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A STUDY OF WELL-BEING VISITS TO FAMILIES ON IOWA'S LIMITED BENEFIT PLAN

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The Authors

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GLOSSARY OF ACRONYMS

AFDC	Aid to Families with Dependent Children
DHHS	U.S. Department of Health and Human Services
DHS	Iowa Department of Human Services
IDPH	Iowa Department of Public Health
FIA	Family Investment Agreement
FIP	Family Investment Program
IAC	Iowa Administrative Code
ICN	Iowa Communications Network
LBP	Limited Benefit Plan
MPR	Mathematica Policy Research, Inc.
PROMISE JOBS	Promoting Independence and Self-Sufficiency Through Employment, Job Opportunities, and Basic Skills
SFY	State Fiscal Year
WIC	Women Infants and Children Supplemental Food Program

EXECUTIVE SUMMARY

On October 1, 1993, Iowa replaced Aid to Families with Dependent Children (AFDC) with a comprehensive welfare reform program officially known as the Family Investment Program (FIP). A central element of FIP is the requirement that welfare recipients carry out individual plans for self-sufficiency called Family Investment Agreements (FIAs). If FIP participants do not comply with the FIA requirement, Iowa offers a short-term alternative cash assistance program known as the Limited Benefit Plan (LBP). The original LBP was a 12-month period consisting of 3 months of cash benefits at the same level as FIP, followed by 3 months of reduced cash benefits, followed by 6 months of no cash benefits. In February 1996, Iowa implemented revised LBP policies that eliminated the 3-month period of level benefits and distinguished between first and subsequent LBP assignments. Under the revised policies, which remain in effect today, a first LBP is a 9-month period consisting of 3 months of reduced cash benefits followed by 6 months of no cash benefits; a subsequent LBP is simply a 6-month period of no cash benefits.

Concerns about potentially detrimental effects of the LBP on children spurred state policy makers to require that the Iowa Department of Human Services (DHS) systematically monitor the well-being of children in families that enter the LBP. In direct response to these requirements, DHS established the Well-Being Visit Program. This program is administered by DHS and the Iowa Department of Public Health (IDPH), in conjunction with local public health agencies in Iowa's 99 counties. DHS contracts with IDPH to administer the program and IDPH subconracts with local public health agencies to conduct the visits. These local agencies employ registered nurses and social workers who conduct the well-being visits. Most LBP families are eligible for two well-being visits, one during the three-month period of reduced benefits and one during the following six-month period of no benefits. While home visits are preferred, DHS allows staff to provide well-being visits at the client's home, at an alternate site, or by telephone.

This report presents findings from a study of the Well-Being Visit Program that Mathematica Policy Research (MPR) conducted for Iowa DHS. The study provides a comprehensive assessment of the existing design, process, and practices of the Well-Being Visit Program, and makes recommendations to address specific issues that will increase the value of the program to DHS and to the children affected by the Limited Benefit Plan.

ORIGIN OF THE STUDY

In early 1997, Iowa DHS had growing concerns that the Well-Being Visit Program was not fulfilling its principal objective of monitoring the well-being of children in LBP families. The completion rate for well-being visits--the proportion of clients referred to the program for which a well-being visit is conducted--hovered around 40 percent, indicating that the program was not reaching the majority of LBP families. Perhaps related to this, some state legislators started to question the value of this program. DHS was also concerned that limitations in the program's data collection and reporting systems were compromising the quality and usefulness of the information

obtained on LBP families. On the basis of these concerns, DHS determined that a systematic study and assessment of the Well-Being Visit Program was warranted.

RESEARCH OBJECTIVES

The goal of this report is to assess the existing design and methodology of the Well-Being Visit Program in order to (1) identify limitations of the program and (2) recommend ways DHS can improve the program and increase the value of the visits. MPR identified four specific objectives for the assessment:

1. ***Understand the low visit completion rate.*** Determine the reasons for the low completion rate of the well-being visits and the changes that could be implemented by DHS to raise the completion rate.

2. ***Assess the conduct of the visits.*** Examine key structural aspects of the visits, the focus of the visits, and training and support resources for staff; determine how to put the original program objectives more effectively into practice.

3. ***Assess the existing system for gathering information at the visits.*** Assess the content, format, and application of the Well-Being Visit Checklist; recommend changes to increase the quality of the visits and the resultant data.

4. ***Assess the existing system for reporting on the visits.*** Examine the program's reporting system; develop recommendations to improve the format, content, and distribution of the Well-Being Visit Monthly Report to make it more accessible and user-friendly.

In conjunction with our assessment of the program, DHS requested that MPR analyze recent data from the well-being visits to identify limitations and, to the extent that limitations permit, highlight substantive findings and suggest policy implications. The results of that analysis are presented in Appendix E (bound separately).

DATA SOURCES

Our assessment of the Well-Being Visit Program is based on data from four sources:

1. ***Focus group discussions.*** To obtain first-hand accounts of the well-being visits, we conducted three focus group discussions with the public health nurses and social workers who conduct the visits. We recruited well-being visitors from several neighboring counties for each discussion, covering a total of 13 Iowa counties with the three discussions.

2. ***Interviews with IDPH and DHS staff.*** To learn more about the program's origins, administrative structure, and current operations, we interviewed state and regional staff at DHS and IDPH.

3. ***Interviews with administrators of local public health agencies.*** To understand the Well-Being Visit Program at the local level, we interviewed supervisory staff at the three local public health agencies that conduct visits in the focus group discussion sites.

4. ***Program Documents.*** To understand the program's history, purpose, and governing contracts, we reviewed a wide range of administrative documents relating to the Well-Being Visit Program.

PROBLEMS AND SOLUTIONS

Currently, the Well-Being Visit Program does not effectively assess the well-being of children in LBP families. It also does not ensure that LBP families with at-risk children are linked to appropriate support services. These shortcomings are the result of flaws in the program's structure and operation. The most critical flaws concern: (1) the visit completion rate; (2) the structure and focus of the visits; (3) the content of the visits, as reflected in the Well-Being Visit Checklist; (4) the program's reporting systems; and (5) the training and institutional support for the nurses and social workers who conduct the well-being visits. MPR assessed the Well-Being Visit Program according to these five areas and developed recommendations to address problems that were identified. Exhibits S.1 through S.5, presented at the end of the Executive Summary, provide comprehensive lists of identified problems and proposed solutions.

The Visit Completion Rate

Problem. For every 100 clients referred for an LBP well-being visit, only 40 are actually visited, and only about 25 of the 40 visited clients are actually seen by a nurse or social worker. The remaining clients are "visited" by telephone. The low rate of visiting LBP clients, particularly through in-person contact, compromises DHS's ability to monitor and ensure the well-being of children in LBP families.

Solution. To improve the well-being visit completion rate, we recommend that DHS emphasize these visits as a helpful service to LBP clients. This would provide incentives for clients to cooperate with the visits and clarify to the public health nurses and social workers the value of the visits. Stronger financial incentives are also needed, and we recommend that DHS increase its payments to the local public health agencies for completed visits, especially those conducted in-person. Table S.1 provides a comprehensive list of our recommendations for increasing the well-being visit completion rate, which include the following:

- Shift the overall tone of the program to emphasize providing services to LBP clients and de-emphasize checking on these clients.

- Increase financial incentives for local public health agencies to complete well-being visits, especially in-person visits, with LBP clients.

- Educate *visitors* about the Well-Being Visit Program and provide them with periodic feedback on their own performance and the performance of their local agency.

- Inform *clients* about the Well-Being Visit Program and the provider of visits in their county.

The Structure and Focus of the Visits

Problem. The LBP well-being visits do not currently focus on children. In fact, children are present at less than half of all well-being visits. With the overall visit completion rate of 40 percent, this implies that children are seen in fewer than 20 percent of LBP families referred for a visit. In addition, the well-being visits focus on educating clients about FIP policies and reconnecting them with PROMISE JOBS and the FIA process. This focus is inconsistent with the program's original objective of assessing the well-being of children.

Solution. To help the Well-Being Visit Program achieve its original objective, we recommend that DHS refocus the program on children. This should include a more consistent effort by DHS to convey the original goals of the program to staff and clients. We also recommend that DHS revise the program's structure and financial incentives to increase the likelihood that children will be included in the visits and observed during a high-risk period. Our detailed recommendations in Table S.2 include the following highlights:

- Increase the emphasis on children in program documents, including contracts, training materials, letters to clients, and the Well-Being Visit Checklist (data collection form).

- Provide an additional financial incentive for conducting well-being visits where children are present and actually seen by the visitor.

- Conduct a single well-being visit two or three months after the termination of cash assistance to observe the family during relatively high-risk period.

The Content of the Well-Being Visits

Problem. The Well-Being Visit Checklist, which is used to collect data during the visits, has serious limitations that compromise the value of the visits and of the resultant data. The checklist devotes little attention to children and their well-being. It also fails to collect information that is needed to monitor the operation of the Well-Being Visit Program.

Solution. To enhance the capacity of the visits to address child well-being and the value of the data gathered at the visits, we recommend that DHS substantially revise the Well-Being Visit Checklist. DHS should shift the focus of the checklist toward child and family well-being and increase the specificity of checklist items and instructions. Our recommendations for the checklist, listed in Table S.3, include the following key revisions:

- Require a systematic record of specific concerns about child and family well-being to be made at every visit.
- Require the visitor to indicate a plan, including referrals to programs and services, for addressing each identified concern relating to child and family well-being.
- Collect data on the method and outcome of every attempt to contact LBP clients for well-being visits; currently there are large gaps in these data that compromise their value in program management.

Reporting on the Well-Being Visits

Problem. The value of the DHS report on the well-being visits is limited by its irregular production, its length, the large amount of data presented, and the absence of a narrative discussion of findings.

Solution. To improve the effectiveness of the Well-Being Visit Monthly Report, we recommend that DHS revise its reporting system to provide a concise tabular and narrative presentation of data on a regular basis. Our detailed recommendations in Table S.4 include the following:

- Revise the report cover memo to state the purpose of the visits and the report.
- Reduce the volume of data included in the report by focusing on findings that are of greatest importance to readers. Do not present all of the data collected by the checklists.
- Add a narrative section to the report that discusses highlights in the data.
- Shift to a consistent *quarterly* distribution schedule for the report.

Staff Training and Support

Problem. At the outset of the program, local agency staff were trained to conduct the well-being visits. However, there has been substantial turnover among those staff and many who conduct the visits have received little or no training. Furthermore, existing training is typically informal and unstandardized. Consequently, many local staff are ill-informed about Well-Being Visit Program

policies and other DHS programs and policies. They are also unsure of their role, resources, and responsibilities as well-being visitors. The inadequacy of training and the resultant gaps in staff knowledge reduce the program's capacity to achieve its objectives.

Solution. To address these problems, we recommend that DHS require IDPH to increase the level and frequence of training for well-being visit staff. Our recommendations, listed in Table S.5, include the following:

- Conduct standardized training for well-being visitors statewide once each year.
- Provide regular program and policy updates to the well-being visitors. Require local agencies to maintain files for all updates and training materials.
- Require annual regional meetings of visitors for the purpose of exchanging information about the program and providing mutual support.
- Mandate that visitors attend all training activities.

DISCUSSION

The Well-Being Visit Program began as an effort to ensure the well-being of children in families on Iowa's Limited Benefit Plan. However, the current program has several limitations that seriously compromise its ability to achieve that objective. First, the program does not reach most children in LBP families. Only 40 percent of referred families even receive a visit, and children are present at less than half of those visits. Second, the visits do not emphasize child well-being. Instead, they focus primarily on informing clients about FIP and PROMISE JOBS policies and only secondarily on well-being issues, if at all. Consequently, the public health professionals who staff the program have come to question its use of their skills and its value to DHS and to the Iowa families it serves.

MPR has concluded that the Well-Being Visit Program's orientation should be shifted toward the health and well-being of children. This would concentrate the program's resources on its original objective--to ensure the well-being of children in LBP families. It would also draw on the expertise and interests of the public health nurses and social workers who conduct the well-being visits. To ensure the full commitment of the public health agencies and their staff to this program, DHS also needs to adjust the program's training, feedback, and financial incentive mechanisms. Training that reflects the child-centered focus should be provided to all current staff and repeated regularly to address the frequent turnover of well-being visitors. Feedback should be provided to visitors on a regular basis to support their individual efforts, and financial incentives should be adjusted to increase the commitment of the local public health agencies to the Well-Being Visit Program. Finally, the program's systems for storing, analyzing, and reporting information on LBP families should be revised to focus on well-being.

Modifying the Well-Being Visit Program to emphasize child well-being would require an integrated effort to adjust basic elements of the program's structure. The payoff would be a program that safeguards the well-being of children in Iowa's most vulnerable families.

TABLE S.1

THE WELL-BEING VISIT COMPLETION RATE

Problem	Solution
1. Financial incentives for local public health agencies to conduct well-being visits are weak.	1. Increase the reimbursement rates paid to local public health agencies for completed well-being visits, especially for in-person visits.
2. Local agency staff who conduct well-being visits are not well-informed about reimbursement policies for the visits.	2. Send an annual memo to local agencies detailing reimbursement rates; address reimbursement rates in all training sessions and materials.
3. Local agency staff receive little positive feedback to support their efforts to contact LBP clients and conduct well-being visits.	3. Provide positive feedback to local agency staff in the following ways: a. Provide a quarterly memo to each local agency that reports the visit completion rate for each of the agencies in their IDPH region. b. Provide a quarterly memo to all local agencies that announces the agencies receiving bonus payments for high visit completion rates.
4. LBP clients lack awareness of the well-being visits.	4. In all DHS contacts with LBP clients, assign a higher priority to informing clients about the Well-Being Visit Program and the provider of well-being visits in their county (the name of the local agency).
5. LBP clients are not receptive to the well-being visits.	5. In all staff contacts with LBP clients present the well-being visits as a helpful service provided *independently* of DHS.
6. The client contact information provided by DHS for well-being visit referrals is limited in scope and accuracy. While local agency staff often obtain corrected contact information through their efforts to locate LBP clients, that information is not systematically used by the program.	6. Have IDPH develop a simple data base to store updated contact information obtained by local agency staff (and reported by them on the well-being visit data collection form). Also, have IDPH implement a system to distribute updated contact information whenever a client is subsequently referred for another well-being visit.

TABLE S.2

THE STRUCTURE AND FOCUS OF WELL-BEING VISITS

Problem	Solution
1. While the original intent of the well-being visits was to focus directly on the well-being of children in LBP families, current visits focus more on educating clients about DHS policies and reconnecting them to PROMISE JOBS and the FIA process.	1. Refocus the visits on children in the following ways: a. Revise the program's contracts and training materials to emphasize that the visits are to focus on child well-being. b. Revise the program's data collection form to place a greater emphasis on child well-being. c. Train local agency staff to refocus the visits on children. d. Provide additional financial incentives to local agencies for conducting in-person visits and visits with children present. e. Require local agency staff to attempt to schedule a well-being visit when children can be present.
2. The short time period between the two well-being visits for clients in a first LBP (one month) makes the second visit redundant.	2. Provide one well-being visit for all LBP clients (rather than two for those in a first LBP and one for those in a second or subsequent LBP).
3. Making the visits in the early months of the LBP limits DHS's ability to assess the well-being of children under benefit termination.	3. Provide a well-being visit several months after the termination of FIP benefits (the second or third month of no FIP assistance).
4. Contrary to DHS's preferences, local agency staff often rely on telephone visits because these visits consume fewer resources than in-person visits and generate the same amount of revenue.	4. Revise the reimbursement rates for completed well-being visits to provide a higher rate for in-person visits than for telephone visits.
5. Stated policies about required visit activities are not consistent across program documents; this leads to staff uncertainty and a lack of consistency in services provided at the visits.	5. Provide a clear and consistent policy statement regarding required visit activities to ensure a minimum level of service is provided at every visit.
6. The lack of specific criteria and procedures for making assessments at the visits dilutes the meaning and value of those assessments.	6. Provide local agency staff with basic criteria to use to assess child and family well-being, to assess the need for follow-up, and to make referrals. These could be provided via the data collection form.

TABLE S.3

VISIT CONTENT AND THE WELL-BEING VISIT CHECKLIST

Problem	Solution
Using the Checklist to Monitor Child and Family Well-Being	
1. The well-being visit checklist, which provides the basis for the content of the visits, places relatively little emphasis on child and family well-being issues.	1. Modify the checklist to require that staff provide a systematic accounting and assessment of specific aspects of child and family well-being at every visit.
2. The checklist collects insufficient information about how the visit staff are responding to well-being concerns presented at the visits.	2. Modify the checklist to require that staff indicate a response to well-being concerns, such as a follow-up visit and/or referrals to programs provided by the visitor's local agency or by other agencies.
3. The checklist collects insufficient information to understand why clients are not referred to various assistance programs and services.	3. Modify the checklist to collect--for each potential referral to a program/service--local availability of the program/service, the client's current recipiency status, and, as appropriate, the reason no referral is made.
Data Quality and Program Performance	
4. The checklist collects insufficient information to monitor staff use of various methods to contact clients and identify particularly successful methods.	4. Modify the checklist to collect information for every attempt to contact each client, including the contact method used, whether contact was made, whether a visit resulted, and the reason for any failed attempt.
5. While up-to-date client contact information is crucial to the success of the program, the current checklist does not emphasize updates and corrections to contact information.	5. Modify the checklist to require systematic documentation of initial client contact information and any updates or corrections to that information obtained by the local agency staff.
6. Reported rates of referral to PROMISE JOBS for reconsideration of the LBP exceed rates of client eligibility for reconsideration.	6. Instruct visit staff to make a PROMISE JOBS referral for reconsideration of the LBP only if eligibility for reconsideration exists.
7. The information collected directly from clients is limited by the narrow set of response categories provided on the checklist.	7. Increase the number of pre-coded response categories for all client information questions.
8. The information collected directly from clients is also limited by the lack of specificity and the word choice in the questions posed to clients.	8. Clearly specify the period for which client income should be reported. For LBP entry, be sensitive to client's perceptions of being assigned to the LBP versus choosing the LBP.
9. The checklist allocates three sizable areas for staff comments, but these comments are not systematically used by IDPH or DHS.	9. Provide a single area for comments that more accurately conveys the priority and use of staff comments.

TABLE S.4

REPORTING ON THE WELL-BEING VISITS

Problem	Solution
1. The length of the well-being visit monthly report (14 pages) is likely to discourage the recipients of the report from reading it.	1. Make the report more concise in the following ways: a. Narrow the content of the cover memo to a brief statement of the purpose of the visits and the purpose of the report. b. Remove the sample checklist (data collection form). Include instructions in the cover memo for how to request a copy of the form. c. Remove the current set of data tables (seven pages) and replace them with a series of several short tables. d. Remove the report guide (explanatory notes) which pertain to the current data tables.
2. The volume of information contained in the report's data tables (up to 240 numbers per table) is likely to overwhelm the reader.	2. Create new tables that each focus on a single concept or issue. Exclude results on follow-up visits and total visits (month-two and month-four combined).
3. To understand the organization and content of the current data tables, the reader must refer to two attachments (a guide to the report and a sample data collection form).	3. Provide a descriptive title, descriptive row and column headings, and explanatory footnotes to tables so that each table can stand on its own.
4. The lack of narrative discussion of the data presented in the tables makes the empirical findings less accessible to the reader.	4. Provide a brief written summary to highlight findings for each data table. (It would be necessary to update this for each edition of the report.)
5. Placing the data tables at the end of the report reduces the visibility of the findings.	5. Place data tables toward the front of the report.
6. The presentation of data as raw counts limits their usefulness and requires the reader to calculate percentages when desired.	6. In the data tables, present results as percentages instead of (or in addition to) raw counts.
7. The "monthly" report is not distributed regularly by DHS because of insufficient resources and commitment to support monthly distribution.	7. Shift to a quarterly report and devote adequate resources to ensure regular quarterly production and distribution.
8. While the report could provide valuable feedback to IDPH and local agency staff of the well-being visit program, these staff do not receive copies of the report.	8. Provide copies of the visit report to all IDPH staff members who work on the program and enough copies to each local public health agency to permit internal distribution to the agency director and each visitor.

TABLE S.5

STAFF TRAINING AND SUPPORT FOR THE WELL-BEING VISITS

Problem	Solution
1. Many current local agency staff have not received any formal training from DHS or IDPH for the well-being visits. This is either because they began working for the program after the last formal training session (1995) or because they did not attend that session.	1. Increase the frequency of training and participation in training. a. Provide one standardized statewide training session every year over the state's fiber optic communications network (rather than the current provision of "up to one" session per year). b. Mandate attendance of all current staff at all training-related activities sponsored by DHS or IDPH.
2. The program's written training materials place primary emphasis on FIP, the FIA, and general self-sufficiency issues, rather than on child and family well-being.	2. Revise all written training materials to focus primary attention on child and family well-being issues.
3. Many local agency staff are not familiar with the information provided in the training materials that have been developed by DHS for the well-being visits.	3. Provide a user-friendly reference manual to each local agency containing the DHS training materials. At least once per year, verify that each local agency has a complete and up-to-date reference manual.
4. While the IDPH community health consultants are a potentially valuable resource for ongoing assistance, training, and support for local agency staff who conduct well-being visits, this potential is not currently realized.	4. Tap the potential of the IDPH community health consultants in the following ways: a. Require each consultant to organize in-person meetings of local agency staff in her region for informal training and support once per year. b. Require the lead IDPH consultant to provide a brief program update to all local agency staff via email once per quarter. c. Emphasize and promote the IDPH consultants as an ongoing resource for local agency staff in all training materials and sessions. d. Provide local agency staff with quick reference list of "whom to contact" that highlights the role of the IDPH consultants.

I. INTRODUCTION TO THE STUDY OF IOWA'S WELL-BEING VISIT PROGRAM

Through Iowa's Well-Being Visit Program, public health professionals provide visits to welfare recipients whose cash benefits have been reduced or terminated because they failed to participate in mandatory employment and training activities. The Iowa Department of Human Services (DHS) established this program in response to concern about the potentially detrimental effects of benefit reductions on the well-being of children.

A. WELFARE REFORM IN IOWA

On October 1, 1993, Iowa replaced Aid to Families with Dependent Children (AFDC) with a comprehensive welfare reform program officially known as the Family Investment Program (FIP). A central element of FIP is the requirement that welfare recipients take steps toward self-sufficiency. Those steps, which are specified in individualized Family Investment Agreements (FIAs) between welfare recipients and the state, may include participating in education programs, engaging in job search, and obtaining employment. FIAs are developed and carried out under the direction of PROMISE JOBS, the provider of employment and training services to welfare recipients in Iowa. The Limited Benefit Plan (LBP) is a short-term alternative assistance program for FIP participants who do not comply with the FIA requirement, which applies to adult FIP recipients who are able-bodied.[1]

The LBP originally provided three months of cash benefits at the same level as under FIP, followed by three months of reduced cash benefits, and then six months of no cash benefits. The

[1]Fraker et al., "Iowa's Limited Benefit Plan: Summary Report," Mathematica Policy Research, May 1997, reports on a recent study of the LBP.

initial period of level benefits was eliminated in February 1996, resulting in the current LBP which provides three months of reduced benefits followed by six months of no cash benefits.

LBP assignments may be canceled if the individual satisfies the FIA requirement during an initial reconsideration period. They may also be canceled on appeal, which happens less frequently than reconsideration. Current LBP policy provides reconsideration rights during the period of reduced benefits (months one through three) only for first assignments to the LBP that are made because an FIA was not signed. There are no reconsideration rights for first assignments after an FIA is signed.

When the LBP assignment ends, individuals may reapply to FIP, but those who do so may again be subject to the FIA requirement. Repetition of the earlier failure to meet that requirement results in assignment to a second or subsequent LBP, which entails six months of no cash benefits. There are no reconsideration rights in a second or subsequent LBP, and the initial reduced benefit period is not provided.

B. THE WELL-BEING VISITS

Concerns about the potentially detrimental effects of the Limited Benefit Plan on children led to policies to safeguard the well-being of children in FIP cases assigned to the LBP. The federal waivers that authorized Iowa to implement FIP included state monitoring of the well-being of children in LBP cases.[2] Similarly, the Iowa Administrative Code required DHS to arrange for social service professionals to conduct home visits to monitor the well-being of LBP families. Iowa DHS

[2]The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 shifted most responsibility for the design of cash assistance programs for families with dependent children from the federal government to the state governments. Previously, states could request federal waivers to implement reforms to their welfare programs. Between 1993 and 1996, 43 states requested and received federal waivers to reform their welfare programs.

developed the Well-Being Visit Program in direct response to these monitoring requirements. This program provides a maximum of two visits to LBP families: one visit during the period of reduced benefits and a second visit during the period of no cash benefits. Under the current version of the LBP, these visits are scheduled in the second month of the LBP for those with reconsideration rights and in the fourth month of the LBP (the first month of no cash benefits) for all. These visits are intended to assess child well-being and link families with at-risk children to appropriate support services.

Iowa DHS and the Iowa Department of Public Health (IDPH) administer the Well-Being Visit Program in conjunction with local public health agencies in each of Iowa's 99 counties. DHS contracts with IDPH to administer the program, and IDPH subcontracts with local public health agencies to conduct the visits. These local agencies employ registered nurses and social workers who make the well-being visits to LBP families.

C. THE NEED FOR THIS STUDY

With the well-being visit completion rate--the proportion of referred clients for which a well-being visit is conducted--at 40 percent DHS became concerned that the program was not fulfilling its principal objective of monitoring the well-being of children in LBP families. Clearly, the majority of LBP families were not being reached by the program. Perhaps related to this, some state legislators questioned the program's value. DHS was also concerned that the potential of the data gathered at the visits was not being realized. In particular, it was concerned that limitations in the data collection instrument and the program's reporting systems were compromising the quality and usefulness of the data. DHS determined that these concerns warranted a systematic study and critical assessment of the Well-Being Visit Program.

D. RESEARCH OBJECTIVES

The main objective of this report is to assess the Well-Being Visit Program--to critically examine the existing design and methodology of the well-being visits in order to: (1) identify limitations and problematic aspects of the program, and (2) develop recommendations to DHS to address these issues, and more generally, increase the value of the visits. This main objective consists of four specific objectives:

1. ***Understand the low visit completion rate.*** Determine what accounts for the low completion rate of the well-being visits and what changes could be implemented by DHS to raise the completion rate.

2. ***Assess the conduct of the visits.*** Examine key structural aspects of the visits, the focus of the visits, and training and support resources for staff; determine what changes could be made in these areas to put the objectives for the visits more effectively into practice.

3. ***Assess the existing system for gathering information at the visits.*** Assess the content, format, and application of the Well-Being Visit Checklist; recommend changes to increase the quality of the visits and the resultant data.

4. ***Assess the existing system for reporting on the visits.*** Examine the program's reporting system; and develop recommendations for improvements to the format, content, and distribution of the report to make it more accessible and user-friendly.

This report presents our findings from the assessment of the Well-Being Visit Program. In conjunction with the assessment, DHS requested that MPR analyze recent data from the well-being visits to identify limitations and, to the extent that limitations permit, to highlight substantive findings and suggest policy implications. The results of the data analysis are presented in Appendix E.

E. SOURCES OF DATA FOR THIS STUDY

We have based our assessment of the Well-Being Visit Program on data from four sources: (1) focus group discussions with the well-being visitors, (2) semi-structured interviews with IDPH and DHS staff who administer the program, (3) semi-structured interviews with administrative staff of local public health agencies that contract with IDPH to operate the program (these agencies employ the registered nurses and social workers who conduct the well-being visits) and (4) program documents.

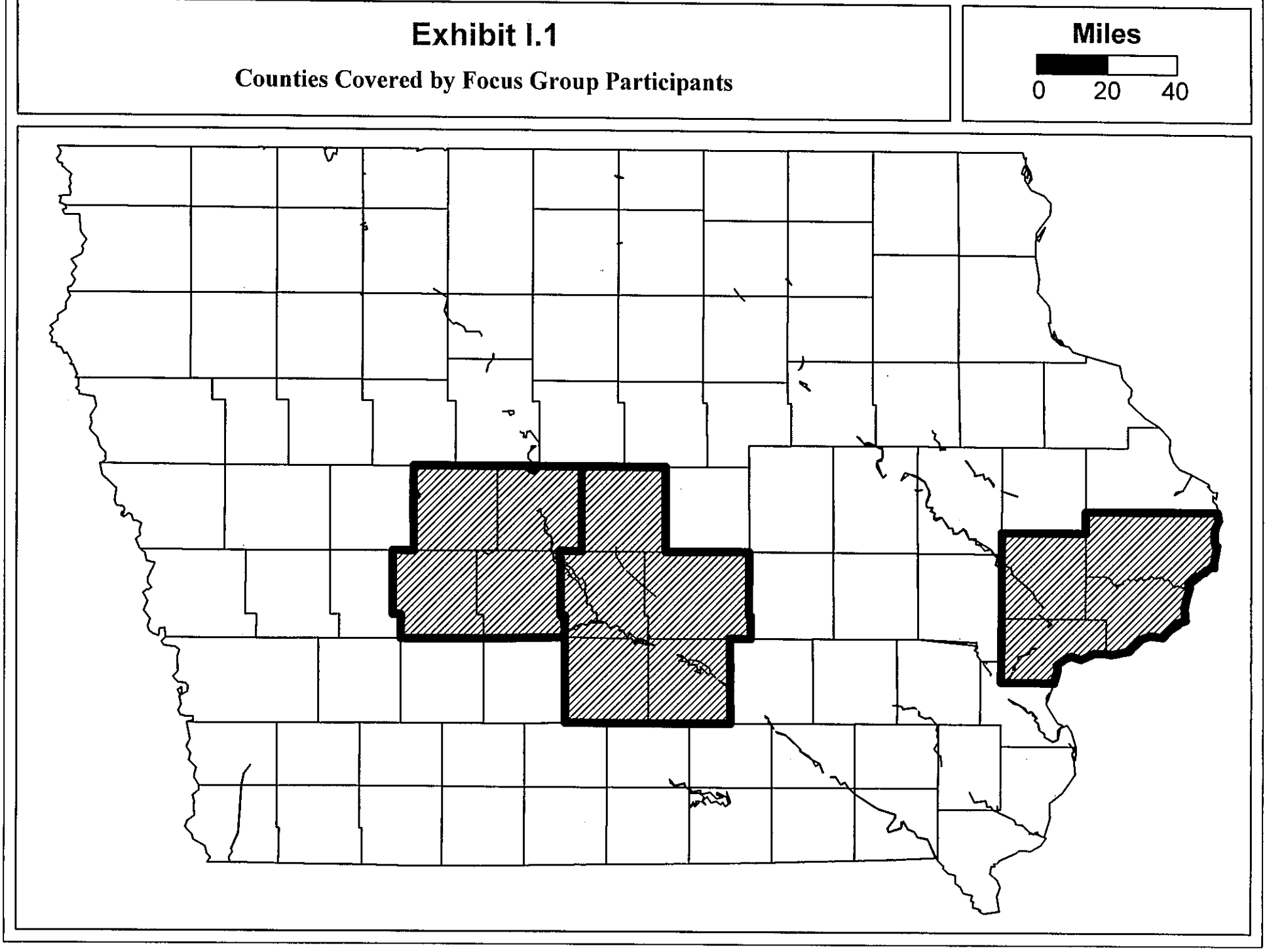
1. Focus Group Discussions

To obtain first-hand accounts of the well-being visits, we conducted three focus group discussions with the public health nurses and social workers who visit the LBP families. The discussions were held in Des Moines (Polk County), Perry (Dallas County), and Davenport (Scott County) during October 1997. For each discussion, we recruited well-being visitors from 4 or 5 counties surrounding the discussion site, covering a total of 13 counties in the three discussions, as shown in Exhibit I.1. The 13 counties provide a mix of rural and urban areas and a range of completion rates for the well-being visits.

Initially we planned to recruit all staff from the agencies in the selected counties who had conducted well-being visits since September 1996 for the focus groups. However, this was not possible in agencies that had used all of their current nurses and social workers to conduct well-being visits because it would have left them without appropriate staff to continue essential agency operations doing the focus group discussion. We worked with these agencies to determine a reasonable number of well-being visitors to recruit for the focus groups. The revised recruitment

Exhibit I.1

Counties Covered by Focus Group Participants



plan targeted 25 nurses and social workers to recruit for the focus group discussions: 8 for discussion one, 8 for discussion two, and 9 for discussion three. All 8 participants attended discussions one and two, and 7 participants attended discussion three. The overall attendance rate was 92 percent. Each of the 13 counties was represented by at least one discussion attendee.

2. Interviews with DHS and IDPH Staff

To understand the program's origins, administrative structure, and current operations, we interviewed state and regional staff at DHS and IDPH. At DHS we interviewed Ann Wiebers, Welfare Reform Waiver Coordinator, who has a broad knowledge of Iowa's welfare reform policy, including the LBP and associated well-being visits. We also interviewed Barbara Russell, a FIP Policy Specialist at DHS, who helped negotiate with IDPH to administer the well-being visit program and who coordinated the initial training of well-being visit staff. Currently, she prepares and distributes the DHS report on the well-being visits, which includes IDPH's tabulations of data from the visits.

At IDPH, we interviewed Karen Fread, Chief of the Bureau of Community Services. She manages her agency's contract with DHS to administer the Well-Being Visit Program and subcontracts with local public health agencies to conduct the visits. She oversees the distribution of DHS referrals for well-being visits to the local public health agencies as well as data entry and processing associated with the visits. We also interviewed Brian Bock, an Information Technology Support Worker at IDPH, who is directly responsible for distributing and tracking referrals for well-being visits and tabulating visit data.

In the IDPH Bureau of Community Services, we interviewed four of the nine Regional Community Health Consultants. These consultants provide technical assistance to local public health agencies on issues related to the IDPH programs they administer, such as the Well-Being Visit

Program. The consultants work in the field, with each responsible for a region of 9 to 12 counties. For this study, we interviewed consultants responsible for 44 of Iowa's 99 counties, as shown in Exhibit I.2.

3. Interviews with Administrators of Local Public Health Agencies

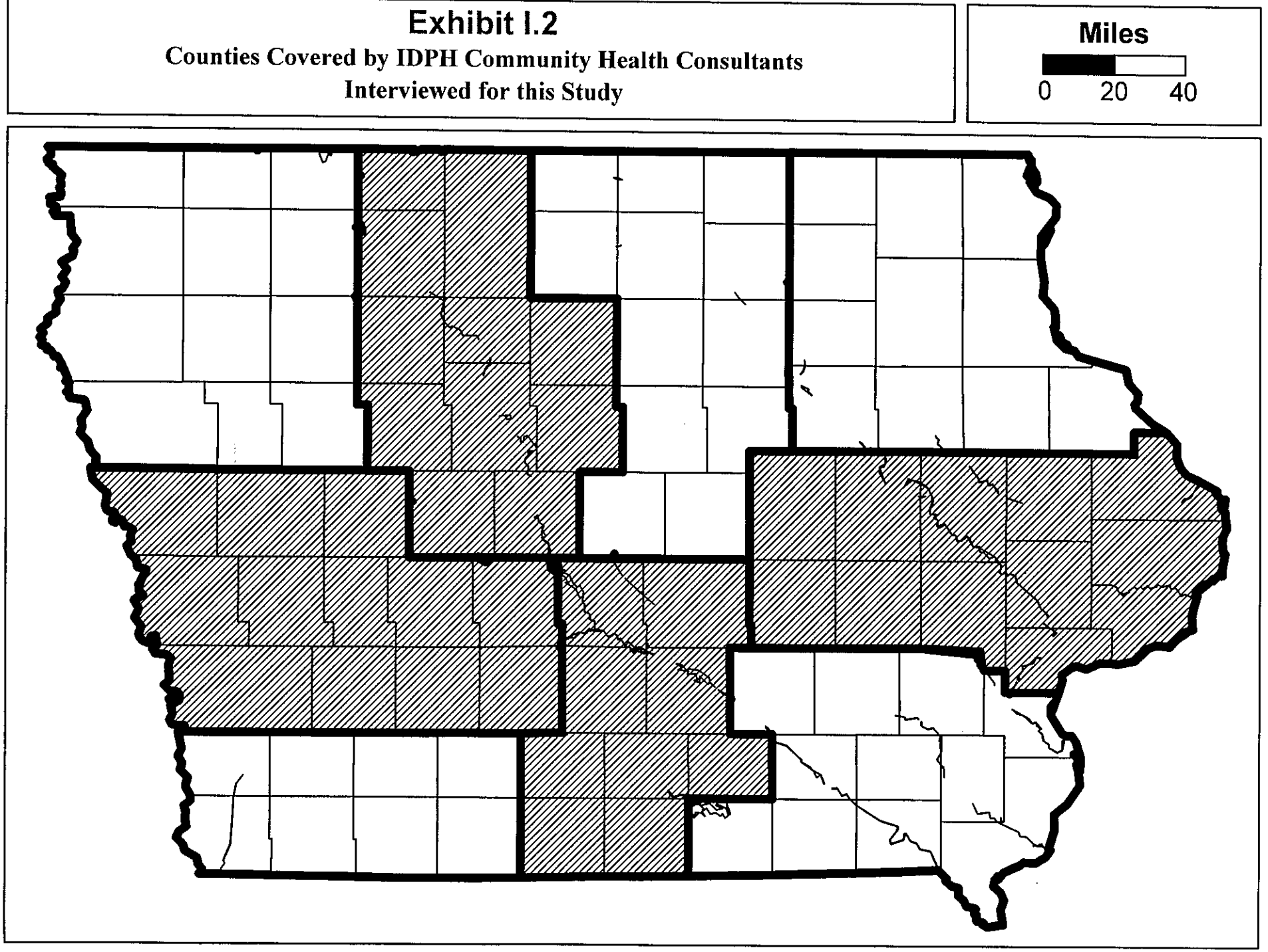
To increase our understanding of the Well-Being Visit Program at the local level, we interviewed supervisory staff in the three local public health agencies in the focus group discussion sites. These local supervisors, along with the IDPH Regional Community Health Consultants, link the nurses and social workers who conduct the well-being visits with IDPH, the agency that administers the program statewide. We believed that these local supervisors would provide useful perspective on the program--one step removed from the front line--that we could not obtain from other sources. Across the three agencies in the discussion sites, we interviewed two agency directors, two supervisors of the staff who conduct visits, one manager of clinical services, and one business office manager.

4. Program Documents

Administrative documents provided information on the history, purpose, and governing contracts of the Well-Being Visit Program. As part of our assessment, we reviewed a wide range of administrative documents relating to the well-being visits. We reviewed the relevant portions of the Iowa Administrative Code and the federal terms and conditions for the waivers that authorized Iowa to replace AFDC with FIP. We reviewed the contract between DHS and IDPH to be the administrator of the Well-Being Visit Program. We reviewed a sample contract between IDPH and a local public health agency to be the direct provider of the visits to LBP families. We reviewed

Exhibit I.2

Counties Covered by IDPH Community Health Consultants Interviewed for this Study



written materials prepared by DHS for training local agency staff to conduct the well-being visits. We also analyzed the Well-being visits. We also analyzed the Well-Being Visit Checklist, which visitors use to record information pertaining to each visit or to document why no visit was made. Finally, we reviewed examples of the report on the well-being visits that DHS periodically prepares and distributes.

F. ORGANIZATION OF THIS REPORT

The remainder of the report is organized into eight chapters. Chapter II provides an overview of the program. Chapter III discusses issues surrounding the staffing of the well-being visits, while Chapter IV addresses the related issues of staff training and institutional support. Chapter V explores possible explanations for the low well-being visit completion rate, and Chapter VI examines the structure and focus of the visits. Chapter VII evaluates the forms and procedures that are used to collect data during the visits. Chapter VIII examines systems for reporting on the visits. Finally, Chapter IX presents our conclusions from this study and a summary of our recommendations to DHS for improvements to the Well-Being Visit Program.

II. OVERVIEW OF THE WELL-BEING VISIT PROGRAM

This chapter is an introduction to Iowa's Well-Being Visit Program that provides visits to families whose cash assistance has been reduced or terminated under the state's Limited Benefit Plan. The chapter includes discussions of the program's origins and objectives, its administrative structure, its provision of visits, and its data and reporting systems. These discussions set the stage for the thorough program assessment presented in the remaining chapters of the report.

A. PROGRAM ORIGINS AND OBJECTIVES

The Well-Being Visit Program originated with Iowa's development of its welfare reform program (FIP) and in particular, the Limited Benefit Plan, under which cash assistance is reduced and eventually terminated for FIP participants who fail to comply with FIP requirements. Concerns that reducing and eliminating cash assistance poses a risk for the well-being of children, led state policy makers to require that Iowa DHS systematically monitor the well-being of children in FIP cases that enter the Limited Benefit Plan.

1. The Federal Objectives

The 1993 U.S. Department of Health and Human Services (DHHS) waiver terms and conditions that authorized Iowa DHS to implement FIP included state monitoring of the well-being of children in LBP families. In a paragraph pertaining to the LBP, the waiver terms and conditions state: "during the LBP, an inquiry will be made as to the well-being of the children."[1] There are two

[1]DHHS "Waiver Terms and Conditions: Iowa--Family Investment Program Demonstration," transmitted by the U.S. DHHS to Iowa DHS on August 13, 1993, page 5, section 2.3(3).

important components of this provision. First, there will be an inquiry during the LBP, and second, the focus of that inquiry is to be child well-being.

The subsequent paragraph in the terms and conditions further develops the well-being visit provision:

> During the LBP [benefit reduction period] a third party counselor will make an inquiry into the well-being of the children. If the participant indicates a desire to develop an FIA, the third party counselor will initiate an appointment with the states JOBS program office. If the participant does not wish to develop an FIA, an additional inquiry as to the well-being of the children will be made approximately 30 days after [benefit termination].[2]

This more detailed statement expands on three issues: (1) who will make the well-being inquiry, (2) the number and timing of the inquiries, and (3) the client's opportunity to develop an FIA. In particular, the terms and conditions specify that a third-party counselor--someone outside of DHS--will make the inquiry. They also specify that there will be one well-being inquiry while the family is still receiving (reduced) cash benefits and a second inquiry once the family's cash benefits have been terminated. Finally, the terms and conditions specify that during the first visit the counselor will facilitate an appointment with the PROMISE JOBS office if the client wishes to engage in the FIA process.[3]

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[2]U.S. DHHS, August 13, 1993, page 5, section 2.3(4).

[3]At the time of the first well-being visit, most individuals assigned to the LBP are eligible to reconsider the decisions that resulted in their being assigned to the LBP. Specifically, they can have their LBP assignment canceled by signing an FIA.

2. The State's Objectives

The state's requirement that DHS inquire into the well-being of children on the LBP is detailed in the Iowa Administrative Code (IAC 441-93.138(4)). The current code (1997) introduces the requirement with this statement:

> *Check on the well-being of the family in LBP households.* For FIP households who have chosen the LBP, [DHS] shall provide for qualified social services professionals to provide home visits to make inquiry into the well-being of the family.

There seems to be less direct emphasis on children in the current code than in the federal terms and conditions.[4] Perhaps the most important difference between the code and the federal terms and conditions, however, is the code's emphasis on the FIA process and family self-sufficiency. While that emphasis is not evident in the introductory statement quoted above, it is found throughout detailed discussion of the visits that follows the introductory statement. The code clearly indicates that the visits are intended to serve the dual purposes of assessing child well-being and promoting the FIA process. In contrast, the federal waiver terms and conditions clearly indicate that the visits are primarily intended to assess child well-being.

DHS's understanding of the Well-Being Visit Program's objectives is consistent with the state code, as described above. For example, the DHS training materials for the program introduce the visits as a means of monitoring well-being, but make no mention of well-being in the discussion of the purpose of the visits. Instead, that discussion focuses exclusively on supporting the family to become self-sufficient. Both the code and the DHS training materials emphasize the FIA and self-

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[4]In the Iowa Administrative Code's earliest mention of LBP well-being visits (1994), the word *children* is used rather than *family*. For example, the code directs DHS to "...make inquiry into the well-being of the children..." (IAC 441-93.134(4), March 1994). At the outset of the Well-Being Visit Program, the relevant language in the code more closely resembled that in the federal waiver.

sufficiency in their discussions of visit activities. Discussions with DHS staff for this study provided additional evidence of the department's "well-being plus FIA" objectives for the visits.

B. ADMINISTRATIVE STRUCTURE OF THE PROGRAM

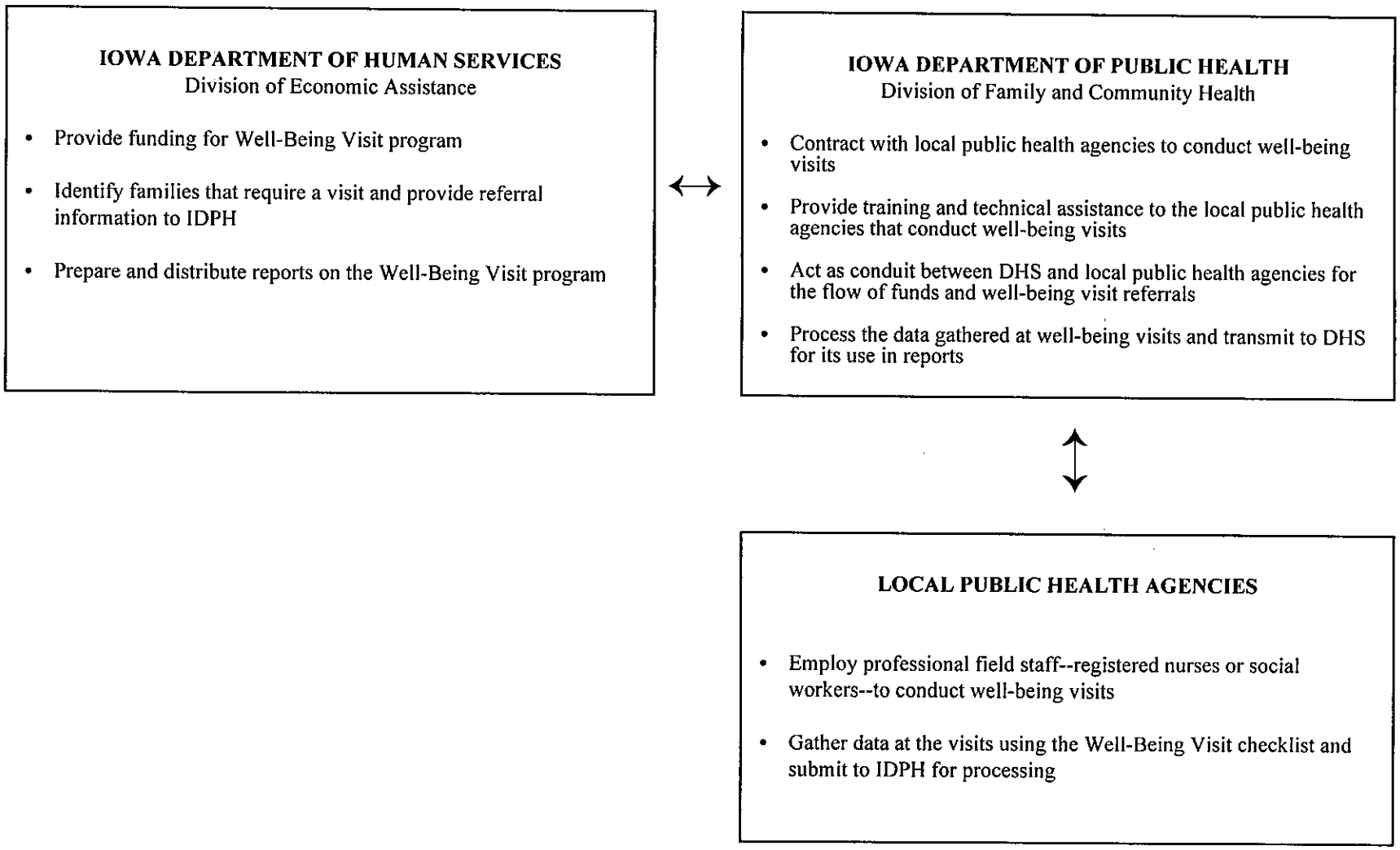
The Well-Being Visit Program is jointly administered by the state human services agency (DHS), the state public health agency (IDPH), and local public health agencies across the state. While the federal waiver requires DHS to monitor the well-being of children in LBP families, it also requires that these visits be made by an outside party. DHS contracts with IDPH, which contracts with local public health agencies to conduct the visits. Below we discuss the role and responsibilities of DHS, IDPH, and the local public health agencies in the administration of the Well-Being Visit Program. A summary of these roles and responsibilities is illustrated in Exhibit II.1.

1. The Iowa Department of Human Services

Iowa DHS plays an important behind-the-scenes role in the Well-Being Visit Program. It provides funding for the program, identifies the families to be visited, and prepares and distributes reports on the program. DHS covers IDPH's annual cost of administering the program ($126,000 in State Fiscal Year (SFY) 1998). In addition, for each referred client, DHS reimburses IDPH $55 if a visit is completed and $25 if a visit is attempted but not completed. IDPH fully passes these payments through to the local public health agencies that conduct the visits. DHS also reimburses IDPH for payments of bonuses to local agencies with visit completion rates of 50 percent or higher ($10 per visit for a completion rate of 50 percent to 74 percent, and $20 per visit for a completion rate of 75 percent to 100 percent).

EXHIBIT II.1

ADMINISTRATIVE STRUCTURE FOR WELL-BEING VISITS AND ORGANIZATIONAL RESPONSIBILITIES



DHS is relatively far removed from the day-to-day administration of the program. However, the department does play important roles at the beginning and end of each monthly cycle of visits. At the beginning, DHS provides IDPH with an electronic referral list of LBP cases, including the latest known address from DHS computer files. When the month's visits have been conducted (or attempted) and the data from the visits have been processed, IDPH provides DHS with state- and county-level summary reports on the data for that month. DHS incorporates the state-level data report into its Well-Being Visit Monthly Report, which it distributes to the department's regional administrators and other appropriate parties. Section H of this chapter provides information on this DHS report.

2. The Iowa Department of Public Health

IDPH acts as a conduit for the flows of funds, data, and information between DHS and the local agencies. Within IDPH, the Bureau of Community Services, which provides financial and technical assistance to local agencies to support the delivery of public health services, is responsible for the Well-Being Visit Program. The bureau contracts with local public health agencies to provide a variety of services, including public health nursing and senior health services, in addition to the well-being visits to LBP families. The bureau employs nine Regional Community Health Consultants to provide technical assistance and support to the local public health agencies that deliver IDPH-funded services. Each consultant works in the field, covering a region of 9 to 12 counties.

Like DHS, IDPH has responsibilities at the beginning and end of each monthly cycle of well-being visits. IDPH receives the electronic list of LBP cases that have been referred for well-being visits during the upcoming month. Using the contact information included with the referral list, IDPH assigns each referral to the appropriate local public health agency, generates agency-specific referral lists, and electronically transmits these lists to the local agencies. Once the well-being visits

have been conducted (or attempted), IDPH receives the program's data collection form, the Well-Being Visit Checklist, that the visitor must fill out for each referral. IDPH staff process the data from the checklists to produce state- and county-level summary data reports for the month. These reports consist of data tables containing monthly and year-to-date totals for the items in the checklist. IDPH transmits the summary reports to DHS, which includes the state-level data tables in its Well-Being Visit Monthly Report.

3. Local Public Health Agencies

There are 101 local agencies under contract to IDPH to deliver the well-being visits to LBP families and other public health services. Most of these agencies deliver public health services for an entire county (in two counties, two agencies are under contract to IDPH). In addition to the Well-Being Visit Program, the local agencies deliver three other IDPH programs: (1) Public Health Nursing, (2) Home Care Aide, and (3) Senior Health. While all of the agencies deliver this common set of public health programs for IDPH, some also deliver other programs relevant to the LBP population. These include the Women Infants and Children Supplemental Food Program (WIC) Well-Child Clinics, immunization clinics, health promotion visits for post-partum women, and the Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

The local agencies vary in their administrative structure; some are visiting nurse associations (VNAs), some are hospital-based agencies, and a few are county government agencies. Despite these structural differences, all of the local public health agencies that provide well-being visits are experienced providers of home visits to address health and well-being issues.

Professional field staff--registered nurses and social workers--employed by the local public health agencies conduct the well-being visits. Agencies that organize their field staff programmatically assign responsibility for these visits to a single nurse or social worker, while

agencies that organize their field staff geographically distribute that responsibility among all professional field staff.[5] Under either system, each nurse or social worker who conducts well-being visits receives a list of DHS referrals for these visits from IDPH at the beginning of each month. For each referral, the staff member is required to make at least three attempts to contact the client and schedule an appointment for a well-being visit. One attempt must be in writing.

The nurse or social worker must also complete a short form, the Well-Being Visit Checklist, to report on the visit or to document why the visit could not be conducted. The local agencies are required to submit completed checklists to IDPH by the tenth of the following month. Based on submitted checklists, the local agencies are reimbursed for attempted visits and completed visits to LBP clients.

C. THE NUMBER AND TIMING OF WELL-BEING VISITS

As stated in the Iowa Administrative Code and the contracts that govern the Well-Being Visit Program, two well-being visits are to be provided to clients in a first LBP assignment and one well-being visit is to be provided to clients in a second or subsequent LBP assignment.[6] The two well-being visits for clients in a first LBP assignment are mandated to occur in months two and four of the LBP period. According to this schedule, the first well-being visit is required during the three-month benefit reduction period, when most clients still have the right to reconsider their LBP assignment. The second well-being visit is required during the first month of the benefit termination

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[5]Among the 13 counties involved in this study, we observed a mix of geographic and programmatic staff strategies. The staffing strategy did not tend to vary by urban/rural status, but agencies that used social workers to conduct the visits tended to apply a programmatic staffing strategy for the visits.

[6]In instances when the client enters a first LBP after signing the Family Investment Agreement (FIA), only the month-four well-being visit is to be provided. Such situations are, however, relatively rare.

period, when the client's reconsideration rights have expired. The single well-being visit for clients in a second (or subsequent) LBP assignment is to be provided in month two of the LBP period. This is the second month of the client's benefit termination period.

D. THE MODE OF WELL-BEING VISITS

Contract agreements that govern the Well-Being Visit Program specify that a home visit should first be attempted; followed, if necessary by an attempt to conduct an in-person visit at an alternate site; followed, if necessary, by an attempt to conduct a visit by telephone. Despite this stated hierarchy of visit modes, any completed visit--regardless of mode--is counted and reimbursed at the same rate by DHS (currently $55 per visit). Given that telephone "visits" generally require fewer resources than in-person visits, the local public health agencies have an incentive to rely on the least-preferred visit mode.

E. THE EMPHASIS OF THE WELL-BEING VISITS

The Iowa Administrative Code and the contracts that govern the Well-Being Visit program specify that the visits are to be provided "in the spirit of supporting the [LBP] family's move toward self-sufficiency." This emphasis is reinforced in the program's policies regarding visit activities. In particular, activities related to the client's participation in a Family Investment Agreement--the self-sufficiency plan required for FIP recipients--are highlighted and emphasized. Although the original motivation for the visits was to monitor the well-being of children in LBP families, there are no policy requirements regarding the involvement of children in the visits.

F. DATA COLLECTION

The Well-Being Visit Program uses a short form called the Well-Being Visit Checklist to gather information on the visits. The checklist serves several key roles: it provides a framework that guides

the content of the visits; it provides a tool to monitor the well-being of LBP families and the performance of the program; and it provides a means for DHS to fulfill the states' reporting requirements for the program. Local public health agencies are compensated for attempting or conducting a visit only after they submit a completed checklist to IDPH. This provides a clear incentive for staff to fill out the checklist.

There have been two versions of the checklist. The original version was developed by DHS with input from IDPH. It was one page long and collected three types of information: (1) whether a visit was conducted by telephone and the reason for that; (2) whether an in-person visit was conducted and where it was conducted (in the client's home or at an alternate site); and (3) the results of the visit. This third piece included whether any further involvement with the client was needed, whether the visitor planned to provide follow-up services to the client, and whether the visitor referred the client to other sources of assistance.

The second version of the checklist was developed in 1996 and is still in use today. DHS revised the original checklist in response to strong public interest in the LBP and recognition that the well-being visits provide an opportunity to learn more about LBP families. Revisions also reflected feedback from the public health field staff who complete the checklist. In revising the checklist, DHS added two direct questions to the client regarding sources of income and reasons for entering the LBP. DHS also added a series of yes/no questions to the visitor regarding the client's understanding of the LBP and the status of the client and his/her family, and it expanded the section on referrals to provide a more comprehensive list of programs and services to which the visitor may refer the client for assistance. Chapter VII of this report focuses on the checklist.

G. REPORTING ON THE VISITS

The reporting system for the Well-Being Visit Program is tied closely to the checklist. Each month local public health agencies send completed checklists to IDPH, which processes the data and generates state and county-level summary data reports. IDPH forwards these data reports and an electronic copy of the underlying data file to DHS. The data tables from the state-level summary report is the basis for DHS's official report on this program, the Well-Being Visit Monthly Report.[7] That report consists of a cover memo from DHS, the state-level data tables, a sample checklist, and explanatory notes to accompany the checklist. The report is distributed to DHS central office staff, DHS regional administrators, and key staff at Iowa Workforce Development (the state labor department) and the Bureau of Refugee Services. Other individuals or organizations that receive a copy include Iowa lawmakers, administrators of other state programs, research organizations, and advocacy groups. Chapter VIII assesses the Well-Being Visit program's reporting system and proposes several improvements to it.

[7]Despite its title, the *Well-Being Visit Monthly Report* is not produced each month. When the reporting interval is two or more months, the report is based on data for the most recent month.

III. STAFFING THE WELL-BEING VISITS

Local public health agencies conduct the LBP well-being visits in accordance with the specifications outlined in their subcontracts with IDPH. Those specifications flow down to the local agencies from the prime contract between DHS and IDPH to administer the Well-Being Visit Program. The local agencies vary in staff size and composition, strategies for organizing field staff, public health services that are provided, and overall goals. This chapter describes the diverse structure and staff composition of the local public health agencies, strategies for staffing the Well-Being Visit program, and staff understanding of and commitment to the objectives of this program.

A. AGENCY STRATEGIES FOR ORGANIZING FIELD STAFF

Local public health agencies in each county organize their field staff to deliver a broad range of services either by geographic area or by program area. The way these agencies organize their staff to conduct the LBP well-being visits reflects their overall organizational strategy. When field staff are organized by geographic area, each staff member is responsible for delivering their agency's full range of public health programs, including LBP well-being visits, to families and individuals residing in a specific area of the county. When field staff are organized by program area, each staff member is responsible for delivering the services of one or two specific programs across the county. The geographically organized agencies tend to have more staff who conduct well-being visits than the programmatically organized agencies, where usually only one or two staff conduct those visits.

There are benefits and drawbacks with both approaches. The geographic organizational strategy is effective for some agencies because it minimizes staff travel time and allows field staff to get to know small pockets of their county's population very well. But this strategy may make it difficult for staff to develop expertise in a specific program because it is just one of many programs they

provide, and it may require staff to divert their attention from one program to another. In contrast, the programmatic strategy facilitates staff development of program expertise and minimizes role conflict. However, it may place excessive demands on staff who work in oversubscribed program areas, and it may leave staff without colleagues to support them in their specific program area. These features of the programmatic organizational structure, combined with the inherent challenges of providing the LBP well-being visits, may result in rapid burnout for staff providing well-being visits under this structure.

B. STAFF CASELOADS AND RESPONSIBILITIES

Well-being visit caseloads for the individual nurses and social workers who conduct these visits vary depending on the local agency's strategy for organizing field staff. Staff in programmatically organized agencies tend to have larger LBP caseloads than staff in geographically organized agencies with a similar total LBP caseload. This is because programmatically organized agencies consolidate all LBP referrals into one or two staff members' caseloads, while geographically organized agencies typically divide these referrals among five or more staff members.

Our focus group discussions with nurses and social workers in 13 counties produced anecdotal evidence that the programmatic organizational strategy may result in individual staff being given more LBP referrals than they can reasonably handle in a month. For example, one focus group participant from an agency with a programmatic staffing strategy stated that 50 percent of her time is allotted to conducting LBP well-being visits, which is insufficient for her to process the 85 to 120 referrals that she receives each month. In a high-volume month, this particular visitor is expected to use only 40 minutes per referral to track down the family's location, make an appointment, travel to and from the appointment, and conduct the actual visit. With that amount of time, some objectives for the visit clearly will not be met.

Across the 13 counties included in this study, individual nurses and social workers were handling between 1 and 200 referrals for well-being visits each month, with those in geographically organized agencies much more toward the lower end of this range. Across the board, staff reported that their well-being visit caseloads had fallen since the initial year of the Well-Being Visit Program, roughly paralleling the 30 percent decline in new assignments to the LBP statewide between state fiscal year (SFY) 1995 and SFY 1997.[1]

Staff responsibilities also vary depending upon the agency's organizational strategy. For example, in agencies that use the programmatic staffing strategy, the staff members who conduct LBP well-being visits are responsible for the LBP referrals and sometimes for referrals from one other program operated by their agency. In contrast, staff in agencies that use the geographic staffing strategy are typically responsible for referrals from all public health programs operated by those agencies. While all local public health agencies provide the same IDPH programs (the Well-Being Visit Program, Public Health Nursing, Home Care Aide, and Senior Health), the agencies differ considerably in their non-IDPH programs. The nature of the non-IDPH programs that a local agency provides may influence its completion rate for the well-being visits. For example, some agencies represented in this study offer the WIC program and well-child clinics whose target populations overlap considerably with the target population for the Well-Being Visit Program. Such overlap facilitates locating and visiting clients, thereby increasing visit completion rates.

Our discussions with administrators and staff of local public health agencies revealed that, while the broad objectives of the Well-Being Visit Program are consistent with the agencies' goals, the well-being visits differ from visits made through other programs in several important respects. For

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[1]Counts of new assignments to the LBP are taken from an internal DHS reports, "Welfare Reform in FY 1995" and "Welfare Reform FY 1997."

example, nursing staff told us the other home visits they provide tend to have a strong medical focus while the well-being visits do not. The large effort required to locate LBP clients, the requirement that well-being visits be prescheduled, and client resistance to actual or attempted well-being visits also distinguish the well-being visits from other visits made by public health staff. These distinguishing features also suggest that it is more difficult to conduct well-being visits than other public health visits.

C. STAFF BACKGROUND AND SKILLS

The DHS contract with IDPH to administer the Well-Being Visit Program requires IDPH to provide registered nurses or social workers to conduct the well-being visits. IDPH contracts with the local public health agencies that employ these staff. Several of these local agencies recently replaced nurses with social workers to conduct the well-being visits. Administrators and staff in these agencies told us that, since the Well-Being Visit Program currently focuses on educating clients about FIP policies and reconnecting them with PROMISE JOBS and the FIA process, social workers are usually better qualified than nurses to conduct the visits.

While interview and focus group participants generally found social workers to be better suited than nurses to conduct the well-being visits, they thought that these visits were not particularly well suited to either group. This was mainly because nurses and social workers generally provide their clients with ongoing care, while LBP clients are visited only once or twice at most. Furthermore, because LBP clients are difficult to contact and visit, nurses and social workers spend more time attempting to reach LBP clients than providing them with care. One nurse noted, "I feel like I've developed a new technique; I'm kind of like a private eye type person." Other focus group participants said they seem to be performing a DHS job rather than a public health job when they are searching for LBP clients. And when they actually succeed in visiting LBP clients, they make

more use of their policy education and referral skills than their professional public health nursing or social work skills.

A number of local agency staff suggested that the program need not rely on such highly skilled staff as nurses and social workers to make the well-being visits. They proposed that members of the community who know the area's social service system and the people it serves could locate and visit LBP clients and refer them to appropriate social service agencies. While this approach of using community outreach workers might reduce the cost of the Well-Being Visit Program, there is a risk that it would lead the program even further away from its original objective of inquiring into the well-being of children in LBP families.

Local public health agencies were chosen to carry out the well-being visits because of their existing structure, health care and home visiting expertise, and longstanding community relationships. Unless community outreach workers could be integrated into the existing structure, using these workers would necessitate the creation of a new service layer for training and oversight, which would reduce the efficiencies of integrating the well-being visits in the existing public health structure. On the other hand, modifying the existing structure to accommodate the community outreach workers could eliminate the role conflict currently faced by the well-being visit staff and would provide for greater program flexibility. A variant of the idea to use community outreach workers would be to use those workers to locate LBP clients and arrange appointments, freeing the nurses and social workers to focus on conducting the well-being visits.

D. STAFF PERCEPTIONS OF PROGRAM OBJECTIVES

Administrators and staff of local public health agencies usually see the main purpose of the well-being visits as providing advice and information to LBP clients about FIP, the FIA, and social services available to them. This contrasts with the original objectives for the program, which give

priority to assessing child and family well-being. Local agency staff agreed that the visits are intended to monitor the well-being of children, but they emphasized that the visits are intended to: (1) ensure that clients understand FIP rules and their rights under those rules, (2) help qualified clients return to FIP, and (3) link families with other types of assistance. The fact that local agency staff give priority to the latter objectives is reflected by the fact that staff refer to the visits as "FIP visits" instead of "well-being visits." Although local agency staff told us that assessing the well-being of children is an important component of the program, their descriptions of their visit activities do not support this. Rather, as we discuss in Chapter VI, their visit activities emphasize FIP related issues.

Although well-being visitors and public health agency administrators voiced strong commitment to the LBP families, their commitment to the Well-Being Visit Program itself appears to be weak. Several factors may contribute to the weak commitment:

- The well-being visits are different from most other home visits conducted by local public health agency staff.
- The program provides staff with little support in locating LBP clients and conducting the well-being visits.
- Local public health agency staff have negative feelings about FIP in general.
- These staff are frustrated by failed attempts to locate and visit LBP families, and they find that their work on this program provides little positive feedback.
- Local public health agency staff view the well-being visits as a component of FIP, instead of as a public health program.
- There is skepticism among staff about whether DHS is committed to ensuring the well-being of LBP families after their benefits have been reduced or terminated.

Improving staff understanding of the original objectives of the Well-Being Visit Program and strengthening their commitment to those objectives will require changes in the program, particularly

in the areas of staff training and support. Chapter IV discusses these program areas in detail and offers recommendations to DHS for improvement.

IV. TRAINING AND SUPPORT FOR WELL-BEING VISIT STAFF

DHS and IDPH share primary responsibility for providing training and support for well-being visit staff. The importance of training and support for these staff is heightened by the inevitable challenges involved in contacting and visiting hard-to-reach LBP families. This chapter describes training and support in the Well-Being Visit Program. We discuss contract requirements for training and support, assess current practices in these areas, and provide recommendations to DHS for improvement. To begin, we describe training and support from the perspective of the nurses and social workers who currently conduct well-being visits.

A. THE VISITORS' PERSPECTIVE ON TRAINING

Conducting focus group discussions with current well-being visitors provided valuable information on training and support. We learned that the level of training received by staff varies considerably from agency to agency and individual to individual. We also learned that the general level of training received by most focus group participants is quite low. Consequently, many nurses and social workers are confused and unsure about DHS policies and about their role, resources, and responsibilities as well-being visitors.

1. Level of Training

Staff training for the well-being visits ranges from none to some formal training. At the low end, some nurses and social workers received essentially no training. In the words of several focus group participants:

- "What training? You're thrown in there! Voila!"

- "What training? I trained myself. I mean, I was handed the [manual] and told to read it and you know go from there.. My supervisor didn't know anything about it...so I had to train myself."

- "We just were handed this packet and [told] 'fill out this packet and go assess their needs.' "

Some staff have received a small amount of training, usually from a current well-being visitor, their supervisor, or the administrator of their agency. As described by focus group participants:

- "I got trained by a person who had only done it a month. I got about an hour of training... We sat down for about an hour and she said, 'Well, this is kind of how you do the paperwork.' "

- "Someone else showed me, who said 'here's the form, and it's pretty self explanatory, if you get stuck, let me know.'"

- "We had about an hour staff meeting and [our administrator] gave us this folder and said, 'this is what your supposed to do, now go out and try it on your own.' "

At the high end, some visiting staff received formal training for the well-being visits, but this training had been provided several years ago. In the words of several focus group participants:

- "I went to the original in-service [training] that they had at [the local community college]. It was a day workshop on the [Iowa Communications Network], and it had people... from IDPH and also from DHS and also from PROMISE JOBS that presented... We received this huge notebook of how you're supposed to do [the visits]... how to contact and what exactly the visit was supposed to include... and I think I went to one follow-up workshop about a year later."

- "I went to a teleconference probably [in 1995]... That was really the only formal information I received. It went through all the rules and regulations of FIP... And it did have DHS workers and Income Maintenance workers involved... We had a booklet that we went through. It talked about procedures for contacting people."

- "[There were a] couple of meetings I went to when [the program] first started. [The meetings] went through the forms and specifics... They gave you some things...to explain the program. One [meeting] was explaining how it got started and how they're

> taken off [FIP] and can't reapply for such a length of time, and then it went into the forms and actually how many contacts [are] required and what's needed [at the visit]."

These comments illustrate the range of training and the fact that even the most highly trained staff have not received any recent training. The general lack of training for the well-being visits has contributed to overall uncertainty among staff.

2. Staff Uncertainty and Confusion

Focus group participants repeatedly expressed uncertainty about the Well-Being Visit program, related DHS programs and policies, and the resources available to them to support their efforts. Some expressed their lack of knowledge about the LBP, PROMISE JOBS, and FIP. One participant even said "I, truthfully, don't even know where PROMISE JOBS is located." Another confessed uncertainty about whom to contact for assistance, information, or support: "Sometimes I just wander around lost for a while, depending on what the issue is. Sometimes I call PROMISE JOBS, sometimes I call DHS, and sometimes I call [the IDPH staff member who oversees data processing]." Not one focus group participant mentioned their IDPH Regional Community Health Consultant when asked where they would turn for help with a question or problem regarding the well-being visits--even though the consultants are provided for that purpose.

Other focus group participants lacked information about DHS welfare policies and about available resources to share with LBP families. One stated, "I don't feel like I have a clue some days about who to [tell clients to contact]." Another commented, "the problem...is that when the laws...are changing... I look at [my LBP clients] and say, I'm sorry, I'm here to do this part of this program, but this is not my job and I don't know what those rules and laws...are. I can only tell you as much as I know." This lack of information limits the ability of well-being visit staff to assist LBP families.

B. TRAINING AND SUPPORT PROVIDED BY IOWA DHS

Iowa DHS has an important role in training and support for the Well-Being Visit Program. As the agency that administers FIP and the Limited Benefit Plan, DHS has important information and assistance to provide to the state and local public health agencies that administer the Well-Being Visit Program for families on the LBP.

1. Contract Requirements

The DHS-IDPH contract for the Well-Being Visit Program specifies training and support requirements for DHS, including the following key requirements:

- ***Statewide training***. Help IDPH provide up to one statewide training session per year for well-being visit staff over the Iowa Communications Network (ICN).
- *Support materials*. Provide and update written instructions for conducting well-being visits and completing the Well-Being Visit Checklist; provide staff with up-to-date contact information for DHS county offices and PROMISE JOBS provider agencies.
- ***Technical assistance.*** Provide ongoing technical assistance to the IDPH Regional Community Health Consultants to help them answer questions raised by local agency staff who conduct well-being visits.

2. Statewide Training for the Well-Being Visits

Since the Well-Being Visit Program began, DHS has assisted IDPH to provide two statewide training programs for well-being visit staff over the Iowa Communications Network. The first was held in 1994 at the outset of the Well-Being Visit Program. At that training, DHS, IDPH, and PROMISE JOBS staff gave presentations and well-being visit staff received information about policies and procedures related to FIP, the LBP, and the Well-Being Visit Program. The second training was held in 1995 in preparation for upcoming changes in LBP policy. This training addressed the changes in the LBP structure, the resultant changes in the timing of well-being visits,

and revisions to the Well-Being Visit Checklist. It also provided a review for staff who had attended the 1994 training and provided initial training for staff who had joined the program since that time.

Many current staff did not receive any of the training described above. Due to relatively high turnover of well-being visit staff at the local level many current visitors were not on staff when either of the statewide training sessions was held. Additionally, attendance requirements for those sessions specified that each agency providing well-being visits be represented at the training, not each individual well-being visitor, so some agencies sent only one staff member.

Among staff who had attended at least one of the statewide training programs, there was some concern about the accessibility of the material that was presented. Some of the nurses and social workers found that the training required knowledge that they did not have. In the words of one: "they use acronyms like LBP and FIP and all those others. And ... it's hard to follow when you haven't been involved in the system."

3. Training Materials Provided by DHS

DHS provides a packet of materials to the local public health agencies to support the Well-Being Visit program. Appendix A contains these materials, which include:

1. ***Instructions for Conducting Well-Being Visits.*** This 10-page document provides background information and instructions for the visits. Topics include the purpose of the visits, the timing of the visits and the visit referral process, requirements for contacting clients and scheduling visits, recommended visit activities, and confidentiality requirements. A sample letter for use in contacting clients to schedule visit appointments is also included.

2. ***Instructions for the Well-Being Visit Checklist.*** This 6-page document provides an introduction to the checklist which is used to gather data on the well-being visits, instructions on how to complete the checklist, and instructions on submission for checklists to IDPH.

3. ***Information About FIP, PROMISE JOBS, and FIAs.*** This 8-page document provides background information on Iowa's welfare system with particular emphasis

on programs closely related to the well-being visits. Topics include FIAs, the LBP, PROMISE JOBS components, service delivery areas, and participant responsibilities.

Finally, DHS also provides staff with contact information for DHS county offices and local PROMISE JOBS agencies, to help them resolve questions that arise.

Overall, the training materials provided by DHS contain useful information regarding relevant DHS programs and the roles, requirements, and responsibilities of a well-being visitor. However, that information is not being transmitted to enough current well-being visit staff. Some of the current staff's uncertainty and lack of knowledge could be easily remedied by increasing staff awareness of the information provided in the training materials.

4. Technical Assistance to IDPH

DHS provides technical assistance to the IDPH Regional Community Health Consultants to help them assist the well-being visit staff. However, DHS provides this assistance very infrequently because the IDPH consultants infrequently request it. This is largely because current well-being visit staff only infrequently request assistance from the consultants.

5. Recommendations

To increase the likelihood that the nurses and social workers are well trained to conduct the well-being visits as envisioned by DHS, we recommend that DHS take the following steps:

1. ***Present policy information at a basic level.*** DHS should prepare well-being visit training materials in a way that requires only minimal knowledge of FIP and related DHS programs and policies. This will help local public health staff who may come to the well-being visits with little knowledge of the state's welfare system and policies.

2. ***Provide a new training manual to each local agency.*** DHS should organize the well-being visit training materials into a small reference manual for each local public health agency. Items should be clearly separated and labeled and should include:

- A table of contents to help staff quickly find answers to their questions.

- A "Whom to Contact" sheet that provides a reference list of the appropriate person or agency to call for answers to various questions. For example, "For updated address information on a referral, call your DHS county office at (phone number)"

- A revised well-being visit appointment letter that emphasizes child and family well-being, instead of the FIA and FIP.

C. TRAINING AND SUPPORT PROVIDED BY IDPH

As the agency Iowa DHS has selected to administer the Well-Being Visit Program, IDPH has direct responsibility for providing training and ongoing assistance for staff.

1. Contract Requirements

The DHS-IDPH contract for the well-being visits specifies training and support requirements for IDPH, including reviews of local agencies to promote effective delivery of the visits. Key requirements include the following:

- ***Training visitors.*** IDPH must provide training for the staff of the local public health agencies who conduct the well-being visits.

- ***Providing technical assistance.*** IDPH must provide technical assistance to the staff of the local public health agencies who conduct the well-being visits.

- ***Conducting on-site review.*** IDPH must review each local public health agency that provides well-being visits once per year, and it must identify best practices of visit providers and share those practices with all local public health agencies and DHS twice per year.

2. Training Well-Being Visitors

Requiring IDPH to train well-being visitors is important, particularly with the relatively high level of staff changes and turnover at the local public health agencies. We suspect, however, that this requirement is having little real effect.

We found no evidence of IDPH-sponsored formal training of well-being visit staff since the 1995 statewide training session, and we found only limited evidence of IDPH-sponsored informal training. Not only had many focus group participants received no formal training, many were unaware that any such training had ever taken place. Informal training, has been provided by a few IDPH Regional Community Health Consultants. One consultant provided the agencies in her region with a videotape of the 1995 statewide training for well-being visits. Another organized a meeting for well-being visit staff in her region to train them about social service providers to which they might refer LBP families. Several consultants also mentioned that they sent out sporadic updates over the computer network that links the local agencies. These efforts, however, were the exception rather than the rule.

3. Ongoing Technical Assistance to Well-Being Visitors

The IDPH Regional Community Health Consultants are available to provide technical assistance to the local public health agencies that administer the Well-Being Visit Program and several other IDPH programs.[1] Each consultant is responsible for a region of 9 to 12 counties, and there are nine consultants in total. The consultants describe themselves as "troubleshooters" and "information conduits" between the local agencies and IDPH and, in the case of the Well-Being

[1]The other IDPH Community Health programs delivered by local agencies are Public Health Nursing, Home Care Aide/Chore, and Senior Health.

Visit Program, between the local agencies and DHS. They have significant experience at the local agency level, and are well-equipped to provide assistance to well-being visit staff.

The consultants organize bimonthly meetings for local agency directors and administrators in their region to discuss the delivery of the Well-Being Visit and other IDPH programs. Consultants are also available to provide general technical assistance and answer questions from local staff on an ongoing basis. However, well-being visit staff do not seem to take full advantage of this service. The consultants that we interviewed reported receiving requests for assistance from well-being visit staff less than once per month. The well-being visit staff appear to rely more often on the IDPH technical support worker who processes the well-being visit checklist. While focus group participants were not clear on this IDPH staff member's position, many indicated that he was their first point of contact when they were faced with questions.

4. Site Visits and Reviews for the Well-Being Visits

The IDPH consultants conduct quarterly site visits to each local public health agency in their region to monitor the delivery of the IDPH programs. At each quarterly visit, the consultant focuses on one program but is available to respond to staff questions on the other programs.

For the annual Well-Being Visit Program review, consultants meet with the agency administrator or other supervisory staff and with nurses and social workers who conduct the visits. They also review a sample of completed Well-Being Visit Checklists. IDPH has developed a three-page guide to help the consultant assess the agency's compliance with well-being visit contract requirements. To report the results of the review, the consultant is required to complete a one-page form. A copy of each of these IDPH documents is provided in Appendix B.

We are not certain about how well IDPH is meeting the requirement to identify best practices and publicize these practices. The subject of best practices was not mentioned by the IDPH and

local agency staff whom we interviewed for this study. This suggests that identifying and publicizing best practices is not a high priority.

5. Recommendations

To improve the provision of training and support by IDPH for the Well-Being Visit program, we recommend that DHS require that IDPH do the following:

1. ***Increase statewide training.*** IDPH should conduct one statewide training session *every* year over the Iowa Communications Network. This will enhance training among current staff and address the ongoing need for training of new staff.

2. ***Provide regular updates to visiting staff.*** Each quarter IDPH should distribute a bulletin to local agency staff to communicate policy issues and other relevant information. The bulletin might include policy updates, answers to frequently asked questions, tips for contacting clients and overcoming other challenges, and recent visit statistics. The Regional Community Health Consultants could prepare the bulletin and distribute it over the email network that links local agency staff.

3. ***Organize regional support meetings.*** IDPH should organize one meeting per year for well-being visitors in each region led by the Regional Community Health Consultant. This meeting would provide program updates and promote the exchange of information between staff.

4. ***Monitor training materials.*** At least once per year, IDPH should verify that each local agency has a complete and up-to-date DHS training manual for the well-being visits. We provide recommendations for this manual in Section B.

These recommendations are intended to take advantage of the existing infrastructure, including the Regional Community Health Consultants and the email network that links staff to improve the training and support IDPH provides well-being visit staff.

D. TRAINING AND SUPPORT PROVIDED BY LOCAL AGENCIES

Currently the local public health agencies are not required to provide training for Well-Being Visit Program staff. Consequently, little training is provided at the local level.

1. Current Practices

Given the lack of training requirements for local agencies, training at the local level depends on the initiative of the agency administrator or supervisor of well-being visit staff. Some well-being visitors have received no training from their local agency. Others have received limited training, usually from a supervisor or coworker with previous well-being visit experience. We found that the majority of local agencies believe training for the Well-Being Visit Program is the responsibility of IDPH or DHS. Also, they believe that the Well-Being Visit Program receives lower funding than the other programs provided by their agencies, and this contributes to their own lack of investment in training for the well-being visits.

Only a few focus group participants reported that their agency administrator or supervisor had provided any ongoing support to them for the well-being visits. One participant noted that she has a secretary who updates client addresses and schedules appointments for her well-being visit cases. Such support, however, is unusual.

2. Recommendations

DHS has not expected the local public health agencies to have a significant role in training and support for the Well-Being Visit program. Hence, our recommendations for changes at the local level focus on raising staff participation in IDPH-sponsored training and staff access to support resources. In particular, we recommend that DHS require IDPH to set forth requirements in its contracts with the local public health agencies that would require the following:

1. Attendance of all well-being visit staff at all training related activities. The requirement should state that the reimbursement rate for well-being visits covers expenses associated with staff attendance at training.

2. Maintenance of a complete and up-to-date well-being visit training manual at each local agency.

3. Submission of current staff lists to the agency's IDPH Regional Community Health Consultant every quarter.

These recommendations will help ensure that well-being visit staff receive sufficient training and support.

V. THE WELL-BEING VISIT COMPLETION RATE

Fewer than half of all clients referred for an LBP well-being visit actually receive a visit. This low completion rate compromises the state's ability to monitor the status of LBP families and ensure the well-being of the children in those families. This chapter discusses possible explanations for the low completion rate and makes recommendations to DHS for increasing that rate.

A. THE LOW VISIT COMPLETION RATE

During state fiscal year (SFY) 1997,[1] approximately 40 percent of LBP clients referred for a well-being visit were successfully visited by a nurse or social worker (Exhibit V.1). Only some of the visited clients were seen by a nurse or social worker since some clients were "visited" by telephone. Inability to contact clients is the main reason that visits do not occur. Client refusal of well-being visits is a much less common reason. This suggests that increasing the well-being visit staff's ability to contact clients is critical to raising the visit completion rate.

B. CURRENT POLICIES FOR CONTACTING CLIENTS AND SCHEDULING VISITS

The principal source of the policies that govern attempts to contact and visit clients is the standard contract between IDPH and each local public health agency.[2] The contract specifies the following:

- ***Minimum Number of Contact Attempts.*** For each client referred for a well-being visit, at least three attempts must be made to contact the client and schedule the visit.

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[1]State fiscal year 1997 began July 1, 1996, and ended June 30, 1997.

[2]The DHS-IDPH contract also specifies the requirements for contact attempts but provides less detail than the IDPH-local agency contract.

EXHIBIT V.1

THE WELL-BEING VISIT COMPLETION RATE:
STATE FISCAL YEAR 1997

	Number	Percentage
Cases Referred	8,950	100.0
Cases Visited		
In-Person	2,213	24.7
By Telephone	1,387	15.5
Subtotal	3,600	40.2
Cases Not Visited		
Unable to Contact	4,774	53.5
Client Refused Visit	576	6.4
Subtotal	5,350	59.7

SOURCE: Iowa DHS "Well-Being Visit Monthly Report: June 1997," (August 1997).

- ***Contact Procedures.*** The client may be contacted by telephone to schedule the visit. If that method is unsuccessful, then a letter that explains the visit and sets an appointment for the visit is to be sent to the client. If the letter is returned, staff should request updated client contact information from the local DHS office. At least one of the contact attempts *must* be made by letter.

- ***Unscheduled Visits.*** Staff are prohibited from making well-being visits that have not been scheduled in advance.

While the IDPH-local agency contract specifies that three attempts must be made to contact the client to arrange a well-being visit, it does not specify what constitutes an attempt. However, the DHS well-being visit training materials specify that the following efforts each qualify as *one* contact attempt:

- ***Telephone.*** Speaking with a person by telephone or leaving a message on an answering machine qualifies as a contact attempt.

- ***Letter.*** Mailing or hand-delivering a letter to a client qualifies as a contact attempt.

- ***In-Person.*** Showing up for a scheduled well-being visit appointment, when the client fails to show, qualifies as a contact attempt.

C. FACTORS RESPONSIBLE FOR THE LOW VISIT COMPLETION RATE

Some factors contributing to the low well-being visit completion rate are unlikely to change. However, other contributing factors may be changed to increase the proportion of referred clients who are contacted and visited.

1. Factors Unlikely to Change

The prohibition on unscheduled well-being visits, the limited client contact information available from DHS, and the nature of the LBP population each contribute to the low visit completion. These factors are unlikely to change.

a. No Unscheduled Visits

DHS prohibits local public health agencies from making unscheduled visits to LBP clients under the Well-Being Visit Program. This is standard DHS policy with respect to visiting DHS clients; it is not specific to the Well-Being Visit Program. Therefore, this policy will probably not change, even though it significantly restricts attempts to contact and visit LBP clients. Visiting nurses and social workers expressed frustration at missing opportunities to conduct well-being visits, especially because they *are* able to make unscheduled visits to clients they serve through other programs.

b. Limitations of the Client Contact Information

Each month, DHS provides IDPH with a list of referrals for well-being visits in the following month. The referral list provides client contact information from the DHS computer system, including the client's name, mailing address, and telephone number.[3] The information is subject to two main limitations. First, the client's mailing address may be a post office box rather than a street address. While a client can receive a welfare benefit check from DHS with only a post office box address, this information is often insufficient for a nurse or social worker to arrange and conduct a well-being visit. Second, the address and/or the telephone number may be out of date. The most common problem seems to be the lack of an accurate telephone number. At the focus group discussions, well-being visit staff noted that, "Number one, the phone numbers aren't correct," and "I'm lucky if [in] one out of ten [cases]. . . . the phone number's accurate."

These limitations of the client contact information contained in the DHS computer system are unlikely to be resolved unless more comprehensive contact information is required for the delivery of welfare benefit checks. However, improvements could be made in the maintenance of new client

[3]The DHS computer system is the Iowa Automated Benefit Calculation (IABC) system.

contact information that nurses and social workers acquire through their efforts to contact LBP clients for the well-being visits. This would facilitate subsequent contact with LBP clients.

c. Characteristics of the LBP Population

Families on the LBP tend to move frequently, be resistant to welfare program requirements, and display anger toward the welfare system. These factors make it difficult to contact LBP clients and conduct well-being visits with them.

Transience. Nurses and social workers find the transient nature of the LBP population to be a barrier to locating and contacting clients. Frequent moves mean that a client's contact information is limited (no street address or a missing telephone number) and very possibly out of date. Many letters sent to LBP families for the Well-Being Visit Program are returned as undeliverable, and addresses often turn out to be abandoned houses. Unless the rules of the LBP are dramatically altered, this feature of the LBP population will probably not change. Well-being visit staff need training in how to deal most effectively with this challenge, and program administrators need to acknowledge its negative effect on the visit completion rate.

Noncompliance. Every LBP client who is referred for a well-being visit has failed to comply with FIP requirements regarding participation in employment and training activities, in particular participation in the Family Investment Agreement. For some of these clients, noncompliance with these requirements reflects a general resistance to comply with any requirements or requests made by the welfare system. Staff made the following comments about the attitude of noncompliance among LBP clients and how it applies to well-being visits:

- "The reason why we go to the house and [the clients] are not there is the very same reason that [they] are on the Limited Benefit Plan. It's the same kind of [behavior]."

- "As frustrating as it is that we can't contact these people, again I go back to [the fact that] we're dealing with the people who are most resistant and least interested in seeing anybody. And we couldn't be a friendlier bunch and a better group of people to talk to in terms of helping them but that doesn't mean these families are even receptive to that."

Anger. Previous research indicates that nearly 80 percent of LBP clients perceive their entry into the LBP to have been involuntary.[4] Therefore, anger toward the welfare system for the termination of cash assistance is likely to be found among LBP clients. At the focus group discussions, well-being visit staff told us that LBP clients they are trying to visit often see them as representatives of the welfare system, and they can become targets for the anger those clients harbor toward the welfare system. Clients may express that anger by refusing the well-being visit or being uncooperative during a visit. Well-being visit staff made the following comments about client attitudes and behaviors:

- "They know the minute that they get that [visit appointment] letter that I am somehow affiliated with DHS. And. . . . the first thing that comes out of my mouth is, I'm not DHS. . . . [Otherwise] they don't want to work with me just because they think I'm not on their side."

- "I walked into one [house] yesterday and the person really didn't want me in the door and was just absolutely furious at the entire system."

d. Implications of These Characteristics.

These characteristics of the LBP population--transience, noncompliance with welfare program rules, and anger toward the welfare system--are unlikely to change. DHS and others committed to the success of the Well-Being Visit Program must acknowledge that these characteristics pose barriers to completing the well-being visits. These barriers may mean the program is unlikely to ever achieve a high visit completion rate.

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[4]See *Iowa's Limited Benefit Plan: Summary Report*, by Fraker et al., 1997, table 3, page 6.

2. Factors Amenable to Change

Although some factors will probably not change, other factors contributing to the low visit completion rate could be addressed through reforms to the Well-Being Visit Program. Primary factors amenable to change include inadequate financial and nonfinancial incentives for the local public health agencies and their staff to overcome the barriers to completing visits. Other factors that could be addressed include the absence of systematic updating of client contact information and client ignorance of the Well-Being Visit Program.

a. Financial Incentives

Local public health agencies have limited financial incentives to complete well-being visits and they have no added incentive to conduct in-person visits rather than telephone "visits." Because of limited financial incentives and limited awareness of existing incentives, local agency staff assign low priorities to the well-being visits and put limited effort into them. We recommend that DHS modify its reimbursement policies to increase the financial incentives for completing well-being visits, particularly the in-person visits. We also recommend that DHS train the visiting staff on the structure of financial incentives to increase knowledge and awareness.

Current Reimbursement Policies. DHS currently reimburses IDPH (which reimburses the local public health agencies) $25 per referral with three contact attempts but no completed well-being visit, and $55 per referral with a completed visit. Again, the reimbursement rate is the same for telephone and in-person visits. DHS also provides quarterly financial bonuses for local agencies that achieve high visit completion rates. Agencies that visit 50 to 74 percent of their referrals receive a bonus of $10 per visit, and agencies that visit 75 to 100 percent of their referrals receive a bonus of $25 per visit.

Staff Perceptions of Financial Incentives. Nurses and social workers who conduct the well-being visits generally believe that the funding provided by DHS is insufficient to cover the cost of conducting the visits. They reported that:

- "[The reimbursement] is less than our cost. . . . I mean there's no money incentive [to do the visits]."
- "I'm under the understanding that my agency doesn't want me out running around spending three hours to locate a family. . . . it wouldn't be cost efficient for the agency."
- "The amount of money the agency gets reimbursed, though, is very minimal compared to what [the agency] would get for a Medicare visit or a nursing visit. So, it's not even comparable."

Given limited financial incentives, many staff feel pressure to devote their attention to other activities that generate more revenue relative to their cost, and they seem to place low priority on completing well-being visits.

Incomplete Transmission of Incentives to Staff. Some nurses and social workers are not well-informed about the financial incentives for completing well-being visits. Without accurate and complete information, they may be unlikely to pursue the visits as aggressively as the existing reimbursement schedule warrants. While most of the staff who participated in the focus group discussions were aware of the basic $25 and $55 reimbursement rates, fewer were aware of the bonus payments for high completion rates. Some visit staff were unaware of the equal payment for in-person and telephone visits. For example, one focus group participant was under the mistaken impression that her agency is not reimbursed for telephone visits.

Recommendations Regarding Financial Incentives. To address the limitations of the current financial incentives for completing the well-being visits, we recommend that DHS:

1. ***Review and Adjust the Basic Reimbursement Rates.*** DHS should compare the current well-being visit reimbursement rates to the cost of successfully contacting clients and making high quality visits. The reimbursement for a completed visit should be adjusted upward as appropriate to ensure that adequate effort and resources are devoted to the visits. If DHS prefers in-person visits to telephone visits, the reimbursement structure should provide a higher payment for an in-person visit.

2. ***Educate Local Agency Staff.*** DHS should ensure that all local public health agency staff have accurate information about the basic reimbursement rates and bonus payments for well-being visits. This information should be sent to the local agencies by either DHS or IDPH. It should be covered during all training and retraining of local agency staff on the Well-Being Visit Program.

3. ***Publicize Good Performance.*** Through a newsletter or memorandum, DHS should periodically notify all local public health agencies of the agencies that have received bonus payments for high visit completion rates. For each recipient agency, DHS should display the total bonus payment and the average amount per completed visit.

b. Nonfinancial Incentives

Local public health agencies may establish certain goals and procedures that discourage their staff from devoting much effort to the well-being visits. For example, some of these agencies set monthly productivity goals for the total number of client visits conducted by a staff member across *all* programs. Because LBP clients tend to be much more difficult to contact and visit than clients in other programs, an hour spent on a well-being visit referral is less likely to increase a staff member's measured productivity than an hour spent on a referral from another program. For staff whose productivity goals are specified in this way, LBP well-being visits are unlikely to be a high priority. Reflecting this, some nurses and social workers attempt to fit well-being visits into their schedules as other demands on their time allow, rather than schedule specific time for the well-being visits.

Nonfinancial factors such as job satisfaction may further discourage nurses and social workers from assigning high priority to the well-being visits. In the words of one focus group participant:

> "When I see people, I feel like I can make a difference. But I so rarely see the [well-being visit clients] that I feel like I am wasting my skills and they become a lower priority [than] my [medical] patients."

This can lead to a downward spiral in which a low completion rate for the well-being visits results in a low priority being placed on those visits, which lowers the completion rate even further.

To address these nonfinancial incentives that discourage the public health nurses and social workers from devoting their time and effort to the well-being visits, we recommend that DHS institute the following feedback mechanisms:

1. ***Regular Performance Feedback.*** On a quarterly basis, provide each local public health agency with a report on the visit completion rate for the agency as a whole and for each individual staff member. Also provide each agency with copies of this report for the other local agencies in the same IDPH region.

2. ***Bonus Payment Announcements.*** On a quarterly basis, announce to all local agencies the names of agencies receiving bonus payments for high visit completion rates.

This feedback would tell the agencies and their staff that high completion rates are valued by IDPH and DHS and provide positive recognition to the agencies and staff who perform well. It would also empower agency administrators with information, enabling them to recognize and reward good individual performance and identify and remedy poor performance.

c. The Quality of Client Contact Information

The contact information on well-being visit referrals that is available in DHS computer files is limited in scope and frequently out of date. DHS is unlikely to address these limitations to meet the needs of the Well-Being Visit Program, but the program's own data systems could be routinely updated to reflect new client contact information generated by the program itself.

Nurses and social workers often obtain updated contact information in the process of attempting to contact LBP clients for the initial well-being visit and record that information on the Well-Being Visit Checklist. Despite a note to the contrary on the checklist,[5] these staff expect DHS to copy the corrected contact information from the checklist into its computer system. However, DHS cannot readily process this corrected contact information. Therefore, several months later, the contact information that appears on the DHS list of referrals for the second well-being visit is invariably, incorrect. The distance between what well-being visitors expect and what DHS does creates resentment among well-being visitors toward DHS.

To improve the attitude of the well-being visit staff toward DHS and the quality of the client contact information for the well-being visits, we recommend that DHS work with IDPH to:

1. ***Educate Local Agency Staff.*** Training and retraining of well-being visit staff should include an explanation of why DHS does not copy updated contact information from the well-being checklist into its computer system. This would reduce misunderstanding among local agency staff.

2. ***Use Updated Contact Information.*** IDPH should design and implement a data base for storing corrected client contact information and a system for providing that information to the well-being visitors in a timely way and appropriate format to facilitate subsequent visits. Since IDPH is the recipient of the completed Well-Being Visit Checklists and has funding from DHS for data-oriented work, IDPH is the better candidate to lead this task than the local public health agencies.

d. Inadequate Client Awareness of the Well-Being Visit Program

Client ignorance about the Well-Being Visit Program is another factor that affects visit completion rates. Nurses and social workers who conduct well-being visits find that many of their LBP clients have little knowledge of the Well-Being Visit Program. Those clients do not expect to

[5]The box on the checklist for corrected contact information includes a note stating that the information is "for agency use only." *Agency* refers to the local public health agency. Apparently, many of the well-being visitors do not understand that this implies that DHS will not use or process the corrected contact information.

be contacted and, when contact is attempted, they may be confused by and unreceptive to the idea of a visit. LBP clients often respond to nurses' attempts to schedule a well-being visit by stating that they are not ill and do not need medical attention, and they often assume that social workers who provide these visits are DHS employees. Many clients simply do not understand that a visit by a nurse or social worker from their local public health agency is part of the LBP, and they do not understand the purpose of the visit.

To improve awareness of and receptivity to the Well-Being Visit Program among LBP clients, we recommend that DHS:

1. ***Provide Early Information to Clients About the Well-Being Visits.*** DHS should assign higher priority to educating LBP clients about the well-being visits. Notification of the initial assignment to the LBP should be accompanied by information about the well-being visits, as should notification of the termination of cash benefits. This information should include the name of the local agency providing visits in the client's county.

2. ***Promote the Visits as a Helpful Service.*** Provide guidelines to local agency staff for how to present the well-being visits in letters, telephone calls, and in-person meetings with LBP clients. The visits should be promoted as a helpful service provided *independently* of DHS.

These recommendations, along with those presented earlier in the chapter, would help the Well-Being Visit Program reach more LBP families.

VI. THE STRUCTURE AND FOCUS OF THE WELL-BEING VISITS

The Well-Being Visit Program is structured to provide two visits to clients assigned to the Limited Benefit Plan (LBP). These visits may be conducted at the client's home, at an alternate site, or by telephone. In practice, the visits focus on what the family needs to do to return to FIP--contact PROMISE JOBS, sign a Family Investment Agreement (FIA), and participate in the employment and training activities that are specified in the FIA. While this is consistent with current DHS policies regarding the well-being visits, it departs from the original mandate for the program--to focus on the well-being of children in LBP families. This chapter assesses the current structure and focus of the well-being visits and makes recommendations to DHS for improvement.

A. THE NUMBER AND TIMING OF WELL-BEING VISITS

Under current policies of the Well-Being Visit Program, the visits occur too early in the LBP period to obtain information on the family's ability to meet its needs without cash assistance. We recommend that DHS revise its policy's to provide a single well-being visit to all LBP clients several months after the termination of cash assistance.

1. Current Policies Regarding the Number and Timing of Visits

The Iowa Administrative Code and the contracts for the Well-Being Visit Program specify that two visits are to be made to a client in a first LBP assignment, and one visit is required for a client in a second or subsequent LBP assignment.

A first LBP assignment consists of three months of reduced cash assistance followed by six months of no cash assistance. The well-being visits are mandated to occur during months two and

four of the nine-month period.[1] According to this schedule, the first visit occurs after cash assistance has been reduced (but before it has been terminated entirely), when most clients still have the right to reconsider their assignment to the LBP.[2] The second visit occurs after cash assistance has been terminated and the right to reconsider has expired.

A second or subsequent LBP assignment entails the immediate termination of cash assistance for six months with no reconsideration rights. A single well-being visit is to be conducted in the second month of the assignment period.

2. Limitations of Current Policies

MPR has identified two limitations of current policies specific to timing of the Well-Being Visit Program. First, the requirement that both first and second visits occur during the early months of an LBP assignment limits DHS's ability to observe how children and families fare without cash assistance. Second, for a client in a first assignment, the second visit follows so closely after the first that it is redundant in many respects.

While the first visit can indicate how families cope with reduced cash assistance, it provides no indication of how they would cope with the complete termination of that assistance. The second visit is scheduled for month four, the *first* month of no cash assistance. This still may be too early to assess the family's ability to meet the needs of its children without cash assistance. One of the focus group participants made the following statement:

> They still have resources at four months. They haven't worn out their mother-in-laws and they haven't worn out the food banks and they haven't gone to all their friends. . . . And

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[1]For a client who entered a first LBP after signing (and then abandoning) an FIA, only the month-four well-being visit is to be provided. Such "post-FIA" LBPs are relatively rare.

[2]A client in a post-FIA LBP has no reconsideration rights.

that's why I look at this big black hole . . . after the four month visit . . . [when] all those resources have been exhausted, where are they getting [resources] from?

The short time between the month-two and month-four well-being visits limits the effectiveness of the later visit. Several visitors in the focus group discussions described the month-four visit as "redundant" or "repetitive". In the words of one focus group participant, "If you saw [the family] at two months, more than likely they don't feel it's necessary to see you at four months. So they will either call and cancel or choose not to be there. [They will be] no shows." Another participant reported that the clients she contacts for month-four visits often respond with, "Why are you contacting me again? I told you I was fine last time."

3. Recommendations

We recognize that changing the timing of visits requires legislative approval since the number and timing of the visits is specified in the Iowa Administrative Code. To improve DHS's ability to monitor and assess the well-being of children and families affected by the LBP, we recommend the following changes:

1. ***Require a single well-being visit for all LBP clients.*** DHS should eliminate one of the two visits now mandated for clients in a first LBP assignment. No change would be required for clients in a repeat LBP assignment, for whom one visit is currently required.

2. ***Schedule the well-being visit several months after benefit termination.*** For clients in a first LBP assignment, this would be month five or six of the LBP. For clients in a repeat LBP assignment, this would be month two or three of the LBP.

Conducting *one* well-being visit during the family's second or third month without cash assistance would enable DHS to monitor the well-being of children who are at greatest risk--those

in families whose cash assistance has ended.[3] Eliminating one of the required visits for clients in a first LBP would enable resources to be used to achieve a higher visit completion rate.

B. THE VISIT MODE: IN-PERSON VERSUS TELEPHONE

The well-being visits were originally intended to take place in the client's home. As stated in the state's administrative code: "[DHS] shall provide for qualified social service professionals to provide home visits [to families on the LBP]" (Iowa Administrative Code [441] 93.138(4)). Despite this intention, the program has evolved to rely considerably on telephone visits. Since it is so difficult to assess child and family well-being through a telephone visit, we recommend that DHS revise the structure of reimbursement rates for well-being visits to provide local public health agencies greater financial incentives to conduct home visits.

1. Current Policies Regarding the Visit Mode

Under current Well-Being Visit Program policies, DHS accepts home visits, in-person visits at a site other than the home, and telephone visits. The contracts for conducting the well-being visits specify the following preference ordering of visit modes:

1. ***Home Visit.*** When contact with a client is initially established, the nurse or social worker must first try to arrange a home visit.

2. ***Alternate-Site Visit.*** If a client refuses a home visit, then the nurse or social worker must try to arrange an in-person visit at an alternate site.

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[3]If the requirement in the Iowa Administrative Code for one visit during the period of reduced cash assistance and one visit during the period of no cash assistance is not amended, we encourage DHS to move the latter visit to the second or third month of the period of no cash assistance (rather than the first month). This would reduce the proximity of the two visits and increase the capacity of the Well-Being Visit Program to assess a client's ability to meet the needs of children in the absence of cash assistance. We acknowledge that DHS contract information would be more likely to be out of date with a later second visit, but we believe this could be addressed by more systematic updating of contact information at the first visit.

3. ***Telephone Visit.*** If a client refuses both a home visit and a visit at an alternate site, then the nurse or social worker must try to arrange a telephone visit.

Despite this explicit hierarchy of visit modes, DHS reimburses local public health agencies $55 for a completed visit, regardless of the mode. This reimbursement structure fails to reward local agencies whose staff conduct in-person rather than telephone visits. Since telephone visits require fewer resources, such as staff time and mileage, the single reimbursement rate actually encourages agencies to conduct visits using DHS's least preferred mode.

2. Assessment of Current Practice

More than half of the well-being visits are conducted in the client's home, but home visits are far from universal. Nearly 4 out of 10 well-being visits during state fiscal year 1997 were conducted by telephone. (Exhibit V.1 in the preceding chapter provides data on the visit mode during state fiscal year 1997). At the focus group discussions, well-being visits staff who consistently receive large numbers of referrals for visits were most likely to rely heavily on telephone visits. Staff explained that the time savings associated with telephone visits enabled them to work through their referral lists by the end of the month, which they believed would be impossible with in-person visits.

Clearly, less information on family and child well-being can be obtained through a telephone visit. For example, in a telephone visit, the nurse or social worker cannot observe the client, the children, or their living environment; she can gather only the information that the client is willing to share with her. Focus group participants had this to say about the limitations of telephone visits and the advantages of in-person visits:

- "The thing with the phone visits [is that] you can't really get a feel for what's going on . . . whereas when you're in the home . . . there are a lot of things you see or don't see."

- "I make less referrals over the telephone than I would if I had a face to face visit with them because I get more information from a face to face."

- "There's something to be said [for] sitting next to them on the couch, and them realizing that you are actually being compassionate. And so much more does come out than on the phone."

3. Recommendations

Relying so heavily on telephone visits compromises DHS's capacity to monitor child and family well-being in households affected by the LBP. Therefore, MPR recommends that DHS eliminate its current $55 reimbursement rate for any visit and replace it with a system of variable reimbursement rates that is consistent with the department's preference ordering of visit modes:

1. Home visits would receive the highest reimbursement rate (for example, $60).
2. Alternate site-visits would receive a middle reimbursement rate (for example, $50).
3. Telephone visits would receive the lowest reimbursement rate (for example, $40).

This system of variable reimbursement rates would provide local public health agencies with the financial incentive to conduct well-being visits in person, preferably in the client's home.

C. STANDARDIZATION OF WELL-BEING VISITS

Current policies impose little standardization on the well-being visits. This is reflected in the actual conduct of the visits, which tends to vary considerably across local public health agencies and even among an agency's visiting staff. We recommend that DHS require a higher level of standardization to ensure that core activities are carried out during each visit, regardless of which agency or staff member conducts the visit.

1. Current Policies Regarding Standardization

The contract between DHS and IDPH *requires* that a specified set of standard activities be included in each visit. However, the corresponding contracts between IDPH and the local public health agencies simply *recommend* that those activities be included as appropriate.[4] Visit providers operate under the latter contracts which are very flexible about visit activities. For each visit, the requirement to complete the Well-Being Visit Checklist encourages some standardization of activities across visits, as certain activities must be undertaken for staff to complete the checklist. These include assessing the client's need for referrals to programs and services, planning follow-up services for the client, and inquiring into the client's sources of income. At the same time, the policies impose little standardization on the procedures and criteria to be used in carrying out these activities. For example, there are no standardized criteria for determining whether follow-up services are needed. For the most part, the policies leave such assessments up to the professional judgment of the individual nurse or social worker.

2. Current Level of Standardization

With the flexibility in program policies regarding well-being visit activities and the confidence that local public health agency administrators have in their staff's ability to conduct home visits, the nurses and social workers have much discretion in the conduct of the well-being visits. In this flexible environment, visits may vary because of differences in the professional training and orientation of staff (nursing or social work), their concept of a well-being visit, the size and nature of their client caseload, and their personal commitment to the well-being visits.

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[4]The DHS-IDPH contract reads, "Visit shall include but is not limited to [the following activities] . . . ," while the IDPH-local agency contract reads, "[The contractor] agrees to perform the following activities during a well-being visit, when appropriate to the client's situation."

The professional training and orientation of the well-being visitor is particularly important to the conduct of a visit. For example, nurses are much more likely than social workers to obtain immunization histories and check on other medical issues routinely as part of their visits. In the words of one nurse, "As a nurse I can tell them where they can get their immunization, where they can get medical [care], where free clinics are, where immunization clinics [are]."

The unique standards of individual visitors and their local agencies also affect the conduct of a visit. This discussion between two well-being visitors from different local public health agencies demonstrates the difference in standards:

> ***Visitor 1:*** "I really get into it when I do get [to visit the client]. I spend about 25 minutes to half an hour. Almost every time."
>
> ***Visitor 2:*** "Almost every time? . . . That's a rarity [for us]. A lot of ours can be 5 to 10 minute visits."

There is value in a flexible visit structure that can be adapted to the client's situation and the individual visit provider's skills and strengths. However, individual agencies and visit providers currently seem to have too much flexibility in determining the conduct of the visits. The level of standardization for the well-being visits is inadequate and makes them less useful, particularly as a tool for assessing the well-being of children in LBP families.

3. Recommendations

We recommend that DHS take the following three steps to increase the level of standardization in the well-being visits:

1. ***Distinguish between mandatory and recommended visit activities.*** DHS should review current visit activities and identify which of those activities (or new activities) should be *mandatory* for all well-being visits and which should be *recommended*--that is, conducted when the nurse or social worker deems appropriate.

2. ***Ensure that policy statements regarding visit activities are consistent.*** DHS should review all program contracts and training materials to ensure that they provide consistent statements regarding mandatory and recommended visit activities.

3. ***Standardize the criteria used in visit assessments.*** DHS should provide the visiting staff with basic criteria to be used in assessing child and family well-being, in assessing the need for follow-up services, and in making referrals. These criteria could be imbedded in the Well-Being Visit Checklist. Chapter VII provides a discussion of the checklist.

These recommendations would increase the level of standardization in the conduct of the well-being visits and ensure that fundamental criteria are used and key activities occur in the visits.

D. THE FOCUS ON FIP IN THE WELL-BEING VISITS

Currently, the well-being visits focus on educating clients about FIP policies and reconnecting them with PROMISE JOBS and the FIA process. This focus is consistent with some of DHS's priorities for the visits as articulated in Well-Being Visit Program documents. However, it is inconsistent with the original objective for the visits--to inquire into the well-being of children in LBP families--and with the professional interests and orientation of the nurses and social workers who conduct the visits.

1. Current DHS Policies Regarding the Focus of Well-Being Visits

DHS documents concerning the Well-Being Visit Program identify two conflicting objectives for the visits. Some of these documents include language stating that the visits should facilitate the achievement of self-sufficiency, without involvement by FIP or PROMISE JOBS, by families that have "chosen" the LBP. For example, DHS training materials state the following purpose of the well-being visits:

"Visits are made in the spirit of supporting families who have chosen the LBP. These visits are an extension of the Family Investment Program (FIP) and Family Investment Agreement (FIA) philosophy of supporting families as they move toward self-sufficiency."

On the other hand, some DHS documents include language indicating that the well-being visits should focus on reconnecting client with FIP and PROMISE JOBS so that they can receive training, job search assistance, and financial support for moving to self-sufficiency. For example, DHS training materials specify that:

"Activities during the [well-being] visit may include, but are not limited to:

- Discussing reasons for not participating in the FIA
- Offering to problem solve with perceived problems of FIA participation
- Reminding clients who have [LBP] reconsideration rights of the importance of carefully considering that choice"

In other words, some DHS policies regarding the well-being visits emphasize support for families to work with FIP and PROMISE JOBS to achieve self-sufficiency, while other DHS policies emphasize support for families to work independently to achieve self-sufficiency. However, neither set of policies emphasizes the assessment of child well-being.[5]

2. The Focus of Visits in Current Practice

In practice, the well-being visits focus on providing LBP families with information and referrals that will help them work with FIP and PROMISE JOBS to achieve self-sufficiency. At the focus group discussions, nurses and social workers had this to say about the purpose of the visits:

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[5]The first mention of child well-being is in section III.C. of the DHS-IDPH contract (page 7) of the DHS-IDPH contract, and in Article V. Section A.5.(d) of the IDPH-local agency contract (page 3).

- [The visits are intended] to see if they're eligible to reapply for FIP. [To] check and see . . . "do you understand that you've been reduced to limited benefits?" and those kinds of things.

- [The visits] are intended to go out and make sure that the client is aware of what's happening, that they are looking at the end of their benefits unless they follow through with PROMISE JOBS.

- I think these visits are [to] talk about the [FIP] program, the money, the resources . . . when I go out, my main focus is to find them, to let them know they're getting cut off [FIP].

Focus group participants also universally referred to the visits as the "FIP Visits" rather than the "Well-Being Visits."

There are several limitations of the current focus on FIP in the well-being visits. Most importantly, this focus diverges from the original mission for the visits--to monitor the well-being of children in LBP families. Additionally, the focus on counseling clients about reconciling with PROMISE JOBS and returning to FIP *after* the client has entered the LBP is inconsistent with the philosophy of individual responsibility underlying Iowa's welfare reform. Further, the provision of counseling to LBP clients on reconciling with PROMISE JOBS is more appropriately the domain of DHS or PROMISE JOBS. The nurses and social workers who conduct the visits are more adept at providing public health services than dispensing information on DHS programs.[6]

[6]Many nurses and social workers in the focus group discussions told us that they do not understand the rules governing FIP, PROMISE JOBS, and the FIA. In the words of focus group participant, "The thing is [that] we don't know exactly how these programs work. I'm in the dark as to how these programs work, and I get very little assistance from DHS as to how they work."

E. THE LACK OF FOCUS ON CHILDREN IN THE WELL-BEING VISITS

Children are typically not present during well-being visits to LBP families. We recommend that DHS increase the priority placed on children being present during the visits so that the Well-Being Visit Program can assess and monitor child well-being.

1. Current DHS Policies Regarding the Presence of Children

Currently, the contracts that govern the day-to-day operation of the Well-Being Visit Program do not require children to be present during a well-being visit. In fact, the DHS training materials for the visits state that "there is no requirement that the children be present during the visit, although this is helpful" (1996, page 6). In other words, under current DHS policies, the presence of children during a well-being visit is recommended but not required.

2. Infrequent Presence of Children in Current Practice

Children are present during less than half of the well-being visits. In state fiscal year 1997, children were present during 45 percent of month-two visits and 41 percent of month-four visits (Table E.9, Appendix E). At the focus group discussions, nurses and social workers stated that they rarely, if ever, see the client's children during a well-being visit. One said this: "There's lots of times the kids are not home, though. So [you do] more of . . . looking at the environment and asking the mother about arrangements for the kids than really observing the kids." Other visitors enjoyed greater success observing children because of deliberate efforts to conduct well-being visits late in the day, when children are more likely to be home from school. Therefore, the likelihood of observing children during a well-being visit is partly a function of the visitor's strategy for scheduling and conducting the visits. Currently, DHS policies leave these choices to the discretion of the individual well-being visitors.

3. Recommendations for a Renewed Focus on Children

We recommend a renewed focus on children during the well-being visits. In particular, we recommend that DHS take the following five steps:

1. ***Use program documents to emphasize the focus on children.*** DHS should revise the well-being visit contracts and training materials so that they specify that the primary focus of the visits is child well-being.

2. ***Increase the emphasis on children in the well-being visit checklist.*** DHS should revise the program's data collection form (the Well-Being Visit Checklist) to place a greater emphasis on child well-being (MPR's recommendations in this regard are provided in Chapter VII and Appendix C).

3. ***Train the well-being visitors to focus on children.*** DHS should train well-being visitors about the renewed focus on children and the implications for how the visits are scheduled and conducted; this training could be provided directly by DHS or by the IDPH Regional Community Health Consultants.

4. ***Require staff to make every attempt to schedule a visit when children can be present.*** DHS should revise the well-being visit contracts to specify that staff attempt to schedule visits around children's availability, with particular attention to children who are too young to be enrolled in the school system.

5. ***Provide financial incentives for including children in the visits.*** DHS should offer either a higher reimbursement rate for visits at which children are present or a bonus payment to agencies that include children in a high percentage of visits.

These recommendations would emphasize to the local public health agencies, the well-being visitors, and the families being visited that the well-being of children is the top priority of the program.

VII. GATHERING INFORMATION: THE WELL-BEING VISIT CHECKLIST

The Well-Being Visit Program uses a short form called the Well-Being Visit Checklist to gather information on the well-being visits. The nurses and social workers who conduct the visits are required to complete this form for each LBP client that is referred for a well-being visit. This chapter presents our overall assessment of the current checklist and our proposed revisions to the checklist.

A. OBJECTIVES OF THE WELL-BEING VISIT CHECKLIST

The Iowa Administrative Code (IAC 441-93.138(4), February 1997) specifies that the well-being visitors must report four specific results to DHS:

1. Whether the visitor was denied entry to the home
2. Why no further involvement with the client is needed
3. Whether the visitor needs to provide follow-up services or referral to other services and what services are needed
4. Whether referral to child protective investigations is warranted based on allegations of child abuse or neglect

DHS developed the Well-Being Visit Checklist to help the visiting nurses and social workers gather this information. There have been two versions of the checklist. The original version collected little information beyond the four results required by the code, but it did collect information needed to measure the visit completion rate (the proportion of referred LBP clients for which well-being visits are conducted).

In response to strong state and national interest in the LBP, DHS revised the original checklist to include two direct questions to the LBP client about sources of income and reasons for entering

the LBP, as well as a series of eight questions to the visitor about the client's understanding of the LBP and the status of the client's family. The second version of the checklist was introduced in early 1996 and is still in use today.

B. ASSESSMENT OF THE CURRENT CHECKLIST

To assess the Well-Being Visit Checklist, MPR thoroughly reviewed the current version of the checklist and the data it generates. In addition, MPR gathered information from the users of the checklist through focus group discussions with nurses and social workers who conduct well-being visits.

Our assessment of the well-being visit checklist revealed an important methodological strength of the checklist--it is easy to use. The nurses and social workers who regularly use the checklist find it easy to complete, and note that the checklist is shorter than the forms that they must complete for their other clients. IDPH staff and the administrators of local public health agencies report that the current checklist is not burdensome for staff to fill out, and it has more useful instructions and response categories than the original one.

Even so, our assessment revealed serious limitations in the checklist's capacity to collect reliable and useful data on the well-being visits and LBP families. Most importantly, the checklist does not place a high priority on the fundamental objective of the visits--to monitor the well-being of children in LBP families. Additionally, the checklist has these limitations: (1) it does not request information on the methods used in *successful* contact attempts; (2) it does not collect key information needed to interpret referral rates, such as current participation and refusal of referrals; (3) it only collects information on the need for follow-up services *if* a follow-up visit has been planned; and, (4) it provides too few response categories for the questions on client income sources and reason for

entering the LBP. A section-by-section assessment of the current checklist is presented in Appendix C, along with a copy of that checklist.

C. A REVISED CHECKLIST

To enhance the capacity of the well-being visits to address child well-being and to enhance the value and quality of the data gathered during the visits, we recommend that DHS revise the Well-Being Visit Checklist. We have developed a revised checklist that incorporates our specific recommendations. A draft copy of the revised checklist is presented in Exhibit VII.1. (A detailed written account of our specific recommendations is provided in Appendix C.)

Most importantly, the revised checklist places a renewed emphasis on child and family well-being. This emphasis reflects the original motivation and purpose for the Well-Being Visit Program and is most apparent in Section E of the revised checklist. MPR's revised checklist also provides greater specificity in the wording of checklist items and in the instructions to staff than is provided in the current checklist. All of these changes are intended to improve the usefulness and quality of the data that is collected.

Section A: Basic Client Information. Section A of the revised checklist provides space for the nurse or social worker to copy information from the well-being visit referral list and to record updated client contact information. The area for transcribing the names of dependents that is provided in the current checklist is replaced with space for transcribing client contact information (address and telephone number) for each referral and for recording updates to that information, while still retaining space for recording the *number* of dependents. Systematic recording of up-to-date client contact information will help efforts to contact LBP clients--one of the largest challenges facing the Well-Being Visit Program.

EXHIBIT VII.1

THE REVISED WELL-BEING VISIT CHECKLIST

SECTIONS A-B OF THIS FORM MUST BE COMPLETED FOR EVERY CLIENT REFERRED FOR A VISIT

A. BASIC CLIENT INFORMATION

County Name: _____ Visit type: ☐month-2 ☐month-4 ☐follow-up
County Number: _____ Visit due date: ____/____/____
Agency Number: _____ Soc. Sec #: _____ DHS Case #:_____
Name: _____ Updated Name: _____
Address: _____ Updated Address:_____
_____ _____
Phone: _____ Updated Phone: _____

Note: future referral lists may contain the same address; please keep any updated information on file for future use.

☐Check if client has reconsideration rights (see Referral List) _____ Number of dependents (see Referral List)

B. CONTACT ATTEMPTS

B1. Contact History: *Complete for every client; use numbering systems provided below to fill in the slots.*

#1 Date:____/____/____ Method:____ Contact Made? ☐Yes ➔ Result:___ ☐No ➔ Reason:___
#2 Date:____/____/____ Method:____ Contact Made? ☐Yes ➔ Result:___ ☐No ➔ Reason:___
#3 Date:____/____/____ Method:____ Contact Made? ☐Yes ➔ Result:___ ☐No ➔ Reason:___

Method: 1=telephone calls; 2=mailed appointment letter; 3=attempted visit; 4=other
Result: 1=visit scheduled; 2=visit made; 3=client refused visit, 4=other
Reason: 1=address unknown; 2=phone number unknown; 3=client not home; 4=client moved out of state; 5=other

B2. Were you ever denied entry to the client's home by the client or another household member?☐Yes ☐No [IAC#1]

B3. Did you conduct a well-being visit with this client? ☐Yes➔Proceed ☐No➔Go to Section G

SECTIONS C-F MUST BE COMPLETED IF A VISIT WAS MADE. (IF NO VISIT, GO TO SECTION G)

C. VISIT INFORMATION

C1. Visit type: ☐Telephone ☐Home ☐Alternate site
C2. Date/Time: Date:____/____/____ Start time:_____ End time:_____ Total time:_____
C3. Persons seen or spoken to at visit:____ ____ ____ ____ ____ ____ ____
Person codes: 1=client, 2=client's child, 3=client's spouse/partner, 4=other(specify):_____
Example: if client plus two of client's children are seen, you would report: 1,2,2
C4. Children: ____Total number of client's children living with client
____Number of client's children seen or spoken to at well-being visit
____Number of client's children in school at time of visit

D. PROMISE JOBS AND INCOME MAINTENANCE (FIP)

D1. Does client know about the length of LBP benefit termination (6 months)? ☐Yes ☐No➔Inform client
D2. Does client currently have reconsideration rights (see last line of section A)? ☐Yes ☐No➔Skip to D7
D3. Has client already reconsidered/reconciled with PROMISE JOBS? ☐Yes ☐No➔Proceed to D4
➔Skip to D7
D4. Does client know about reconsideration rights? ☐Yes ☐No➔Inform client
D5. Does client plan to go to PROMISE JOBS to reconsider on his/her own? ☐Yes ☐No➔Proceed to D6
➔Skip to D7
D6. Are you referring this client to PROMISE JOBS for reconsideration? ☐Yes ☐No
D7. Are you referring this client to IM for redetermination of exempt status? ☐Yes ☐No

EXHIBIT VII.1 *(continued)*

E. WELL-BEING CONCERNS, ACTION PLAN, AND REFERRALS

For questions E1 and E2 please indicate your level of concern using the following codes:
0=not at all concerned, 1=somewhat concerned, 2=very concerned, 3=uncertain, 99=not applicable

E1. **Child well-being:** Please indicate your level of concern regarding the family's current ability to provide adequate care for the *children* in each of the following areas:

_____food/nutrition _____health care _____clothing _____adult supervision
_____shelter/housing _____emotional needs _____safety _____other: (specify)_____

E2. **Family well-being:** Please indicate your level of concern regarding the status of the family as a whole--meaning the client, the children, and other adults living in household--in each of the following areas:

_____telephone access _____support network _____mental health _____domestic violence
_____transportation access _____physical health _____alcohol/drug use _____other: (specify)_____

E3. Have you noted *any* concerns or possible concerns in E1 or E2 (any values of 1,2, or 3)?

☐Yes→proceed to E4 ☐No→skip to E5

E4. **Action plan:** Please indicate your plans for addressing the concerns that were identified in E1 and E2. Check all that apply. *At least one item must be checked if you checked Yes in E3.*

☐a I will make a referral to Child Protective Services or Investigations [IAC#4]

☐b I will place the client/child(ren) on my agency's caseload for other services (specify):_____

☐c I will refer the client/child(ren) to programs or services offered by other agencies (specify):_____

☐d I will make a follow-up visit to this family (in addition to any month-four well-being visit).

☐e I will take the following other action:_____

☐f Client is already linked to all appropriate services and programs (Please document these in E5)

E5. **Referrals to Programs and Services:** Please indicate whether or not the client is currently receiving assistance from each program or service. If not, please indicate whether you are referring the client to the given program/service. Please use the codes provided below to fill in the referral code (if Referral=Yes) or the reason code (if Referral=No)

	Recipient?		Referral?		Referral	Reason
	Yes	No	Yes	No	Code	Code
Food Stamps	☐	☐	☐	☐	_____	_____
WIC	☐	☐	☐	☐	_____	_____
Food pantry	☐	☐	☐	☐	_____	_____
Title-19/Medicaid	☐	☐	☐	☐	_____	_____
Well-Child Clinic	☐	☐	☐	☐	_____	_____
Other health care services	☐	☐	☐	☐	_____	_____
Mental health/counseling services	☐	☐	☐	☐	_____	_____
Substance abuse services	☐	☐	☐	☐	_____	_____
Domestic violence services/shelter	☐	☐	☐	☐	_____	_____
General Relief	☐	☐	☐	☐	_____	_____
Child Support Enforcement	☐	☐	☐	☐	_____	_____
Housing assistance	☐	☐	☐	☐	_____	_____
Homeless shelters	☐	☐	☐	☐	_____	_____
Transportation assistance/services	☐	☐	☐	☐	_____	_____
Child care assistance/services	☐	☐	☐	☐	_____	_____
Clothing assistance	☐	☐	☐	☐	_____	_____
Education or training services	☐	☐	☐	☐	_____	_____
Other:_____	☐	☐	☐	☐	_____	_____
Other:_____	☐	☐	☐	☐	_____	_____

Referral codes: 1=made appointment for client; 2=gave client name & phone number; 3=gave client address of program/service
Reason codes: 1=client current recipient; 2=client does not need; 3=client refused; 4=no such service available in county/ reasonable distance

EXHIBIT VII.1 *(continued)*

F. CLIENT INFORMATION

Please read questions F1-F4 directly to the client.

F1. I'd like to ask you a few questions which will help us to see how you are doing. Did you have any of the following sources of income or government assistance in the past 4 weeks? *Read each source and check the appropriate box.*

Yes	No		Yes	No	
☐	☐	Own employment	☐	☐	FIP / LBP
☐	☐	Employment of spouse/partner	☐	☐	Title 19 / Medicaid
☐	☐	Unemployment insurance	☐	☐	Food Stamps
☐	☐	Child support from absent parent	☐	☐	WIC
☐	☐	Money from other family/friends	☐	☐	SSI or Social Security
☐	☐	Other:_____	☐	☐	General Relief
			☐	☐	Child care assistance

☐ Check here if client refused to answer the question

F2. Please tell me the main reason that you entered the Limited Benefit Plan (LBP). *Check one reason only.*

- ☐ Wanted to make it on my own/leave public assistance
- ☐ Did not understand the program requirements
- ☐ Did not meet PROMISE JOBS requirements (appointments, activities, FIA)
  - ➜ What was the main reason? ___ (codes: 1=child care; 2=transportation; 3=health problem; 4=other)
- ☐ Caseworker assigned me to it, no choice
- ☐ Do not remember why / not sure why
- ☐ Other: _____

☐ Check here if client refused to answer the question

F3. Do you expect to be on FIP (receiving FIP benefits) one year from now?

- ☐ Yes➜Skip to Section G
- ☐ No

☐ Check here if client refused to answer the question

F4. Why won't you need FIP at that time? *Check all applicable answers.*

- ☐ Own employment
- ☐ Employment of spouse/partner
- ☐ Child support
- ☐ Support from family/friends
- ☐ Will have moved out of state
- ☐ Other:_____

☐ Check here if client refused to answer the question

G. COMMENTS

➜Please return to item C2 and record the "End time" and "Total time" of the visit.

RN/SW Name (print)_____ DHS Social Worker Name_____

RN/SW Signature_____ Date_____

Section B: Contact Attempts. Section B of the revised checklist collects information on up to three contact attempts for *every* well-being visit referral, whether or not a visit is ultimately conducted. The current checklist collects no information about contact attempts that result in a visit. This limits DHS's capacity to monitor the success rates of different contact methods. The revised checklist requires the visitor to report the date of each contact attempt, the contact method used, and the outcome of a successful contact attempt (visit or no visit) or the reason for an unsuccessful attempt. Collecting this additional information will enable DHS to identify both barriers to contacting clients and successful contact methods. Finally, in response to a requirement in the Iowa Administrative Code, this section also directs the nurse or social worker to report whether the visitor was denied entry to the client's home for a well-being visit.

Section C: Visit Information. Section C of the revised checklist requests information on the visit mode--that is, home visit, in-person visit at an alternate site, or telephone visit. This information, which is also collected in the current checklist, enables DHS to monitor staff reliance on different modes for the well-being visits. This section of the revised checklist collects new information about the duration of the visit, the persons present during the visit, and the involvement of children in the visit. This new information will help DHS understand how successful the visits are in reaching the children in LBP families.

Section D: PROMISE JOBS and Income Maintenance. Section D of the revised checklist collects data on client knowledge of LBP policies, client reconsideration of the LBP, and referrals to PROMISE JOBS for reconsideration and to FIP for redetermination of exempt status. In the revised checklist, referrals to PROMISE JOBS for reconsideration of the LBP assignment are to be considered *only* if the client has active LBP reconsideration rights and has not already reconsidered.

This is an important change from the current checklist which does not place these conditions on such referrals.[1]

Section E: Well-Being Concerns, Action Plan, and Referrals. Section E of the revised checklist reflects our effort to achieve consistency between the checklist and the original objective of the Well-Being Visit Program--to monitor and ensure the well-being of children in LBP families. This section requires the visitor to assess specific aspects of child and family well-being. It also requires the visitor to indicate a plan for addressing any concerns that she identifies. The plan may include follow-up visits with the family and/or referrals to appropriate programs or services offered by the local public health agency or other appropriate agencies.

Section E also collects information about all referrals made during the well-being visit, either to address concerns identified by the visitor in the well-being assessment or to help the family in another way. To understand why referrals are sometimes not made, this section also gathers information about the reason for not making a referral, including whether the client is already receiving benefits or services from a specific program.

Section F: Client Information. Section F of the revised checklist addresses DHS's interest in obtaining descriptive information on LBP families. Similar to the current checklist, the revised checklist includes questions about the client's sources of income and the client's reasons for entry into the LBP. Unlike the current version the revised version includes questions about the client's plans regarding future participation in FIP. An important structural change in the client information section of the revised checklist is the omission of the "gate-keeper" question on the client's willingness to answer questions that exists in the current checklist. Instead the revised checklist

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[1]Appendix E (bound separately) reports our analysis of recent data from the Well-Being Visits Checklist. When reconsideration was *not* an option, 23 percent of clients were referred to PROMISE JOBS.

requires that all client information questions are asked of every client who is visited. Other revisions include (1) the specification of a time frame for identifying income sources (the past four weeks), (2) more comprehensive response categories for the income question, including some important non-cash forms of government assistance, and (3) new wording for the question about entry into the LBP and its response categories that acknowledges that a client may perceive that entry into the LBP came by assignment rather than by choice.

Section G: Visitor Comments. Section G of the revised checklist allows the nurse or social worker to comment on any other aspects of the well-being visit. The current checklist provides three areas for visitor comments, but those comments are neither entered into the IDPH data base for the well-being visits nor systematically reported to DHS in some other format. In recognition of the low probability that the Well-Being Visit Program will ever have the capacity for extensive use of visitor comments, the revised checklist reduces the amount of space available for them. We did not wish to eliminate all opportunity for the visitor to provide comments, because the nurses and social workers who conduct the visits value that opportunity.

VIII. REPORTING ON THE WELL-BEING VISITS

IDPH and DHS share responsibility for reporting on the Well-Being Visit Program. IDPH enters and processes the data gathered during the well-being visits. DHS produces a report based on those data, which it distributes to inform policymakers, program administrators, and others about the program's performance and the families that are visited. To assess the program's reporting system, MPR interviewed IDPH and DHS staff and reviewed the Well-Being Visit Monthly Report produced by DHS. This chapter presents our findings and recommendations regarding data processing, the format and content of the DHS visit report, and the dissemination of that report.

A. DATA PROCESSING

Each month, staff of the IDPH Bureau of Community Health process the well-being visit data in five steps. First, they receive the data from the local public health agencies, in the form of completed Well-Being Visit Checklists. These are due at IDPH by the tenth day of the month following the visits. Second, the IDPH staff enter these data into a computer file.[1] In the third step, IDPH staff generate 100 data reports, one for each of Iowa's 99 counties and one for the state as a whole. The report format is the same across political jurisdictions, consisting of seven tables that correspond to one or more sections of the Well-Being Visit Checklist. Each table is saved in a separate computer file; therefore, seven files are used to save a full report for a single county or for the state as a whole.[2] In the fourth step, IDPH creates a unified report for each political jurisdiction. This step is repeated 100 times, resulting in 99 county reports and one statewide report. In the final

[1]Paradox is the data base software used by IDPH.

[2]A total of 700 files are used--seven for each of the ninety-nine counties and seven for the state as a whole.

step of the data processing, IDPH sends all 100 reports to DHS on a floppy disk (or via email). The statewide report is also sent to DHS in hard copy form. The reports are due at DHS by the fifth day of the month following the month that the data were due at IDPH.

There are two notable strengths of the data processing system for the Well-Being Visit Program. First, IDPH receives completed checklists from the local public health agencies on a regular and timely basis. The agencies are motivated to complete these forms and submit them to IDPH because submission of a completed checklist is a requirement for reimbursement. Second, IDPH efficiently processes the data from the checklists and provides the data reports to DHS on a timely basis.

Our principal concern with data processing for the Well-Being Visit Program is that information is lost during data processing because certain responses to checklist items are not coded. For example, if a well-being visitor writes "Food Stamps" next to *other* under sources of client income, this is entered into the IDPH data base only as *other* income. This is particularly limiting with respect to the optional client information section of the checklist, where *other* responses are common.[3] To address this issue, we recommend precoding a more comprehensive set of responses on the checklist or coding *other* responses during data entry.

B. THE WELL-BEING VISIT MONTHLY REPORT

We have identified several aspects of the format and content of the Well-Being Visit Report that limit its usefulness. We have assessed the report as a whole and each of its four components: (1) the cover memo, (2) the sample Well-Being Visit Checklist, (3) the well-being visit report guide,

[3]Appendix E (bound separately) documents the incidence of *other* sources of income in Table E.7 and the incidence of *other* reasons for entry into the LBP in Table E.8.

and (4) the statewide data report. A copy of the visit report on well-being visits conducted in June of 1997 is provided in Appendix D.

1. Overall Assessment of the Visit Report

The visit report provides a thorough presentation and documentation of the data gathered during the well-being visits. However, several of the report's features detract from the usefulness of the data. The total length of the report--14 pages--may discourage recipients from reading it. The sheer volume of information contained in the report tables, especially the tables in the statewide data report, may be difficult to follow. The lack of any discussion of the data, along with the large volume of data in the tables, reduces the accessibility of the findings. The placement of the data tables at the end of the report, after the sample checklist and report guide, reduces the visibility of the findings.

To address these limitations, we recommend that DHS make the following four changes in the visit report:

1. Shorten the substantive content of the cover memo.
2. Reduce the volume of data presented in the report tables.
3. Provide a written summary of data highlights.
4. Move the data tables to the front of the report.

These recommendations are further developed in the assessments of specific components of the report that follow.

2. The Cover Memo

The cover memo that transmits the visit report to its recipients provides background information on the Well-Being Visit Program, the checklist, and the IDPH data reports (tables). It also identifies the components of the visit report. This is useful information; however, we recommend that DHS make the following changes to improve the effectiveness of the cover memo:

1. Identify the period covered by the report on the SUBJECT line of the memo. For example: "Well-Being Visit Monthly Report: *Findings from the June 1997 Visits, Plus Year-to-Date Findings for SFY 1997.*" Omit the discussion in the first paragraph page two that identifies the period covered by the report.

2. Revise the first two paragraphs of the memo to provide a brief statement of the purpose of the Well-Being Visit Program and the purpose of the visit report.

3. Omit the discussion of the revised checklist (currently in paragraph three) and scale back the discussion of the visit schedule and the IDPH data reports (currently in paragraph four).

4. Move the contact source for county-level data (currently in the first paragraph on page two) to a "Further Information" line, which would follow the "Attachments" line at the bottom of the memo.

These recommendations would create a concise memo that conveys the key information about the attached visit report.

3. The Sample Checklist

A sample Well-Being Visit Checklist is the second piece of the visit report. The sample checklist is not essential to the reader's understanding of the data tables, as long as they are appropriately labeled. Therefore, we recommend that DHS omit the sample checklist from the report and, instead, include instructions on the proposed "Further Information" line of the cover memo about how to request a copy of the checklist.

4. The Report Guide

A well-being visit report guide is the third piece of the visit report. This three-page guide provides explanatory notes to the data tables currently presented in the report. These notes help readers understand those tables. However, in conjunction with our recommendations regarding the presentation of data, we recommend that DHS replace the guide with a narrative discussion of key findings in the data.

5. The Presentation of Data

The statewide data report is the fourth piece of the visit report (county-level data reports are prepared but are not included in the visit report). The data report consists of a series of tables that provide a thorough accounting of the data collected on the Well-Being Visit Checklist. The tables present eight columns of results for each checklist item.[4] With 13 to 30 different checklist items per page, there are up to 240 numbers presented on a single page. We are concerned that the large volume of numbers presented limits the accessibility and usefulness of the data to the reader. We are also concerned that presenting raw counts instead of percentages further limits the usefulness of the data. Currently, DHS computes and manually appends a few selected percentages to the first page of the data tables (for example, the *percentage* of referred cases that received a home visit is presented, in addition to the *number* of such cases).

To address these limitations of the data report, we recommend that DHS:

1. Continue to have a comprehensive series of data tables for *internal* use rather than regular external distribution. Instructions could be added to the proposed "Further Information" line of the report's cover memo to explain how to request a copy of the comprehensive tables.

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[4] These counts are based on four categories of visits (month two, month four, follow-up, and total) each measured in two different time periods (current month and fiscal year-to-date).

2. Produce a new series of 5 to 10 tables for external distribution as part of the visit report. To develop this series of tables, we recommend that DHS:

   a. Present only those data (checklist items) that are of most importance to the recipients.

   b. Focus on one concept or issue per table (for example, the visit completion rate, or client income sources).

   c. Present results as percentages instead of (or in addition to) raw counts to facilitate reader comprehension.

   d. Include results for month-two and month-four well-being visits but *not* for follow-up visits.[5] Follow-up visits are so rare (only one was conducted in SFY 1997) that the allocation of space to those visits clutters the tables and detracts from the impact of more important data.

   e. Determine on a table-by-table basis whether results for *total* visits (month-two plus month-four) are important and should be included.

   f. Provide a descriptive title, descriptive row and column headings, and explanatory notes for each table. These would permit the tables to stand alone, independent of the sample checklist and report guide, which we recommend omitting.

3. Add a narrative discussion of the data, consisting of a short paragraph on each table. It would be necessary to update this component for each new visit report, so that it would highlight findings for the specific reporting period.

C. REPORT PRODUCTION AND DISTRIBUTION

Once IDPH has processed the data from the well-being visits and generated the data reports, DHS produces and distributes the visit report.

[5] Follow-up visits are optional supplemental visits that may be made in addition to the required month-two and month-four visits.

1. Report Production

Producing the visit report is not a complicated process. DHS prints the statewide data report (tables) from the electronic files provided by IDPH. DHS also updates the cover memo and assembles the pieces of the report (the cover memo, the sample checklist, the report guide, and the data tables).

Despite the simplicity of the production process, DHS does not consistently produce the visit report each month. This is *not* related to the data report, since IDPH provides the underlying files in a timely manner. Instead, the irregular production of the report appears to come from constraints on the availability of DHS staff and a lack of commitment at DHS to producing and distributing the report every month. One DHS staff member told us that DHS has been considering a shift to a quarterly production schedule for the visit report. We recommend this shift to quarterly production provided that DHS commits sufficient staff resources so that the report could be produced every quarter.

2. Report Distribution

The distribution list for the visit report consists of the administrators of the five DHS regions, two senior administrators of the DHS Bureau of Refugee Services, and one senior administrator of Iowa Workforce Development. In addition, the report's "cc list" contains 23 named individuals or organizations, including DHS central office staff, state government agencies, state elected officials, research organizations, and advocacy groups.

Administrators and staff at IDPH and the local public health agencies are notably absent from the report distribution list and cc list. The nurses and social workers who conduct the well-being visits would like to receive feedback from DHS. In the words of one focus group participant, "It

would be really good if [DHS] could give us info[rmation] on where [the checklist] goes when it's through with us."

We strongly recommend that DHS distribute copies of the visit report to all IDPH staff members who work on the Well-Being Visit Program (including the Regional Community Health Consultants at the Bureau of Community Services) and provide sufficient copies to each local public health agency to permit internal distribution to the agency director and to each nurse or social worker who conducts well-being visits. In addition to the visit report, which contains statewide data, DHS should also consider sending each local agency copies of the relevant county-level data tables that are prepared by IDPH. Providing such feedback to the public health staff who administer the Well-Being Visit Program could increase their commitment to the program.

IX. SUMMARY AND CONCLUSIONS

The Well-Being Visit Program was established to monitor the well-being of children in families on Iowa's Limited Benefit Plan (LBP). Currently, this program has limited capacity to achieve this objective and, therefore, fails to ensure that LBP families with at-risk children are linked to appropriate support services. These shortcomings are the result of flaws in the program's structure and operation. The most critical flaws concern: (1) the visit completion rate; (2) the structure and focus of the visits; (3) the content of the visits, as reflected in the Well-Being Visit Checklist; (4) reporting on the visits; and (5) training and institutional support for the nurses and social workers who conduct the visits. This chapter summarizes MPR's assessment of the Well-Being Visit Program and our recommendations for improvement and presents our final conclusions. Comprehensive lists of problems and recommended solutions in each of the five areas of concern are provided in Exhibits IX.1 through IX.5, presented at the end of the chapter.

A. THE VISIT COMPLETION RATE

For every 100 LBP clients referred for a well-being visit, only 40 are visited at all, and only about 25 of the 40 are seen by a nurse or social worker. The remaining clients are "visited" by telephone. The low completion rate of well-being visits, and in-person visits in particular, compromises DHS's ability to monitor and ensure the well-being of children in LBP families. To improve the well-being visit completion rate, we recommend that DHS emphasize these visits as a helpful service to clients and their children. This would provide incentives for clients to cooperate with the visits. We also recommend that DHS increase payments to local public health agencies for

completed visits, especially those conducted in-person, to increase the financial incentives for those agencies. Our specific recommendations are presented in Exhibit IX.1.

B. THE STRUCTURE AND FOCUS OF THE WELL-BEING VISITS

Currently, the well-being visits do not focus on children. Children are present at less than half of all well-being visits, and the visits focus on educating clients about FIP policies and reconnecting them with PROMISE JOBS and the FIA process. To address this departure from the original objectives for the well-being visits, we recommend that DHS take steps to refocus the program on children. In particular, DHS should clearly communicate this focus to staff and clients and revise the program and its financial incentives to promote the child-centered focus. Our specific recommendations are presented in Exhibit IX.2.

C. VISIT CONTENT AND THE WELL-BEING VISIT CHECKLIST

The Well-Being Visit Checklist, which is used to collect data during the visits, has serious limitations that compromise the value of the visits and the resultant data. The checklist devotes little attention to children and their well-being. It also fails to collect information that is needed to monitor the operation of the Well-Being Visit Program. To enhance the capacity of the visits to address child well-being and to enhance the value of the data gathered on the visits, we recommend that DHS substantially revise the checklist. DHS should shift the focus of the checklist toward child and family well-being and increase the specificity of checklist items and instructions. Our specific recommendations are presented in Exhibit IX.3.

D. REPORTING ON THE WELL-BEING VISITS

The value of the DHS report on the well-being visits is limited by its irregular production, its length, the large amount of data presented, and the absence of a narrative discussion of findings. To

improve the effectiveness of the report, we recommend that DHS revise its reporting system to provide a concise tabular and narrative presentation of data on a regular quarterly basis. Our specific recommendations are presented in Exhibit IX.4.

E. STAFF TRAINING AND SUPPORT FOR THE WELL-BEING VISITS

At the outset of the program, local agency staff were trained to conduct the well-being visits. However, there has been substantial turnover among those staff and many who currently conduct the visits have received little or no training. Furthermore, existing training is typically informal and unstandardized. Consequently, many local staff are ill-informed about Well-Being Visit Program policies and other DHS programs and policies. They are also unsure of their role, resources, and responsibilities as well-being visitors. To address these problems, we recommend that DHS increase training resources and requirements for well-being visitors. Our specific recommendations are presented in Exhibit IX.5.

F. CONCLUSIONS

We conclude that the focus and practice of the Well-Being Visit Program should be shifted toward the health and well-being of children. This would concentrate the program's resources on its original objective--to ensure the well-being of children in LBP families. It would also draw on the expertise and interests of the public health nurses and social workers who conduct the well-being visits. To ensure the full commitment of the public health agencies and their staff to this program, DHS also needs to adjust the program's training, feedback, and financial incentive mechanisms. Training that reflects the child-centered focus should be provided to all current staff and repeated regularly to address the frequent turnover of well-being visit staff at the local level. Feedback should be provided to visitors on a regular basis to support their individual efforts, and financial incentives

should be adjusted to increase the commitment of the local agencies to the well-being visits. Finally, systems for storing, analyzing, and reporting information on LBP clients should be revised to focus on well-being.

Modifying the Well-Being Visit Program to emphasize child well-being would require an integrated effort to adjust basic elements of the program's structure. The payoff would be a program that safeguards the well-being of children in Iowa's most vulnerable families.

EXHIBIT IX.1

THE WELL-BEING VISIT COMPLETION RATE

Problem	Solution
1. Financial incentives for local public health agencies to conduct well-being visits are weak.	1. Increase the reimbursement rates paid to local public health agencies for completed well-being visits, especially for in-person visits.
2. Local agency staff who conduct well-being visits are not well-informed about reimbursement policies for the visits.	2. Send an annual memo to local agencies detailing reimbursement rates; address reimbursement rates in all training sessions and materials.
3. Local agency staff receive little positive feedback to support their efforts to contact LBP clients and conduct well-being visits.	3. Provide positive feedback to local agency staff in the following ways: a. Provide a quarterly memo to each local agency that reports the visit completion rate for each of the agencies in their IDPH region. b. Provide a quarterly memo to all local agencies that announces the agencies receiving bonus payments for high visit completion rates.
4. LBP clients lack awareness of the well-being visits.	4. In all DHS contacts with LBP clients, assign a higher priority to informing clients about the Well-Being Visit Program and the provider of well-being visits in their county (the name of the local agency).
5. LBP clients are not receptive to the well-being visits.	5. In all staff contacts with LBP clients present the well-being visits as a helpful service provided *independently* of DHS.
6. The client contact information provided by DHS for well-being visit referrals is limited in scope and accuracy. While local agency staff often obtain corrected contact information through their efforts to locate LBP clients, that information is not systematically used by the program.	6. Have IDPH develop a simple data base to store updated contact information obtained by local agency staff (and reported by them on the well-being visit data collection form). Also, have IDPH implement a system to distribute updated contact information whenever a client is subsequently referred for another well-being visit.

EXHIBIT IX.2

THE STRUCTURE AND FOCUS OF WELL-BEING VISITS

Problem	Solution
1. While the original intent of the well-being visits was to focus directly on the well-being of children in LBP families, current visits focus more on educating clients about DHS policies and reconnecting them to PROMISE JOBS and the FIA process.	1. Refocus the visits on children in the following ways: a. Revise the program's contracts and training materials to emphasize that the visits are to focus on child well-being. b. Revise the program's data collection form to place a greater emphasis on child well-being. c. Train local agency staff to refocus the visits on children. d. Provide additional financial incentives to local agencies for conducting in-person visits and visits with children present. e. Require local agency staff to attempt to schedule a well-being visit when children can be present.
2. The short time period between the two well-being visits for clients in a first LBP (one month) makes the second visit redundant.	2. Provide one well-being visit for all LBP clients (rather than two for those in a first LBP and one for those in a second or subsequent LBP).
3. Making the visits in the early months of the LBP limits DHS's ability to assess the well-being of children under benefit termination.	3. Provide a well-being visit several months after the termination of FIP benefits (the second or third month of no FIP assistance).
4. Contrary to DHS's preferences, local agency staff often rely on telephone visits because these visits consume fewer resources than in-person visits and generate the same amount of revenue.	4. Revise the reimbursement rates for completed well-being visits to provide a higher rate for in-person visits than for telephone visits.
5. Stated policies about required visit activities are not consistent across program documents; this leads to staff uncertainty and a lack of consistency in services provided at the visits.	5. Provide a clear and consistent policy statement regarding required visit activities to ensure a minimum level of service is provided at every visit.
6. The lack of specific criteria and procedures for making assessments at the visits dilutes the meaning and value of those assessments.	6. Provide local agency staff with basic criteria to use to assess child and family well-being, to assess the need for follow-up, and to make referrals. These could be provided via the data collection form.

EXHIBIT IX.3

VISIT CONTENT AND THE WELL-BEING VISIT CHECKLIST

Problem	Solution
Using the Checklist to Monitor Child and Family Well-Being	
1. The well-being visit checklist, which provides the basis for the content of the visits, places relatively little emphasis on child and family well-being issues.	1. Modify the checklist to require that staff provide a systematic accounting and assessment of specific aspects of child and family well-being at every visit.
2. The checklist collects insufficient information about how the visit staff are responding to well-being concerns presented at the visits.	2. Modify the checklist to require that staff indicate a response to well-being concerns, such as a follow-up visit and/or referrals to programs provided by the visitor's local agency or by other agencies.
3. The checklist collects insufficient information to understand why clients are not referred to various assistance programs and services.	3. Modify the checklist to collect--for each potential referral to a program/service--local availability of the program/service, the client's current recipiency status, and, as appropriate, the reason no referral is made.
Data Quality and Program Performance	
4. The checklist collects insufficient information to monitor staff use of various methods to contact clients and identify particularly successful methods.	4. Modify the checklist to collect information for every attempt to contact each client, including the contact method used, whether contact was made, whether a visit resulted, and the reason for any failed attempt.
5. While up-to-date client contact information is crucial to the success of the program, the current checklist does not emphasize updates and corrections to contact information.	5. Modify the checklist to require systematic documentation of initial client contact information and any updates or corrections to that information obtained by the local agency staff.
6. Reported rates of referral to PROMISE JOBS for reconsideration of the LBP exceed rates of client eligibility for reconsideration.	6. Instruct visit staff to make a PROMISE JOBS referral for reconsideration of the LBP only if eligibility for reconsideration exists.
7. The information collected directly from clients is limited by the narrow set of response categories provided on the checklist.	7. Increase the number of pre-coded response categories for all client information questions.
8. The information collected directly from clients is also limited by the lack of specificity and the word choice in the questions posed to clients.	8. Clearly specify the period for which client income should be reported. For LBP entry, be sensitive to client's perceptions of being assigned to the LBP versus choosing the LBP.
9. The checklist allocates three sizable areas for staff comments, but these comments are not systematically used by IDPH or DHS.	9. Provide a single area for comments that more accurately conveys the priority and use of staff comments.

EXHIBIT IX.4

REPORTING ON THE WELL-BEING VISITS

Problem	Solution
1. The length of the well-being visit monthly report (14 pages) is likely to discourage the recipients of the report from reading it.	1. Make the report more concise in the following ways: a. Narrow the content of the cover memo to a brief statement of the purpose of the visits and the purpose of the report. b. Remove the sample checklist (data collection form). Include instructions in the cover memo for how to request a copy of the form. c. Remove the current set of data tables (seven pages) and replace them with a series of several short tables. d. Remove the report guide (explanatory notes) which pertain to the current data tables.
2. The volume of information contained in the report's data tables (up to 240 numbers per table) is likely to overwhelm the reader.	2. Create new tables that each focus on a single concept or issue. Exclude results on follow-up visits and total visits (month-two and month-four combined).
3. To understand the organization and content of the current data tables, the reader must refer to two attachments (a guide to the report and a sample data collection form).	3. Provide a descriptive title, descriptive row and column headings, and explanatory footnotes to tables so that each table can stand on its own.
4. The lack of narrative discussion of the data presented in the tables makes the empirical findings less accessible to the reader.	4. Provide a brief written summary to highlight findings for each data table. (It would be necessary to update this for each edition of the report.)
5. Placing the data tables at the end of the report reduces the visibility of the findings.	5. Place data tables toward the front of the report.
6. The presentation of data as raw counts limits their usefulness and requires the reader to calculate percentages when desired.	6. In the data tables, present results as percentages instead of (or in addition to) raw counts.
7. The "monthly" report is not distributed regularly by DHS because of insufficient resources and commitment to support monthly distribution.	7. Shift to a quarterly report and devote adequate resources to ensure regular quarterly production and distribution.
8. While the report could provide valuable feedback to IDPH and local agency staff of the well-being visit program, these staff do not receive copies of the report.	8. Provide copies of the visit report to all IDPH staff members who work on the program and enough copies to each local public health agency to permit internal distribution to the agency director and each visitor.

EXHIBIT IX.5

STAFF TRAINING AND SUPPORT FOR THE WELL-BEING VISITS

Problem	Solution
1. Many current local agency staff have not received any formal training from DHS or IDPH for the well-being visits. This is either because they began working for the program after the last formal training session (1995) or because they did not attend that session.	1. Increase the frequency of training and participation in training. a. Provide one standardized statewide training session every year over the state's fiber optic communications network (rather than the current provision of "up to one" session per year). b. Mandate attendance of all current staff at all training-related activities sponsored by DHS or IDPH.
2. The program's written training materials place primary emphasis on FIP, the FIA, and general self-sufficiency issues, rather than on child and family well-being.	2. Revise all written training materials to focus primary attention on child and family well-being issues.
3. Many local agency staff are not familiar with the information provided in the training materials that have been developed by DHS for the well-being visits.	3. Provide a user-friendly reference manual to each local agency containing the DHS training materials. At least once per year, verify that each local agency has a complete and up-to-date reference manual.
4. While the IDPH community health consultants are a potentially valuable resource for ongoing assistance, training, and support for local agency staff who conduct well-being visits, this potential is not currently realized.	4. Tap the potential of the IDPH community health consultants in the following ways: a. Require each consultant to organize in-person meetings of local agency staff in her region for informal training and support once per year. b. Require the lead IDPH consultant to provide a brief program update to all local agency staff via email once per quarter. c. Emphasize and promote the IDPH consultants as an ongoing resource for local agency staff in all training materials and sessions. d. Provide local agency staff with quick reference list of "whom to contact" that highlights the role of the IDPH consultants.

APPENDIX A

WELL-BEING VISIT
TRAINING MATERIALS

FAMILY INVESTMENT PROGRAM (FIP)

WELL-BEING VISITS

For Family Investment Program (FIP) households who have chosen the limited benefit plan (LBP), the Department of Human Services (DHS) is required to provide for qualified social services professionals to make a home visit to make inquiry into the well-being of the family.

DHS contracts with the Iowa Department of Public Health (IDPH) for these visits. IDPH, in turn, subcontracts with local agencies, in each county, which provide public health nursing and home care aide services. Registered Nurses and Social Workers (RN/SW) from these agencies make the visits.

The local agencies report the results of the visits to IDPH by documenting the information on the Family Investment Program Well-Being Visit Checklist. IDPH then reports the results to DHS.

Purpose of Visit

Visits are made in the spirit of supporting families who have chosen the LBP. These visits are an extension of the Family Investment Program (FIP) and Family Investment Agreement (FIA) philosophy of supporting families as they move toward self-sufficiency.

If at any of the visits, initial or follow-up, the family denies entry to the person assigned to make the visit, document this on the Well-Being Visit Checklist and take no further action on this referral. If the same family is referred again for a visit in another month, follow the same procedures again to attempt to make a visit.

When Visits Are Made

Families with LBPs Which Began Prior to 2/1/96

For families who choose an LBP instead of signing an FIA:

- a visit is made in month five of the LBP,
- a second visit is made in month seven of the LBP.

The month five visit occurs during the period of reduced benefits, before the entire FIP case is canceled.

The first 45 days and month five and six are the reconsideration periods when families who have chosen an LBP instead of signing an FIA have the option of reconsidering and signing an FIA. If the family reconsiders during one of these periods and signs an FIA, the LBP will be stopped and they will remain eligible for FIP.

The month seven visit occurs in the first month of the period of ineligibility. The reconsideration option is no longer available at this point.

For families who choose an LBP after signing an FIA:

- one visit is made in month seven of the LBP.

This visit occurs in the first month of the period of ineligibility. These families do not have an option to reconsider.

Families With LBPs Which Begin 2/1/96 or After

For families who choose a FIRST LBP instead of signing an FIA:

- a visit is made in month two of the LBP, and
- a second visit is made in month four of the LBP.

The month two visit occurs during the period of reduced benefits, before the entire FIP case is canceled.

The entire three-month period of reduced benefits is the reconsideration period when families who have chosen a first LBP instead of signing an FIA have the option of reconsidering and signing an FIA. If the family reconsiders and signs an FIA, the LBP will be stopped and FIP can continue.

The month four visit occurs during the first month of the period of ineligibility. The reconsideration option is no longer available at this point.

For families who choose a FIRST LBP after signing an FIA:

- one visit is made in month four of the LBP.

This visit occurs during the first month of the period of ineligibility. These families do not have an option to reconsider.

For families who choose a SECOND OR SUBSEQUENT LBP (whether or not an FIA has been signed):

- one visit is made in month two of the LBP.

  For these families the period of ineligibility begins immediately, with the first month of the LBP. These families do not have an option to reconsider.

Follow-up Visit

A follow-up visit may be made each time a family is referred for a well-being visit. Determining whether a follow-up visit should be made will be left to the professional judgment of the RN/SW making the visit and the willingness of the client to have a follow-up visit.

Referring Clients for a Well-being Visit

By the 25th of each month DHS creates a file for IDPH, listing each family due for a visit in the next month.

Every family in an LBP is referred for a visit, whether or not the family is continuing to receive FIP. Once a Notice of Decision is issued imposing the LBP, the LBP continues until its set period expires or it is stopped by PROMISE JOBS or the income maintenance worker. An LBP may be stopped before the LBP period ends if one of the following applies:

- the person who chose the LBP has reconsideration rights, chooses to reconsider during the appropriate time period and signs an FIA
- the income maintenance worker determines the client was referred to PROMISE JOBS in error
- PROMISE JOBS determines the LBP was imposed in error.

NOTE: Additionally, if family members who were included in the LBP but who did NOT choose the LBP do not continue to live with the person who chose the LBP, the income maintenance worker can stop the LBP for those persons. The LBP will remain in effect for the person who choose it and any household members who continue to live with that person.

If the family reconsiders and signs the FIA AND the LBP is stopped before the date the referral list is prepared for IDPH, the referral is not made. If a family has reconsidered, but the LBP has not yet been stopped when the referral list is prepared, the family will be referred and a visit must be offered.

The referral lists give the following information:

- Name and social security number of the client choosing the LBP.
- Names and social security numbers of other family members who are included in the LBP.
- Address and phone number.
- County.
- Whether the LBP was chosen before or after signing the FIA.
- Month and year the LBP began.
- Due date of the visit.

The address included in the referral information is the mailing address appearing in the DHS computer system at the time the referral list is prepared. If the client appears to have moved or if the mailing address is not the actual living address, contact the local DHS contact person to see if a current living address is available.

IDPH distributes the referral lists to the local agencies making the visits.

Type of Visit

Whenever possible, a face-to-face home visit must be made.

If a client refuses to allow a face-to-face home visit, attempt to schedule a face-to-face visit at an alternate site.

If the client refuses any type of face-to-face visit, attempt to schedule a telephone visit.

If the client refuses the telephone visit also, do not make any further attempt to visit the client based on this month's referral.

When a family is referred for a second visit, follow the same procedures for attempting to schedule the visit even if the family refused or could not be contacted for the first visit.

Document the type of visit done on the Checklist.

Procedures for Scheduling Visits

Make three attempts to contact the client and schedule an appointment for a visit.

- If a telephone number for the client is available, visits may be scheduled by telephone. If a telephone number is available and multiple attempts to

call have been made on more than one day, that would be considered one attempt to contact.

- If a telephone number is not available, or if you are unable to reach the client by telephone, send an appointment letter using the recommended language provided by DHS. The appointment letter will explain the purpose of the visit and give the date and time when you will visit, unless the client contacts the agency to reschedule or to refuse the visit. Sending a letter would be considered one attempt to contact.
- If an appointment letter is returned by the post office, contact the local DHS contact person to determine if a new address or telephone number is available.
- If a scheduled visit is made and the address is correct but the client is not at home, a second appointment letter can be left at the home. Making a scheduled visit would be considered one attempt to contact. Leaving a second letter at the home would also be considered one attempt to contact.

If you are unable to contact the client after making at least three attempts, at least one of which was in writing, complete the Family Investment Program Well-Being Visit Checklist to document why the visit could not be made.

Do not make any unannounced visits.

Client Living in Another County

If the client has moved to another county in Iowa, transfer the referral to the agency making well-being visits in that county by sending a message on WONDER, with a copy to IDPH. When transferring referrals, do so as soon as possible to allow the receiving agency time to do the visit in the correct month. Complete a Well-Being Visit Checklist (sections A, number 4 under section B and section I only) to document that the referral was transferred.

Client Living Out of State

If the client has moved to a state bordering Iowa, the visit may be made if permitted under the agency's customary procedures for traveling across state lines.

If the home visit cannot be made because the client is living out of state and it is not possible to do a face-to-face visit in Iowa, make a telephone visit, if you can reach the client by telephone and the client agrees to a telephone visit.

Client Refuses Visit

If a client is contacted but refuses the visit, complete the Checklist to document the refusal.

When a client who refused the first visit is referred for a second visit, follow the same procedures for attempting to schedule an appointment.

Activities During a Visit

The visits are intended to encourage the families' own self-sufficiency efforts and to reinforce and support those efforts. Attempt to make a visit for every family referred, even if the family has stopped receiving FIP for another reason.

The visit should be with the person who chose the LBP or, in the case of two-parent households, with either parent. There is no requirement that the children (or the other parent in a two-parent home) be present during the visit, although this is helpful.

Activities during the home visit may include, but are not limited to:

- Discussing reasons for not participating in the FIA.
- Offering to problem solve with perceived problems of the FIA participation.
- Reminding clients who have reconsideration rights of the importance of carefully considering that choice. NOTE: Persons who are not currently eligible for FIP for another reason or who do not want to reapply for FIP currently can still contact IM or PJ and ask to reconsider. If this is done during the reconsideration period, the client's right to reconsider is preserved and if that client should need to reapply for FIP before the LBP period ends, the client will have the right to sign an FIA and end the LBP.
- Being a liaison with PROMISE JOBS and income maintenance (IM) staff: Refer clients who wish to reconsider and sign an FIA to PROMISE JOBS. Refer questions about exemption from PROMISE JOBS to the IM worker. Refer clients who need to reapply for assistance to the local DHS office.
- Contacting IM when conditions seem to warrant exemption.
- Assessing family ability to assess their situation and plan for the well-being of the children.
- Discussing specific plans pertaining to, for example, child care, to ensure that the family has realistic plans for the future.
- Using the minimum sufficient level of care concept as the standard for evaluating the family plan for the future. Minimum sufficient level of care may be defined as the point below which a child's mental, physical, or

emotional health or the safety of the community are threatened if the child remains solely under the care and supervision of the family.
- Planning appropriate follow-up visits or referrals for services if the minimum sufficient level of care standard is not met.

For families who had a visit in month two or month five, the second visit in month four or month seven is a follow-up to the assistance offered in the first visit.

When referring the client to PROMISE JOBS for an FIA appointment or to DHS or other agencies for assistance, use your professional judgment to determine how the referral should be made:
- The necessary information could be provided to the client to allow the client to make a self-referral. The client should be empowered to act on his or her own behalf as much as possible.
- If you believe it is necessary, a follow-up visit or telephone call could be scheduled to determine if the client needs further assistance with the referrals.
- Assist the client in making the referral, if necessary.
- Follow normal established procedures to make referrals to Child Protective Investigations.

Sharing Information

RNs/SWs conducting well-being visits must safeguard client information in conformance with Iowa Code Section 217.30 and the Code of Federal Regulations (45 CFR).

Based on contracts/subcontracts, financial agreements, and nonfinancial agreements between DHS and various entities, DHS income maintenance and service staff, RNs/SWs conducting well-being visits, and PROMISE JOBS workers are all subject to the same laws, rules, and policies with regard to confidentiality.

On a practical level, this means that some information can be shared within an agency and between these agencies on a need-to-know basis, without a release of information from the client. However, DHS must adhere to all specific state regulations governing the release of child abuse and third-party mental health and substance abuse information. This means that DHS employees cannot discuss a family's child abuse history or third-party mental health or substance abuse information with the RN/SW. Otherwise, workers from DHS, PROMISE JOBS, and RNs/SWs doing well-being visits can share information about a participant to the extent that the other worker needs to know this information in order to do his or her job. It is the responsibility of

each agency to determine what information is needed in order to provide services.

For example, DHS will provide IDPH with information necessary to do the FIP well-being visits, including names, social security numbers, addresses, phone numbers, the date an LBP started and whether the LBP was chosen before or after the FIA was signed. However, the RN/SW might find that the client has moved or that the phone number has been disconnected. In this instance, the RN/SW can call the local DHS contact person to learn whether DHS has a more current phone number or address for the client. DHS can share this information with the RN/SW conducting the well-being visit because the information is needed by the RN/SW to do his or her job.

Ask each client if he or she has a DHS social worker and record that information on the Family Investment Program Well-Being Visit Checklist. The purpose of this question is to help determine what supportive resources are available to the family and whether the DHS social worker could assist in arranging follow-up services. This would be a DHS social worker rather than the income maintenance worker who handles the client's FIP, food stamps, and Medicaid case. There is no need to contact the DHS social worker in most cases, but you may do so if problems or questions are identified in the well-being visit which you believe should be discussed with the DHS social worker. These concerns could include; child health needs, parenting skills issues, household management concerns, mental health and/or substance abuse concerns, etc. The primary role of the RN/SW in these situations would be to relay information to the DHS social worker that will enable them to provide more effective services. The DHS social worker could discuss in general the focus of their involvement with the family to allow for the best coordination of services to the family.

Telephone numbers for local DHS contact persons have been provided. When additional information is needed, this contact person will either provide the information or refer you to the appropriate DHS income maintenance worker or DHS social worker who can provide the information. A list of local PROMISE JOBS agencies has also been provided for use when additional information is needed from PROMISE JOBS.

It is important to note that DHS and PROMISE JOBS staff will not disclose information over the telephone unless they are certain that the person to whom they are speaking is authorized to receive that information. They should use one of the following methods to ascertain this:

- Positive voice recognition,
- Having a record of the telephone number of the RN/SW already on file or checking it in the telephone book or other source, and calling back to that number before disclosing the information.

If it is impossible for DHS or PROMISE JOBS to be certain that the caller is an authorized person, other methods of getting the information will be suggested, such as coming to the office with the participant or submitting a written request.

Reporting Results of a Visit

Complete a Family Investment Program Well-Being Visit Checklist form for each family referred for a visit, each time the family is referred, even if the visit cannot be made. Also complete a form for each follow-up visit.

Retain one copy of the completed form. Send the original to IDPH together with the billing vouchers.

Due Date for Visits

All visits are to be completed in the month indicated on the referral list.

GLOSSARY

Family Investment Program (FIP) -- Effective 7/1/93 the Aid to Dependent Children (ADC) Program was renamed the Family Investment Program (FIP).

Family Investment Agreement (FIA) -- An individualized self-sufficiency agreement between the FIP participant and the state which addresses: actions the FIP participant will take, services to be provided by the state, and time tables to be met by the family to attain self-sufficiency.

Limited Benefit Plan (LBP) -- Persons who choose not to participate in the FIA enter an LBP.

A family with an LBP that began before February 1, 1996 may be eligible for:
- three months of full FIP benefits,
- followed by three months of reduced benefits,
- followed by six months of ineligibility for FIP.

A family with a **first** LBP that began on or after February 1, 1996, may be eligible for:
- three months of reduced benefits,
- followed by six months of ineligibility for FIP.

A family with a **second or subsequent** LBP that began on or after February 1, 1996 will be ineligible for FIP for six months.

PROMISE JOBS (PJ) -- The work and training program for FIP participants.

Income Maintenance Worker -- DHS employee who handles a family's FIP, food stamp and Medicaid case.

DHS Social Worker -- DHS employee responsible for planning and providing services, including social case work, for a client receiving assistance under one of the department's service programs.

LETTERHEAD OF AGENCY

Date

_____
_____
_____

Dear _____

I have been asked to visit with you because you are in a Limited Benefit Plan (LBP).

I am planning to visit your home on _____, at _____.

If this isn't a good time for you or if you don't want me to visit your home, please call me at _____.

The reason for the visit is to answer your questions and to talk about the choices you may have. We can talk about your reason for not taking part in the Family Investment Agreement and any questions or problems you have with the agreement. If you like, we can talk about your plans to support your family without FIP benefits. I can also tell you about other programs or services that may be able to help you.

Please feel free to call me if you have any questions about the visit or if you would like to meet at a different time or place.

I look forward to meeting you on the _____.

Sincerely,

FAMILY INVESTMENT PROGRAM (FIP)
WELL-BEING VISIT CHECKLIST
INSTRUCTIONS

The well-being visit checklist is the form completed by RNs and Social Workers making well-being visits.

Complete the checklist each time a family is referred for a visit. Complete a checklist even if you are unable to contact the client or the client refuses the visit. If two persons with the same DHS case number are referred in the same month (for example, a husband and wife or an adult and a child on the same DHS case), complete one form for the family. Also complete a checklist for each follow-up visit made.

Following are instructions for completing the revised version of the form, dated 1/96. Begin using the revised version effective February 1, 1996. Destroy any remaining copies of the previous version, dated 9/94.

The revised form is a two sided, single sheet. Retain a copy of each form completed. Send the original checklist and an original and three copies of the claim form to: Iowa Department of Public Health, Community Services Bureau, Lucas State Office Building, Des Moines, Iowa 50319.

To meet the requirements of the contracts between IDPH and your agency, the following time frames must be followed:

Month Visit Is Due	Date Checklist and Claim Due In IDPH Office
February 1996	March 11, 1996
March 1996	April 10, 1996
April 1996	May 10, 1996
May 1996	June 10, 1996
June 1996	July 10, 1996

Calculate the number of referrals billed to IDPH as follows:

- Count the number of DHS cases on the monthly referral list
- Add referrals coming into your county from another county
- Subtract any referrals going to another county

Example:		
	Number of DHS cases on February referral list	12
	Cases transferred from another county	+ 1
	Cases transferred to other counties	- 3
	Number of referrals to be billed for month	10

Additional copies of the checklist can be ordered from Anamosa, by calling 1-800-432-9163. Order by the DHS form number, 470-3161.

PAGE 1:

SECTION A

Complete the top of the checklist and section A. Use the referral information provided on the referral list to complete this section. The following information must be entered on the checklist for each visit made or attempted:

- Date the visit is due.
- Check one box to indicate whether this is a month 2, 4, 5, 7, or follow-up visit.
- If the client has reconsideration rights, check the box for reconsideration rights.
- Number and name of the county in which the client lives.
- Agency number
- Name of the client(s) who chose the FIP limited benefit plan (LBP).
- Social security number of the client(s) who chose the LBP.
- DHS case number.
- Names of other family members affected by the LBP (all the household members included on the referral for that case).

If the address or telephone number provided on the referral is incorrect, enter the correct address or telephone number, for your own use. If the client is currently receiving FIP, food stamps or Medicaid, and the client has moved, refer the client to the county DHS office to report the new address.

SECTION B: Face-To-Face Visit Not Done

Complete Section B if a face-to-face visit was not done. Check only one box in Section B.

1. Unable to Contact
Check box if unable to locate or contact client.

For each attempt to contact, list the date (month/day/year) and enter the number code for the method of attempted contact (applicable method codes are 01 through 09). 3 attempts to contact a client are required, including at least one in writing.

2. Refused Visit
Check box if the client is contacted but refuses the visit. Give the date (month/day/year) the client refused and the number code for the method of refusal (applicable method codes are 11 through 19).

3. Telephone Visit Only
Check box if the client refuses the face-to-face visit but agrees to a telephone visit. Give the date (month/day/year) the telephone visit was done. A telephone visit is acceptable only if the client refuses a face-to-face visit. If a telephone visit is made, complete Sections D, E, F, G, H and I the same as for a face-to-face visit.

4. Referred to Another County
When a referral is transferred to another county, the agency originally receiving the referral forwards the referral by WONDER to the other county, with a copy of the message to IDPH. When a referral has been transferred, the receiving agency checks the box and enters "received from" and "name of the sending county" when completing the checklist. The agency transferring the referral completes a checklist on the same case by filling in Section A, and Section I and checking this box and filling in the name of the county the referral was transferred to.

The agency ending up with the referral will receive payment for the referral.

SECTION C: Type of Visit

Complete only if a face-to-face visit was made.

Enter the date (month/day/year) the face-to-face visit was done (whether in the client's home or at an alternate location).

1. Home Visit
Check box if a face-to-face visit was made in the client's home.

2. Alternate Site Visit
Check box if the client refuses a face-to-face visit in the home but agrees to a face-to-face visit at another location. Enter the number code to indicate the location of the visit (applicable location codes are 21 through 29).

SECTION D: Results

Complete if either a face-to-face or telephone visit was made. Check all that apply.

1. Refuses further involvement
Check box if the client refuses any further assistance or follow-up visits.

2. Referrals completed/information given
Check box if all necessary referrals were made and information given at the visit and no follow-up is necessary.

3. Has reconsidered and begun FIA
Check box if the client has reconsidered and signed an FIA (or is currently working with PROMISE JOBS to develop an FIA).

4. Will reconsider and begin FIA
Check box if the client decides at the time of the visit to reconsider and sign an FIA. Refer the client to the income maintenance and PROMISE JOBS workers to reconsider.

5. Will not need FIP
Check box if the client will not need FIP. Enter the number code giving the reason why FIP will not be needed (applicable reason codes are 31 through 39).

SECTION E: Referrals Made

Check Yes or No to indicate whether any referrals were made during the visit. If referrals were made, check all that apply from numbers 1 through 17.

If number 15, Immunizations is checked, check the applicable box to indicate whether the immunizations were given during the visit or if the client was referred for immunizations.

If number 16, Other DHS Services is checked, enter the number code to indicate which other DHS services the client was referred to (applicable codes are 81 through 89).

If number 17, Other is checked, enter the number code to indicate which other services the client was referred to (applicable codes are 91 through 99).

SIDE 2

Top of Page

Enter county number and client's name.

SECTION F: Follow-Up Services Planned

Complete this section only if you intend to return for a follow-up visit. If a follow-up visit is planned, check all that apply.

1. Unable to complete visit
Check box if a second visit must be scheduled because you were unable to complete the visit during the first scheduled appointment. Enter the number code to indicate why the visit could not be completed during the first appointment (applicable reason codes are 41 through 49).

2. Additional assessment needed
Check box if an additional visit is necessary because of concerns about the well-being of the children. Enter the number code to indicate the reason (applicable reason codes are 51 through 59).

3. Needs identified
Check box if an additional visit is necessary to provide assistance. Enter the number code to indicate what additional assistance is required (applicable reason codes are 61 through 69).

4. Referrals planned
Check box if a follow-up visit is necessary to make additional referrals. Enter the number code to indicate the reason (applicable reason codes are 71 through 79).

SECTION G: Optional Client Information

Complete this section for each face-to-face or telephone visit. Answers in this sections should reflect the client's answers to these questions.

1. Are you willing to answer the following questions...?
Check Yes or No to indicate whether the client is willing to answer the questions in section G.

2. What is your current source of income?
Check boxes a through h to indicate the client's current source of income. Check all that apply.

3. Why did you choose the Limited Benefit Plan?
Check box h through k to indicate why the client chose the LBP.

SECTION H: Additional Information

Complete this section for each face-to-face or telephone visit. Complete this section after the visit has ended.

1. through 8. Answer each question by checking Yes or No. Identify concerns about any of these issues in the adjoining comments section.

SECTION I

Enter the following information:

- Print the name of the RN or social worker making the visit.
- Enter the name of the client's DHS social worker, if any. Ask each client if they have a DHS social worker (this is not the income maintenance worker).
- Signature of the RN or social worker making the visit.
- Date the checklist is completed (month/day/year).

(PAGE 1) Iowa Department of Human Services **FAMILY INVESTMENT PROGRAM (FIP) WELL-BEING VISIT CHECKLIST**

VISIT DUE: ____/____/____ ☐5-Month Visit ☐7-Month Visit
☐2-Month Visit ☐Reconsideration Rights ☐4-Month Visit ☐Follow-up

COUNTY NUMBER & NAME #

AGENCY NUMBER ☐01 ☐02 ☐____

A CLIENT NAME *(last, first)* **SS NUMBER** **DHS CASE NUMBER**

DEPENDENT NAMES *(last, first)*		

ADDRESS/PHONE CORRECTION For Agency Use Only.

B FACE-TO-FACE VISIT NOT DONE Complete section B or C.

☐1 UNABLE TO CONTACT: (Must list three attempt dates and methods. Unanswered telephone calls do not count as an attempt.)

#1 Date____/____/____ Method:____

#2 Date____/____/____ Method:____

#3 Date____/____/____ Method:____

METHODS *(Write the number of the method for each of your three attempts.)*
01=Letter, no response
02=Letter, returned
03=Face-to-face attempted, no show
04=Message left
05=Moved out of state
06=Current address unknown
07=No further information
09=Other:____

☐2 REFUSED VISIT: Date____/____/____ Method:____

METHODS *(Write the number of the method of refusal.)*
11= In Writing to Agency 12=Telephone Call/Message 13=Verbal Response
19=Other:____

☐3 TELEPHONE VISIT ONLY (Face to face refused) Date:____/____/____
(Complete Sections D, E, F, G and H)

☐4 REFERRED TO ANOTHER COUNTY (Specify):____
(Please notify other county and IDPH of referral as soon as you discover it.)

COMMENTS:

C TYPE OF VISIT Complete only if a face-to-face visit is begun or completed.

☐1 HOME VISIT
☐2 ALTERNATE SITE VISIT (Specify): ____ Date:____/____/____

21=Local Agency 22=WIC Clinic 23=Hospital 24=Family's Member Home
25=Friend's Home 26=Job Site 29=Other:____

D RESULTS Complete this section if face-to-face or telephone visit is completed.

NO FURTHER INVOLVEMENT NEEDED
☐1 Refuses further involvement
☐2 Referrals completed/information given
☐3 Has reconsidered and begun FIA
☐4 Will reconsider and begin FIA
☐5 Will not need FIP (Why?)____

31=Getting/Got Married
32=Now Employed
33=Seeking Employment on Own
34=Support from Others
35=Planning to Leave the State
39=Other:____

E REFERRALS MADE ☐ Yes ☐ No Check all that apply.

☐1 Income Maintenance
☐2 Area Education Agency
☐3 WIC
☐4 Counseling Services
☐5 Housing
☐6 Child Care
☐7 Child Protective Services
☐8 Child Protective Investigations
☐9 PROMISE JOBS
☐10 Food Pantry
☐11 Transportation
☐12 Health Care Provider
☐13 Employment Services
☐14 Mental Health/Substance Abuse
☐15 Immunizations: *(Check one)*
☐ Given
☐ Referred
☐16 Other DHS Services. Specify one:____

81=Food Stamps 82=Title XIX—Medical Assistance 89=Other:____

☐17 Other. Specify one:____

91=Well Child Clinic 92=Maternal Health Clinic 93=Public Health Nursing 94=Home Care Aide Services
95=Fuel Assistance 96=Legal Assistance 97=Outreach/General Relief 98=Child Support Recovery
99=____

(Please complete both sides.)

(PAGE 2) FIP CHECKLIST **COUNTY NUMBER:** # **CLIENT NAME:** (Last, First)

FOLLOW-UP SERVICES PLANNED (Complete this section only if you intend to return for a follow-up visit.)

☐1 Unable to complete visit .....REASON:_____
41=Client had to leave for work 42=Client confused about options
43=Client not English speaking 44=Client left for appointment 49=_____

☐2 Additional assessment needed relative to the well-being of children....REASON:_____
51=Children not present, concerns 52= Environmental concerns 53 Health Concerns about child
54=Potential negative/abuse behavior 55=Inadequate support/other services 59=_____

☐3 Needs identified .....SPECIFY:_____
61=Assistance accessing community resources 62=Clarification of DHS Services
63=Assistance meeting health needs 64=Assistance with education/needs of children
69=Other_____

☐4 Referrals planned.....SPECIFY:_____
71=Concern with client's follow-up on refs made 72=Concern with client's follow-up on refs suggested
79=_____

OPTIONAL CLIENT INFORMATION

1 "Are you willing to answer the following questions to help us see how well the program is working?" ☐ Yes ☐ No

2 "What is your current source of Income?" **(Check all that apply.)**
- ☐ a Full-time employment
- ☐ b Part-time employment
- ☐ c Child Support
- ☐ d Support from others
- ☐ e Social Security or SSI
- ☐ f No response
- ☐ g Other: (Specify)_____

3 "Why did you choose the Limited Benefits Program?"
- ☐ h I didn't understand.
- ☐ i I decided to make it on my own.
- ☐ j I didn't want to be in the PROMISE JOBS Program.
- ☐ k Other: (Specify)_____

COMMENTS:

ADDITIONAL INFORMATION (To be completed by staff on all visits completed.)

1 Do you believe the client understood the LBP before your visit?
- ☐ Yes
- ☐ No *(Identify your concerns in the comment space.)*

2 Do you believe the client understood the LBP after your visit?
- ☐ Yes
- ☐ No *(Identify your concerns in the comment space.)*

3 Do you have concerns regarding the client's functioning abilities?
- ☐ Yes *(Identify your concerns in the comment space.)*
- ☐ No

4 Client referred to Income Maintenance worker for redetermination for exempt status.
- ☐ Yes
- ☐ No

5 Do you have concerns regarding the well being of the children?
- ☐ Yes *(Identify your concerns in the comment space.)*
- ☐ No

6 Does the client have an established plan for the future?
- ☐ Yes
- ☐ No

7 Was (were) the child(ren) present during the visit?
- ☐ Yes
- ☐ No

8 Are the basic needs being met?
- ☐ Yes
- ☐ No (Identify your concerns in the comment space.)

COMMENTS:

RN/SW NAME (Please Print) **NAME OF DHS SOCIAL WORKER** (Not IM Worker)

RN/SW SIGNATURE **DATE**

February 1996

THE FAMILY INVESTMENT PROGRAM

PROMISE JOBS AND FAMILY INVESTMENT AGREEMENTS

Background

The goal of self-sufficiency for welfare recipients has been the foundation of the PROMISE program in Iowa since 1987. The enactment of 1993 State legislation for the Family Investment Program (FIP) provided an opportunity for a welfare reform effort which not only embodies the concept of self-sufficiency but adds an essential element of personal responsibility for the achievement of that goal.

Family Investment Agreement

A key element of FIP is the establishment of Family Investment Agreements (FIA) as the instrument to enable welfare recipients to attain self-sufficiency. The FIA empowers people to take advantage of options by making real choices. No longer is public assistance a traditional compliance system where financial sanctions are imposed for failure to achieve short-term requirements. Instead, families have the opportunity and support to move out of dependence on public assistance, and real consequences are realized by those who choose not to participate in this process.

The FIA is individualized to the circumstances of each family. There is no standard length. In order to insure the most effective and efficient system, FIP participants who have the potential to move into self-sufficiency with short-term assistance are able to do that without experiencing barriers which impede their progress. Likewise, participants who require extensive long-term agreements can receive appropriate assistance without facing an arbitrary cutoff date. The participant and the PROMISE JOBS worker work with the full range of programs and resources and together establish the date by which the family plans to leave FIP. The PROMISE JOBS worker has the flexibility to develop the most effective and efficient FIA.

A major philosophical change is in the new approach to "barriers to participation," and "sanctions for nonparticipation". Within the context of the FIA, issues previously considered to be barriers are now identified as issues to be resolved so that participation can result.

Limited Benefit Plan

The concept of "sanctions" is revised in the FIA system. In the PROMISE JOBS/FIA environment, lack of effort or refusal to participate will result in the beginning of a Limited Benefit Plan (LBP).

Participants who choose not to develop an FIA enter into the LBP. Participants in a first LBP are eligible to receive FIP for a period of three months, reflecting the needs of the children only. At the end of this period of reduced benefits, the total FIP grant will be terminated. The entire household is ineligible for FIP for six months following the end of the reduced benefits. The participant may reconsider the choice of the LBP at any time during the three-month period of reduced benefits.

Participants who choose not to carry out the terms of the FIA enter into the LBP. Participants in this circumstance in a first LBP are eligible for FIP for a period of three months, reflecting the needs of the children only. At the end of this period of reduced benefits, the total FIP grant will be terminated. The entire household is ineligible for FIP for six months following the end of the reduced benefits. There is no opportunity to reconsider the choice of the LBP.

Participants who choose a second or subsequent LBP are cancelled and, along with the entire household, are ineligible for FIP for six months. There is no opportunity to reconsider the choice of any second or later LBPs.

PROMISE JOBS Components

Components of the PROMISE JOBS program are orientation, assessment to the level needed, job seeking skills training, job search, classroom training ranging from basic education to post-secondary education opportunities, and work experience, along with unpaid community service, and parenting skills training. In addition, FIP participants can meet FIA obligations through employment.

Service Areas

The primary local delivery agencies for PROMISE JOBS are

- Job Service offices and
- Job Training Partnership Act (JTPA) offices

in sixteen Service Delivery Areas (SDAs) which follow the boundaries of the Job Training Partnership Act (JTPA). SDAs are comprised of consortiums of counties, thereby enhancing coordination with county offices of the Department of Human Services.

The PROMISE JOBS provider agencies establish extensive linkages and coordination agreements with other human service and educational programs in each SDA.

Participant Responsibilities and Choices

The final responsibility in implementing the Iowa Family Investment Program is with the individual participant. Note that this individual is no longer a welfare recipient, but

a participant in a program designed to assist in attainment of family self-sufficiency. FIP is designed to enable rather than to maintain.

As a participant in PROMISE JOBS, each individual has the opportunity to change their life's circumstances. Iowans deserve choices and options and the right to exercise them. FIP establishes a system which operationalizes those rights and responsibilities for Iowans receiving public assistance.

How the PROMISE JOBS/FIA and LBP System Works

Following is a step-by-step example of how the PROMISE JOBS system works:

Step 1: An individual applies at a county DHS office for assistance through the Family Investment Program (FIP). The application process includes printed material and a video review of the FIA, and a brief explanation of PROMISE JOBS and FIAs by the DHS income maintenance (IM) worker.

Step 2: The participant is determined eligible for assistance by the worker and

a. Receives a Notice of Decision (NOD) which contains information about participant responsibility concerning the FIA along with a letter which tells the participant to contact PROMISE JOBS within ten calendar days to schedule FIA orientation.

b. A participant who does not establish an orientation appointment or who fails to keep or reschedule an orientation appointment receives *Your PROMISE JOBS Reminder* which advises that those who do not attend orientation have indicated thereby a choice of the LBP.

c. A participant who does not respond to the reminder within ten calendar days receives an NOD establishing the beginning date of the LBP.

Step 3: A participant who establishes and keeps the orientation appointment receives a full orientation to PROMISE JOBS and the FIA from PROMISE JOBS staff.

Step 4: At this step, the participant has two options:

a. Participants may choose to begin PROMISE JOBS and FIA development.

b. Participants may choose not to develop an FIA and will enter, instead, into the LBP. Participants in a first LBP will generally be eligible for FIP for a period of three months, reflecting the needs of the children only. At the end of this period of reduced benefits, the total FIP grant will be terminated. The entire household will not be eligible for FIP for six months following the end of the reduced benefits.

During month two or four of the LBP, a visit to promote the well-being of the family is offered by qualified social services professionals.

A participant who chooses a first LBP option before completing the FIA may reconsider and begin development of the FIA at any time during the three month period of reduced benefits.

See below for a description of the resolution opportunities that are available during the LBP.

Step 5: The PROMISE JOBS worker will meet individually with the participant who chooses the FIA to begin the development of the FIA. This meeting will, at a minimum, assess the following:

a. Family profile and goals (including FaDSS criteria);

b. Work background;

c. Educational background;

d. Housing needs (e.g., locale, adequacy, potential impact on rent assistance);

e. Child care needs;

f. Transportation needs;

g. Health care needs (physical/mental);

h. Financial evaluation (current financial status; projected needs for self-sufficiency);

i. Other barriers which may require referral to other services for assistance and resolution (e.g., substance addiction, sexual or

domestic abuse history, overwhelming family stress, long-term dependency on welfare).

If, after assessment, an FIA without further assessment is the participant's choice, the PROMISE JOBS worker and the participant have the authority to immediately negotiate that type of agreement.

Problems that make participation difficult or that pose strong barriers to participation do not exclude the participant from development of an FIA. They are instead be addressed in the FIA with specific steps to solve the problems or remove the barriers.

Step 6: FIAs detail the expectations of both the state and the family in accomplishing the FIA. The PROMISE JOBS worker and the participant outline the chosen activities and appropriate referrals in the FIA. Activities and services may be pursued sequentially or concurrently, depending on family circumstances. Vocational assessment and employability planning are part of the FIA process.

Participants may use all of the PROMISE JOBS components and employment as part of the FIA.

The FIA will include extra time needed for families who have significant barriers to self-sufficiency and for whom FaDSS or other family development services are not available.

Step 7: Some families will have significant barriers which prohibit successful participation in work and training activities under PROMISE JOBS. Because PROMISE JOBS is a holistic process, looking at all of the needs of the family, these participants will be referred to FaDSS or other family development services to the extent that funding is available. A referral could be made to appropriate family development services at any time that "significant barriers" surface or are identified. The FIA could show this referral as a service to be provided before other activities are pursued or it could show that family development services will support participation in other activities.

For families referred to family development services, such as FaDSS, the family development specialist will be responsible for providing the family development services and determining when other activities, such as work and training activities, should begin. For families receiving child welfare services, there will be close coordination between the PROMISE JOBS worker and the child welfare social worker.

Step 8: Every FIA will have expectations, responsibilities, and consequences regarding the time frame during which the participant will become self-sufficient and the FIA will end. That time frame may conclude in any of the following ways:

a. The participant achieves self-sufficiency before the ending date of the FIA, the FIA concludes successfully, and need for public assistance ends.

b. The participant demonstrates effort and satisfactory progress but is unable to achieve self-sufficiency before the ending date of the FIA. In this situation, the FIA will be renegotiated and amended. Examples of circumstances where there is a need to renegotiate the ending date of the FIA are: becoming employed but not yet self-sufficient; actively job seeking; receiving post-secondary classroom training; or participating in parenting classes or other developmental activities. The FIA can also be renegotiated and amended when a major change in life circumstances makes it clear that the participant cannot reach self-sufficiency by the ending date.

c. The participant refuses to participate in the self-sufficiency process after completing the FIA. This third option will result in the beginning of an LBP. Because the PROMISE JOBS worker and the participant need to be able to evaluate ongoing efforts and progress, the FIA will contain benchmarks in progress which are understood, achievable, and measurable by both the participant and the FIA worker.

For the participants who abandon their FIA, i.e., who choose not to participate or make no effort toward self-sufficiency after the FIA is completed, the LBP will begin at the point at which all avenues to negotiate participation have been exhausted.

These avenues include supervisory review and intervention if appropriate and review and approval or denial of the LBP request by state-level staff. Participants in a first LBP will be eligible for a period of up to three months of reduced benefits. At the end of this period of reduced benefits, the total FIP grant will be terminated.

During month four of the LBP, a visit to promote the well-being of the family is offered by qualified social services professionals.

See IV.E for a description of the resolution opportunities that are available to the participant before the LBP begins.

Resolution Process for Limited Benefit Plan Chosen Before Signing an FIA

A participant may or may not be making a good decision when selecting a LBP upon approval of assistance and before an FIA is developed.

Step 1: The participant will be informed, at the time of FIP application and when the LBP begins, that the participant can reconsider the choice of the LBP at any time during the three-month period of reduced benefits. The FIP participant who wants to begin the FIA process may notify the DHS county office or the local PROMISE JOBS office.

Step 2: As a safeguard for the participant, a qualified social services professional, will contact the client during the month two of a first LBP, after the three-month period of reduced benefits has begun. The purpose of this visit is twofold: to ensure the participant understands the option to reconsider the LBP choice and to promote the well-being of the family. This social services professional will discuss the repercussions of their decision with the client, discern whether the decision might be dysfunctional, and provide an opportunity for the client to change their mind.

Step 3: If the client indicates a desire to participate in the FIA process, the third-party counselor may help set up an appointment with the PROMISE JOBS office.

Step 4: If the FIP participant does not enter the FIA process at this time, an additional inquiry as to the well-being of the children will be made in month four of the LBP.

Resolution Process for Limited Benefit Plan Chosen by Abandoning the FIA

Step 1: When the PROMISE JOBS worker and the participant disagree on issues of participation and cooperation, they will negotiate for a solution, e.g., clearing misunderstandings of expectations or identifying barriers to participation and evaluating a need for renegotiation and amendment of the FIA.

Step 2: If the participant and the PROMISE JOBS worker cannot find the grounds to show that the FIA is being fulfilled:

a. The PROMISE JOBS supervisor will be involved to provide further advocacy, counseling, or negotiation support.

b. Local PROMISE JOBS management has the option of involving an impartial third party to assist in the resolution process.

Step 3: If the first two steps do not lead to fulfillment of the FIA, the case is referred to the DHS Division of Economic Assistance for state level review and approval or denial of the LBP.

If none of the above steps lead to fulfillment of the FIA, the FIP participant enters the LBP.

Step 4: During month four of the first LBP, a visit to promote the well-being of the family is offered by qualified social services professionals.

Right of Appeal

The participant has the same appeal rights which exist for all negative actions taken by the Department of Human Services. The participant may appeal the existence of a first LBP at the time of the Notice of Decision which establishes the beginning of the LBP and the three-month period of reduced benefits or at the time of the Notice of Decision which cancels the FIP eligibility for the entire case.

The participant may appeal the existence of a second or subsequent LBP at the time of the Notice of Decision which cancels the FIP eligibility for the entire case.

Judicial review upon petition of the participant is always available.

APPENDIX B

WELL-BEING VISIT
CONTRACT REVIEW MATERIALS

IOWA DEPARTMENT OF PUBLIC HEALTH
Division of Family and Community Health
Community Services Bureau
April 1995

FIP CONTRACT MINIMUM STANDARDS AND INTERPRETATIONS

1. Staff qualifications

Those persons performing program functions shall meet the IDPH qualifications of an RN or a social worker.

*IDPH SW qualifications are a Bachelors or Masters in:
-Social Work/or
-Sociology/or
-Psychology/or
-Counseling/or
-Family and Community Health/or
-Human Services

2. FIP visits

There will be three attempts to contact each client referred:

* attempts may be by telephone, letter, or if letter is returned, by contacting the DHS Income Maintenance worker for a possible new address.
*one of the three attempts (when unable to contact by phone) must be in writing

Agency shall make no unannounced visits to clients.

When client refuses a home visit, there is evidence that agency attempted to meet client at another location, and if that refused, attempted a telephone visit.

When client has moved outside of the agency service area, there is evidence that attempts were still made to locate client, and/or referral was transferred to the county of client's new residence, if appropriate.

There is a procedure in place to provide visits to non English speaking persons.

There is evidence that the following activities were performed, when appropriate to client situations, at each visit:

*reasons for not participating in FIP
*problem solving with resource information
*acting as liaison with DHS services
*assessing family's future planning for the well-being of their children
*planning follow-up visits or referrals when the minimum sufficient level of care standard isn't met (determined by the professional's judgment)

Follow-up visits were completed (maximum of one) when needs were identified by the professional's assessment and the client was willing for assistance.

DHS social worker was notified when agency identified problems or had questions on assisting family, as:

*child health needs
*parenting skills
*household management concerns
*mental health or substance abuse concerns

3. Confidentiality

There is a policy in place to assure confidentiality of client's information, and whom has access to this information.

DHS and contracting agency may share information on clients when pertaining to FIP services.

DHS social worker is not to disclose information on the client or family in regards to child abuse, substance abuse, or mental health issues without a release of information.

4. Reports

A report is completed for each agency referral on the program form provided by the IDPH.

Data collected shall include, but not be limited to:

*method of contact
*method of refusal
*type of visit
*results of visit
*follow-up services planned
*referrals made

Only one form was completed per case (husband and wife, or adult and child is one case).

Forms are submitted to the IDPH in a timely manner by the tenth day of the month following the month visits were made.

Follow-up visit report forms are completed and sent to the IDPH.

5. Fiscal

There is a financial system in place to maintain accuracy and accountability of items pertaining to costing and reimbursement for this program:

*time records showing evidence and documentation of contacts
*actual cost and expenses of providing the services in detail to properly reflect the net costs (direct and indirect)
*a system in place to establish these costs as a program cost center
*a method to track reimbursable visits with the claims

An cost report is completed using the HCFA cost reporting methodology, or by a methodology approved by the IDPH.

IOWA DEPARTMENT OF PUBLIC HEALTH
Division of Family and Community Health
Community Services Bureau

Agency_____ Date_____

CHC_____

FIP CONTRACT SITE REVIEW

	YES	NO	COMMENT
1. Appropriate staff qualifications			
2. Attempts per referral for contact -visit/contact made/or -three attempts made/one in writing/or -referred to appropriate County of residence			
3. Evidence of activities performed at visit -why not participating -resource information -liasion with DHS services -assessing well-being of children -future plans to provide for children			
4. If assessed need, follow-up visit completed			
5. DHS Social Worker notified when problem/questions were identified			
6. Confidentiality policy in place and followed			
7. Report completed on each referral			
8. IDPH form filled out completely			
9. IDPH form submitted timely to IDPH			
10. Financial system identified to track costs and reimbursement of program			
11. HCFA/alternative methodology cost report completed when requested			

(6/95)
A:(#23)FIPREV

APPENDIX C

WELL-BEING VISIT CHECKLIST: DETAILED ASSESSMENT

This appendix presents a section-by-section assessment of the current version of the Well-Being Visit Checklist. The current checklist consists of nine discrete sections, designated A through I, each of which is intended to obtain a specific type of information on LBP families. In addition, there are three blank areas provided for visitor comments. A copy of the checklist is provided at the end of this appendix.

SECTION A: CLIENT REFERRAL INFORMATION

The top of the checklist and Section A provide space for the visitor to transcribe identifying information on the LBP client. Section A also provides space to record corrections to the addresses or telephone numbers visitors obtained while attempting to contact the client. We recommend that DHS:

1. Replace the subsection currently devoted to the transcribing of "Dependent Names" with a single item for recording the *number* of dependents. Our research revealed that the dependent names are rarely used by the nurses and social workers and are not used at all to report data from the visits. Names can be retrieved from the visit referral list if necessary, so we recommend that this space on the checklist be used for other purposes.

2. Designate space on the checklist for the visitor to record all the address and telephone information, including what DHS provided and corrections. DHS should specify that the corrected information will not be entered into the DHS data system.

Client contact information is crucial to the well-being visitor's work, and these changes will provide a basis for systematically documenting the initial contact information and corrections to that information.

SECTIONS B AND C: CONTACTING CLIENTS AND THE VISIT COMPLETION RATE

Checklist Sections B and C collect information about the visit mode (home, alternate site, telephone) or, if no visit was conducted, information about the three required contact attempts.

Because contact attempt information is required only if there is ultimately *no* visit, no information is collected about contact attempts that result in a well-being visit. This limits the potential for using the checklist data to monitor the success rates of different contact methods. Additionally, the list of pre-coded contact attempt "methods" in Section B is actually a collection of methods, outcomes, and reasons for a failed attempt. The ambiguity of this information further compromises DHS's ability to measure contact success rates by method.

We offer two recommendations to improve Sections B and C of the current checklist:

1. Collect data on all contact attempts regardless of whether a visit is ultimately conducted. This would help DHS monitor the use and success of different contact methods.

2. Create distinct "Contact Attempts" and "Visit Information" sections. This will help DHS monitor contact methods, visit completion rates, and modes used to complete visits. The following information should be included:

   - The "Contact Attempts" section would collect the following information for each attempt: (1) date, (2) method, (3) outcome (contact made/contact not made), and (4) result of contact or reason for no contact. Responses for the second and fourth items could be pre-coded and listed on the form.

   - The "Visit Information" section would collect information on the visit mode (home, alternate site, telephone), the duration of the visit, and the persons present at the visit.

SECTION D: ABSENCE OF NEED FOR FURTHER INVOLVEMENT

Section D of the checklist fulfills the requirement in the Iowa Administrative Code that the well-being visitor report why no further involvement with the client is needed. Unfortunately, the code is not specific about the agencies whose further involvement may be required or about the criteria to determine whether further involvement is necessary. This ambiguity in the code is reflected in the current checklist. We recommend the following changes to improve Section D of the current checklist:

1. Provide a list of the elements of client and child well-being to be considered to assess whether further involvement by an agency is needed.

2. Require the visitor to identify the agency whose potential involvement is being considered.

3. Move the current checklist items concerning reconsideration of the LBP and future FIP participation to the client information section of the checklist.

These changes will help DHS monitor the need for further involvement in a more meaningful way.

SECTION E: REFERRALS TO PROGRAMS AND SERVICES

Section E of the checklist collects information about the programs or services to which the LBP client was referred during the well-being visit. This fulfills the state code requirements to report referrals provided to the client for further assistance and referrals made to child protective investigations. However, Section E fails to obtain information that is critical to understanding the reported referrals. For example, it does not collect information about whether the client is currently receiving assistance from the program, or whether the client refused a referral. For referrals to PROMISE JOBS, the lack of a referral means one thing if a client has no LBP reconsideration rights, and another thing if the client has those rights. However, the current checklist does not link information on reconsideration rights to referrals to PROMISE JOBS. This makes it difficult to determine if the visitors refer clients who are eligible for reconsideration to PROMISE JOBS, and if they avoid making such referrals for clients who are ineligible for reconsideration.[1]

We recommend the following changes to improve Section E of the current checklist:

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[1]Appendix E (bound separately) of this report presents our analysis of recent data from the well-being visit checklist. When reconsideration of the LBP assignment was not an option, 23 percent of clients were referred to PROMISE JOBS.

1. Collect information about referrals to PROMISE JOBS and DHS separately from information about referrals to other programs and services.

2. Record information on the client's LBP reconsideration rights next to information about PROMISE JOBS referrals.

3. Collect information about current participation in programs, which would indicate that a referral would be redundant.

4. Collect information about the reason visitors do not make a referral (client already is receiving the program/service; client does not need the program/service; client needs the program/service but refuses the referral).

5. Collect information about the nature of the referral (visitor provided the client with the address of the program/service; visitor provided the client with the name and phone number of a contact at the program/service; visitor made an appointment for the client with the program/service).

If implemented, these recommendations would substantially improve the ability of DHS to monitor the needs of LBP families and the sources of assistance to which they have been referred.

SECTION F: PLANNED FOLLOW-UP SERVICES

Section F of the current checklist collects information about follow-up services planned by the visiting nurse or social worker for the LBP family. It identifies several needs that might warrant follow-up: (1) to assess the well-being of the children in the family, (2) to help the client meet the family's needs, and (3) to check on the client's follow-up on referrals made during the well-being visit. This section of the checklist fulfills the requirement in the Iowa Administrative Code that the well-being visitor report whether there is a need to provide follow-up services.

While Section F of the current checklist touches on some important issues relating to child and family well-being, it is of almost no value to DHS because it is completed for only about one percent of well-being visits.[2] This is because the checklist instructs the visitor to complete Section F *only*

[2]This finding is reported in Table E.5 of Appendix E (bound separately).

if a follow-up visit is planned, which is rare.[3] In the Well-Being Visit Program, a follow-up visit must be an additional visit that supplements the standard well-being visits provided in month two and month four of the LBP. The Well-Being Visit Program does not reimburse local public health agencies for conducting follow-up visits.

Despite the infrequency of follow-up visits and the absence of funding for them, state policy makers and DHS administrators do seem to be concerned about follow-up on LBP cases. The Iowa Administrative Code and the Well-Being Visit Program contract between DHS and IDPH clearly specify that follow-up services or referrals be provided when the basic needs of children in an LBP family are not being met. The code also specifies that DHS monitor follow-up and referrals. The code and the contract provide a framework for determining whether follow-up services or referrals are necessary, known as the *minimum sufficient level of care*. It is defined as ". . . the point below which a child's mental, physical, or emotional health or safety of the community are threatened if the child remains solely in the care and supervision of the family."[4]

The current checklist does not require the visitor to consider specific aspects of well-being at each visit or to document whether sufficient care is being provided. Therefore, the checklist does not provide a systematic documentation of the visitor's plans for follow-up when sufficient care is not being provided. These limitations restrict the capacity of the Well-Being Visit Program to achieve its principal goal--to monitor the well-being of children in LBP families. To address these limitations, we recommend the following changes to Section F of the checklist:

1. Collect information on specific aspects of child and family well-being for *all* visited clients (not just those for whom a follow-up visit or referral is planned).

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[3]Follow-up visits are extremely rare. In state fiscal year 1997, only 1 of the 3,600 well-being visits was a follow-up visit.

[4]This is the definition provided in the well-being visit training materials developed by DHS.

2. Collect information on the client's need for follow-up services or referrals to services, using the specific concerns regarding child and family well-being as the basis for that determination.

3. Collect information on the visitor's plan to address any identified needs for follow-up services or referrals to services.

SECTION G: OPTIONAL CLIENT INFORMATION

Section G of the current checklist collects information directly from clients on their sources of income and reasons for entering the LBP. This section was added when the checklist was revised to make it a better tool for learning about LBP families. Section G begins with an initial "gatekeeper" question on the client's willingness to answer questions. Only clients who answer "yes" to this initial question are asked about income and LBP entry.[5]

There is a high incidence of "other" responses to the questions on income sources (31 percent) and LBP entry (49 percent).[6] This occurs because the checklist provides only a few response categories for each question, and the checklist does not offer an appropriate response category for those clients who perceive that they were *assigned* to the LBP.

To improve Section G of the current checklist, we recommend that DHS:

1. Drop the initial question on willingness to answer questions on income sources and LBP entry and add a pre-coded response of "No response--client refused" for each question. This would preserve the client's right to decline to answer, but encourage the client to respond to each question. (Currently, clients may be screened out from responding to both questions on the basis of their response to the initial question on willingness.)

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[5]About 84 percent of visited clients say they are willing to answer questions. This is the weighted average of willingness to answer optional questions by clients visited in LBP month two and month four, as reported in Table E.6 of Appendix E (bound separately).

[6]This is the weighted average of "other" responses by clients visited in LBP month two and month four, as reported in Table E.8 of Appendix E (bound separately).

2. Provide additional pre-coded responses for income sources and LBP entry.[7] This would reduce the incidence of unspecified "other" responses and thereby increase knowledge about LBP families.

3. Provide pre-coded responses for frequently mentioned sources of noncash income, such as Food Stamps, Medicaid, and WIC.

4. Provide a time frame for identifying income sources and clearly specify whose income the client should report.

5. Change the wording of the LBP question from "Why did you *choose* the LBP?" to "Why did you *enter* the LBP?" Provide pre-coded responses appropriate for clients who perceive that they chose the LBP and those who perceive that they were assigned to it (even though DHS's perception might be different).

6. Change the wording of the LBP question from Limited Benefits *Program* to Limited Benefit *Plan* to make it consistent with DHS language.

If implemented, these recommendations would improve the quality of data on LBP families obtained through the Well-Being Visit Checklist.

SECTION H: ADDITIONAL INFORMATION

Section H was added when the original checklist was revised as part of the effort to obtain better information about LBP families. In this section, the well-being visitor is asked to respond to eight questions that require some assessment of the status of the client or her children. The subjectivity of the questions included in this section limits the value of the information obtained. As one focus group participant stated:

> Some of those questions I feel really bogus answering. . . . Like "are the basic needs being met." I mean, what my definition of basic needs [is] might be different than somebody

[7]We recommend adding the following pre-coded income sources to the checklist: FIP/LBP cash assistance, employment of spouse/partner, unemployment insurance, and general relief, in addition to the following sources of noncash assistance: Food Stamps, Title 19/Medicaid, and WIC. We also recommend adding the following pre-coded reasons for entry into the LBP: did not meet PROMISE JOBS requirements, assigned by caseworker, do not know/remember why.

else's. But a lot of times I can't, I don't feel like I can ethically or consciously ... put yes [basic needs are being met] because I am not sure in my own mind what they are.

Another had similar observations:

> . . . question number six, it's my least favorite, "does the client have an established plan for the future?" I hate answering that question. I feel so accountable no matter what I say there.

While the visitors fully complete all other sections of the checklist, they fail to complete this section about 8 to 16 percent of the time. This provides additional evidence of the troublesome nature of these questions.[8]

To address these concerns, we recommend that DHS revise Section H to:

1. Include a few specific questions about child well-being, instead of the current general questions (H.5, H.8). Specific questions might address the children's needs for food, clothing, shelter, medical care, and supervision.

2. Include a few specific questions about the family's well-being, instead of the current general question on client functioning (H.3). Specific questions might address the family's physical and mental health and its access to a telephone and transportation.

3. Include a few specific questions about the client's understanding of LBP policies, instead of the current general questions (H.1, H.2). Specific questions might address the client's knowledge of LBP reconsideration rights and the length of the benefit termination period.

4. Provide an "uncertain/don't know" response category for any question that requires the visiting nurse or social worker to make a subjective assessment.

If implemented, these recommendations would support DHS's efforts to collect data on the status of LBP families and improve the meaningfulness and reliability of the information that is gathered.

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[8]The rate of nonresponse to the questions in Section F ranges from 8 percent to 16 percent, as reported in Table E.8 of Appendix E (bound separately).

CHECKLIST COMMENT AREAS

Three empty boxes on the current checklist provide space for well-being visitors to write comments. Among well-being visit staff, there is considerable confusion regarding the purpose of these comments. The most common misconception is that the comments written by staff are systematically used by DHS or IDPH. Since this is not the case, we recommend that less space on the checklist be allotted for comments. Because staff value the opportunity to comment, we recommend that DHS retain some space for comments.

(PAGE 1) Iowa Department of Human Services **FAMILY INVESTMENT PROGRAM (FIP) WELL-BEING VISIT CHECKLIST**

VISIT DUE: ____/____/____ ☐5-Month Visit ☐7-Month Visit
☐2-Month Visit ☐Reconsideration Rights ☐4-Month Visit ☐Follow-up

COUNTY NUMBER & NAME #

AGENCY NUMBER ☐01 ☐02 ☐____

A CLIENT NAME *(last, first)* **SS NUMBER** **DHS CASE NUMBER**

DEPENDENT NAMES *(last, first)*		

ADDRESS/PHONE CORRECTION For Agency Use Only.

B FACE-TO-FACE VISIT NOT DONE Complete section B or C.

☐1 UNABLE TO CONTACT: (Must list three attempt dates and methods. Unanswered telephone calls do not count as an attempt.)

#1 Date____/____/____ Method:____

#2 Date____/____/____ Method:____

#3 Date____/____/____ Method:____

METHODS *(Write the number of the method for each of your three attempts.)*
01=Letter, no response 02=Letter, returned
03=Face-to-face attempted, no show 04=Message left
05=Moved out of state 06=Current address unknown
07=No further information
09=Other:____

☐2 REFUSED VISIT: Date____/____/____ Method:____

METHODS *(Write the number of the method of refusal.)*
11= In Writing to Agency 12=Telephone Call/Message 13=Verbal Response
19=Other:____

☐3 TELEPHONE VISIT ONLY (Face to face refused) Date:____/____/____
(Complete Sections D, E, F, G and H)

☐4 REFERRED TO ANOTHER COUNTY (Specify):____
(Please notify other county and IDPH of referral as soon as you discover it.)

COMMENTS:

C TYPE OF VISIT Complete only if a face-to-face visit is begun or completed.

☐1 HOME VISIT
☐2 ALTERNATE SITE VISIT (Specify): ____ Date:____/____/____

21=Local Agency 22=WIC Clinic 23=Hospital 24=Family's Member Home
25=Friend's Home 26=Job Site 29=Other:____

D RESULTS Complete this section if face-to-face or telephone visit is completed.

NO FURTHER INVOLVEMENT NEEDED
☐1 Refuses further involvement
☐2 Referrals completed/information given
☐3 Has reconsidered and begun FIA
☐4 Will reconsider and begin FIA
☐5 Will not need FIP (Why?)____

31=Getting/Got Married
32=Now Employed
33=Seeking Employment on Own
34=Support from Others
35=Planning to Leave the State
39=Other:____

E REFERRALS MADE ☐ Yes ☐ No Check all that apply.

☐1 Income Maintenance
☐2 Area Education Agency
☐3 WIC
☐4 Counseling Services
☐5 Housing
☐6 Child Care
☐7 Child Protective Services
☐8 Child Protective Investigations
☐9 PROMISE JOBS
☐10 Food Pantry
☐11 Transportation
☐12 Health Care Provider
☐13 Employment Services
☐14 Mental Health/Substance Abuse
☐15 Immunizations: *(Check one)*
☐ Given
☐ Referred
☐16 Other DHS Services. Specify one:____

81=Food Stamps 82=Title XIX—Medical Assistance 89=Other:____

☐17 Other. Specify one:____

91=Well Child Clinic 92=Maternal Health Clinic 93=Public Health Nursing 94=Home Care Aide Services
95=Fuel Assistance 96=Legal Assistance 97=Outreach/General Relief 98=Child Support Recovery
99=____

(Please complete both sides.)

(PAGE 2) FIP CHECKLIST **COUNTY NUMBER:** # **CLIENT NAME:** *(Last, First)*

FOLLOW-UP SERVICES PLANNED (Complete this section only if you intend to return for a follow-up visit.)

☐1 Unable to complete visit .....REASON:_____
41=Client had to leave for work 42=Client confused about options
43=Client not English speaking 44=Client left for appointment 49=_____

☐2 Additional assessment needed relative to the well-being of children....REASON:_____
51=Children not present, concerns 52= Environmental concerns 53 Health Concerns about child
54=Potential negative/abuse behavior 55=Inadequate support/other services 59=_____

☐3 Needs identified .....SPECIFY:_____
61=Assistance accessing community resources 62=Clarification of DHS Services
63=Assistance meeting health needs 64=Assistance with education/needs of children
69=Other_____

☐4 Referrals planned.....SPECIFY:_____
71=Concern with client's follow-up on refs made 72=Concern with client's follow-up on refs suggested
79=_____

OPTIONAL CLIENT INFORMATION

1 "Are you willing to answer the following questions to help us see how well the program is working?" ☐ Yes ☐ No

2 "What is your current source of Income?" **(Check all that apply.)**
- ☐ a Full-time employment
- ☐ b Part-time employment
- ☐ c Child Support
- ☐ d Support from others
- ☐ e Social Security or SSI
- ☐ f No response
- ☐ g Other: (Specify)_____

3 "Why did you choose the Limited Benefits Program?"
- ☐ h I didn't understand.
- ☐ i I decided to make it on my own.
- ☐ j I didn't want to be in the PROMISE JOBS Program.
- ☐ k Other: (Specify)_____

COMMENTS:

ADDITIONAL INFORMATION (To be completed by staff on all visits completed.)

1 Do you believe the client understood the LBP before your visit?
- ☐ Yes
- ☐ No *(Identify your concerns in the comment space.)*

2 Do you believe the client understood the LBP after your visit?
- ☐ Yes
- ☐ No *(Identify your concerns in the comment space.)*

3 Do you have concerns regarding the client's functioning abilities?
- ☐ Yes *(Identify your concerns in the comment space.)*
- ☐ No

4 Client referred to Income Maintenance worker for redetermination for exempt status.
- ☐ Yes
- ☐ No

5 Do you have concerns regarding the well being of the children?
- ☐ Yes *(Identify your concerns in the comment space.)*
- ☐ No

6 Does the client have an established plan for the future?
- ☐ Yes
- ☐ No

7 Was (were) the child(ren) present during the visit?
- ☐ Yes
- ☐ No

8 Are the basic needs being met?
- ☐ Yes
- ☐ No (Identify your concerns in the comment space.)

COMMENTS:

RN/SW NAME (Please Print) **NAME OF DHS SOCIAL WORKER** (Not IM Worker)

RN/SW SIGNATURE **DATE**

APPENDIX D

WELL-BEING VISIT
MONTHLY REPORT: JUNE 1997

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

MEMO

August 15, 1997

TO: DHS Regional Administrators
John Williams and Dianne Milobar, Iowa Workforce Development
Wayne Johnson, Bureau of Refugee Services

FROM: Douglas E. Howard, Administrator, Division of Economic Assistance

SUBJECT: Well-Being Visit Monthly Reports

The Department of Human Services (DHS) is contracting with the Iowa Department of Public Health (IDPH) to perform the well-being visits for Family Investment Program (FIP) participants who have chosen the limited benefit plan (LBP). IDPH is subcontracting with public health-oriented agencies who employ social workers and registered nurses to do the visits in each county.

The results of each visit are recorded on the attached form, "Family Investment Program (FIP) Well-Being Visit Checklist". IDPH collects this information and prepares statewide reports and reports for each county, which contain the quantitative results of the visits for the month and year-to-date totals.

A revised version of the checklist has been developed and used for all visits beginning February 1, 1996. The revised checklist requests additional information from the client and the nurse or social worker making the visit. This additional information has been included in the report.

For families whose limited benefit plans began before February 1, 1996, visits were made in months five and seven of the limited benefit plan. For families whose limited benefit plans began February 1, 1996, or after, visits are made in month two and month four. The final month five visits for limited benefit plans begun before February 1, 1996, were made in May 1996 and the final month seven visits were made in July 1996. The reports for fiscal year 1997 include monthly and year-to-date totals for month two, months four and seven combined, and follow-up visits made during the month, in addition to totals for all visits done in the month and year-to-date.

The attached report provides statewide data for visits completed during the month of June 1997 (year-to-date covers the fiscal year 1997, July 1996 through June 1997). If information concerning an individual county is required, contact Barbara Russell, Division of Economic Assistance, 515-281-3132.

Also attached is an explanation of the data included in the report titled "Well-Being Visit Reports - Guide".

cc: Senator Tom Harkin
Senator Charles Grassley
Senator Elaine Szymoniak
Council on Human Services (8 copies)
Sally Titus Cunningham, Deputy Director for Services
Mary Nelson, Division of Adult, Children and Family Services
Jim Krogman, Office of Field Support
Gloria Conrad, Barbara Russell, Norma Hohlfeld, Deb Bingaman, Ann Wiebers, Anita Finders, Shari Seivert, Division of Economic Assistance
Barbara Galloway, Attorney General's Office
Thelma Williams, Department of Health and Human Services
Institute for Social and Economic Development
Mathematica Policy Research, Inc.
Karen McCarthy, Department of Human Rights, Division of Community Action Agencies
Charlotte Nelson, Commission on Status of Women
Martin Ozga, Legal Services Corporation of Iowa
Paul Stanfield, Public Policy Services
Anita Varme, Headstart Coordinator, Department of Education (20 copies)

Attachments

(PAGE 1) Iowa Department of Human Services **FAMILY INVESTMENT PROGRAM (FIP) WELL-BEING VISIT CHECKLIST**

VISIT DUE: ____/____/____ ☐5-Month Visit ☐7-Month Visit
☐2-Month Visit ☐Reconsideration Rights ☐4-Month Visit ☐Follow-up

COUNTY NUMBER & NAME #

AGENCY NUMBER ☐01 ☐02 ☐____

A CLIENT NAME *(last, first)* | **SS NUMBER** | **DHS CASE NUMBER**

DEPENDENT NAMES *(last, first)*		

ADDRESS/PHONE CORRECTION For Agency Use Only.

B FACE-TO-FACE VISIT NOT DONE Complete section B or C.

☐1 UNABLE TO CONTACT: (Must list three attempt dates and methods. Unanswered telephone calls do not count as an attempt.)

#1 Date____/____/____ Method:____

#2 Date____/____/____ Method:____

#3 Date____/____/____ Method:____

METHODS *(Write the number of the method for each of your three attempts.)*
01=Letter, no response
02=Letter, returned
03=Face-to-face attempted, no show
04=Message left
05=Moved out of state
06=Current address unknown
07=No further information
09=Other:____

☐2 REFUSED VISIT: Date____/____/____ Method:____

METHODS *(Write the number of the method of refusal.)*
11= In Writing to Agency 12=Telephone Call/Message 13=Verbal Response
19=Other:____

☐3 TELEPHONE VISIT ONLY (Face to face refused) Date:____/____/____
(Complete Sections D, E, F, G and H)

☐4 REFERRED TO ANOTHER COUNTY (Specify):____
(Please notify other county and IDPH of referral as soon as you discover it.)

COMMENTS:

C TYPE OF VISIT Complete only if a face-to-face visit is begun or completed.

☐1 HOME VISIT
☐2 ALTERNATE SITE VISIT (Specify): ____ Date:____/____/____

21=Local Agency 22=WIC Clinic 23=Hospital 24=Family's Member Home
25=Friend's Home 26=Job Site 29=Other:____

D RESULTS Complete this section if face-to-face or telephone visit is completed.

NO FURTHER INVOLVEMENT NEEDED
☐1 Refuses further involvement
☐2 Referrals completed/information given
☐3 Has reconsidered and begun FIA
☐4 Will reconsider and begin FIA
☐5 Will not need FIP (Why?)____

31=Getting/Got Married
32=Now Employed
33=Seeking Employment on Own
34=Support from Others
35=Planning to Leave the State
39=Other:____

E REFERRALS MADE ☐ Yes ☐ No Check all that apply.

☐1 Income Maintenance
☐2 Area Education Agency
☐3 WIC
☐4 Counseling Services
☐5 Housing
☐6 Child Care
☐7 Child Protective Services
☐8 Child Protective Investigations
☐9 PROMISE JOBS
☐10 Food Pantry
☐11 Transportation
☐12 Health Care Provider
☐13 Employment Services
☐14 Mental Health/Substance Abuse
☐15 Immunizations: *(Check one)*
  ☐ Given
  ☐ Referred
☐16 Other DHS Services. Specify one:____

81=Food Stamps 82=Title XIX—Medical Assistance 89=Other:____

☐17 Other. Specify one:____

91=Well Child Clinic 92=Maternal Health Clinic 93=Public Health Nursing 94=Home Care Aide Services
95=Fuel Assistance 96=Legal Assistance 97=Outreach/General Relief 98=Child Support Recovery
99=____

(Please complete both sides.)

(PAGE 2) FIP CHECKLIST **COUNTY NUMBER:** # **CLIENT NAME:** (Last, First)

FOLLOW-UP SERVICES PLANNED (Complete this section only if you intend to return for a follow-up visit.)

☐1 Unable to complete visit .....REASON:_____
41=Client had to leave for work 42=Client confused about options
43=Client not English speaking 44=Client left for appointment 49=_____

☐2 Additional assessment needed relative to the well-being of children....REASON:_____
51=Children not present, concerns 52= Environmental concerns 53 Health Concerns about child
54=Potential negative/abuse behavior 55=Inadequate support/other services 59=_____

☐3 Needs identified .....SPECIFY:_____
61=Assistance accessing community resources 62=Clarification of DHS Services
63=Assistance meeting health needs 64=Assistance with education/needs of children
69=Other_____

☐4 Referrals planned.....SPECIFY:_____
71=Concern with client's follow-up on refs made 72=Concern with client's follow-up on refs suggested
79=_____

OPTIONAL CLIENT INFORMATION

1 "Are you willing to answer the following questions to help us see how well the program is working?" ☐ Yes ☐ No

2 "What is your current source of income?" (Check all that apply.)
- ☐ a Full-time employment
- ☐ b Part-time employment
- ☐ c Child Support
- ☐ d Support from others
- ☐ e Social Security or SSI
- ☐ f No response
- ☐ g Other: (Specify)_____

3 "Why did you choose the Limited Benefits Program?"
- ☐ h I didn't understand.
- ☐ i I decided to make it on my own.
- ☐ j I didn't want to be in the PROMISE JOBS Program.
- ☐ k Other: (Specify)_____

COMMENTS:

ADDITIONAL INFORMATION (To be completed by staff on all visits completed.)

1 Do you believe the client understood the LBP before your visit?
- ☐ Yes
- ☐ No *(Identify your concerns in the comment space.)*

2 Do you believe the client understood the LBP after your visit?
- ☐ Yes
- ☐ No *(Identify your concerns in the comment space.)*

3 Do you have concerns regarding the client's functioning abilities?
- ☐ Yes *(Identify your concerns in the comment space.)*
- ☐ No

4 Client referred to Income Maintenance worker for redetermination for exempt status.
- ☐ Yes
- ☐ No

5 Do you have concerns regarding the well being of the children?
- ☐ Yes *(Identify your concerns in the comment space.)*
- ☐ No

6 Does the client have an established plan for the future?
- ☐ Yes
- ☐ No

7 Was (were) the child(ren) present during the visit?
- ☐ Yes
- ☐ No

8 Are the basic needs being met?
- ☐ Yes
- ☐ No (Identify your concerns in the comment space.)

COMMENTS:

RN/SW NAME (Please Print) **NAME OF DHS SOCIAL WORKER** (Not IM Worker)

RN/SW SIGNATURE **DATE**

Well-Being Visit Report -- Guide

Each section of the well-being visit report gives monthly and year-to-date totals for month 2, months 4 and 7 combined, and follow-up visits, in addition to totals for all visits done in the month and year-to-date.

PAGE 1

Includes the number of cases referred and data from sections B and C of the Well-Being Visit Checklist.

Section A. Cases Referred

Number of families referred for a visit.

Section B. Face-to-Face Not Done

Number of visits not made because the family could not be contacted, refused a visit or agreed to only a telephone visit. Total of results from 1, 2, and 3 below.

1. Unable to contact -- Number of families who could not be contacted after a minimum of three attempts. For each unsuccessful attempt to contact, the reason the attempt was unsuccessful is recorded.

2. Refused visit -- Number of visits not made because the family refused the visit. For each family refusing a visit, the method of refusal is recorded.

3. Telephone visit only -- Number who agreed to a telephone visit only.

Section C. Type of Visit

Number of face-to-face visits completed, including home visits and visits made at an alternate location, at the family's request. Total of results from 1 and 2 below.

1. Home visit -- Number of visits completed in the family's home.

2. Alternate site -- Number of visits completed at an alternate location. The number done at each type of alternate location is given.

Also noted on the first page are: the percentage of referrals, for the month and year-to-date, for whom a face-to-face visit could not be done because the client could not be contacted, refused a visit or accepted a telephone visit only and the percentage of referrals for whom a home visit or alternate site visit was done.

PAGE 2

Includes data from section D of the checklist, including the number of families who do not require any further involvement from the nurse or social worker making the visit and

the reasons why no further involvement is required. If the client stated that FIP is no longer needed, the reason is listed.

Section D. Results
Completed if no further follow-up by the visitor is required after the face-to-face or telephone visit. 1 through 5 below indicate why further involvement is not needed. Visitors are instructed to record all reasons that apply for each family.

1. Refuse -- Family refuses further involvement.

2. Ref/info given -- All necessary referrals have been completed and information given.

3. Reconsidered/begun FIA -- Family has reconsidered and signed an FIA or is working with PROMISE JOBS to do so.

4. Will reconsider/begin FIA -- Family decided at the time of the visit to reconsider and has been referred to PROMISE JOBS to sign an FIA.

5. Will not need FIP -- Family has indicated they no longer need FIP. Total who will not need FIP is given as well as number for each reason.

PAGES 3 AND 4
Include data from section E of the checklist, including the number of families referred for other services and the type of referral made.

Section E. Referrals Made
Number of referrals made.

1. through 17. Number of referrals made to each agency or service. One family could have multiple referrals.

PAGE 5
Includes data from section F of the checklist, including the number of families for whom follow-up services are planned and the reason for follow-up.

Section F. Follow-up Planned
Completed when follow-up visits or services are planned, to indicate why follow-up is needed. For 1 through 4 below, the total number of families needing follow-up is given, in addition to the number for each specific reason.

1. Unable to complete visit -- Number of visits begun but not completed and the reasons why.

2. Additional assessment -- Number for whom follow-up will be done because the visitor has concerns about the well-being of the children and the reasons for that concern.

3. Needs identified -- Number for whom another visit is needed to provide assistance and reason for the need.

4. Referrals planned-- Number for whom follow-up is needed to make additional referrals or because of concern about the client's ability to follow-up on referrals made or suggested and the reason for the need.

PAGE 6

Includes data from section G of the checklist, including the client's response to questions about the family's current source of income and why the Limited Benefit Plan was chosen. Information in this section was not collected prior to February 1, 1996.

Section G. Optional Client Information

Numbers represent the family's responses to these questions.

1. Willing to answer -- Number willing to answer the optional questions.

2. Current source of income -- Number of families reporting each source of income.

3. Why LBP was chosen -- Number who state LBP was chosen for each reason, when known.

PAGE 7

Includes data from section H of the checklist, including the responses of the nurse or social worker making the visit to questions concerning the family's situation. Information in this section was not collected prior to February 1, 1996.

Section H. Additional Information

Visitors record their answers to questions 1 through 8, for each family for whom a face-to-face or telephone visit is completed, when an assessment has been made.

VISITS REPORT
6/01/97 to 6/30/97
FY97
8/14/97

00 State

	2-MONTH VISITS	YTD	4 & 7-MONTH VISITS	YTD	FOLLOW UP VISITS	YTD	TOTAL VISITS	YTD	% of Referra Total for Month	% of Referra Total for YTD
A. Cases Referred	469	4775	244	4174	0	1	713	8950		
B. Face-to-Face Not Done	338	3511	199	3225	0	1	537	6737		
1. Unable to contact	238	2451	149	2323	0	0	387	4774	54%	53%
01 Letter no response	288	3040	183	2766	0	0	471	5806		
02 Letter returned	15	157	18	183	0	0	33	340		
03 Face-to-face attempted	190	2023	107	1802	0	0	297	3825		
04 Message left	106	992	64	884	0	0	170	1876		
05 Moved out of State	25	181	20	236	0	0	45	417		
06 Address unknown	18	283	22	352	0	0	40	635		
07 No further information	32	481	11	558	0	0	43	1039		
09 Other	40	193	19	182	0	0	59	375		
Total	714	7350	444	6963	0	0	1158	14313		
Three attempts not made	0	0	0	0	0	0	0	0		
2. Refused visit	35	321	16	255	0	0	51	576	7%	7%
11 Written	0	8	0	2	0	0	0	10		
12 Telephone	30	266	12	216	0	0	42	482		
13 Verbal	4	28	3	23	0	0	7	51		
19 Other	1	19	1	14	0	0	2	33		
Total	35	321	16	255	0	0	51	576		
3. Telephone visit only	65	739	34	647	0	1	99	1387	14%	16%
C. Type of visit	131	1264	45	949	0	0	176	2213		
1. Home visit	125	1197	42	891	0	0	167	2088	24%	23%
2. Alternate site	6	67	3	58	0	0	9	125	1%	1%
21 Local agency	0	33	1	34	0	0	1	67		
22 WIC Clinic	3	14	0	8	0	0	3	22		
23 Hospital	1	1	0	2	0	0	1	3		
24 Family's home	0	4	0	2	0	0	0	6		
25 Friend's home	0	0	0	0	0	0	0	0		
26 Job site	2	7	1	4	0	0	3	11		
29 Other	0	8	1	8	0	0	1	16		

D. Results	2-MONTH VISITS	YTD	4 & 7-MONTH VISITS	YTD	FOLLOW UP VISITS	YTD	TOTAL VISITS	YTD
1. Refuse	23	169	10	224	0	0	33	393
2. Ref/Info given	71	676	37	555	0	0	108	1231
3. Reconsidered/begun FIA	22	351	6	183	0	0	28	534
4. Will reconsider/begin FIA	45	558	4	252	0	0	49	810
5. Will not need FIP	50	510	25	575	0	1	75	1086
31 Marriage	4	20	3	27	0	0	7	47
32 Employed	37	295	16	324	0	1	53	620
33 Seeking employment	2	47	2	70	0	0	4	117
34 Support from others	2	39	2	64	0	0	4	103
35 Planning to leave Iowa	0	12	1	7	0	0	1	19
39 Other	5	97	1	83	0	0	6	180

	2-MONTH VISITS	YTD	4 & 7-MONTH VISITS	YTD	FOLLOW UP VISITS	YTD	TOTAL VISITS	YTD
E. Referrals Made Cases with referrals made	114	1316	43	877	0	1	157	2194
1. IM	63	610	19	384	0	0	82	994
2. Area Education Agency	1	14	0	8	0	0	1	22
3. WIC	21	214	6	147	0	0	27	361
4. Counseling	7	66	2	61	0	0	9	127
5. Housing	1	25	2	24	0	0	3	49
6. Child Care	10	86	4	67	0	0	14	153
7. Child Protective Services	0	1	0	2	0	0	0	3
8. Child Protect Investigation	0	7	2	5	0	0	2	12
9. PROMISE Jobs	80	834	13	412	0	0	93	1246
10. Food Pantry	16	179	7	140	0	0	23	319
11. Transportation	2	21	0	18	0	0	2	39
12. Health Care Provider	8	47	2	38	0	0	10	85
13. Employment Services	4	170	2	142	0	0	6	312
14. Mental Health/Substance	1	8	0	16	0	0	1	24
15. Immunization	14	171	4	110	0	0	18	281
Given	2	34	2	25	0	0	4	59
Referred	12	137	2	84	0	0	14	221

	2-MONTH VISITS	YTD	4 & 7-MONTH VISITS	YTD	FOLLOW UP VISITS	YTD	TOTAL VISITS	YTD
16. Other DHS Services	17	174	14	159	0	0	31	333
81 Food Stamps	8	65	7	75	0	0	15	140
82 Title XIX	7	76	6	69	0	0	13	145
83 IM Worker	0	0	0	0	0	0	0	0
89 Other	2	33	1	13	0	0	3	46
17. Other Services	42	354	21	265	0	1	63	620
91 Well Child Clinic	17	112	4	63	0	0	21	175
92 Maternal Health Clinic	0	13	0	8	0	0	0	21
93 Public Health Nursing	2	10	1	9	0	0	3	19
94 Home Care Aide Services	0	2	0	0	0	0	0	2
95 Fuel Assistance	1	38	4	44	0	1	5	83
96 Legal Assistance	3	13	1	15	0	0	4	28
97 Outreach/General Relief	3	50	5	53	0	0	8	103
98 Child Support Recovery	0	16	1	15	0	0	1	31
99 Other	16	100	5	58	0	0	21	158

F. Follow-up Planned	2-MONTH VISITS	YTD	4 & 7-MONTH VISITS	YTD	FOLLOW UP VISITS	YTD	TOTAL VISITS	YTD
1. Unable to complete visit	1	6	0	5	0	0	1	11
41 Left for work	0	1	0	1	0	0	0	2
42 Confused about options	0	0	0	0	0	0	0	0
43 Not English speaking	0	0	0	0	0	0	0	0
44 Left for appointment	0	2	0	0	0	0	0	2
49 Other	1	3	0	4	0	0	1	7
2. Additional assessment	1	4	0	8	0	0	1	12
51 Children not present	0	0	0	1	0	0	0	1
52 Environmental concerns	0	1	0	1	0	0	0	2
53 Health concerns children	0	0	0	1	0	0	0	1
54 Potential Abuse/neg bhvr	0	1	0	1	0	0	0	2
55 Inadequate support/srvcs	0	1	0	2	0	0	0	3
59 Other	1	1	0	2	0	0	1	3
3. Needs identified	2	40	1	20	0	0	3	60
61 Access to comm resources	2	10	0	7	0	0	2	17
62 Clarify DHS services	0	12	1	8	0	0	1	20
63 Assisting health needs	0	11	0	3	0	0	0	14
64 Edn/needs of children	0	2	0	1	0	0	0	3
69 Other	0	5	0	1	0	0	0	6
4. Referrals planned	1	11	0	7	0	0	1	18
71 Cncrn cl f-up refs made	0	1	0	1	0	0	0	2
72 Cncrn cl f-up refs sugg	0	7	0	3	0	0	0	10
79 Other	1	3	0	3	0	0	1	6

G. Optional Client Information	2-MONTH VISITS	YTD	4 & 7-MONTH VISITS	YTD	FOLLOW UP VISITS	YTD	TOTAL VISITS	YTD
1. Willing to answer								
Yes	161	1601	69	1236	0	1	230	2838
No	33	238	10	180	0	0	43	418
2. Current source of income								
a. Full-time employment	42	418	20	372	0	0	62	790
b. Part-time employment	26	312	20	293	0	1	46	606
c. Child Support	10	131	7	120	0	0	17	251
d. Support from others	36	302	14	302	0	1	50	605
e. Social Security or SSI	14	75	3	53	0	0	17	128
f. No response	5	36	0	17	0	0	5	53
g. Other	54	611	19	329	0	0	73	940
3. Why LBP was chosen								
h. Didn't understand	37	497	12	334	0	0	49	831
i. Decided to self support	30	287	17	332	0	0	47	619
j. Didn't want PROMISE jobs	12	124	8	116	0	0	20	240
k. Other	73	653	27	427	0	1	100	1081

H. Additional Information	2-MONTH VISITS	YTD	4 & 7-MONTH VISITS	YTD	FOLLOW UP VISITS	YTD	TOTAL VISITS	YTD
1. LBP understood before visit								
Yes	126	1229	58	1047	0	0	184	2276
No	53	520	13	288	0	0	66	808
2. LBP understood after visit								
Yes	171	1653	65	1230	0	0	236	2883
No	9	87	6	97	0	0	15	184
3. Concern: fuctioning ability								
Yes	25	137	3	115	0	0	28	2777
No	156	1577	68	1200	0	0	224	904
4. Refer for redetermination								
Yes	53	558	17	346	0	0	70	904
No	129	1150	56	964	0	0	185	2114
5. Concern: well being								
Yes	15	100	6	86	0	0	21	186
No	161	1538	64	1162	0	0	225	2700
6. Client has plan								
Yes	133	1327	52	981	0	0	185	2308
No	42	362	18	305	0	0	60	667
7. Child present for visit								
Yes	99	843	30	635	0	0	129	1478
No	70	746	40	589	0	0	110	1335
8. Basic needs met								
Yes	156	1518	63	1156	0	0	219	2674
No	13	60	5	46	0	0	18	106

APPENDIX E

ANALYSIS OF DATA COLLECTED DURING THE WELL-BEING VISITS

(BOUND SEPARATELY)