PROGRAM SUMMARY

SUPPORTING TEEN FAMILIES

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Preface

Wisconsin Promising Practices Program

Program Background. The Wisconsin Promising Practices (WPP) program is one component of the What Works: Reducing Health Disparities in Wisconsin Communities project. "What Works" is a three-year, collaborative project between the Wisconsin Division of Public Health, Minority Health Program and the University of Wisconsin Population Health Institute, funded by the Wisconsin Partnership Program. The overarching goal of the What Works project is to identify and disseminate both evidence-based practices from the research literature and promising practices being implemented in Wisconsin communities that have the potential to improve minority health and reduce racial and ethnic health disparities in our state. This Program Summary provides documentation of a promising Wisconsin program.
Conceptual Framework. We have defined as "promising," a practice, intervention or program that:

1. Focuses on improving health in a racial or ethnic minority population;
2. Produces at least one positive outcome that can be demonstrated with systematically collected quantitative and/or qualitative data;
3. Is based to some degree on proven practices from the research literature and/or the experience of community practitioners and leaders; and
4. Is well suited to its context in terms of language, belief systems and other cultural factors.

A promising practice, by our definition, may be an adaptation of an evidence-based practice to a setting or population that differs from the one in which it was originally developed, or a practice which is developed "from the ground up" to fit a particular context.

As shown below, the WPP program distinguishes promising practices from both evidence-based practices and best practices in several ways. The expectations of a program's ability to demonstrate its effectiveness in a scientifically sound manner are less rigorous for promising practices than for evidence-based or best practices, and promising practices do not need to demonstrate that they are replicable in multiple settings. Nonetheless, documenting and sharing information about promising local strategies is an important step in building the evidence base for effective public health interventions.

Wisconsin Promising Practices Program
Conceptual Framework for Evidence Categories

EVIDENCE-BASED PRACTICES (EBP)	BEST PRACTICES	PROMISING PRACTICES
Criteria for Evidence of Effectiveness		
Effectiveness has been confirmed by systematic research or expert consensus. EBP models tend to regard the results of systematic reviews of controlled experimental studies as the highest level of evidence.	Similar evidence requirements as for EBPs, but may rely more heavily on expert consensus rather than reviews of controlled experimental studies than do some EBP models.	Produces at least one positive outcome that can be demonstrated with systematically collected quantitative and/or qualitative data.
Expert review of effectiveness required		
Yes	Yes	No
Proven to be replicable in multiple settings		
Yes	Yes	No
Suitability to a particular context		
Not a consideration	Not a consideration	Highly valued

Program Summary Contents. The information included in this Program Summary is intended to provide a broad understanding of how the program has been planned, implemented and evaluated to date. Included in each Program Summary is information about the theoretical and other frameworks which inform the program's design, a detailed description of how the program has been implemented, an overview of the resources invested in the program, and a discussion of program evaluation methods and key outcomes. The WPP program also recognizes that understanding the local context in which an intervention has been implemented is critical to making an informed decision about whether it might be appropriate for another community or setting. Therefore, each Program Summary also includes reflections by program staff members on the political, organizational and other contextual factors that have contributed to the program's success.

Purpose of the Program Summaries. A major objective of the Wisconsin Promising Practices program is to recognize community voices and provide them a systematic means for sharing stories about their own experiences with successful interventions. We hope that by providing a forum for community-based organizations to document and share their promising practices, others might learn from them and consider whether aspects of these programs may be appropriate to implement in their own communities. However, publication of these Program Summaries does not constitute an endorsement by the Wisconsin Division of Public Health, the University of Wisconsin Population Health Institute or the Wisconsin Partnership Fund of any programs or practices described herein.

For more information about the Wisconsin Promising Practices program or the What Works project, please visit our website at
http://dhs.wisconsin.gov/health/MinorityHealth/prompractices/index.htm

Executive Summary

Supporting Teen Families was designed to serve the growing teen parent population in Milwaukee County. Delivered as a home visiting program, Supporting Teen Families is designed to allow teen parents to develop assets to form safe, healthy families and avoid repeat teen pregnancies. Supporting Teen Families is a prevention-based program, for teen mothers and their support systems, that utilizes a multigenerational approach to case management, serving both pregnant and parenting teen mothers, their parent or other adult support person, and the father of the baby or the teen mother's boyfriend.

Supporting Teen Families serves teens living in Milwaukee County who are 19 years of age or younger at time of intake. While the program serves any pregnant/parenting teen, our primary population includes African-American and Hispanic teens living in Milwaukee zip codes that have the highest incidence of teen pregnancy, child abuse and poverty.

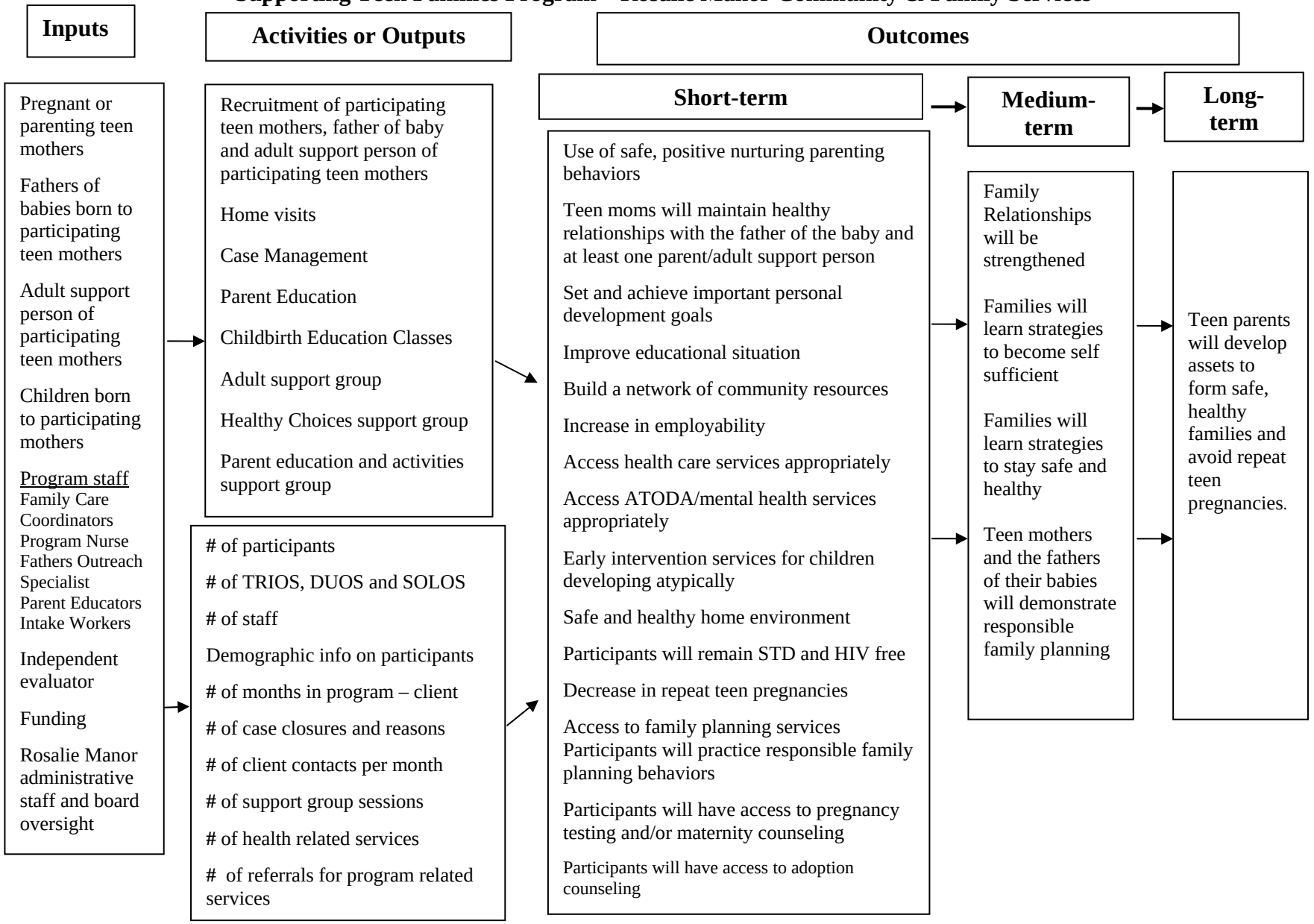
The program's hypothesis is: teen mothers who participate in a home-visitation program with an adult support person AND the father of the baby (TRIOS) will report significantly better outcomes at a 12-month follow-up than those who participate in the program with only one partner (DUOS), or without the involvement of either of these support people (SOLOS). The specific outcome areas addressed by this hypothesis are:

1. Building strong family relationships;
2. Learning strategies to become self-sufficient;
3. Learning strategies to stay safe and healthy; and
4. Demonstrating responsible family planning behaviors and attitudes.

Evaluation of the Supporting Teen Families program involves documenting client participation and receipt of services, as well as the administration of a pre- and post-test telephone survey. While future evaluation activities will involve assessing differences in outcomes for the groups described above, a current analysis of telephone survey results for a sub-set of mothers (n=35) from Years 2 and 3 of the program shows positive outcomes for several short-term indicators for this group. Parenting teens reported engaging in nurturing parenting behaviors with their babies more frequently at follow-up than at baseline. Also at follow-up, a majority of mothers reported improvements in access to health care, improvements in their babies' healthcare, and that they had learned about their babies' physical growth and emotional development from their family care coordinator.

Logic Model

Supporting Teen Families Program – Rosalie Manor Community & Family Services



Program Hypothesis: Teen mothers who participate in a home visitation program with an adult support person AND the father of the baby (TRIOS) will report significantly better outcomes at 12-month follow up than those who participate in the program with only one partner (DUOS) or without the involvement of these support people (SOLOS).

Intervention Context

Target population. The Supporting Teen Families program is designed to serve:

- Milwaukee County pregnant and parenting teen mothers under the age of 19;
- The babies of these pregnant and parenting teen mothers;
- The fathers of the babies;
- Adults in support of the teen mothers;
- Persons of any race or ethnicity, however the program is targeted for teen mothers of color; and
- Persons living at or below the poverty level.

Prevalence of data and other information describing the issue addressed by the program.
The Supporting Teen Families program was designed in 2005. While teen pregnancy remains an issue for Milwaukee, at the time it was an even bigger situation. According to The Right Start for America's Newborns which measured information from 2002[1], Milwaukee's rate of teen births was one of the highest among the nation's 50 largest cities, ranking second for the percentage of total births to teens. The Right Start's 2002 key indicators reveal that in Milwaukee, 18.7% of total births were to teens (as compared to the 50-city average of 12.7%). In 2001, 24.9% of teen births were to women who were already mothers in Milwaukee, and that percentage increased to 25.8% in 2002 (while the 2002 50-city average is 21.8%). Compared to the 50-city average of 43.9% of total births to unmarried women, in Milwaukee 60.3% of total births were to unmarried women. As noted in Table 1 below, Milwaukee also fared poorly on such measures as maternal education, prenatal care usage, smoking during pregnancy, infant birth-weights, and pre-term births.

Table 1: Rankings of Milwaukee, Wisconsin 2002

Indicator		**Percent Milwaukee**	**Milwaukee's Ranking (50 = worst; 1= best)**	**Percent 50-City Average**
1.	Total teen births	18.7%	49	12.7%
2.	Repeat teen births	25.8%	44	21.8%
3.	Total births to unmarried mothers	60.3%	43	43.9%
4.	Low maternal education (mothers with less than 12 years of education)	35.8%	43	27.3%
5.	Late or no prenatal care	5.6%	32	4.9%
6.	Smoking during pregnancy	13.5%	32	8.8%
7.	Low-birth-weight births (less than 5.5 lbs.)	9.3%	33	8.8%
8.	Pre-term births (less than 37 weeks of gestation)	14%	37	13.0%

Source: The Right Start for America's Newborns – Annie E. Casey Foundation, 2005

According to 2004 data, Wisconsin rated second highest for pregnancy rates per 1,000 black women aged 15 to 19.[2] While teen pregnancy remains an issue in the African American community, high teen birth rates make this an important issue for the Hispanic community as

well. In analyzing teen sexual activity, pregnancy, and childbearing among major racial/ethnic groups in the U.S., the National Campaign to Prevent Teen Pregnancy (2004) concludes that the Hispanic population is the fastest growing group in the U.S., and that Hispanic youth have the highest teen birth rate nationally. While the overall U.S. teen birth rate decreased 28.5% between 1990 and 2000, the Hispanic teen birth rate decreased only 15.0% during that same period.

Program Framework and Rationale

The Supporting Teen Families program was derived from a former program developed by Rosalie Manor, Supporting Today's Teen Parents. Both programs used Family Care Coordinators (FCC) who provide home visits to teen mothers. The goals of both programs are to reduce the incidence of child abuse and neglect, reduce subsequent pregnancies, and increase the teen mother's self-sufficiency skills. While the goals remain the same, the Supporting Today's Teen Parents program did not offer specific components that could help teens succeed. Therefore, when we had the opportunity to apply for federal funding to improve this model, we took the basic premise and utilized our staff's ideas to improve the program's design. The following are new components that were included in the Supporting Teen Families design:

- ***Serving the adult support person of the teen mother*** –Because many of the teen parents we serve are under the age of 17, they live with their parent or other adult support person such as an aunt or grandmother. Our FCCs realized that the adult was often in greater need of social services than the teen mother herself. We included service to the adult support person because of our organization's belief that the more stable and successful they are, the better the outcome of the teen.
- ***Parents as Teachers*[3]***curriculum*** – Understanding appropriate child development is important in reducing the incidence of child abuse and neglect. This is an area that teen parents need assistance in learning. Of the five core values incorporated into the overall curriculum and program design of the Parents as Teachers logic model, two resonate with the Supporting Teen Families program: 1.) all young children and their families deserve the same opportunities to succeed, regardless of any demographic, geographic or economic considerations; and 2.) an understanding and appreciation of the history and traditions of diverse cultures is essential in serving families. We liked the fact that the Parents as Teachers curriculum provided child development information not only in a fun way (finger-plays, reading books, making toys out of household items), but incorporated the aforementioned core values into the program design as well.
- ***Employing a Job/Housing coach*** – In the previous program, jobs and housing were the two consistent issues with which teens needed assistance. In order to allow case managers to handle other needs, we hired a Job/Housing Coach to handle these issues.
- ***Father's Outreach Specialist*** – Because fathers are an important component in the life of a child we included two Father's Outreach Specialists positions to work directly with the fathers of the babies or boyfriends of teen mothers.
- ***Nurse*** – We incorporated a part-time nurse to handle basic medical needs for all family members, conduct childbirth education classes and to make sure all family members had a primary care physician.

- ***Intake Specialist*** – In order to best handle program recruitment we decided to incorporate a position focused on recruiting participants, handling intake paperwork, and disseminating cases to staff. This bilingual (Spanish) staff person recruits prenatal and postnatal teens from area schools, medical clinics and birthing hospitals.
- ***Support Groups*** – Three support groups were developed including:
    - *Grandparent Support Group* **–** offers the teen's parent/adult support person the opportunity to build their social support group and decrease stress and isolation;
    - *Healthy Choices Group* **–** held for teen mothers and the fathers of the babies to teach the importance of making positive decisions related to their sexual health, promote a positive relationship between the two, and decrease the sense of isolation for the teen mom; and
    - *Parents Education and Activity Group* **–** this group is open to all participants and utilizes the Parents as Teachers group-based curriculum.

The following is a brief description of each staff position as created in 2005 and how they work together to serve the client:

- ***Family Care Coordinator (FCC)*** – The FCC works with the teen mother and the adult support person providing case management and implementing the Parents as Teachers curriculum. Case management includes a 90-day care plan that is designed in tandem with the teen/adult support person and the FCC. Goals are set and monitored. The teen mother receives up to three monthly visits, one of which is the Parents as Teachers curriculum implementation. The adult support person receives up to two monthly visits. The caseload is capped at 25 families (25 teen mothers and 25 adult support people). A total of four full time FCCs are employed in this program, two of whom are bilingual.
- ***Father's Outreach Specialist (FOS)*** – The FOS works with the fathers or boyfriends of the teen mothers. Each father receives up to two monthly visits. They too work from a care plan that is regularly monitored. A total of two full time FOSes are employed in this program, one of whom is bilingual.
- ***Intake Specialist*** – The intake specialist is responsible for program recruitment and intake forms. A total of one bilingual staff is employed in this program.
- ***Nurse*** – The nurse provides childbirth education classes and a minimum of one visit per enrolled family member. She is available for consultation when another staff person requests it. One part time staff is employed.
- ***Job/Housing Specialist*** – This position provides resources, leads and assistance in finding employment or safe and affordable housing. One full time staff is employed in this program.

Behavioral theory or other theoretical frameworks used to inform the design of the program.
Supporting Teen Families, a program designed in 2005, is based on many theories and best practices in serving teen parents. The theories used are based around the following programmatic areas: a home visiting model, a multigenerational approach to service, including nursing services as a program component and incorporating fathers into service delivery.

The primary method of service delivery for Supporting Teen Families is home visitation. Rosalie Manor has been offering this type of service delivery since 1989. The overall home

visiting design was based on the research of Deborah Daro[4], DSW and collateral works by several researchers at the National Committee for the Prevention of Child Abuse and elsewhere. The program also draws upon the experiences of "Healthy Start," Hawaii's Statewide Home Visitor program.[5] Modeled after the Hawaii Healthy Start program, one of the underlying goals of Supporting Teen Families is to strengthen and empower new parents in a culturally competent approach toward healthy family growth, and to decrease child abuse or neglect as a result.

Olds[6,7] has urged that health and human services groups not make recommendations about, design, or implement home-visitation programs without considering the empirical evidence about the types of programs that are more successful. Current research[8] indicates that more successful programs contain the following critical elements, which Rosalie Manor's programs have been and will continue to consistently incorporate in the design and implementation of our home visitation programs:

- A focus on families in greater need of services (as opposed to universal programs that may avoid stigmatizing families but might dilute scarce resources), including families with low-birth-weight and pre-term infants; children with chronic illness and disabilities; low-income, unmarried teenage mothers; parents with low IQs; and families with a history of substance abuse;
- Intervention beginning in pregnancy and continuing through the second to fifth year of life;
- Flexibility and family specificity, so that the duration and frequency of visits and the kinds of services provided can be adjusted to a family's need and risk level;
- Active promotion of positive health-related behaviors and specific qualities of infant care-giving instead of focusing solely on social support;
- A broad multi-problem focus to address the full complement of family needs (as opposed to a focus on a single domain such as increasing birth weights or reducing child abuse);
- Measures to reduce family stress by improving its social and physical environments; and
- The use of nurses or well-trained paraprofessionals.

In addition to these elements, we view families as systems made up of individuals with overlapping and interacting needs and behaviors. We believe families are resilient, dynamic, and capable and should be viewed as having assets and strengths. It is up to service providers to recognize these strengths, assets and needs and to help the family to develop to their fullest potential possible, while intervening in a respectful and dignified manner that encourages family input and growth. We see ourselves as partners with the families we serve, not as the "know it all" experts, and we do not do things "to" families, but rather we do things "with" families to facilitate the growth and development of the family unit. We believe families are best served in their home and in their community using a culturally competent systems approach in delivering these services. Our goal is to have staff that is culturally reflective of the population served. We believe that families need to be involved in designing and implementing their own case planning and in the review of such plans, and that they have the right to be included in such activities with their families.

When designing the program, our staff saw a need to serve not only teen mothers but also their support system. This idea matches research[9] detailing the importance of a multigenerational,

family systems approach for service. Most African-American adolescent mothers are unmarried and raise their children in maternal three-generation households. Support is a critical component within adolescent parenting families, and young mothers are likely to feel more competent in their role as parents if they have support from those in their proximal environment.

In "*Family Processes Within Three-Generation Households and Adolescent Mothers' Satisfaction With Father Involvement,*"[10] Krishnakumar and Black's findings indicated that mothers' parenting efficacy is dependent on their view of fathers, and when the young mothers reported positive relationships with fathers, they felt more efficacious as parents over time. Adolescent mothers' parenting efficacy hinge on their relationship with fathers, the importance they give to the role of fathers, quality of grandmother-father relationships, and adolescent mothers' depressive symptoms. Moreover, in three-generation families, "*Efforts to increase paternal involvement should focus on role clarification for grandmothers and fathers and on parenting activities for mothers and fathers, regardless of their romantic relationship.*" [10] Krishnakumar and Black's report also included the following findings:

- Fathers who were involved in care-giving activities had positive relationships with adolescent mothers and grandmothers;
- Fathers who were in positive and supportive relationships with grandmothers were more likely to be involved with their children over time than were fathers who had conflictual and negative relationships with grandmothers;
- When grandmothers reported positive relationships with the two young parents, adolescent mothers reported positive relationships with their male partners; and
- Mothers who reported positive partner relationships also reported high parenting efficacy and satisfaction with father involvement.

Various research investigations illustrate the importance of adopting a family systems perspective when working with young parents and their families. Mothers play critical roles in the lives of their children who are teen parents. When parents have conflictual and unsupported relationships with the father of the baby or regard them in a negative light, fathers may distance themselves from adolescent mothers and their children. Therefore, the teen mother's parent should be included in early intervention programs designed for young parents. Healthy relationships with all family members may help fathers become active members of the family, gaining skills that may help them remain involved with their children and partners over time.[10]

Father involvement is directly linked to adolescent mothers' parenting efficacy. Mothers who feel confident in their parenting skills invite fathers to be involved, and when fathers are involved, mothers feel more confident and secure in their roles as parents. Two-parent involvement in childrearing creates a healthy environment for children, and both parents should be involved in skill-oriented parent education programs that will help fulfill their roles as providers, caregivers, and nurturers of their children.[10]

Children who have infrequent or inconsistent contact with their fathers are at higher risk for a host of negative outcomes. These outcomes include:

1. Children in father-absent homes are five times more likely to be poor. In 2002, 7.8 percent of children in married-couple families were living in poverty, compared to 38.4 percent of children in female-householder families.[11]

2. Even after controlling for income, youths in father-absent households still had significantly higher odds of incarceration than those in mother-father families. Youths who never had a father in the household experienced the highest odds.[12]
3. A 2002 Department of Justice survey of 7,000 inmates revealed that 39% of jail inmates lived in mother-only households. Approximately forty-six percent of jail inmates in 2002 had a previously incarcerated family member. One-fifth experienced a father in prison or jail.[13]
4. Researchers using a pool from both the U.S. and New Zealand found strong evidence that father absence has an effect on early sexual activity and teenage pregnancy. Teens without fathers were twice as likely to be involved in early sexual activity and seven times more likely to get pregnant as an adolescent.[14]

In addition to connecting families with each other through the program, each family will have the opportunity to receive home visiting services from a nurse. There are many benefits of a nurse-family partnership. A study[15] by Olds and colleagues found:

1. Nurse-visited women of low socioeconomic status had 43 percent fewer subsequent pregnancies compared to the control group; and
2. Nurse-visited women of low socioeconomic status delayed the birth of their second child an average of 12 months longer compared to the control group.

The Supporting Teen Families program provides holistic and comprehensive services bringing together the teen mother, her parent or other adult support person, and the father of the baby. Through integration of aforementioned research data and proven strategies, Supporting Teen Families provides a support system for the entire family. We believe that the solutions to healthy, strong families cannot rely on supporting just the adolescent mother or the father in isolation. People present or absent in one's proximal environments (such as one's partners and parents) influence one's and one's children's well-being; thus, it is important to understand each teen mother's relationships, or lack thereof, especially with her adult support person and the father of the baby.

Program Implementation

Table 2, below, outlines the Supporting Teen Families work plan.

Table 2. Supporting Teen Families Work Plan

WORK PLAN	TIMETABLE	PERSONNEL RESPONSIBLE
Participant Recruitment and Enrollment		
Recruit at area schools, community programs and area hospitals.	June 2009 and ongoing	Intake Specialist
Continue to foster and enhance community connections with area clinics, hospital, schools and other community programs.	June 2009 and ongoing	Program Director, Program Supervisor and FCC staff
Recruit and enroll participants for groups.	June 2009 and ongoing	Intake Specialist

Table 2. Supporting Teen Families Work Plan (continued)

WORK PLAN (continued)	TIMETABLE	PERSONNEL RESPONSIBLE
Home Visiting Components Offered by FCC		
Provide case management services for teen mothers, their parents or identified support person, and the fathers of their babies.	June 2009 and ongoing	Family Care Coordinators (FCC)
Provide parenting education for all family components of this program.	June 2009 and ongoing	FCC staff
Provide guidance for positive parenting techniques with families.	June 2009 and ongoing	FCC staff
Perform screenings for developmental appropriateness and typical social emotional development.	June 2009 ongoing	FCC staff
Develop care plans for teen parents, support persons and fathers of their babies detailing long- and short-term goals and steps needed to achieve these goals.	June 2009 and ongoing	FCC staff
Work with teen mothers and the fathers of the babies to develop positive life skills individually.	June 2009 and ongoing	FCC staff
Provide referrals to community based organizations that benefit the family.	June 2009 and ongoing	FCC staff
Report suspected cases of child abuse and neglect to the Bureau of Milwaukee Child Welfare.	June 2009 and ongoing	FCC staff and Program Director
Nursing Services		
Visit families and complete medical screenings.	June 2009 and ongoing	Nurse
Hold a childbirth education class.	September 2009	Nurse
Ensure that each family has a medical home.	June 2009 and ongoing	Nurse
Provide nutrition education individually and in group based format.	June 2009 and ongoing	Nurse
Group Based Services		
Recruit for group participation for group sessions set prior to June, 2009	June 2009 and ongoing	FCC staff

Since 2005 we did tweak the Supporting Teen Families program based on the needs of the clients. These changes included were based on client feedback during home visits and focus groups held by evaluators:

- ***Eliminating the Job/Housing Coach position*** – We learned this position was not utilized to its highest capacity. The teen parents felt more comfortable working with their case manager and didn't feel comfortable working with another staff person on job/housing issues.
- ***Eliminating one Father's Outreach Specialist*** – Because we assumed we would be serving the same number of fathers as teen mothers, we hired two Father's Outreach Specialists. After one year it became clear that the enrollment of fathers was far

below initial expectations, and we eliminated one of the Father's Outreach Specialist positions. *Eliminating One Case Manager position* – We initially had 4 Family Care Coordinators based on our assumption we would have 100 teen mothers in our program at all times. What we realized was that we were never at capacity at one time, and could better utilize funds budgeted for this position for a position that was needed.

- ***Creating two Parent Educator positions*** – Initially we thought the case manager could visit the teen mother once a month providing case management services and on a second monthly visit would implement the Parents as Teachers curriculum. Unfortunately, this proved too difficult for both the teen and the Family Care Coordinator to focus on different topics at different visits. Because we eliminated the Job/Housing Coach and one Family Care Coordinator, we allocated those dollars to two Parent Educators who focus solely on the Parents as Teachers curriculum.
- ***Incorporating central scheduling –*** Scheduling for each Family Care Coordinator is now done by the Intake Specialist. This change was made to increase the number of visits completed verses attempted. Instead of the FCC contacting the client at a later date to set their next appointment, the FCC now calls the Intake Specialist when the home visit is completed to set up the next meeting with the client, and then gives the client a card with the date and time. We believe this will make the appointments seem more professional to the client thereby increasing the completed home visit rate.

The program design in place at the time this Project Summary was written is as follows:

- Family Care Coordinators – 3 full time, 1 bilingual (Spanish)
- Father's Outreach Specialist – 1 full time
- Nurse – 1 part-time
- Intake Specialist including recruitment and scheduling duties – 1 full time bilingual (Spanish)
- Parent Educators – 2 full time, 1 bilingual (Spanish)

The service delivery model remains the same as when the program began in 2005.

Summary of Inputs

START-UP OR OTHER ONE-TIME EXPENSES

DESCRIPTION	**AMOUNT**
Parents As Teachers Staff training for 2 staff members	*$1,650*
TOTAL ONE-TIME EXPENSES:	**$ 1,650**

ANNUAL OPERATING EXPENSES/BUDGET for FISCAL YEAR 2008-09

EXPENSES		
CATEGORY	**DESCRIPTION**	**AMOUNT**
PERSONNEL	*Salary for 7 FTE staff members, one .6 FTE nurse position, one .34 FTE program director and one .34 FTE program manager*	*$271,656*
	Benefits for direct service staff	*$70,485*

ANNUAL OPERATING EXPENSES/BUDGET for FISCAL YEAR 2008-09 (continued)

EXPENSES		
CATEGORY	**DESCRIPTION**	**AMOUNT**
TRAINING COSTS	*Staff education general training opportunities*	*$5,800*
TRAVEL	*Mileage reimbursement for staff at $0.45/mile ($100/mo. x 12 months x 8 staff)*	*$9,600*
	Travel expenses for program groups (bus tickets = 200 tickets x 12 months)	*$2,400*
	Annual conference travel expenses (4 people)	*$6,000*
CONTRACTUAL	*Project evaluation*	*$29,000*
	IT manager ($22/ hr x 30 hours/week)	*$10,296*
	Development assistant	*$9,000*
SUPPLIES	*Program related printing*	*$2,000*
	Program related postage	*$2,000*
	Evaluation/client retention incentives	*$500*
	Program supplies	*$16,500*
	Administrative supplies including IT	*$16,250*
SHARED/INDIRECT COSTS	*Administration salaries for six .15 FTE staff members*	*$49,397*
	Benefits for administration staff	*$12,732*
	Insurance	*$3,000*
	Utilities	*$17,431*
	Telephone – cell and landline costs	*$8,820*
	Depreciation	*$22,000*
OTHER		
		TOTAL ANNUAL EXPENSES: $ 566,517

REVENUE		
CATEGORY	**DESCRIPTION**	**AMOUNT**
GOVERNMENT	*Federal Adolescent Pregnancy Program Grant*	*$340,000*
FOUNDATIONS	*Northwestern Mutual Foundation*	*$10,000*
	Elizabeth Brinn Foundation	*$5,000*
	Windhover Foundation	*$10,000*

REVENUE (continued)		
CATEGORY	**DESCRIPTION**	**AMOUNT**
	Catholic Community Foundation	*$11,000*
	M&I Foundation	*$2,000*
	St. William Parish	*$500*
	Park Bank Foundation	*$1,000*
INDIVIDUAL	*Individual donations*	*$603*
OTHER	*Medicaid billing*	*$69,113*
	In Kind Social Work Interns	*$10,384*
	In Kind volunteer hours and donated program supplies for program participants	*$80,913*
	Rosalie Manor match (CCF withdrawal)	*$26,004*
		TOTAL REVENUE: $566,517

Program Evaluation

Overview of Program Evaluation Activities. Supporting Teen Families measures its objectives through an ongoing evaluation process, completed by an external evaluation team at the University of Wisconsin-Milwaukee. Staff collect data via the administration of a pre- and post-survey called the Core Instrument Surveys developed by the Adolescent Family Life program, which we have modified to include Supporting Teen Families objectives.

Supporting Teen Families staff administer baseline surveys during the first meeting with participating mothers and fathers. Staff from the UW-Milwaukee Center for Urban Initiatives Research (CUIR) administer follow-up surveys over the phone when a participating mother or father reaches her/his one-year anniversary of enrollment, or upon closeout of participation in the program, whichever comes first.

Included in this survey are questions regarding satisfaction with the current living arrangements, feelings of safety, level of school completion, parenting attitudes and behaviors, employment status as well as basic medical information such as preventive care and sexual health.

Rosalie Manor has faced large challenges in collecting follow-up data on program participants. As mentioned above, the funding source requires that the program collect follow-up data 12 months post intake or upon closeout of participation, whichever comes first. It has been difficult to retain program participants for a year or longer, an experience by many inner-city home-visiting programs. In addition, lack of participation and the transience of participants are the factors that most often contribute to closeout prior to the 12-month anniversary. For these reasons, it has been very difficult to get the follow-up survey completed. Lastly, follow-up surveys are completed via telephone and are administered by staff from UW-Milwaukee CUIR. Often times, phone numbers change or are disconnected or the participant does not recognize the caller, creating additional barriers to completing the follow-up survey. For these reasons, there is a small sub-set of matched pre- and post-test surveys for this project.

The remainder of this section contains process and short-term outcome indicators for a small sub-set of mothers served in Years 2 and 3 of the program (n=35), for whom we were able to gather both baseline and follow-up data. The data presented below reflects only the responses of these mothers and is not representative of our larger client population.

Process Evaluation

Demographic information. As shown in Table 3, the majority of mothers in this group are African American. Their ages at the time baseline data was gathered ranged from 13 to 19 years (age data was unavailable for four mothers). Fifteen of the mothers were pregnant at the time baseline data was gathered, while 17 were parenting at baseline (data was unavailable for 3 mothers).

Table 3.
Demographic Information

Indicator	Value
Race and ethnicity (n=35)	
African American	25; 71%
Hispanic or Latino	7; 20%
White	2; 6%
Asian	1; 3%
Age (n=31, missing data=4)	
Median age at baseline	17
Age range at baseline	13 to 19
Parenting status (n=32, missing data=3)	
Pregnant at baseline	15
Parenting at baseline	17

Program dosage information. The number of attempted and completed phone calls, home visits and other contacts by Rosalie Manor staff is documented for each client in an in-house database. Table 4 below summarizes information about the number of completed home visits and phone calls by staff members to the 35 mothers discussed in this section.

Table 4.
Home visits and Phone Calls completed by Rosalie Manor staff

Indicator	Value n=35
Home visits	
Median number of home visits per client	5
Range	1 to 83
Phone calls	
Median number of phone calls per client	5
Range	0 to 56

Short-term Outcomes

Program outcomes are assessed for Supporting Teen Families clients related to four program objectives:

- Strong family relationships will be increased;
- Teen mothers will report learning strategies to become self-sufficient;
- Teen mothers report learning strategies to stay safe and healthy; and
- Teen mothers will report increased responsible family planning behaviors and attitudes.

We were able to show at least one positive short-term outcome for these 35 mothers for two of the four objectives.

Objective 1*: *Strong family relationships will be increased.

At both baseline and follow-up, clients who are parenting are asked how often they engage in eight specific nurturing behaviors with their child. The behaviors include singing songs or nursery rhymes, playing games such as "peek-a-boo," reading or telling stories, playing with toys such as blocks, visiting relatives with the child, hugging or showing physical affection, and putting their child to bed. Table 3 below shows that Supporting Teen Families clients reported engaging in these behaviors more frequently after participation in the Supporting Teen Families program. Additionally, the majority of all 35 clients reported during their follow-up survey that they had learned about the importance of these behaviors from their Rosalie Manor family care coordinator.

Indicator:

- Self-reported frequency of nurturing parenting behaviors

Table 5.
Objective 1. Short-term outcome

Indicator	**Value** n=16; missing data=1
Increases in self-reported frequency of engagement in nurturing parenting behaviors from baseline to follow-up	Significant increase in mean frequency; p<.001

Clients were also asked whether participation in the Supporting Teen Families program helped them to improve their relationship with the father of their baby and their adult support person. While less than half reported that the program helped them to improve their relationship with the father of their baby (45.7% n=34; missing data=1), 20 of the 34 mothers who responded to this question reported that their relationship with their adult support person had improved because of their participation in the program (58.8%).

Objective 3. Teen mothers report learning strategies to stay safe and healthy

A majority of the mothers reported at follow-up that their participation in the Supporting Teen Families program had helped them in the area of access to health care and that they had learned about their baby's physical growth and emotional development from their Rosalie Manor family care coordinator.

Indicator:

- Self-reported increase in access to health care
- Self-reported improvement in baby's health care
- Self-reported increase in knowledge of baby's physical growth and emotional development

Table 6.
Objective 3. Short-term outcome

Indicator	Value
Self-reported improvement in their access to health care (n=35)	22; 62.9%
Self-reported improvement in baby's health care (n=31; missing data=4)	18; 58.1%
Clients reporting that they learned about their baby's physical growth and emotional development from their family care coordinator (n=32; missing data=3)	26; 81.2%

Additionally, although the question was not specific to health and safety, a majority of clients also reported on the follow-up survey that they "learned something from this program that they wouldn't have learned anywhere else" (58.8%; n=34; missing data=1).

Future efforts to measure Long-term Outcomes. The overall analysis of long-term outcomes will review the program's hypothesis. We anticipate teen mothers who participate in Supporting Teen Families with their adult support person and the father of the baby (i.e., as TRIOS) will be significantly more likely to report **strong family relationships**, ***learning strategies to become self-sufficient, learning strategies to stay safe and healthy*** at 12-month follow-up than will those participating with either their adult support person or the father of the baby (as DUOS) or alone (as SOLOS). These will be measured annually and will be analyzed at the end of program year 5. In addition, two single item indicators, **mothers who say the program improved their access to health care** and **mothers who say the program improved their baby's health** will be evaluated between TRIOS-DUOS-SOLOS.

Staff Reflections on Project

Keys to the program's success. There are several elements of Supporting Teen Families that are necessary to make the program successful, including organizational support, staff, and community partnerships.

Organizational support. One of the reasons the Supporting Teen Families program is successful is due to the multidisciplinary team of staff working with each family as well as the program delivery itself (home visiting). While this program is successful, it is expensive to operate. It requires up to 3 staff working with each program (Family Care Coordinator, Parent Educator and Father's Outreach Specialist), along with a nurse and an Intake Specialist. It would be impossible to keep program fidelity if these staff positions were not in place. If an organization does not support this project through both its mission and fundraising efforts, this program will most likely fail.

Staff. Perhaps the greatest key to success for Supporting Teen Families is staff. First is the program manager. When hiring a manager, it is important for the person to have a degree in social work or other closely related field as well as previous experience in supervising staff. It is the manager who will assist staff in making important decisions regarding the safety of the participant and this person must be well-versed in understanding area safety nets (in Milwaukee, the Bureau of Milwaukee Child Welfare). It is also important for the manager to understand and adhere to program evaluation commitments, including timely completion of paperwork, regularly scheduled documentation of data, and overseeing program fidelity.

Case management staff are extremely important for the success of Supporting Teen Families. While we do place emphasis on an educational background and would prefer staff to have a bachelor degree in social work or other related field, we've learned there are life-skills that usually play a larger role in case management success.

Family Care Coordinators and Father's Outreach Specialists must have the ability to work with teens and adults, be a "people-person," have excellent time-management skills, be able to work independently and with a team, be diligent with paperwork, be committed to prevention of child abuse and neglect, and be able to perform home visits alone.

All staff must have a clear understanding of issues around domestic violence, child abuse, and child neglect and must know they are mandated reporters.

Without these key staff traits in place, the program will be less successful.

Community Partnerships. Supporting Teen Families is a voluntary program and therefore participant recruitment is necessary. In order to recruit, it is imperative that an organization have a good relationship with area schools, hospitals, doctors' offices, health clinics and other community-based organizations. Because of our long history in working with teen parents, we continually receive referrals from middle and high schools and area hospitals. Without this referral stream, program recruitment would be difficult and the Supporting Teen Families program less successful.

Situations or contexts where this program is not likely to be appropriate or effective.
The Supporting Teen Families model is one that is unique to the target population served by Rosalie Manor. Supporting Teen Families was designed to serve Milwaukee urban teen mothers, specifically those living in the most impoverished neighborhoods. In Milwaukee, this population is primarily African American and Hispanic. Understanding the unique needs of the teen mothers that another Wisconsin city might serve would be important in tweaking the services to meet those needs. For example, our program offers case management services to the teen's adult support person. This service may not be needed in another city working with a different population.

Other lessons learned. There have been many lessons learned during the project period. First, it is important to know the needs of the population you will serve. We assumed that teenage girls were having babies with teenage boys. When designing the program, we planned for two Father's Outreach Specialists, each working with 50 fathers. Once we began services, we quickly learned that most of our teen mothers were dating men over the age of majority. Therefore, while fathers were interested in the program, they were reluctant to officially enroll in the program for fear of legal ramifications. Since the fathers would not officially enroll (a program requirement), we ultimately reduced the number of Father's Outreach Specialists from two to one.

We also learned that teens found it difficult to have a Family Care Coordinator who not only helped them with their basic needs, but also with parent education. Therefore, we hired two Parent Educators to implement the Parents as Teachers curriculum.

Regarding our evaluation, we learned the importance of understanding what *needed* to be collected. When Supporting Teen Families was originally designed, we tried to measure too many things and initially collected too much data. Throughout the program, we learned how imperative it is to understand the ultimate goals of the program and align the outcomes and subsequently the items that need to be collected. It also became clear during the project that it is important to have a database/tracking system that will collect the appropriate data and that is easily managed. We had a consultant create a database for us that initially seemed it would meet our needs. However as time passed, it became clear that our database does not perform as well as we had hoped. For future projects, we would get a different database.

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