HOPE EVALUATION YEAR 1 REPORT

PREPARED FOR HEALTHY OUTCOMES FROM POSITIVE EXPERIENCES (HOPE)

BY TUFTS INTERDISCIPLINARY EVALUATION RESEARCH

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SECTION I: INTRODUCTION

Healthy Outcomes from Positive Experiences (HOPE) Overview

HOPE is a framework built on research that identifies positive experiences in childhood as having mitigating effects on toxic stress and preventive associations with healthier outcomes later in life (Narayan et al., 2018). Through their trainings, HOPE aims to enhance the understanding of these associations among child and family care providers (e.g., physicians, home visitors, and educators) in order to shift the paradigm (i.e., knowledge, beliefs, and application to practice) of care providers from a deficit-based perspective to a strength-based perspective. The HOPE framework comprises the *4 Building Blocks of HOPE*, which include: (1) relationships with the family and with other children and adults through interpersonal activities; (2) safe, equitable, stable environments for living, playing and learning at home and in school; (3) social and civic engagement to develop a sense of belonging and connectedness; and (4) opportunities for social and emotional growth (HOPE, 2021).

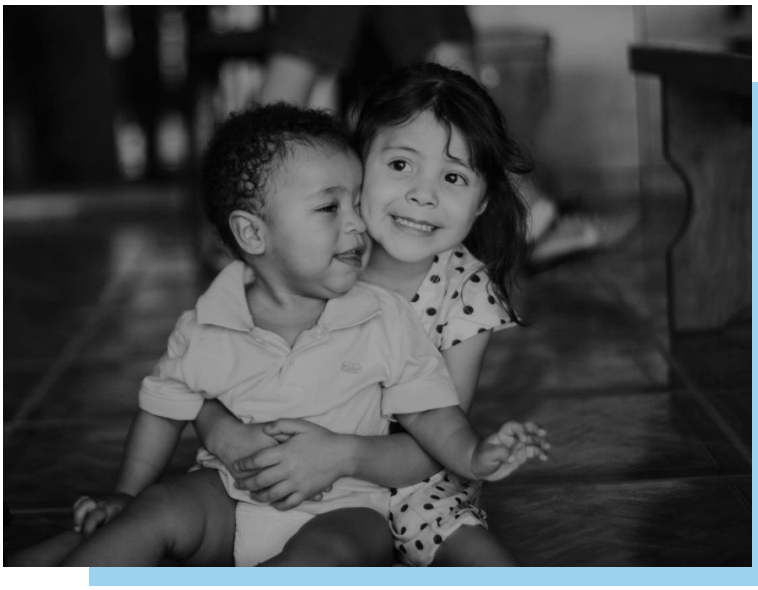
With the goal of shifting the paradigm as described above, HOPE aspires to encourage child and family care providers to appropriate the *4 Building Blocks* to guide their interactions with families. The overarching aim is to counter adverse childhood experiences, recognize child and family strengths, and improve relationships between providers and families. HOPE is not a manualized program with a prescriptive format or timeline; instead, providers are encouraged to use their creativity and knowledge to determine specifically how to apply the 4 Building Blocks in their own practice settings. The HOPE framework reflects a biopsychosocial systems model (Morris & Bronfenbrenner, 2006) that embeds children's development within multiple levels of systems, including the individual child themselves, their families and communities, and the political and cultural climates. In contrast to frameworks that share common elements with HOPE but place their emphasis on the family (e.g., Strengthening Families), community (e.g., Help Me Grow), or policy (e.g., Essentials for Childhood)—HOPE leaders situate HOPE as having a child-centered focus.

HOPE Implementation

HOPE offers a suite of training options that present research on the impact of positive and negative childhood experiences on the brain and behavior, and in the more extensive workshops, address translating the HOPE framework into practice. These trainings are offered in 1-hour, 2-hour, and 4-hour formats, each beginning with a HOPE 101 keynote presentation. HOPE 101 is a review of research findings about adverse childhood experiences (ACEs) and positive childhood experiences (PCEs) that are central to HOPE's framework, including the long-term consequences of ACEs on health, the mitigating effects of PCEs on exposure to ACEs, and the *4 Building Blocks of HOPE*. The 1-hour workshop format introduces some ideas about weaving HOPE principles into attendees' work with families. Their "intermediate" 2- and 4-hour workshop formats allow for more extensive interactive components such as skill-building exercises and small-group brainstorming focused on how to incorporate the HOPE framework into practice. Through its training workshop[1], HOPE leaders aim to educate attendees about ACEs and PCEs, bring about a shift in attendees' mindsets to increase recognition of families as having existing strengths and being capable of building upon those strengths, and foster a change in attendees' professional practice—be it the way they interact with families, modify a client intake form to be more aligned with HOPE tenets, or alter an organizational policy to be more HOPE-informed. In addition to the information presented at the trainings, HOPE provides access to downloadable handouts on their website (such as those highlighting the *4 Building Blocks of HOPE* or a "HOPE-informed checklist for decision-making"); training attendees and organizations may utilize these materials as either guidance for HOPE-informed content development with their organization or as visuals or handouts for families in their workplaces.

[1] Workshops and trainings are used interchangeably throughout the report

In order to learn about how organizations move from training to implementation of HOPE in their practices, HOPE initiated the Hope Innovation Network (HIN), whose regular meetings would inform HOPE about implementation approaches, successes, and challenges, The HIN also was meant to serve as a forum for the generation and mutual sharing of ideas and resources among members; in our view, to serve as a Community of Practice (CoP), a learning and support community where members have shared goals and interests, and who engage in collaborative and ongoing learning.



Evaluating HOPE

Tufts Interdisciplinary Evaluation Research (TIER) conducted a one-year implementation evaluation of HOPE (September 2020–August 2021). An implementation—or process—evaluation emphasizes the description of a program's operations and how those who are receiving the program (in this case, a HOPE training) experience it. Process evaluations have great utility for programs in their early stages, as they offer valuable information meant for practical use; process evaluations also can lead to opportunities for modification of aspects of the program's design and operations (Jacobs & Goldberg, 2007). The decision to conduct an implementation evaluation reflects HOPE's early stage of development as a framework and model for training child and family care providers. The HOPE framework and its applications and dissemination processes continued to evolve correspondent to the conduct of the evaluation. As such, the evaluation incorporated an iterative process whereby evaluation activities were responsive to the emergent ideas and desires of HOPE principals. HOPE's primary modality for disseminating its framework is via a suite of training workshops. Feedback from individual attendees of these workshops using survey methods

comprised a cornerstone of this evaluation, along with in-depth interviews and a focus group with a small group of "early adopters" of the HOPE framework gathered by HOPE principals to form the Hope Innovation Network (HIN) whose role it was to brainstorm ideas and provide feedback about HOPE implementation.

The overarching goals of this evaluation were to: (1) build HOPE's evaluation capacity through the design of pre-and post-measures that could be used for ongoing assessment of HOPE trainings and workshops, (2) assess the effectiveness of HOPE's core training model, (3) describe HOPE implementation processes and perceived effects, and (4) develop and pilot outcome measures for use with providers and families. We began the evaluation process with a thorough review of HOPE materials and approaches, and then developed specific evaluation aims, research questions, and mixed methods design based on this review and in collaboration with HOPE principals. To achieve these goals, TIER employed a mixed methods approach to document five stages of the HOPE training to implementation life cycle during 2020 and 2021; these stages are reflected in our evaluation aims and make up the structure of this report. They include: (*1) Knowledge Acquisition, (2) Planning for Knowledge Application, (3) Implementation, (4) Implementation Innovation and Scaffolding, and (5) Providers' Perceptions of HOPE's Influences*. See Table 1 for evaluation aims, research questions, and evaluation activities.

HOPE's longer-term evaluation goals were focused on potential outcomes of HOPE, particularly on children and families. Though an outcomes-focused evaluation would have been premature based on HOPE's developmental stage as a program, we began the process of developing a pre-post implementation survey targeting parents who were receiving services from a provider implementing a HOPE-Informed enhancement. Initial piloting of the pre-survey is discussed in detail in Appendix D.

Table 1. Summary of Evaluation Aims, HOPE Life Cycle Stage, Research Questions, and Data Sources

Evaluation Aim	Stage of the HOPE Life Cycle	Research Questions	Data Sources
1. Assess the effectiveness of HOPE's primary training model (live events)[2]	Knowledge Acquisition	1. Did HOPE workshop attendees acquire new or advanced knowledge of ACEs and PCEs, and increased confidence addressing these topics in their work?	Provider Pre-Post Workshop Surveys
		2. Were workshop attendees satisfied with the training? Did they find it relevant and effective?	
2. Assess whether HOPE training workshops prepare attendees to create HOPE-informed changes in their work with families	Plans for Knowledge Application	1. Did workshop attendees exhibit knowledge of, and confidence in using, HOPE-related concepts three months post-workshop?	Provider Three-Month Follow Up Survey
		2. Did the HOPE workshop influence attendees' way of thinking about how they work with families?	Provider Post-Workshop Surveys
		3. Did workshop attendees acquire skills to apply HOPE-informed changes in their work?	
		4. Did workshop attendees intend to implement any changes in their work after the training?	
		5. Did workshop attendees develop specific implementation ideas during their workshop participation?	
		6. Were those who make decisions about organization-wide changes in practice, programming, and policy present at HOPE workshops, along with direct service providers?	
3. Describe HOPE implementation across a range of organizations	Implementation	1. What did HOPE look like in practice when being implemented across a range of organizations?	Provider Three-Month Follow-Up Survey
		2. How do individuals and organizations describe the HOPE-informed changes they have made in their practice?	Provider interviews and focus groups
		3. What barriers did organizations and providers encounter as they tried to create and implement HOPE enhancements?	Provider Three-Month Follow-Up Survey

[2] Due to COVID-19 restrictions, HOPE's "live" training events were synchronous virtual events, not in-person training events.

Evaluation Aim	Stage of the HOPE life cycle	Research questions	Data Sources
4. Describe the inaugural HOPE Innovation Network (HIN) and its effectiveness in supporting organizations who aim to implement a HOPE enhancement	Implementation Innovation and Scaffolding	1. What did HIN members find valuable about their HIN participation?	Observations of HIN meetings
		2. How did participation in the HIN assist its members in moving forward with and sustaining HOPE implementation?	Interviews and focus group with providers and administrators who participated in the inaugural HIN
		3. In what ways could the HIN be improved?	
5. Identify the perceived influences of implementing HOPE on families and providers	Providers' Perceptions of HOPE's Influences	1. Did providers who implemented a HOPE-informed change in practice perceive any changes among parents or providers?	Provider Three-Month Follow-Up Survey
			Provider interviews and focus groups

Report Organization

This report begins with an overview of methods, followed by findings, organized by evaluation aim. Each findings section includes the analytic sample(s) used to answer that set of research questions, data sources employed, and a brief conclusion for that particular evaluation aim. The report ends with overall conclusions and recommendations.

SECTION II: METHOD

As described above and outlined in Table 1, we employed a mixed methods design for this evaluation. Primary data collection activities included provider Pre-and Post-Workshop Surveys, Provider Three-Month Follow-Up Surveys, and interviews and focus groups. We also used extant tracking data collected by HOPE to determine the number of trainings and workshops delivered between January 2020 and July 2021. We describe data collection activities here, beginning with a brief summary of the HOPE tracking data. This study was approved by the Tufts Institutional Review Board.

HOPE's Internal Tracking of its Trainings and Presentations[3]

HOPE manually tracked select details of the training workshops they delivered between January 2020 and July 2021. In order to document the total number of attendees at HOPE training workshops and other events, TIER conducted descriptive analysis (i.e., frequencies) of these data. During this 19-month period, HOPE hosted or participated in 66 HOPE training workshops and

[3] As part of the evaluation, TIER assisted HOPE with tracking its trainings that had taken place from January 2020—July 2021. We present information on this task here, but it was not related to an evaluation aim or research question.

other types of events, such as panel discussions. Of the 66 events, 27 were 1-hour workshops or keynote addresses,[4] 22 were 2-hour workshops, six were 4-hour workshops, two were panel discussions, two were webinars, and eight events were not categorized as a specific type. In total, 12,262 individuals[5] from across the United States attended events at which HOPE leaders were present and the HOPE framework and/or the research behind the development of the HOPE framework were discussed. HOPE's three training workshop formats—1-hour, 2-hour, and 4-hour—were typically attended by providers from one organization or more than one affiliated organization. Organizations that attended a HOPE workshop reported to HOPE the sectors they anticipated attendees would be from; the most frequently reported sectors were early childhood education (14 workshops), substance use prevention (10 workshops), and education (7 workshops).[6]

[4] HOPE leaders describe the central HOPE content—encompassing the research behind HOPE and an overview of the HOPE framework—as HOPE 101. The content of a HOPE 1-hour training workshop and a HOPE keynote address are the same, but the latter typically occurs in the context of a conference at which HOPE is not the only focus.
[5] Some individuals attended more than one event; this information was not tracked by HOPE.
[6] Some workshops were attended by providers from several sectors.

Provider Pre-, Post-,[7] and Three-Month Follow-Up Workshop Surveys

To build HOPE's internal evaluation capacity, our team developed Provider Pre-and Post-Workshop Surveys, and Provider Three-Month Follow-Up Surveys. These surveys were used in this evaluation to assess knowledge gains and plans for implementation among attendees, and can be used by HOPE for ongoing monitoring and evaluation of training effectiveness. The surveys were designed to be completed by providers who attended HOPE's 1-, 2-, or 4-hour training workshops, and not by those who attended other types of events at which HOPE was presenting (e.g., panel discussions). Our development of these surveys was an iterative process; we periodically reviewed survey results and modified or added new survey items as our understanding of HOPE's goals evolved. The Pre-and Post-Workshop Surveys and Three-Month Follow-Up Surveys are described below, followed by distribution procedures for each.

Survey Descriptions

As mentioned above, and as will be described in more detail below, there were several iterations of the Pre-Post Workshop Surveys. In the following sections, we describe the final versions of each. For Pre-and Post Workshop Surveys and Three-Month Follow-Up Surveys, see Appendices A and B, respectively.[8]

Pre- and Post-Workshop Survey Description

Background and Demographic Characteristics. The Pre-Workshop Survey asked attendees about their job characteristics, including role, sector, and years of experience; race, ethnicity, and state they work in; and training information, including how they learned about the workshop, and whether it was mandatory.

[7] Throughout the report, we refer to "Provider Pre and Post Workshop Surveys" as either "pre-post workshop surveys," "Pre-Workshop Survey(s)," or "Post-Workshop Survey(s)".
[8] The versions of the pre-post workshop surveys in the appendices are the final versions, not the previous iterations of the surveys.

Knowledge Acquisition. To determine the extent to which attendees appeared to gain knowledge about key HOPE concepts, we asked about their perceived understanding and confidence, and then asked them to demonstrate their understanding.

- *Perceived understanding and confidence.* We asked respondents to rate their agreement with the following statements on both the Pre-and the Post-Workshop Surveys: *(1) I have a good understanding of how Adverse Childhood Experiences (ACEs; e.g., child abuse and neglect, parental mental illness, & parental substance abuse) influence development;* (2) I have a good understanding of how Positive Childhood Experiences (PCEs; e.g., feeling able to talk with their family about their feelings; feeling safe and protected by an adult at home; feeling supported by friends) influence development; and (3) provider confidence with incorporating discussions of PCEs into their work (e.g., I feel confident that I know how to incorporate discussions about PCEs in my work with families). For each of these items, responses were recorded on a VAS of 0 to 100, where higher scores indicated greater understanding and greater confidence, respectively.
- *Demonstrated understanding of HOPE concepts.* To assess attendees' ability to apply the HOPE concepts taught during the training to practical situations involving families, we presented them with three challenging scenarios that direct service providers may encounter and asked them to choose which of three options most aligned with the HOPE framework. These multiple-choice questions were only asked on the Post-Workshop Survey.

Attendance and Training Satisfaction. Questions related to attendance and satisfaction were asked only on the Post-Workshop Survey. To assess training attendance, we asked workshop attendees how much of the workshop they had attended (i.e., not at all, less than half, about half, all). To assess satisfaction, we asked attendees about: (1) the relevance of the HOPE training to their work; (2) the effectiveness of the learning modes used during the workshop (e.g., Zoom breakout rooms, chat boxes); and (3) the extent to which they learned concrete ways to incorporate HOPE into their work. Responses for these three items were recorded using a visual analog scale (VAS) of 0 to 100, where higher scores indicated greater agreement.

Acquisition of Implementation Skills. To understand whether attendees perceived themselves as able to translate any knowledge they acquired during the HOPE training to their work with families, we asked two questions on the Post-Workshop Survey. Respondents rated the extent to which they learned from the HOPE training specific ways to translate what is known about ACEs and PCEs into their work with families. Responses ranged on a Likert scale from 1 = *strongly disagree* to 5 = *strongly agree*, where higher scores indicated greater agreement.

Intention to Implement HOPE-Informed Changes. We also asked attendees to report their likelihood of taking action to incorporate HOPE concepts in their work with families following the training. On a Likert scale of 1 = *not at all likely to* 5 = *very likely*, where higher scores indicated a greater likelihood, respondents rated whether they would: (1) have conversations with colleagues about the degree to which their work incorporates the HOPE framework, (2) evaluate the tools they already use in their work for alignment with HOPE principles, and (3) adjust the way that they or direct services staff in their organization interact with families so that their approaches are better aligned with HOPE principles.

Pre-Existing Implementation Plan. To understand whether attendees perceived they would implement what they learned at the HOPE training, we asked one question on the Post-Workshop Survey: Do you have an idea in mind about how you will take what you learned during this HOPE workshop and create a HOPE-informed change or enhancement in your work with families?

Three-Month Follow-Up Survey Description

For providers who attended a 1-, 2-, or 4-hour HOPE training, we created a Three-Month Follow-Up survey to: (1) assess their knowledge of the HOPE principles three months post-training, (2) determine whether they made a HOPE-informed change since receiving training, (3) characterize the type of HOPE-informed changes they made, and (4) identify potential barriers to implementing a HOPE-informed change they encountered. In addition, we asked any providers who indicated they had begun implementing a HOPE-informed change in their work to report on perceived effects of their interactions with families and staff members' reactions to the change.

Perceived Knowledge and Confidence Across Time Points. To assess attendees' knowledge about HOPE-related concepts three months post-workshop, we asked attendees to select the best or closest representation of what HOPE is from a list of three choices. We also asked them to rate, as they did on the Pre-and Post-Workshop Surveys, their understanding of how ACEs and PCEs influence development and their level of confidence in knowing how to incorporate PCEs in their work with families. For each of these items, responses were recorded on a VAS of 0 to 100, where higher scores indicated greater understanding and greater confidence, respectively

Changes Implemented. To assess comprehension of the HOPE framework three months after training and ensure that workshop attendees responded to implementation questions about HOPE rather than a different program, we constructed several multiple-choice questions. We asked respondents to select the *best or closest representation of what HOPE is*. To learn whether workshop attendees had implemented any HOPE-informed changes in their work with families, we asked—*Have you implemented a HOPE-informed change in your work?* When respondents answered "no," we asked them whether they

planned to implement a HOPE-informed change in their work and if they said "yes," we asked whether they *set a goal date* to do so. When respondents answered "yes," we asked them: (1) to provide a description (i.e., open-ended response) of the HOPE-informed change they have implemented, (2) how they would rate the level of difficulty (i.e., 1 = *very easy* to 6 = *very difficult*) of the process of implementing the HOPE-informed change, and (3) how they think the families with whom they work are reacting to the HOPE-informed change they have implemented (i.e., *do not notice much of a difference, I am not sure whether there is a difference, I have noticed an improvement, I do not work directly with families*). Using a multiple-choice question, respondents chose a description of what most accurately describes how often they have integrated a HOPE-informed change into their work (i.e., *tried it, implemented it a few times, incorporated it into regular practice*).

Reception to HOPE-Informed Change and Identification of Potential Barriers. We asked respondents to provide examples (i.e., open-ended responses) of how both staff members at their organizations and the families they work with responded to the HOPE-informed change they have suggested or tried to implement. We also asked respondents to select barriers that they have faced, if any, when trying to integrate HOPE principles into their work (e.g., *haven't had time to decide how to implement HOPE, lack of tools, don't remember HOPE principles*). Finally, we asked respondents to describe (i.e., open-ended responses) what would help them implement or continue implementing HOPE into their work with families and what they needed to move forward with HOPE implementation practices.

Survey Distribution

During the Pre-and Post-Workshop Survey data collection period of February 2, 2021 through July 15, 2021, HOPE conducted 19 workshops. With the assistance of TIER, HOPE distributed web-based Pre-, Post-, and/or Three-Month Follow-Up Surveys to attendees from 13 of those 19 workshops,[9] and a Three-Month Follow-Up Survey to attendees from one workshop that occurred prior to the data collection period, for a total of 14 workshops in the final sample.

Surveys were distributed electronically, as follows: Pre-Workshop Surveys were distributed via a link provided to attendees in the chat box at the start of the workshop or via email sent prior to the workshop date; links to the Post-Workshop Survey were provided in the chat box at the end of the workshop and/or emailed immediately after the workshop, with several reminders sent to

[9] For the six workshops that were not included in this sample, the host organization either 1) had their own internal evaluation surveys, or 2) declined HOPE's distribution of the surveys for other reasons.

attendees within the two weeks attendees were given to respond; and links to the Three-Month-Follow-Up Survey were provided via email, again with multiple reminders sent to attendees during the two-week window within which they could respond.

Data Collection Phases

There were two phases of data collection. In Phase 1, a pilot phase, Pre-and Post-Workshop Surveys were distributed anonymously to attendees. In Phase 2, only attendees who completed a Pre-Workshop Survey were invited to complete a Post-Workshop Survey. The Three-Month Follow-Up Survey was sent to attendees who had participated in Phase 1 data collection, and to all attendees who had attended the one workshop that occurred prior to the start of the pre-post data collection.

Survey Versions

As mentioned above, these surveys were developed using an iterative process, resulting in three different versions of the Pre-and Post-Workshop Surveys used at various points over the data collection period, as follows:

- *Version 1* was sent to attendees of the four workshops conducted between February 1st, 2021, and March 19th, 2021. After administration, we realized that three of the knowledge acquisition questions were double-barreled[10] (e.g., I know a lot about Adverse Childhood Experiences (ACEs) and how they influence development). Whenever we used data from this version of the pre-post surveys, we excluded the answers from these three questions in our analyses.[11]
- *Version 2,* which was sent to attendees of the five workshops conducted between March 20th, 2021 and May 25th, 2021, included the corrected version of these three *knowledge acquisition* questions.
- *Version 3,* which was sent to attendees of the three workshops conducted between May 26th, 2021 and July 15th, 2021 contained seven additional questions, which asked respondents: (1) whether they learned specific ways to translate what is known about ACEs and PCEs into their work with families, (2) how the information presented during the workshop influenced them to rethink the way that they or their organization works with families or individuals, (3) whether

[10] A survey item is referred to as double-barreled when it assesses more than one construct, and it cannot be determined which construct respondents were referring to when selecting their response.
[11] The double-barreled versions of the perceived understanding questions in Version 1 of the survey were: (1) I know a lot about Adverse Childhood Experiences (ACEs) and how they influence development, (2) I know a lot about Positive Childhood Experiences (PCEs) and how they influence development. The perceived confidence question was not double-barreled but was different than the version on the final survey; the question was I feel confident incorporating a strengths-based framework into my work.

they developed a HOPE-informed change during the workshop, (4) whether they have what they need to return to work and implement this HOPE informed change, (5) if they obtained what they needed to implement this HOPE-informed change from the workshop, (6) what they need to implement their HOPE informed change if they do not currently have it, and (7) if the people who make decisions about program, practice, or policy changes at their organization attended the workshop or another HOPE workshop. Version 3 no longer asked respondents if they learned concrete ways to incorporate HOPE into their work. The Pre-Workshop Survey was also revised to ask respondents their race and ethnicity.

Survey Samples

See Table 2 for workshops and response rates for all survey types. We administered Pre-and Post-Workshop Surveys to attendees from 13 workshops, and administered the Three-Month Follow-Up Survey to attendees of five workshops, four of which were included in the Phase 1 data collection, and one of which occurred prior to the Pre-and Post-Workshop Survey data collection period.[12]

Overall, 59.4% (n = 805) of attendees completed a provider Pre-Workshop Survey, and 36.2% (n = 491) completed a Post-Workshop Survey. Two-thirds of attendees (n = 890; 65.7%) from which we collected Pre-and/or Post-Workshop Surveys attended 1-hour workshops, 28.9% (n = 392) attended 2-hour workshops, and only 5.4% (n = 73) attended 4-hour workshops. While the overall response rate for the pre-post-workshop survey was relatively high, only 12.8% of the 390 we invited to complete the Three-Month Follow-Up Survey responded.

[12] We selected these five workshops because they had occurred early enough in the data collection period for at least three months to have elapsed since the workshop date.

Table 2. Workshop Attendees and Response Rates for Pre-, Post-, and Three-Month Follow-Up Surveys, by Workshop Characteristics, Survey Versions and Samples[13]

Format	Name	Attendees *n*	Pre- *n* (%)	Post- *n* (%)	Attendees Who Were Sent Three-Month Follow-up Survey *n*	Three-Month Follow-Up *n* (%)
1-Hour	United Way Stephen's Point[P1,V1]	20	6 (30.0%)	7 (35.0%)	n/a	n/a
	Building Healthier Communities - Leadership Workshop[P1,V1]	41	23 (56.1%)	11 (26.8%)	23	2 (8.7%)
	Pennsylvania Early Intervention[P1,V2]	187	163 (87.2%)	101 (54.0%)	n/a	n/a
	Georgia Brains for Babies[P1,V2]	300	141 (47.0%)	104 (34.7%)	141	14 (9.9%)
	Massachusetts Department of Mental Health[P1,V2]	67	59 (88.1%)	37 (55.2%)	n/a	n/a
	Pennsylvania Parents as Teachers[P1,V2]	275	60 (21.8%)	72 (26.2%)	n/a	n/a
	Subtotal	**890**	**452 (50.8%)**	**332 (37.3%)**	**163**	**16 (9.8%)**
2-Hour	Nemours/Better Together[P1,V1]	10	9 (90.0%)	6 (60.0%)	9	3 (33.3%)
	Building Healthier Communities[P1,V1]	95	67(70.5%)	37 (38.9%)	67	9 (13.4%)
	Riverside University Health System[P2,V3]	116	71 (61.2%)	17 (14.7%)	n/a	n/a
	Davis County Health Department[P2,V3]	141	141 (100.0%)	60 (42.6%)	n/a	n/a
	Parents as Teachers[P2,V3]	30	24 (80.0%)	15 (50.0%)	n/a	n/a
	Subtotal	**392**	**312 (79.6%)**	**135 (34.4%)**	**73**	**12 (16.4%)**
4-Hour	Great Start Michigan[3M]	150	n/a	n/a	150	22 (14.7%)
	United Way of Southeast Michigan[P2,V2]	38	24 (63.2%)	16 (42.1%)	n/a	n/a
	Family Promise of Barry County[P2,V3]	35	17 (48.6%)	8 (22.9%)	n/a	n/a
	Subtotal	**73**	**44 (56.2%)**	**24 (32.9%)**	**150**	**22 (14.7%)**
Total		**1,355**	**808 (59.4%)**	**491 (36.2%)**	**390**	**50 (12.8%)**

Note. [P1]indicates Phase 1 sample; [P2]indicates Phase 2 sample; [V1]indicates attendees were administered Survey Version 1; [V2]indicates attendees were administered Survey Version 2; and [V3]indicates attendees were administered Survey Version 3.

[13] We conducted chi-square analyses to determine whether there were differences in respondents who completed only Pre-Workshop Surveys versus those who completed both Pre-and Post-Workshop Surveys, by their background characteristic (i.e., number of years in field, sector in which they work, whether respondent provided direct vs. indirect services to families).

Quantitative Analytic Plan[14]

All analyses were conducted in SPSS (IBM Corp, 2020). For all analyses, statistical significance was defined as $p < .05$. Levene's Test for Equality of Variances was computed for each independent samples t-tests and one-way analysis of variance (ANOVA). When the assumption of equality of variances was violated, the appropriate t-or F-test was reported. Cohen's *d* was calculated to determine the practical significance of any significant mean difference, where a $d < .20$ indicated a small effect, a $d < .50$ indicated a medium effect, and a $d < .80$ indicated a large effect (Cohen, 1988). Below we describe the analytic strategies used to address each of the evaluation aims.

Analytic Methods, by Evaluation Aim

See Table 3 for evaluation aims, research questions, data sources and samples, and statistics.

Aim 1: Assess the Effectiveness of HOPE's Primary Training Model (Live Events)

To compare attendees' knowledge and confidence scores pre-and post-workshop, we conducted independent or paired samples t-tests. For Phase 2 respondents only (i.e., matched sample) we examined the magnitude of change in knowledge and confidence by subtracting respondents' pre-workshop scores from their post-workshop scores, with positive difference scores indicating an increase in knowledge or confidence. Finally, we ran frequencies to describe whether attendees were able to demonstrate understanding of the HOPE approach, and whether they were satisfied with the training overall.

Aim 2: Assess Whether HOPE Training Workshops Prepare Attendees to Create HOPE-Informed Changes in Their Work with Families

We conducted descriptive analyses on responses from the Three-Month Follow-Up Survey and the post-workshop survey to learn whether HOPE workshop attendees who participated in HOPE training appeared to understand key HOPE-related concepts, were confident in their abilities to use these concepts in their work with families, were influenced by the training to think about families more positively, and had ideas about how to implement HOPE into their practice.

[14] For the qualitative analytic plan, see following section.

Aim 3: Describe HOPE Implementation Across a Range of Organizations

We used both quantitative and qualitative data to understand how workshop attendees appear to have incorporated HOPE into their own work. For the quantitative component, we conducted descriptive analyses of Three-Month Follow-Up Survey responses pertaining to whether respondents had made any HOPE-informed changes, the types of changes they were making, and what barriers, if any, they have encountered during the implementation process.

Aim 4: Describe the Inaugural HOPE Innovation Network (HIN) and Its Effectiveness in Supporting Organizations That Aim to Implement a HOPE Enhancement

We use only qualitative data to address this aim.

Aim 5: Identify the Perceived Influences of Implementing HOPE on Families and Providers

We largely used qualitative data to address this aim. Quantitative data were drawn from one question on the Three-Month Follow-Up Survey, for which we conducted descriptive analyses.

Table 3. Evaluation Aims, Research Questions, Data Sources and Samples, and Statistical Tests

Evaluation Question and Construct		Data Collection Phase 1					Data Collection Phase 2				Statistical Test
		Survey Version 1		Survey Version 2		3-month	Survey Version 2		Survey Version 3		
		pre (*n*=105)	post (*n*=61)	pre (*n*=423)	post (*n*=314)	(*n*=50)	pre (*n*=24)	post (*n*=16)	pre (*n*=253)	post (*n*=100)	
Aim 1: Assess the effectiveness of HOPE's primary training model (live events)											
1. Did HOPE workshop attendees acquire new or advanced knowledge of ACEs and PCEs, and increased confidence addressing these topics in their work?	*Perceived understanding and confidence*			x	x						Ind. *t*-tests
							x	x	x	x	Paired *t*-tests
	Differences in change magnitude						x	x	x	x	ANOVA
	Demonstrated understanding		x		x			x		x	Freq
2. Were workshop attendees satisfied with the training? Did they find it relevant and effective?			x		x			x		x	Freq
Aim 2: Assess whether HOPE training workshops prepare attendees to create HOPE-informed changes in their work with families											
1. Did workshop attendees exhibit knowledge of, and confidence in using, HOPE-related concepts three months post-workshop?	*Perceived understanding and confidence*					x					*M* and *SD*
	Demonstrated understanding					x					Freq
	Knowledge and confidence across timepoints			x	x	x	x	x	x	x	*M* and *SD*
2. Did the workshop influence attendees' way of thinking about how they work with families?										x	Freq
3. Did workshop attendees acquire skills to apply HOPE-informed changes in their work?										x	Freq
4. Did workshop attendees intend to implement any changes in their work after the training?			x		x			x		x	Freq and Paired *t*-tests
5. Did workshop attendees develop specific implementation ideas during their workshop participation?										x	Freq

Evaluation Question and Construct		Data Collection Phase 1					Data Collection Phase 2				Statistical Test
		Survey Version 1		Survey Version 2		3-month (*n*=50)	Survey Version 2		Survey Version 3		
		pre (*n*=105)	post (*n*=61)	pre (*n*=423)	post (*n*=314)		pre (*n*=24)	post (*n*=16)	pre (*n*=253)	post (*n*=100)	
6. Were those who make decisions about organization-wide changes in practice, programming, and policy present at workshops, along with direct service providers?										x	Freq
Aim 3. Describe HOPE implementation across a range of organizations											
1. What did HOPE look like in practice when being implemented across a range of organizations?						x					Freq
2. How do individuals and organizations describe the HOPE-informed changes they have made in their practice?		n/a—qualitative data only									
3. What barriers did organizations and providers encounter as they tried to create and implement HOPE enhancements?						x					Freq
Aim 4. Describe the inaugural HOPE Innovation Network (HIN) and its effectiveness in supporting organizations											
1. What did HIN members find valuable about their HIN participation?		n/a— qualitative data only									
2. How did participation in the HIN assist its members in moving forward with and sustaining HOPE implementation?		n/a—qualitative data only									
3. In what ways could the HIN be improved?		n/a—qualitative data only									
Aim 5. Identify the perceived influences of implementing HOPE on families											
1. Did providers who implemented a HOPE-informed change in practice perceive any changes among parents or providers?	*Reactions of families, children, and parents*					x					Freq
	Reactions of providers	n/a qualitative data only									

Note: Freq = frequencies; Ind. *t*-tests = independent sample *t*-tests; Paired *t*-tests = paired sample *t*-tests; *M* and *SD* = means and standard deviations

Provider Interviews and Focus Groups

We conducted interviews and an intra-organization focus group with providers who had received HOPE training. Our intent was: (1) to learn what HOPE-informed enhancements providers had created or were implementing,(2) to assess providers' experiences participating in the HOPE Innovation Network (HIN), and (3) to identify potential impacts of HOPE by interviewing[15] providers who use programs that have components that overlap with HOPE.

We conducted semi-structured interviews and focus groups with 11 individuals, with the aim of distinguishing the ways that HOPE has been adapted and implemented at their respective organizations. Interview topics included HOPE training history, motivations and goals for adapting HOPE, details of the HOPE enhancement, implementation successes and challenges, perceived changes related to the HOPE enhancement, and experiences participating in the HIN. Interview and focus group participants included two pediatricians; a pediatrician's intern; a program manager of a home visiting program; two administrators of child maltreatment prevention agencies; an administrator of a childcare resource service; and coordinators, a consultant, and an evaluator of a community-based substance use prevention organization.

Qualitative Data Analytic Strategy

Interview and focus group data were transcribed and coded using NVivo. We identified themes as we organized the data by the stages of the HOPE life cycle (e.g., training, implementation). Examples of themes that describe aspects of HOPE enhancements include descriptions of the provider's orientation when enacting the HOPE enhancement (i.e., is the provider making a behavioral or a cognitive shift when they enact the enhancement?), descriptions of the intention of the enhancement (i.e., to make a behavioral or cognitive impact on families), and facilitators

[15] When we refer to "interviewing" we use that term to refer to qualitative data collection both one-on-one (interviews) and in a group setting (focus group).

of and barriers to implementation. In addition to descriptive categorizing of the HIN data, coding themes centered around components of a Community of Practice (Wenger, 1998). Open-ended data from pre-post workshop surveys and Three-Month Follow-Up Surveys were coded thematically rather than according to question; for example, if a survey respondent noted a barrier to implementation in response to a question about how a parent responded to a HOPE-informed change the respondent had made, we coded the response in terms of the type of barrier it represented.

SECTION III: FINDINGS

This section begins with a description of the respondent sample, and then moves to evaluation findings. We present the findings by evaluation aim; each evaluation aim section begins with a table depicting the evaluation aim, research questions, and data sources, and ends with brief conclusions and/or recommendations for that particular aim. The sections are organized to mirror the chronology of the HOPE life cycle. We begin with education about the HOPE framework (i.e., HOPE training workshops), then provide an overview of the period during which training attendees attempt to conceptualize and begin to implement a HOPE-informed enhancement to their program or practice, and end with a description of those enhancements (i.e., HOPE implementation). We then discuss potential effects of HOPE-informed enhancements and conclude with recommendations for strengthening the HOPE training model and framework.

Respondent Sample

The descriptive information presented here is drawn from the Pre-Workshop Surveys administered to all training attendees.

Job Characteristics

Role and Sector

We asked attendees about whether they provided direct service to families; of respondents who answered this question (n = 701), the majority (68.1%) reported that they do provide direct services to families in their role.

Respondents selected their role and sector from a list of options. We coded sectors into four categories: *healthcare* (e.g., hospitals substance use treatment, early intervention programs, and mental health); *education* (e.g., early childhood education, after school care, elementary education, secondary education, and higher education); *community /family support* (e.g., home visiting, community-based family support services, community outreach/engagement, public benefit programs, youth recreation); and *child welfare/juvenile justice* (e.g., child protective services, law enforcement, legal services). As shown in Table 4, more than a third of respondents worked in the community/family support sector, around a quarter in the education sector, and a little less than one-fifth worked in the healthcare and child welfare/juvenile justice sectors. Table 4 also shows the distribution of roles across sectors; the largest group of respondents were either administrators or supervisors/coordinators, who together represented more than one-third (35.3%) of the sample. Social workers, home visitors, and counselors were the next biggest group, comprising 28.7% of the sample.

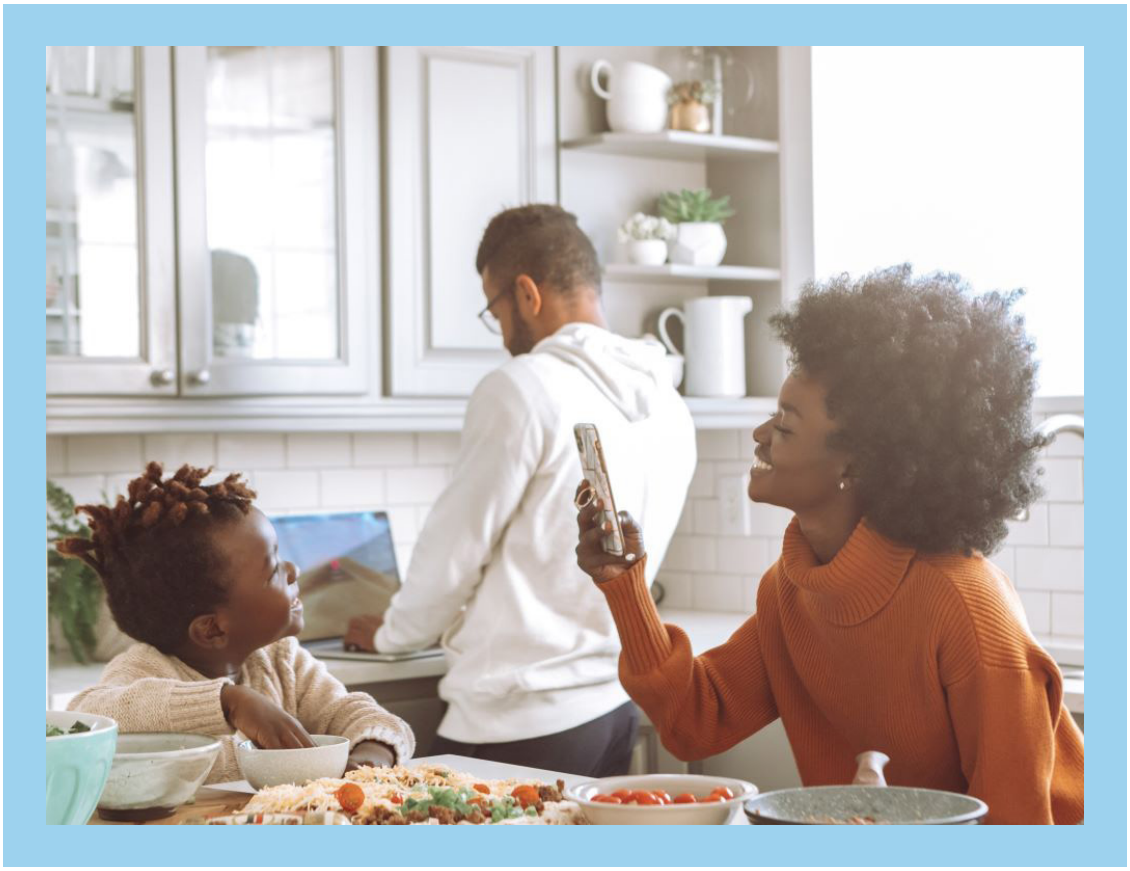


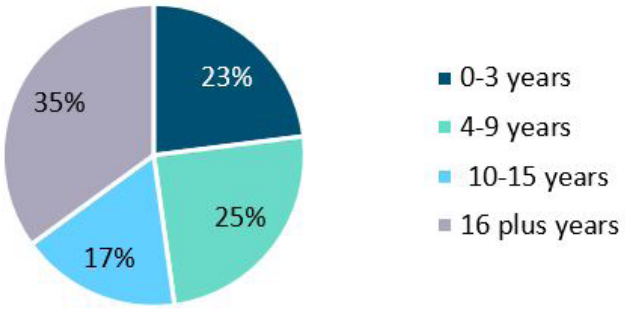
Table 4. Frequency of Respondent Role by Sector (n = 686)

			Sector			
Role	***n***	**%**	**Healthcare**	**Education**	**Community/ Family Support**	**Child Welfare/ Juvenile Justice**
Administrative Staff (e.g., administrative assistant)	**18**	**2.6%**	3	7	4	4
Administrator (e.g., director/program manager)	**149**	**21.7%**	27	42	58	22
Applied behavioral analyst/ABA/BCBA Provider	**1**	**0.1%**	0	1	0	0
Attorney	**1**	**0.1%**	0	0	1	0
Child or Family Advocate/Guardian Ad litem	**11**	**1.6%**	0	0	6	5
Community Engagement and Prevention Specialist	**25**	**3.6%**	5	2	18	0
Consultant/Advisor	**18**	**2.6%**	1	15	0	2
Counselor/Therapist	**57**	**8.3%**	25	5	16	11
Developmental Specialist	**7**	**1.0%**	4	3	0	0
Family Support Provider	**24**	**3.5%**	0	9	10	5
Foster Parent/Therapeutic Foster Parent	**7**	**1.0%**	0	0	1	6
Home Visitor	**64**	**9.3%**	2	2	59	1
Law Enforcement Officer	**2**	**0.3%**	1	0	0	1
Nurse	**30**	**4.4%**	9	1	19	1
Nurse Home Visitor	**2**	**0.3%**	1	0	1	0
Occupational Therapist	**14**	**2.0%**	8	5	1	0
Other (please specify)	**4**	**0.6%**	0	2	1	1
Out of Schooltime Educator (e.g., YMCA)	**1**	**0.1%**	0	1	0	0
Physical Therapist	**2**	**0.3%**	1	1	0	0
Physician	**1**	**0.1%**	1	0	0	0
Physician's Assistant/Nurse Practitioner	**3**	**0.4%**	2	1	0	0
Psychologist	**12**	**1.7%**	3	1	0	8
Religious Leader	**1**	**0.1%**	0	0	1	0
Researcher/Evaluator	**13**	**1.9%**	3	4	2	4
Social Worker/Caseworker	**76**	**11.1%**	9	11	18	38
Speech-Language Pathologist	**3**	**0.4%**	1	2	0	0
Student	**10**	**1.5%**	1	6	3	0
Supervisor/Coordinator	**93**	**13.6%**	18	27	31	17
Teacher	**20**	**2.9%**	0	12	7	1
Trainer/Technical Assistance Provider/Coach	**17**	**2.5%**	1	9	5	2
Total	**686**	**--**	**126 (18.3%)**	**169 (24.6%)**	**262 (38.2%)**	**129 (18.8%)**

Years of Experience

We asked attendees how many years they had worked in their current field. As seen in Figure 1., respondents were relatively experienced in their fields, with more than half (52.2%) having worked for at least ten years.

Figure 1. Years of Work Experience in Current Field (n =795)



Race, Ethnicity, and Geographic Distribution of Respondents

Race and Ethnicity

As seen in Table 5, the vast majority of attendees were White, non-Hispanic, and worked in the United States.

Table 5. Survey Respondent Race and Ethnicity, and Work Location

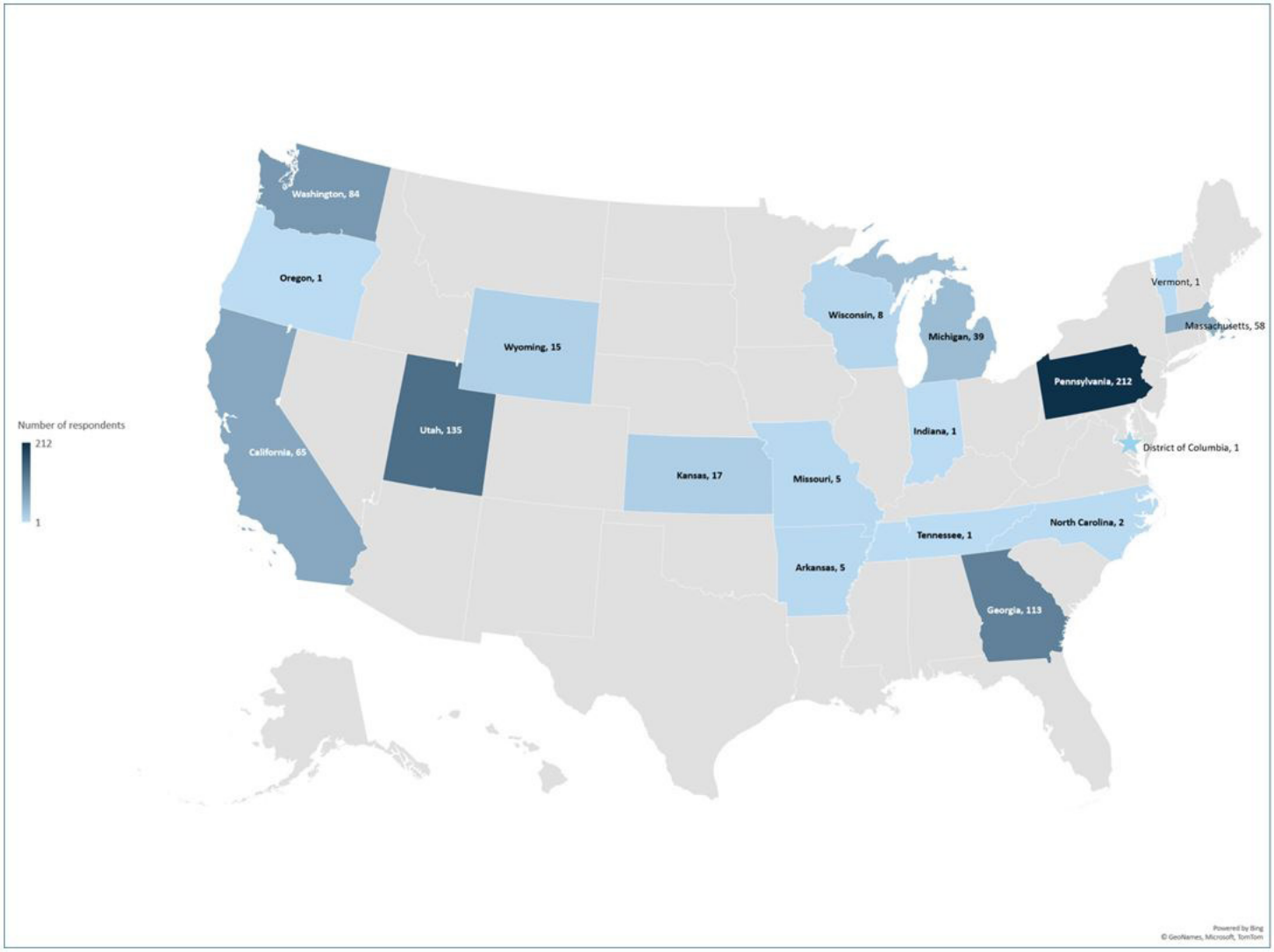
Characteristics		n	%
Race	White	174	87.9%
	Asian		4.6%
	Black or African American		3.4%
	Native Hawaiian or Other Pacific Islander		2.3%
	American Indian or Alaska Native		1.7%
Ethnicity	Non-Hispanic	170	90%
	Hispanic		10%
Work in the US	Yes	802	99.8%
	No		1.2%

Note. Race and ethnicity data were only collected on survey versions 2 and 3.

Geographic Distribution

Across all workshops, respondents represented 17 states plus the District of Columbia, with most attendees located in Pennsylvania, Utah, Georgia, Washington, and California (see Figure 2).

Figure 2. Geographic Distribution of Respondents (n = 763)



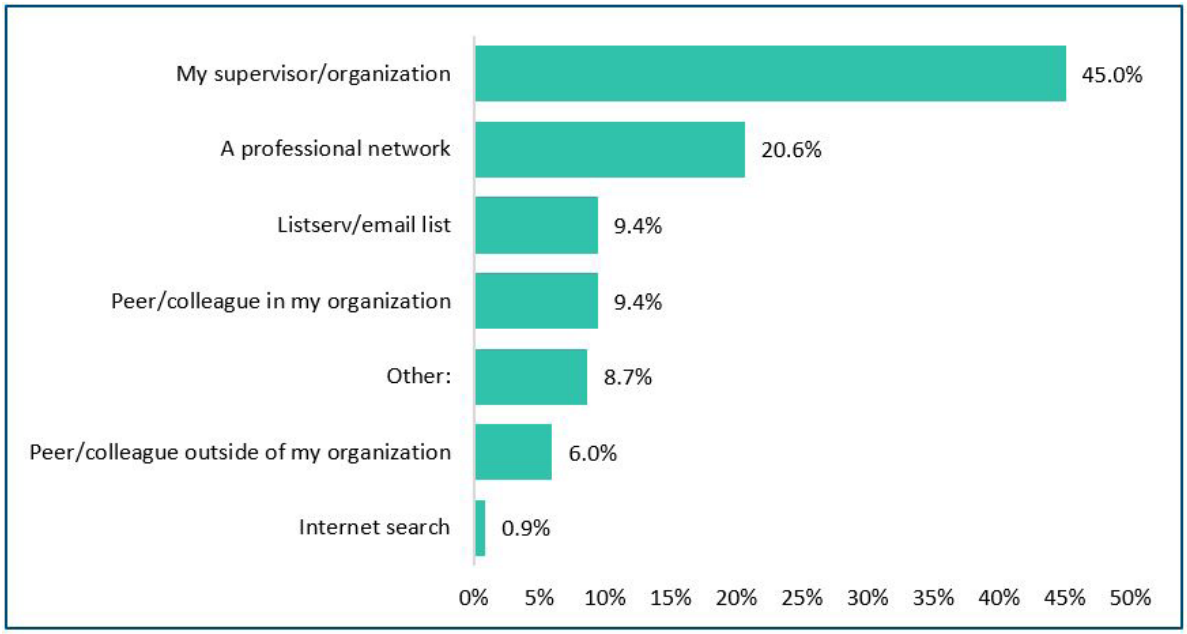
Information about Training

Finally, we asked attendees how they had learned about the HOPE workshop, and whether their workplace had made attendance of the training mandatory.

Learned About Workshop

As shown in Figure 3, most respondents had learned about HOPE from their supervisor or organization, followed by a professional network.

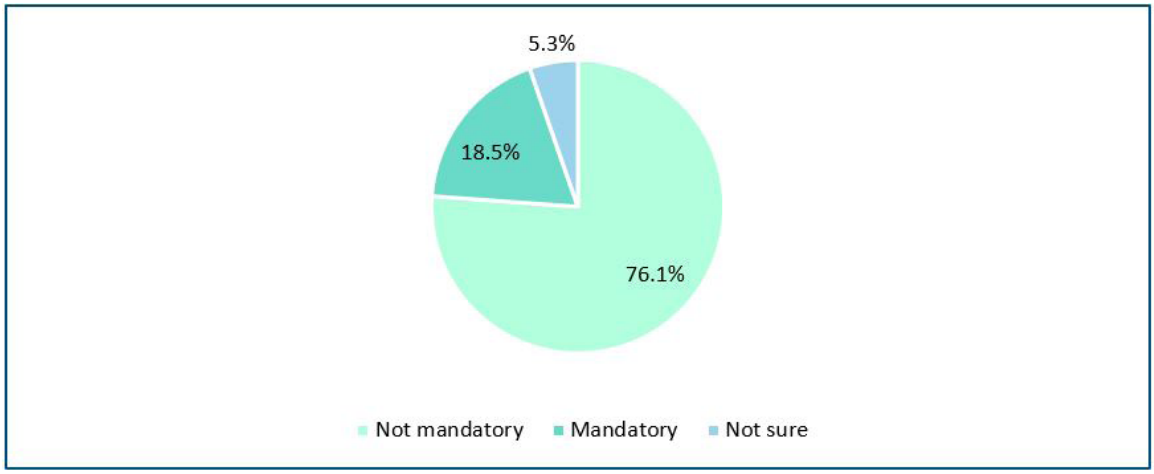
Figure 3. How Attendees Learned About Workshop (n = 786)



Mandatory Attendance

Of respondents who answered the question about whether the HOPE workshop was mandatory (n = 805), the majority reported that it was not (see Figure 4).

Figure 4. Whether Training Attendance Was Mandatory (n = 805)



Aim 1. Effectiveness of HOPE Trainings

To reflect the intentions HOPE leaders have for the outcomes of their training workshops—namely that they be the vehicles that educate people about HOPE and enable training attendees to advance from knowledge acquisition, to planning for knowledge application, to implementation—we assessed whether attendees were gaining new knowledge or expanding existing knowledge about ACEs and PCEs, and whether they felt confidence in their ability to incorporate PCEs into their work with families. We also asked attendees about their satisfaction with the trainings.

Evaluation Aim 1: Assess the effectiveness of HOPE's primary training model (live events)
Evaluation Questions
1. *Did HOPE workshop attendees acquire new or advanced knowledge of ACEs and PCEs, and increased confidence addressing these topics in their work?* 2. *Were workshop attendees satisfied with the training? Did they find it relevant and effective?*
Data Sources
◦ Provider Pre- and Post-Workshop Survey[16]

[16] Analyses were conducted using survey versions 1, 2, and 3, from Phases 1 and 2 of data collection; specific versions are noted throughout the section. For more detail on analytic samples by research question, see Method section.

Did HOPE workshop attendees acquire new or advanced knowledge of ACEs and PCEs, and increased confidence addressing these topics in their work?

To answer this question, we assessed survey respondents' perceived understanding of, and confidence in using, key HOPE concepts, as well as their demonstrated understanding of these concepts.

Perceived Understanding and Confidence

To assess whether post-workshop scores in perceived understanding and confidence were higher than pre-workshop scores, we conducted independent and paired samples t-tests.[17] The boxes below depict the questions we used to measure respondents' understanding and confidence.

Measuring respondents' perceived understanding of ACEs and PCEs:

ACESs -- *I have a good understanding about how ACEs influence development (Examples of ACEs: child abuse and neglect, parental mental illness, & parental substance abuse).*

PCEs -- *I have a good understanding about how PCEs influence development (Examples of PCEs: feeling able to talk with their family about their feelings; feeling safe and protected by an adult at home; feeling supported by friends).*

Measuring respondents' confidence:

I feel confident that I know how to incorporate discussions about Positive Childhood Experiences in my work with families.

[17] Independent samples *t*-tests were conducted for Phase 1 respondents who completed Pre- or Post-Survey version 2 and paired samples *t*-tests were conducted for Phase 2 respondents who completed Pre- and Post-Survey versions 2 and 3.

As shown in Table 6, for both matched and unmatched samples, when compared to Pre-Workshop Survey scores, Post-Workshop Survey scores indicated a greater perceived understanding of ACEs and PCEs, as well as greater confidence in knowing how to incorporate discussions about PCEs into their work with families, with medium to large effects. See Table 6. The fact that these findings were true for the matched sample suggests that the content shared with attendees during the HOPE workshops effectively increased both their knowledge and confidence.

Table 6. Pre- and Post-Workshop Survey Knowledge Acquisition Scores; Phase 1 and Phase 2 Samples

		Pre-Workshop Survey		Post-Workshop Survey				
Survey Item	**Phase**	***n***	***M (SD)*; Range**	***n***	***M (SD)*; Range**	***t*-statistic (*df*)**	**Cohen's *d***	***M* difference (*SD*); Range**
I have a good understanding about how ACEs influence development.	1	360	74.34 (21.81); 0.00–100.00	238	86.74 (12.80); 45.00–100.00	**8.75 (588.48)**	0.69	n/a
	2	108	76.78 (17.97); 10.00–100.00	n/a	85.84 (11.31); 50.00–100.00	**5.96 (107)**	0.60	9.06 (15.80); -20.00–60.00
I have a good understanding about how PCEs influence development.	1	355	69.6 (23.09); 0.00–100.00	238	84.86 (13.94); 36.00–100.00	**10.03 (585.15)**	0.80	n/a
	2	107	70.69 (22.49); 0.00–100.00	n/a	84.34 (12.72); 45.00–100.00	**6.23 (106)**	0.75	13.65 (22.65); -47.00–100.00
I feel confident that I know how to incorporate discussions about PCEs in my work with families.	1	412	67.13 (23.58); 0.00–100.00	308	82.24 (17.45); 2.00–100.00	**9.88 (717.93)**	0.73	n/a
	2	104	59.62 (23.53); 0.00–100.00	n/a	81.63 (14.22); 45.00–100.00	**9.46 (103)**	1.13	22.01 (23.72); -25.00–100.00

Note. Boldface indicates *p*-value < .001.

Differences in Magnitude of Change in Perceived Understanding and Confidence by Training Format and Attendee Years of Experience. To test whether the average magnitude of change differed by training format (i.e., 2-hour vs. 4-hour)[18] or the number of years respondents worked in the field, we conducted bivariate analyses using the difference scores for Phase 2 (i.e., matched sample) respondents only[19] (See Table 6 above). No significant differences emerged in the average difference scores of the three items (i.e., understanding of ACEs and PCEs, and confidence in knowing how to discuss PCEs) by training format.[20] Similarly, no significant differences emerged in the average difference scores of either the understanding of ACEs or PCEs[21] by the number of years respondents worked in their field. There was, however, an effect for years of experience on the magnitude of change in confidence in discussing PCEs.[22] Specifically, on average, respondents who worked in their field for 0–3 years (*M* difference = 26.71, *SD* = 23.48) and 10–15 years (*M* difference = 27.94, *SD* = 26.49) reported having more confidence knowing how to discuss PCEs with families than respondents who worked in their field 16 or more years (*M* difference = 12.41, *SD* = 15.21).

Demonstrated Understanding of HOPE Concepts

We asked respondents, in the Post-Workshop Survey, to demonstrate their understanding of HOPE concepts by selecting the correct depiction of a HOPE-informed response in a hypothetical scenario between providers (i.e., a home visitor, physician, or teacher) and families. Of respondents (n = 491),[23] the overwhelming majority selected the correct response for each scenario, as shown in the text boxes below.

[18] Note that, because Phase 2 data collection only included 2-and 4-hour workshops, we were not able to include 1-hour workshop attendees in these analyses.
[19] Difference scores based on responses from Pre-and Post-Survey versions 2 and 3.
[20] ACEs: $t(106) = 0.33$, $p = 0.75$; PCEs, $t(105) = -1.06$, $p = .29$; confidence discussing PCEs: $t(30.31) = -1.12$, $p = .27$.
[21] ACEs: $F(3, 104) = 2.08$, $p = .11$; PCEs: $F(3, 103) = 2.55$, $p = .06$.
[22] Confidence discussing PCEs: $F(3, 54.50) = 4.09$, $p < .05$.
[23] Post-workshop survey versions 1, 2, and 3 from Phases 1 and 2 of data collection.

Hypothetical Scenario 1: A home visitor arrives at a family's home and notices the children are out front unsupervised, performing tricks on their bikes without helmets. The home visitor knocks at the door and mom answers.

95.3% of respondents selected the correct answer — *Riding bikes is great exercise. Good job, mom, for encouraging them to get outside and play. I noticed they didn't have helmets on. There's an organization that offers helmets to families in the neighborhood. If that would be helpful, let me know, and I can send you the information.*

Hypothetical Scenario 2: A parent arrives at a 3-month well-child check, and the physician notices that the baby's weight has dropped significantly from the last visit

95.9% of respondents selected the correct answer — *I see that you're still breastfeeding, which is wonderful. The baby has lost a little weight, so I'd love to learn more about how feedings are going and brainstorm with you some ways to tip the scale a bit. We have tons of resources here to support you, but first I want to hear how things are going.*

Hypothetical Scenario 3: A preschooler is acting out in a Head Start program, hitting and biting his peers. The teacher calls the parents in for a meeting.

97.8% of respondents selected the correct answer — *Your son is so inquisitive, and he is normally the first child to raise his hand when we ask the group a question. We'd love to harness his energy to learn new things as it relates to peer interactions. He tends to bite or hit his peers when he's frustrated or having a hard time sharing. We know he's capable of learning new behaviors here, and we'd love to partner with you on a plan to help teach him a new skill.*

Were workshop attendees satisfied with the training? Did they find it relevant and effective?

Training Attendance and Satisfaction

Following participation in a HOPE workshop, respondents (n= 491)[24] reported whether they attended the webinar in its entirety and rated their satisfaction with the training. Most (93.3%) attended the webinar in its entirety, with very few respondents (4.7%) only attending about half

[24] Post-Workshop Survey versions 1, 2, and 3 from Phases 1 and 2 of data collection.

of the webinar and less than half of the webinar (0.4%). On average, survey respondents reported high levels of training satisfaction (i.e., scores of 86 and above, where the highest possible score is 100), with most agreeing that the workshop:

- Was relevant to their work (M = 91.30, SD = 14.38; n = 462, range 0.00 - 100.00),
- Made effective use of virtual tools, including the chat box, polls, and breakout rooms (M = 89.75, SD = 16.38; n = 453, range 0.00 - 100.00), and
- Introduced them to concrete ways of incorporate HOPE into their work (M = 86.64, SD = 16.20; n = 356, range 20.00 - 100.00)

Aim 1. Effectiveness of HOPE Trainings: Conclusions

Based on responses from attendees who completed Pre-and Post-Workshop Surveys, it appears that HOPE's short-term training goals have effectively been met. Key findings are as follows:

Increasing Perceived Knowledge and Confidence

Workshop attendees who completed Pre-and Post-Workshop Surveys reported increased knowledge of how ACEs and PCEs influence development, and greater confidence in knowing how to discuss PCEs with families in their practice (with medium to large effect sizes). These findings suggest that HOPE's goal of increasing providers' perceived knowledge and confidence in these key areas was attained.

Change in Perceived Knowledge and Confidence

The magnitude of change in respondents' perceived knowledge and confidence acquisition did not differ by training format (2-vs. 4-hour). A possible explanation for this is that the material covered across both workshops was largely the same; both included HOPE 101, and both likely covered some of the same strategies for integrating HOPE. This is important information for HOPE, but is limited by the fact that the most common mode of training, the 1-hour workshop, was not included in this comparison because Phase 2 pre-post workshop surveys were only collected from attendees at 2-hour and 4-hour workshops.

Demonstrated Understanding of HOPE Concepts

Workshop attendees who completed Post-Workshop Surveys demonstrated a strong awareness of how to correctly apply the information presented at the HOPE training to hypothetical practice-based scenarios. The ability to recognize key elements of knowledge application is an initial step towards successfully translating HOPE tenets into practice

Training Satisfaction

Overall, workshop attendees who completed the Post-Workshop Survey were highly satisfied with their HOPE training experience as they perceived the workshop to be relevant and potentially useful to their work. It appears that the trainings were engaging as most attendees who completed the Post-Workshop Survey stayed for the entire session. Because training was perceived as engaging and relevant, it is likely that it served as a valuable vehicle for knowledge and confidence acquisition (Wang & Degol, 2014).

Aim 2. Planning to Implement HOPE-Informed Changes

Being introduced to new ideas and imagining how they might change one's personal or organizational practice is exciting for practitioners. Providers may experience a period of enthusiasm and generativity following a training and then may encounter doubts (either their own or others') and barriers to translating their new knowledge into practice. Applying the knowledge acquired and ideas generated following a training is not an immediate, fluid process. As part of our evaluation, we aimed to identify and document the processes involved as organizations that receive HOPE training move toward establishing goals, creating a HOPE-informed enhancement that is fitting for their organization and its families, and implementing it. To address this aim, we used data from the Post-Workshop and Provider Three-Month Follow-Up Surveys[25] to determine whether attendees who participated in HOPE training appeared to understand key HOPE-related concepts, were confident in their abilities to use these concepts in their work with families, were influenced by the training to think about families more positively, and had ideas about how to implement HOPE into their practice.

[25] We had initially planned to complement these quantitative data with comprehensive case studies of two organizations that intended to either expand and formalize a HOPE enhancement or launch a HOPE enhancement following participation in HOPE training. Unfortunately, one of these organizations was unable to commit to participation in the evaluation and the other did not participate in HOPE training during the evaluation period.

Evaluation Aim 2: Assess whether HOPE training workshops prepare attendees to create HOPE-informed changes in their work with families
Evaluation Questions
1. *Did workshop attendees exhibit knowledge of and confidence in using, HOPE-related concepts three months post-workshop?* 2. *Did the HOPE workshop influence attendees' way of thinking about how they work with families?* 3. *Did workshop attendees acquire skills to apply HOPE-informed changes in their work?* 4. *Did workshop attendees intend to implement any changes in their work after the training?* 5. *Did workshop attendees develop specific implementation ideas during their workshop participation?* 6. *Were those who make decisions about organization-wide changes in practice, programming, and policy present at HOPE workshops, along with direct service providers?*
Data Sources
◦ Pre- and Post-Workshop Survey[26] ◦ Provider Three-Month Follow-Up Survey

Did workshop attendees exhibit knowledge of, and confidence in using, HOPE-related concepts three-months post-workshop?

Perceived Understanding and Confidence at Three-Month Follow-Up

Being knowledgeable about the HOPE-related concepts of ACEs and PCEs and having confidence in knowing how to incorporate PCEs into discussions with families is an important prerequisite to conceptualizing and implementing HOPE-informed changes in one's work. Of the respondents who completed a Three-Month Follow-Up Survey (n = 50), 23 answered questions about whether they had a good understanding of how ACEs and PCEs influence development and whether they were confident knowing how to discuss PCEs with families. On average, respondents reported high levels of understanding related to how ACEs (M = 88.17, SD= 10.05; range = 62–100) and PCEs (M = 80.43, SD = 19.01; range = 38–100) influence development, with more moderate levels of confidence related to their ability to discuss PCEs with families (M = 72.00, SD = 25.23; range = 21–100). Subsequent ad-hoc analyses of these three items confirmed that on average, respondents' understanding of ACEs and PCEs was slightly higher than their confidence ($t(22)$ = 3.03, p <.01 & $t(22)$ = 3.67, p <.01, respectively).

[26] Analyses were conducted using survey versions 2, and 3, from Phases 1 and 2 of data collection; specific versions are noted throughout the section. For more detail on analytic samples by research question, see Method section.

Demonstrated Understanding of HOPE Concepts at Three-Month Follow-Up

Relatedly, of the Three-Month Follow-Up Survey respondents who answered the question about the best representation of HOPE from the options presented (*n*= 48), 89.6% identified the correct response (see text box below) indicating that most workshop attendees understood what the HOPE framework was.

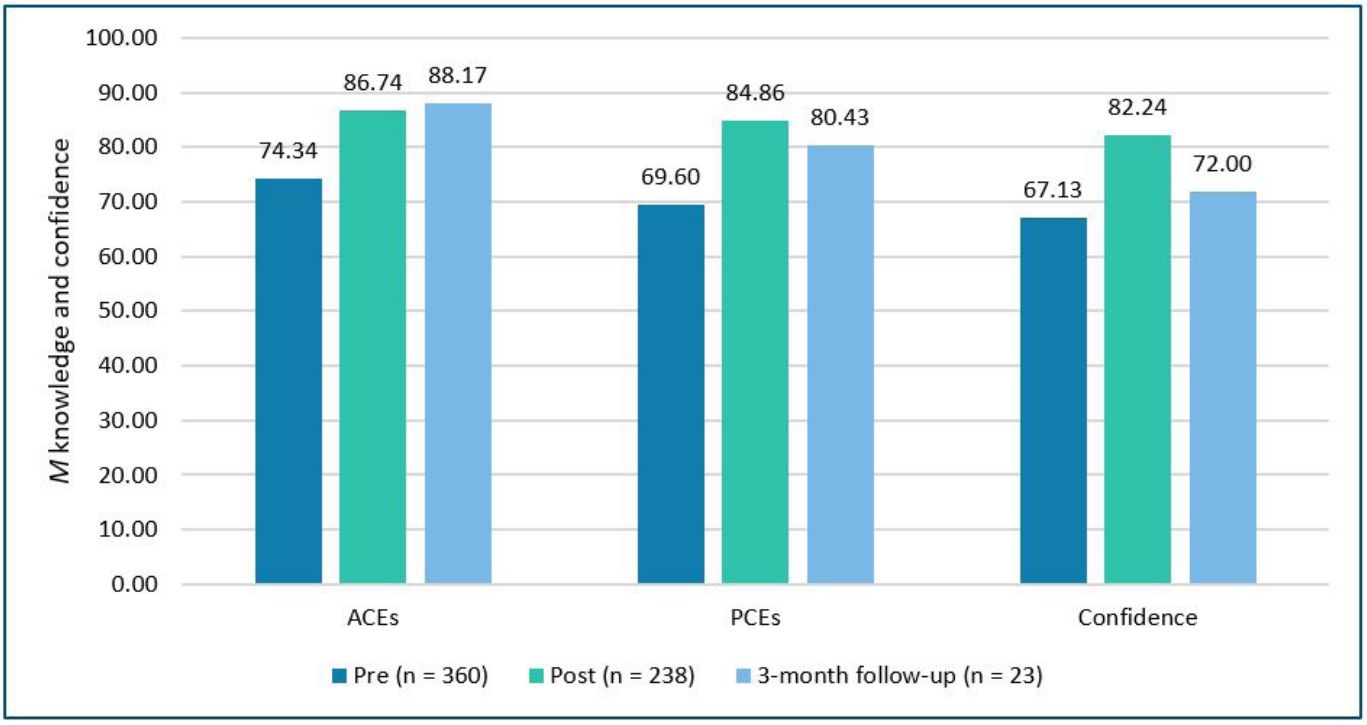
HOPE is focused on how Positive Childhood Experiences (PCEs) can improve long-term health and well-being. HOPE aims to increase providers' practices that encourage positive relationships, safe and equitable environments, community engagement, and healthy social and emotional development.

Perceived Knowledge and Confidence Across Timepoints

While the different samples used across workshops precluded our ability to test whether attendees "retained" knowledge and confidence during the three months following workshop participation, we were still interested in gaining an overall picture of knowledge scores at each time point. As seen in Figure 5, ACEs knowledge mean scores were high for respondents who completed the Pre-and Post-Workshop Survey[27] and for respondents who completed the Three-Month Follow-Up Survey. In contrast, respondent PCEs knowledge mean scores were slightly lower for respondents who completed the Three-Month Follow-Up Survey than respondents who completed the post-workshop survey (i.e., ~ 4-point difference). Following the same pattern but more pronounced, PCEs confidence mean scores were lower for respondents who completed the Three-Month Follow-Up Survey than respondents who completed the Post-Workshop Survey (i.e., ~ 10-point difference). The pattern in these scores suggests that workshop attendees who completed the Three-Month Follow-Up Survey appear to, on average, have slightly lower levels of understanding of how PCEs influence development, as well as lower confidence in their ability to discuss PCEs with families.

[27] Pre-and Post-Workshop Survey versions 2 and 3, from Phases 1 and 2 of data collection.

Figure 5. Mean Scores on Understanding of ACEs and PCEs and Confidence in Three Samples at Three Time Points



As stated above, these scores are drawn from three separate samples of attendees, and while some respondents are represented across samples some are not. However, the pattern in these scores does indicate that workshop attendees who completed the Three-Month Follow-Up Survey appear to, on average, have slightly lower levels of understanding of how PCEs influence development, as well as lower confidence in their ability to discuss PCEs with families.

Did the HOPE workshop influence attendees' way of thinking about how they work with families?

Intention to Implement HOPE

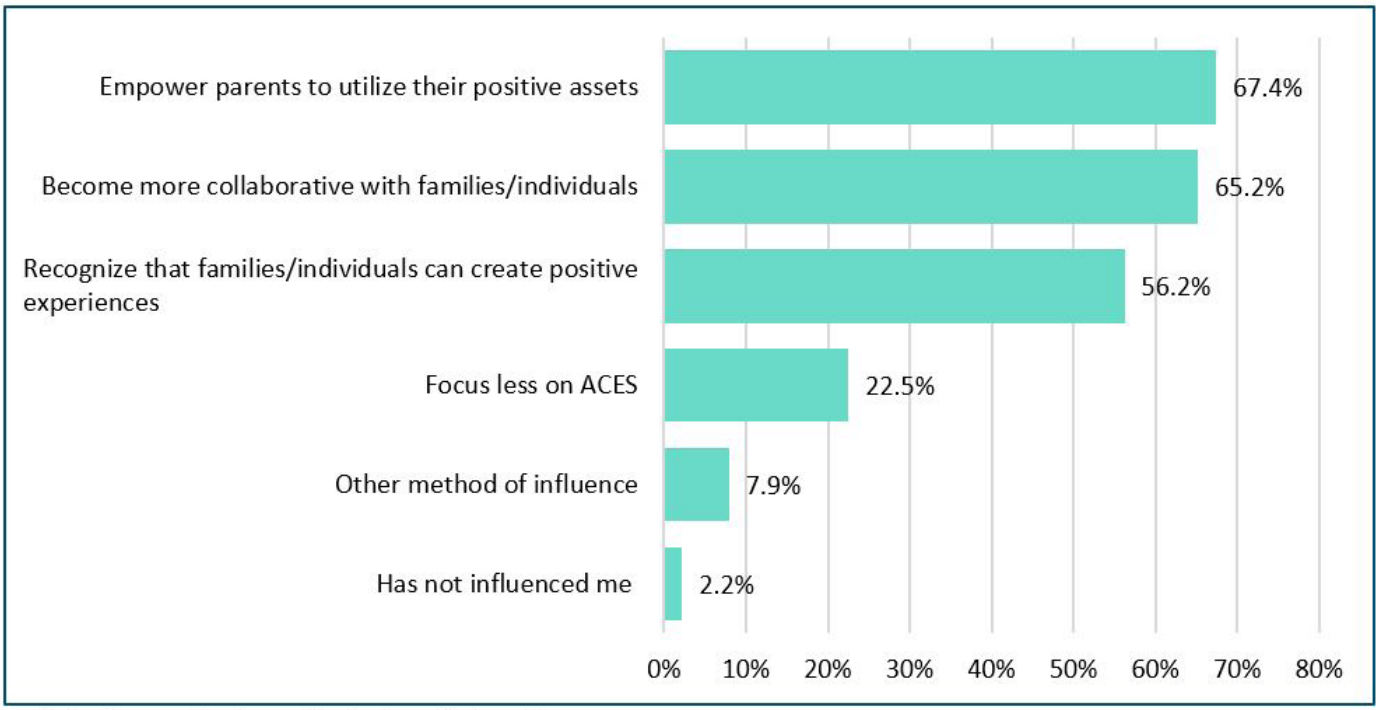
Of Post-Workshop Survey respondents who answered the questions pertaining to whether participating in the training had influenced them to rethink their approaches to working with families or individuals (n = 89),[28] more than half of respondents (see Figure 6) reported that participating in a HOPE workshop:

[28] Post-workshop survey version 3, Phase 2 of data collection

- Made them realize that part of their role in working with families/individuals is to empower parents to tap into the positive assets they have,
- Influenced them to shift their orientation to being more collaborative and trying to make more shared decisions with the families/individuals they work with, and
- Influenced them to recognize that all families/individuals have the potential to create positive experiences.

Only two respondents reported that HOPE workshop participation had not influenced them to rethink how they or their organization work(s) with families. Although these findings do not predict respondents' long-term perceptions of how HOPE participation influences their work with families, they suggest that there were short-term perception changes, with most attendees appearing to have received the messages HOPE had intended.

Figure 6. Influence of Training on Attendees' Rethinking How They Work with Families (n = 89)



Note: Respondents could select multiple options.

Did HOPE workshop attendees acquire skills to apply HOPE-informed changes in their work?

Acquisition of Implementation Skills

Of respondents who answered Post-Workshop Survey[29] questions about whether they learned specific ways to translate what is known about ACEs and PCEs into their work with families (*n*= 90), most respondents (96.7%) agreed that they learned specific ways to translate what is known about ACEs and PCEs into their work with families, with very few respondents (*n*= 3) disagreeing. Of respondents who also reported whether they had what they needed to return to work and implement a HOPE-informed change to programming, practice, or policy (*n*= 86) most (87.2%) said "yes", with only 12.8% saying "no." Of the 75 respondents who said "yes," the majority (96.0%) indicated that they had gotten what they need from the HOPE workshop.

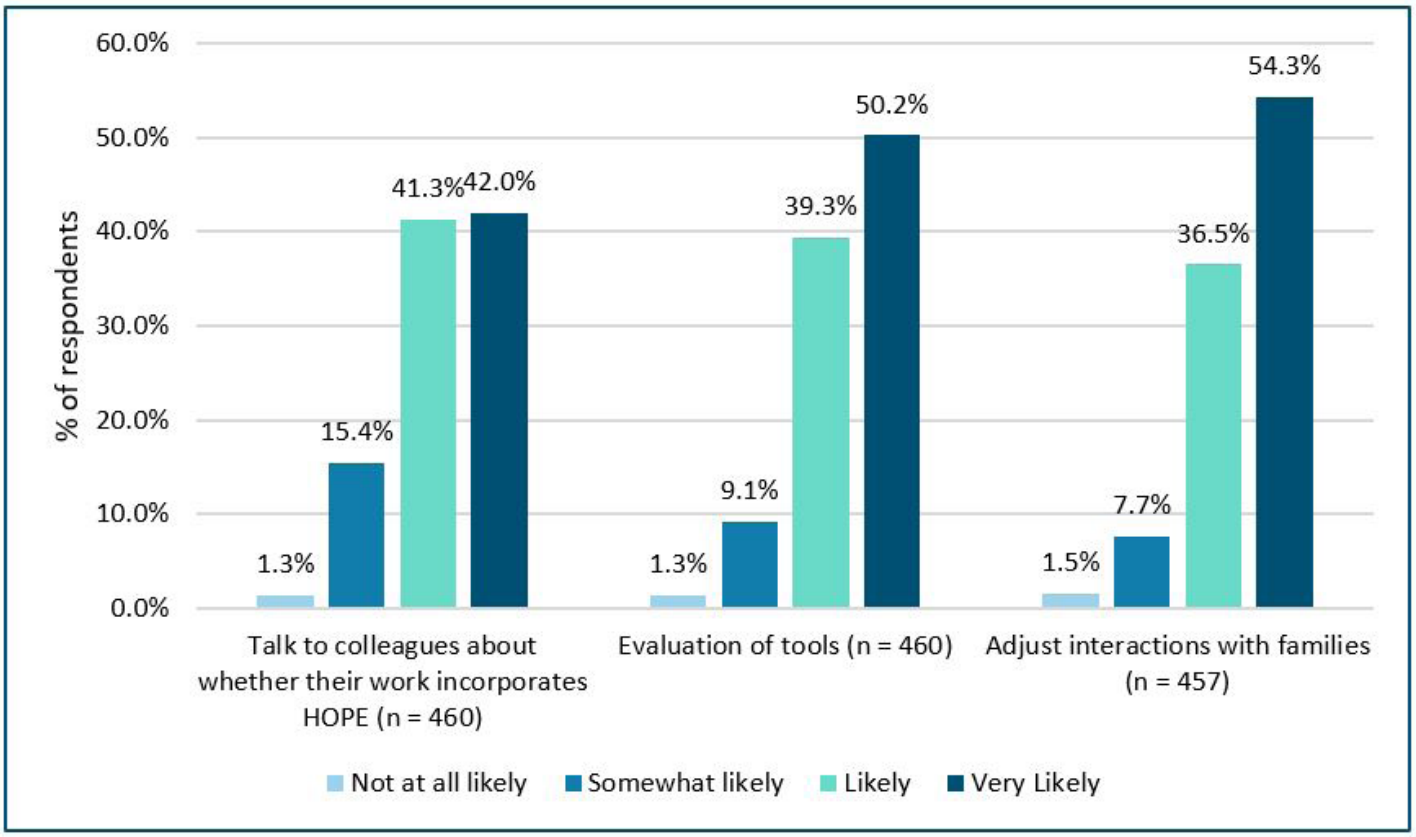
Did workshop attendees intend to implement any changes in their work after the training?

Intention to Implement HOPE-Informed Changes

Of respondents who completed Post-Workshop Survey question related to whether they were likely to return to work and pursue a change related to the HOPE framework and principles (*n* = 460),[30] slightly more than half (54.3%) of respondents reported being very likely to adjust the way they or other direct services staff in their organizations interact with families so that their approaches are more aligned with HOPE principles. Similarly, half of respondents reported being very likely to evaluate the tools they use to consider their alignment with the HOPE framework. Slightly more than 40% of respondents reported being very likely to talk with colleagues about whether their work incorporates HOPE (see Figure 7).

[28] Post-workshop survey version 3, Phase 2 of data collection.

Figure 7. Possible Post-Workshop Actions to Incorporate HOPE



We conducted *t*-tests to see whether respondents were more likely to intend to implement one type of change over another. Results suggest that more respondents endorsed being *likely/very likely* to adjust interactions with families and evaluate the tools they use than endorsed being *likely/very likely* to talk with their colleagues about HOPE ($t(456)= 5.04$, $p <.001$ & $t(459)= 3.83$, $p <.001$, respectively). Together, these findings suggest that respondents were relatively intent on making a change in practice aligned with HOPE tenets following a HOPE training, and that they may be more comfortable making individual-level HOPE-informed changes, than attempting to address it with others.

Did workshop attendees develop specific implementation ideas during their workshop participation?

We drew from close-ended and open-ended Post-Workshop Survey data to explore this question.

[30] Post-workshop survey versions 1, 2, and 3 from Phases 1 and 2 of data collection.
[31] Post-workshop survey version 3, Phase 2 of data collection.

Of respondents to the Post-Workshop Survey who answered the question, *"Do you have an idea in mind about how you will take what you learned during this HOPE workshop and create a HOPE-informed change or enhancement in your work with families?"* (n = 88),[31] slightly more than half of respondents reported that they developed an idea for a HOPE informed change or enhancement during the HOPE workshop (55.7%). About a fifth of respondents reported they did not have an idea yet (19.3%) and another fifth reported they already had an idea in mind when they came to the workshop (18.2%). Very few selected "other" (5.7%) and only one respondent said they did not see the need to create a HOPE informed change or enhancement in their work.

Some respondents provided information in open-ended responses to several questions on the Post-Workshop Survey about how they might take what they learned during the workshop and create a HOPE-informed change in their work. Of respondents who described their intended change, most described their thoughts in relatively general terms. One respondent stated that the HOPE training gave them the confidence to shift from ACEs to a more positive HOPE framework in conversation, for example, and another reported that they would "*share the knowledge and opportunities for development with my colleagues."* Two other respondents wrote:

> ***"Although I do not currently work directly with children or families, I would still like to begin practicing some of the principles of cognitive reframing in my interactions with staff and coworkers. My hope is that my peers would begin to incorporate some of these same principles in the work that they do with youth and families."***

> ***"I will continue to think about how I can incorporate the HOPE framework into my sessions as well as sharing the knowledge and opportunities for development with my colleagues."***

One respondent indicated that the workshop content reinforced or would bolster their existing practices:

> ***The workshop was very helpful in giving a language and framework to the work I already do. I already work to foster resilience in my clients and students so I now have a framework to work from.***

Two respondents described their intentions to implement HOPE-informed changes with a bit more specificity, with one indicating that they would make use of resources provided during the workshop (*"handouts, how to contact the team, and the website"*), and another writing:

> ***We'll be having an office presentation on the basics that were given in this webinar. Appropriate materials will be generated for myself and my volunteers, to be used in our outreach setting.***

Not all attendees had begun to formulate an idea during or immediately following the workshop about how to integrate HOPE principles in their work, even when they had a favorable reaction to the training. For example, one respondent wrote,

> ***The presenters are knowledgeable and did a nice job with presenting the information. I am totally on board with the need to incorporate a strength-based perspective and celebrating and encouraging client resiliency that is aligned with HOPE principles but I already do that and did not necessarily learn new material to implement. Perhaps this material is more vital to [new staff].***

The desire for additional guidance to enable implementation changes was noted by multiple respondents in open-ended responses on the Post-Workshop Survey. Some of these respondents reported a need for more depth and a more thorough understanding of the concepts presented during the training. As a more concrete action item, one respondent reported having the need for *"a follow up webinar with more scenarios, role play, [and] script practice on how to effectively incorporate this framework into practice."* Another respondent stated, *"I'd like to see more opportunity to do real-world problem-solving and response practice like in the post-[survey]."* Finally, one respondent cited a specific change to the HOPE training by stating, *"At some point it would be helpful to see examples of HOPE working with very difficult issues where a more immediate intervention is necessary but the clinician wants to proceed in a HOPE-informed way."* Of the two remaining responses for needing implementation guidance, one cited a need for *"feedback on specific scenarios or suggestions for areas where we'd be like[ly] to utilize HOPE"* and the other suggested creating more of an opportunity to ask questions during the training to allow for HOPE to be incorporated within their practice.

Were those who make decisions about organization-wide changes in practice, programming and policy present at HOPE workshops, along with direct service providers?

Of respondents who answered the question *Did the people who make decisions about program, practice, or policy changes at your organization attend this training or another HOPE training?* (n = 84),[32] about two-thirds (65.5%) indicated that the decision-makers were present, with slightly more than a third (34.5%) indicating they were not. It is worth further examination to determine whether the presence of decision-makers has an influence on the likelihood of implementing HOPE-informed changes post-training.

[32] Post-workshop survey versions 3, Phase 2 of data collection.

Aim 2. Planning to Implement HOPE-Informed Changes: Conclusions and Recommendations

Perceived Understanding of ACEs and PCEs

On average, respondents indicated high levels of perceived understanding of how ACEs and PCEs influence development three months after their participation in a HOPE training. As noted earlier in the section, we were unable to compare these responses with pre-workshop understanding, so we do not know whether this level of understanding can be attributed to HOPE. However, results from the matched-sample t-tests presented for Evaluation Aim 1 do suggest that the training may be having an impact on attendees' understanding of these concepts. The fact that respondents' understanding of ACEs in particular was fairly high across time points could also be a natural artifact of the prevalence of ACEs information to which family-serving providers have been exposed for the past two decades since the seminal work describing the *Adverse Childhood Experiences Survey* (Felitti et al., 1998).

Confidence Integrating PCEs

Both knowledge and confidence are key constructs affecting whether a change in mindset or behavior is realized. Results of our analyses suggest that perceived understanding of ACEs and PCEs was relatively high among those attendees that completed a Three-Month Follow-Up Survey. We have more questions about practitioners' confidence in their ability to incorporate discussions of Positive Childhood Experiences (PCEs) into conversations with families and in HOPE's potential to boost confidence in meaningful ways.

Ability to Translate HOPE Knowledge in Practice

One of HOPE's training goals is for all attendees to leave HOPE trainings better prepared to bring PCEs more to the forefront in their work with families. Low confidence in the ability to incorporate PCEs into their work with families may represent a barrier to providers' ability to translate their knowledge (some of it acquired via HOPE training) and to implement HOPE-informed practice. This potential gap offers an area for HOPE to focus on when refining training approaches as part of Quality Improvement. Some providers may enter a HOPE training with an emergent idea, ready or almost ready for implementation; others may develop an idea during a training. Most respondents reported either that they developed an idea for a HOPE-informed change or enhancement during the HOPE workshop (though often these ideas lacked specificity) or had not yet developed an idea. In order to increase the translation of HOPE training to practice, HOPE should devote attention to techniques for working with attendees during trainings to assist them in conceptualizing ways to infuse HOPE-informed ideals and approaches into their work.

Aim 3. Implementation

As it is not a manualized program and currently there are no prescriptive criteria required of those who implement it, the HOPE framework is very flexible, and it is entirely up to individuals within organizations to conceptualize a HOPE enhancement, carry it out, and assess its effectiveness. To understand how workshop attendees appear to have incorporated HOPE into their own work, we asked HOPE workshop attendees and other HOPE stakeholders (i.e., members of HIN) if they had made any HOPE-informed changes, the types of changes they were making, and what barriers, if any, they have encountered during the implementation process. For this aim, we used data from the Three-Month Follow-Up Survey and qualitative data from our interviews and focus group.

Evaluation Aim 3: Describe HOPE implementation across a range of organizations
Evaluation Questions
1. *What did HOPE look like in practice when being implemented across a range of organizations?* 2. *How do individuals and organizations describe the HOPE-informed changes they have made in their practice?* 3. *What barriers did organizations and providers encounter as they tried to create and implement HOPE enhancements?*
Data Sources
◦ Three-Month Follow-Up Survey ◦ Provider interviews and focus group ◦ HIN meeting observations

What did HOPE look like in practice when being implemented across a range of organizations?

HOPE-Informed Enhancements

Of the respondents who completed a Three-Month Follow-Up Survey and answered the question about their actual or planned implementation efforts (n = 47), 59.6% indicated they had, and 40.4% indicated they had not, implemented a HOPE-informed change in their work. As seen in Table 7 there was variability within and across organizations in how many attendees reported implementing changes.[33] Of those who had not yet implemented HOPE but reported whether they planned to implement it in the future (n = 9), seven said they were planning to. However,

[33] Small sample sizes precluded significance testing for differences between workshops.

no respondents had yet set a goal date, suggesting they did not have concrete plans to begin implementation.

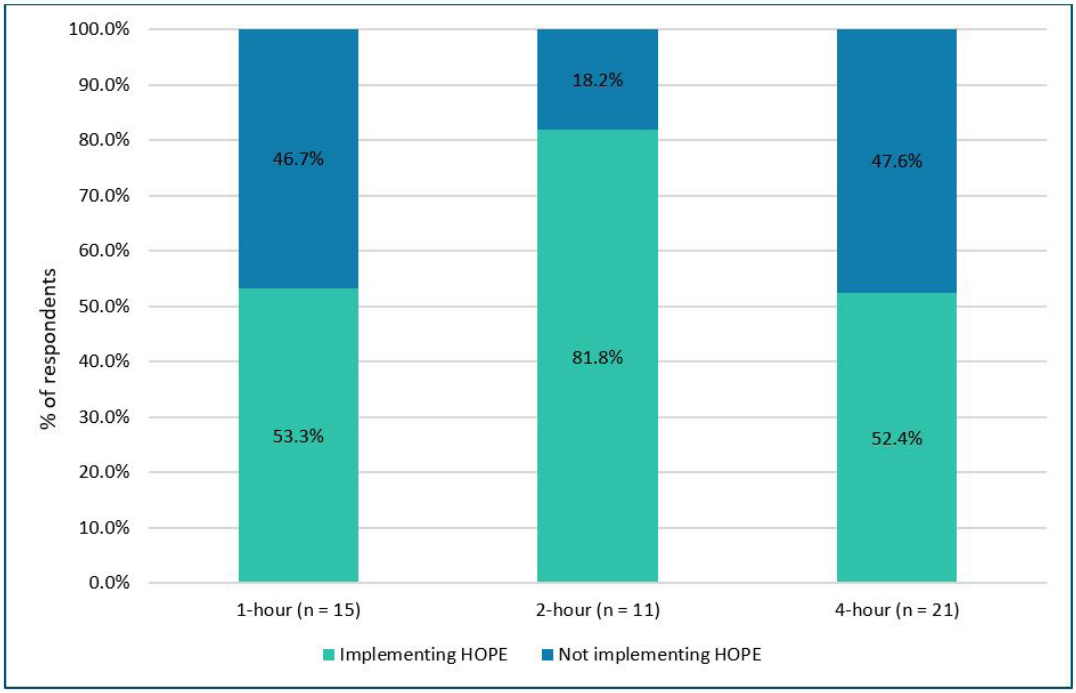
Table 7. Number of Respondents that Have Implemented/Not Implemented a HOPE-Informed Change by Workshop (n = 47)

Workshop	Implementing HOPE	Not Implementing HOPE
Nemours	3	0
Building Healthier Communities - Provider	6	2
Building Healthier Communities - Leadership	0	2
Georgia Brains for Babies	8	5
Great Start Michigan	11	10
Total	**28**	**19**

We also examined the number of respondents implementing HOPE by the length of the workshop they attended. Figure 8 shows the distribution of respondents who reported whether they were implementing a HOPE-informed change (n = 47), by training format. There was some variability in whether respondents implemented a HOPE-informed change into their work by the training format they had (i.e., 1-hour, 2-hour, 4-hour). As seen in Figure 8, about half of respondents who completed either a 1-hour or 4-hour training implemented HOPE and half did not. However, of respondents who completed the 2-hour training format, a larger proportion reported that they implemented HOPE.[34]

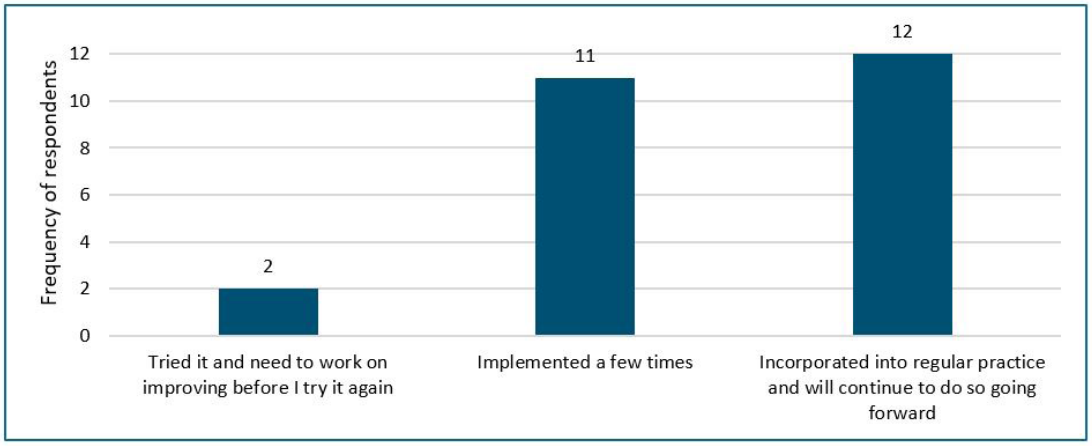
[34] Small sample sizes precluded signifance testing for difference by workshop format.

Figure 8. Percent of Respondents Who Have Implemented/Not Implemented a Hope-Informed Change by Workshop Format (n = 47)



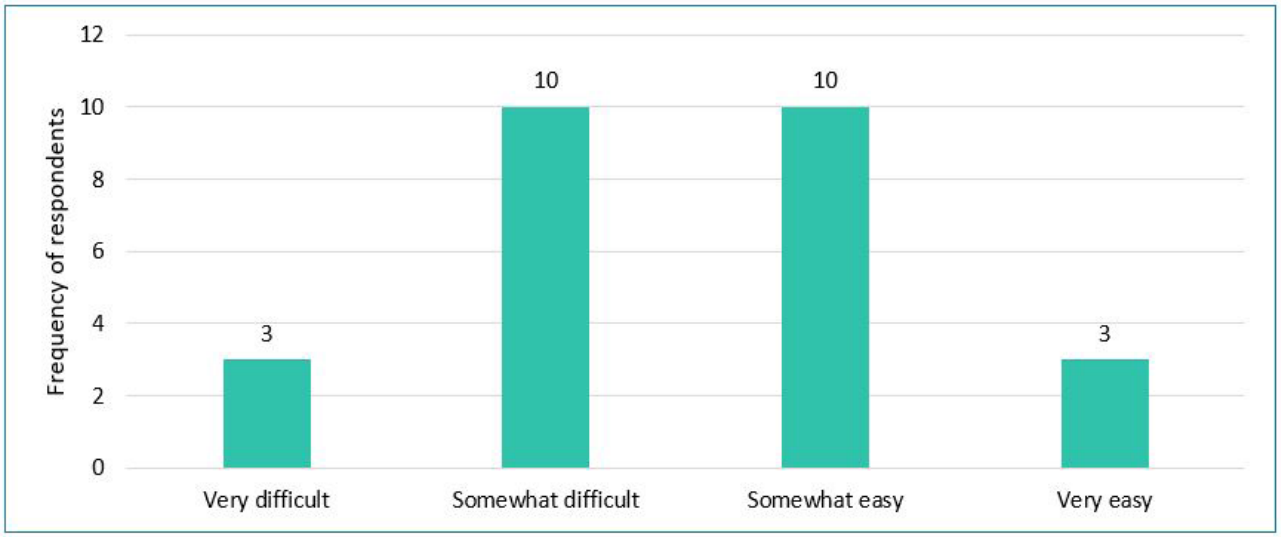
Of respondents who indicated they had implemented a HOPE-informed change in their work and answered the follow-up question of how they had attempted to implement it (n = 25), about half of respondents reported incorporating it into their regular practice and planning to continue doing so going forward, and 44.0% reported having implemented it a few times. Only two respondents reported that they needed to improve their HOPE-informed change before implementing it again. See Figure 9.

Figure 9. Status of HOPE Implementation Efforts in Workplace (n = 25)



Of respondents who said they had implemented a HOPE-informed change in their work and reported on how difficult it was to implement (n = 26), half of respondents reported that it was somewhat easy or very easy to implement a HOPE-informed change, with half reporting the opposite. See Figure 10. Barriers that may influence implementation are discussed later in Aim 3 (see *What barriers did organizations and providers encounter as they tried to create and implement HOPE enhancements?*).

Figure 10. Respondents' Ease in Implementing a HOPE-Informed Change into Work Since Workshop Participation (n = 26)



How do individuals and organizations describe the HOPE-informed changes they have made in their practice?

We conducted in-depth interviews and one intra-organizational focus group with members of the HOPE Innovation Network (HIN) who were implementing a HOPE enhancement (n = 9), as well as a home visiting program that was not part of HIN but was part of a statewide HOPE Community of Practice. Table 8 describes the types of enhancements that each of these organizations was conducting and categorizes the nature of the enhancement as either behavioral, cognitive, or both—from the standpoint of the provider's role in the enhancement and the intended impact of the enhancement. An enhancement characterized as *behavioral* was one in which the providers conducted their practice in a way that was new or different from what they had typically done. In other words, they made a change in action in the way they interacted with families, the programming they conducted, the curriculum they used, or their protocols or way of conducting their work. An enhancement characterized as *cognitive* was one in which it was evident that providers involved in the enhancement were changing their mindset or something

fundamental about the way they think about their work with families, such as a change in the way they viewed families and processed their interactions with them internally.

The information presented in Table 8 illustrates the broad applicability of HOPE principles to various sectors, types of organizations, and modes of service delivery, and the range of ways that individuals interpret what value HOPE can add to their work and to families. Each of these unique enhancements can be characterized in terms of both the nature of the enhancement for the providers and the nature of the enhancement for the families who were exposed to them. Three of the six HOPE enhancements were both behavioral and cognitive, two were solely behavioral, and one was solely cognitive. The intended effects of each enhancement on families also varied across the organizations showcased in Table 8, with four categorized as both cognitive and behavioral, one as only cognitive, and one as only behavioral.

Table 8. Description of HOPE-Informed Enhancements Created and Implemented by Six Organizations

Organization Type	HOPE Enhancement Description	Type of change provider/organization made		Intended impact of enhancement	
		Behavioral	Cognitive	Behavioral	Cognitive
Pediatric Community Clinic	*Created a strengths-based self-assessment tool for families based on the four HOPE Building Blocks. Families were asked to complete the self-assessment during wellness visits in the clinic. Residents incorporated families' responses to these assessments into conversations during the visits, sometimes making referrals to both fortify the Building Block and emphasize the positive value it can have, as well as address the family's need. The tool is often referred to during sick visits when residents are discussing next steps with families, to highlight the family's strengths. Rather than a model in which doctors are only giving prescriptive advice and solving families' problems, residents were having conversations with families about building on their strengths.*	✓	✓	✓	✓
Hospital-Owned Pediatrics Practice	*Deepened their understanding of the benefits of an enhancement created before their introduction to HOPE. The enhancement focused on helping parents and children recognize and manage difficult emotions such as anger and sadness by equipping them with self-care skills such as breathing and use of a glitter jar. The focus on emotional development and the provision of support in this area by a health provider align with HOPE Building Blocks 1 and 4.*		✓	✓	✓
Social Service Agency	*Incorporated HOPE information into internal and external trainings that also covered ACEs and resilience. Training audiences included childcare and child development providers. Also integrated HOPE concepts into cross-sector conversations about how to ensure that pediatricians know how to support families who experienced ACEs.*	✓	✓		✓
Home Visiting Program	*Trained home visiting staff in HOPE Building Blocks 2 and 3 so that home visitors could add this content into work with families, depending on the family's needs and the home visitor's discretion. Created group-based activities for families around each of the HOPE Building Blocks. Also conducted multiple trainings on HOPE for cross-sector organizations in the community (e.g., civic clubs, school districts).*	✓		✓	✓
Substance Use Prevention Community Coalition	*Incorporated HOPE-informed questions about PCEs into community surveys. HOPE-informed data collection was intended to inform community-directed media campaign strategies around substance use in the community. Also integrated HOPE framework into Science of the Positive framework they were already using.*	✓	✓	✓	✓
Child Maltreatment Prevention Community Organization	*To their Parent Café presentations, added community resources based on the needs of families attending; these resources were aligned with HOPE Building Blocks 2 and 3.*	✓		✓	

The Nature of the Enhacement for Providers

Behavioral and Cognitive. The community clinic's enhancement represents both behavioral and cognitive shifts for the providers, who are engaging with families in a different way by discussing the strengths-based self-assessment tool during clinic visits, and thereby veering from the usual orientation that medical providers have toward patients by changing the way they think about their role vis-à-vis the family. The provider explained, "*Rather than using a deficits-based approach and saying 'you have this problem, I have a resource, I'm going to give it to you you're going to use it,' we're saying, 'there are these things, these four Building Blocks that are positive and helpful for your child.'*" The creator of the enhancement envisioned that a *"culture change"* can come about for the pediatric residents involved in the enhancement—that by changing the way they talk to families, they may also come to view families in a more asset-based and less deficits-based way.

The substance use prevention coalition's enhancement represented a behavioral change due to the introduction of new types of questions, aligned with the *4 Building Blocks*, into a community survey. With the results of the survey, the coalition members we spoke with endeavored to identify existing strengths among youth and how these could be promoted, so that they could disseminate this information to the community through various communication channels in order to reduce youth substance use. In addition, one coalition leader explained the cognitive reframing that coalition leaders did in order to integrate HOPE into their existing way of thinking about substance use prevention:

> ***"The fact that we could rewire a child's brain… So if they are experiencing negative effects and some trauma in their lives, that positive interaction can actually kind of mitigate the negative reaction so that they can have a successful future, you know, with less depression, less mental health issues, hopefully less substance abuse issues. And the other thing that I think is interesting is, … the community was really feeling like, this is who we are, kids are going to be kids, there's nothing you can do about it. This HOPE science says there is something we can do about it. By focusing on the positive, there is something we can do about it. And so that was inspiring too because that's what we're doing with our substance use prevention, we're focusing on the positive and we can make change, correcting those misperceptions."***

In order to disseminate this message to the community through media campaigns, coalition leaders did a lot of cognitive work amongst themselves to: (1) understand the *4 Building Blocks*, (2) map them onto the framework they were already using (The Science of the Positive), (3) craft communications that would reflect their integrated framework, and (4) using this framework, *"build positive community norms."*

In addition to conceptualizing the substance abuse prevention coalition's enhancement as both behavioral and cognitive, we also characterized the social service agency's enhancement as having both behavioral and cognitive features. The agency had been conducting trainings for professionals who work with children and families prior to learning about the HOPE framework, and viewed HOPE as complementary to the frameworks they already used and as a way to augment their trainings that address trauma-informed, culturally responsive, strengths-based service delivery. Consequently, they added a HOPE component to their trainings—a behavioral change—and as the provider we spoke with explained, *"We sort of have started to use HOPE as the transition in telling the narrative of ACEs to resilience."* These providers, then, seem to have found the HOPE framework useful in helping others to understand that resilient functioning is possible for their families despite ACEs.

Cognitive. The emphasis on helping children and families cope well with challenging emotions that was the focus of the hospital-owned clinic's enhancement has both behavioral and cognitive components. Unlike other providers, this provider created the enhancement prior to being exposed to HOPE through a HOPE 101 presentation. Subsequent to learning about the research behind HOPE, they immediately identified the similarities between HOPE and their enhancement, and retroactively applied the HOPE framework to the work already in progress. Similar to the community clinic, the hospital-owned pediatrics practice provider made a significant behavioral change by talking to families in a different way about topics that typically arose during well visits. The HOPE framework also allowed the provider to draw connections between these topics of conversation and the *4 Building Blocks*, and though they were not explicitly about physical health, the provider came to view them as critically important in promoting overall good health. In doing so, this provider began viewing their relationship with patients and families differently—as more of a longitudinal relationship with long-term impacts, as opposed to one that is limited by offering short-term solutions such as prescriptions for medication. This provider described having experienced a cognitive evolution in how they think about their relationship with patients, and it was the HOPE framework that helped them to see that and deepened their understanding of the benefit of that type of relationship for families. Eventually, this provider also created a "conversation tool" based on the *4 Building Blocks* that promoted "discoveries" about the existing supports patients had; at the time our evaluation concluded, they had tried using this tool with three patients. If they continue to use it, it would become a behavioral component of their enhancement.

Behavioral. The home visiting program had previously established a strengths-based philosophy when one of its administrators was introduced to HOPE. Protective factors, the importance of the parent-child relationship, and viewing parents as having agency in creating positive experiences for their children were already embedded in the program's curriculum. Due to this pre-existing ethos, we did not characterize the HOPE enhancement this organization developed as representing a cognitive shift for the providers who created it; rather the HOPE framework had a reinforcing impact on them. The enhancement they described was behavioral in nature; from the *4 Building Blocks* they created a new set of tools that they used to introduce the *4 Building Blocks* to the families in their programs. Using the *4 Building Blocks* they created family-oriented activities—for example, a 'safe communities' event where families could navigate around to services in a mock community constructed by the program and talk to representatives of each service.

The HOPE enhancement added by the maltreatment prevention organization was suggested to them by a member of the HOPE leadership team rather than conceived within the organization. This enhancement introduced new resources into their Parent Café presentations, and represents a behavioral change made by the providers that was based on two of the *4 Building Blocks.*

The Nature of the Enhacement for Families

Behavioral and Cognitive. The community clinic provider described both behavioral and cognitive elements to the changes they intended to achieve by introducing the *4 Building Blocks* self-assessment to families. Whereas families may be accustomed to a more transactional interaction with their child's doctor, the enhancement, as described by the provider, *"invites [the family] in to problem solve with me rather than me saying 'get outside [and be active].' So it invites them into the creative process and by having a tool in front of them it's a little bit easier than me just talking."* This approach promotes a new behavior for many families—that is, contributing their ideas and engaging in joint problem-solving with the doctor rather than being told by the doctor what they should do. It may also present families with a different way of thinking about health. The provider gave the example of how residents in their clinic might change their approach to talking about having a healthy weight with families: *"So rather than me saying 'buy fruits and vegetables, no sugar sweetened beverages' [I'm] having a conversation with a family with this [Building Blocks self-assessment] saying 'yeah I do notice that your weight has gone up quite a bit. Tell me a little bit more about your environment. You were saying you're spending a lot of time playing video games; what other places do you have to play?'"* In this example, the provider seemed to be positioning the family to view themselves as having some influence over lifestyle choices that might influence their weight, thus presenting the opportunity for cognitive and behavioral changes.

Another example of a behavioral and cognitive enhancement at the family level was one used by the hospital-owned pediatric practice. Described by the provider as having the potential to

influence families' cognition and behavior, the provider explained, *"the parents, once [they] hear, 'Oh, I don't have to be afraid of when my child is scared. I don't have to tell him to stop being scared. I can say, "Let's do some breathing together. Or you know let's do that little glitter jar thing you did with [the doctor].' They have language around it of what to do..."* The provider aimed to prompt parents to think differently about their children's difficult emotions and provide new tools for them to draw on to change their, and their children's, reactions to these emotions. As far as the intended influence on children, the enhancement focused on giving children tools to better cope with *"yucky feelings"* and in this way to have a parallel behavioral and cognitive influence on children. This provider further noted that the enhancement had the intention of giving parents an alternative to punishment when a child behaves in a counterproductive way due to their emotions, which could lead to a behavioral shift within the family.

The home visiting program's enhancement targeted both cognitive and behavioral changes for families, which they addressed during home visitor-family visits and group meetings with parents. The enhancement aimed to give parents who have experienced a lot of ACEs *"the vehicle to show them, hey you know what it can be different. There's another way...this does not have to be your destiny; just because this is what happened in your family of origin doesn't mean that that's what's going to happen [to you]."* Home visitors were encouraged to work on giving families tools, via the 4 Building Blocks, to build up their protective factors. One of the skills home visitors emphasized with families was developing children's social-emotional competence (Building Block 4), including by developing parents' own self-regulation skills, and encouraging parents to work with their young child to solve problems, label their feelings and help them express those feelings, and reassure their child that they were in a safe and stable relationship.

The enhancement being implemented by the substance abuse prevention agency had short-term and long-term aims. In the short term, the enhancement was targeting cognitive outcomes for community members by projecting the positive, rather than negative, side of data they collected from the community back to the community. For instance, rather than reporting the relatively small, minority percentage of youth who use marijuana monthly, they report the large, majority percentage of youth who do not. They hoped that by doing so they could "correct misperceptions" of youth and promote the message that if adults commit to building positive relationships with youth and spread the message that *"most youth are making healthy and safe choices,"* it may help to reduce underage substance use in the community.

Cognitive. The social service agency's enhancement had the intention of influencing the thinking of other providers who work with families, by using trainings to raise awareness about the HOPE framework and its potential to offer a bridge between ACEs and positive outcomes for families who experience them. In past trainings, this group learned that another strengths-based framework that they covered in their trainings, Strengthening Families, was perceived by some trainees as a *"heavy lift,"* but they observed that trainees viewed the *4 Building Blocks* as *"accessible"* and *"an entry point"* to developing the Strengthening Families work in practice.

Behavioral. The maltreatment prevention organization's enhancement was intended to have a behavioral effect on families by encouraging them to use a wider range of community resources that could address their needs.

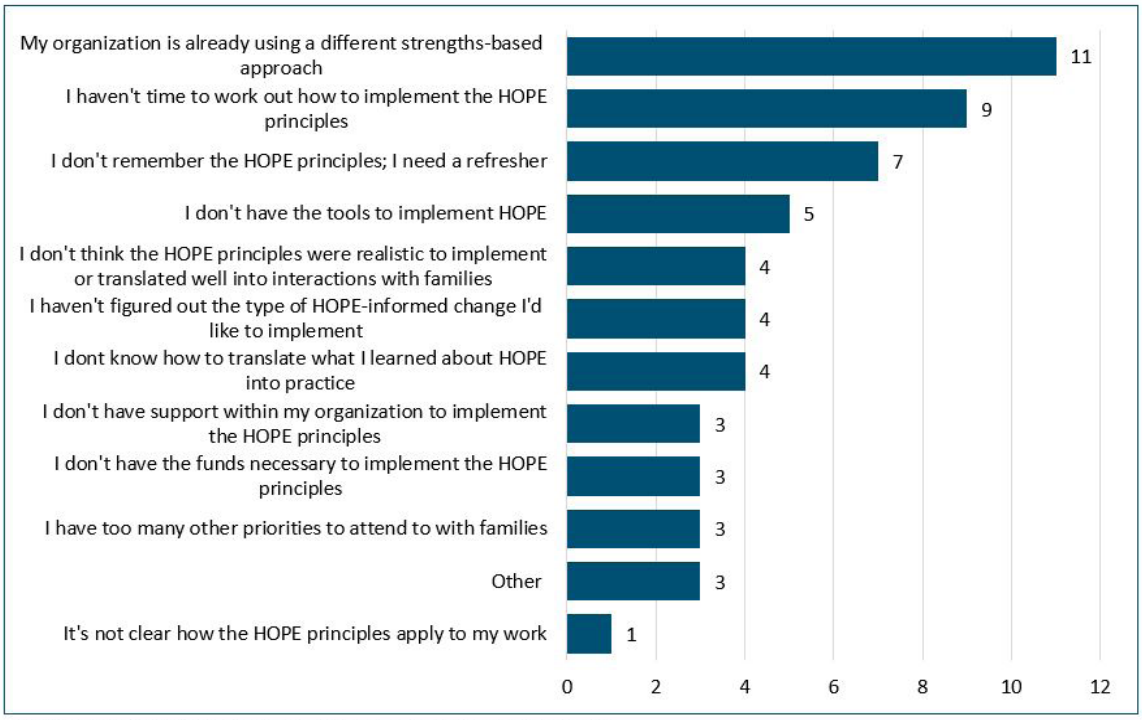
What barriers did organizations and providers encounter as they tried to create and implement HOPE enhancements?

We examined this question using closed-and open-ended responses from the Three-Month Follow-Up Survey, and qualitative data gathered through our interviews and focus group.

Barriers Reported on the Three-Month Follow-Up Survey

Of the respondents who answered the Three-Month Follow-Up Survey questions about the barriers they experienced while implementing HOPE (n = 35), most reported that they were already using a different strengths-based approach and/or that they had not had time to identify a HOPE-informed change to implement. The most frequently reported perceived barrier to HOPE implementation—that organizations are already using a different strengths-based approach—suggests that HOPE workshop attendees may benefit from discussions about how the HOPE framework might intersect with and overlay strengths-based approaches that organizations have already adopted. The next most frequently reported response—that workshop attendees have not had time to figure out how to implement HOPE—suggests that future workshops should focus on preparing attendees to advance implementation without significant additional efforts from their organization. Notably, none of the respondents selected that they thought HOPE was unrealistic to implement with families as a barrier. See Figure 11.

Figure 11. Barriers to Implementation (n = 35)



Note: Respondents could select more than one type of barrier

Additional insights about potential barriers to implementing HOPE came from open-ended responses on the Three-Month Follow-Up Survey about what would help workshop attendees to incorporate HOPE into everyday work with families, and what they felt they needed to move HOPE implementation forward (n = 29). Responses included: (1) ongoing education from HOPE (e.g., more HOPE training or resources such as regular emails in order to promote practice, a reminder of HOPE-informed practices, reminders about the *4 Building Blocks, "a guide to implement [HOPE] in an already strengths-based practice"*); (2) resources about HOPE (e.g., posters, handouts, infographics, email content, and social media toolkits that are easy to read and digest); and (3) guidance specific to a particular sector or type of organization (e.g.,*"a deeper dive into examples of how other schools are using this"*). An open-ended response provided by one provider elaborated on two of these points:

> ***I think there might be different goals depending on what type of work each person does within an organization. Direct service providers need concrete examples of things they can do when working with kids and families. As an administrator, I can share an overview of the HOPE concepts, but I'd like action step items I can implement to help support the HOPE mission. I can encourage relationships, safe environments, engagement, and social-emotional development, but how does that look in our particular organization? I think an organizational team needs to be developed to look at how these concepts can be implemented in our agency. Also a team at the community level to help with the bigger picture of sharing these concepts with families. So, I guess I need coaching on how to best move this information forward.***

Barriers Described in the Interviews and Focus Group

Interviewees[35] who talked with us about their experiences implementing HOPE also discussed challenges they had encountered. A recurring theme among the interviews with the two pediatricians was about the challenge of translating HOPE into practice within a system that

[35] Interviewees refer to individuals who participated in both one-on-one interviews and group interviews (i.e., focus groups).

typically has prescribed solutions for addressing problems. One pediatrician explained, *"This is not something we were trained in. So you are kind of going on your own, you're kind of improvising in a way...a lot of what we've been trained to do [has an] algorithm; if X Y, and Z then you do A, and it's cookbook."* Further, the community clinic pediatrician indicated that the nature of the HOPE enhancement they were doing—using a strengths-based assessment focused on the *4 Building Blocks* of HOPE and encouraging residents to use it as a conversation guide with families—was not prescriptive, but rather a tool that required residents to improvise and to change their mindset when working with families. They stated, *"doctors really like being able to say, I have a score of seven, and for a score of seven, this is exactly what I do and then follow it to see it improve."* The HOPE enhancement used in that clinic, in contrast, does not allow practitioners to have a plan for how the conversation with a family will go before entering the examination room.

Further, one pediatrician noted that medicine typically does not operate from a strengths-based perspective:

> ***"The way physicians are trained is deficits-based. We're trained to identify a problem and diagnose that problem and treat it and it's just been in the last few years that the field of pediatrics has pushed us to be more strength-based and those changes take a while to percolate through trainees and the people that are teaching trainees. ...that culture change takes a while to get through the field."***

Other barriers noted by interviewees included: (1) having to decipher how to integrate HOPE with another strengths-based framework they were already using, and (2) being unsure how to apply the HOPE framework in practice.

Speaking to the issue of integrating the framework into praxis, one pediatrician commented about the challenges of introducing the *4 Building Blocks* to families, having noticed that for many families it seemed to highlight the actual or perceived absence of assets in each of the Building Block areas and made them feel worse about themselves or their circumstances. This information was a potential barrier to implementation, leading to repeated efforts to try building other types of tools that would not have the same effect. This is one example of the iterative nature of developing a HOPE enhancement. Implementing new ways of thinking and doing is not

always straightforward and may require considerable time and effort. This pediatrician showed persistence when initial efforts did not achieve intended goals; it is likely that not all providers would exhibit the level of tenacity that this pediatrician did.

Aim 3. Implementation: Conclusions and Recommendations

Tailoring the HOPE Framework

The qualitative interviews and focus group with HIN members who were conducting a HOPE-enhanced practice provided more detailed information about what kinds of implementation activities providers and organizations were engaging in. They demonstrated the breadth with which HOPE principles were being translated to practice, suggesting that it is possible to appropriate these principles from current training to"make them their own" in practice whether by targeting cognitive change in individual mindset or behavioral change in materials and approaches used with families or communities. In addition, one provider noted that they had received feedback that the HOPE framework was, in comparison to another strengths-based framework, potentially more accessible than other frameworks as an entry-point to strengths-based work. HOPE might consider in more detail how its framework dovetails with other strengths-based approaches.

Exploring Barriers to HOPE Implementation

Those survey respondents who had implemented a HOPE-informed change generally noted that it was relatively easy to do so in their workplace. Yet, since a substantial minority (40%) of Three-Month Follow-Up Survey respondents indicated that they had not implemented a HOPE-informed change, it is important to consider why that is the case. Explanations for the absence of implementation include lack of congruence between who bears responsibility for organizational decision making and actual implementation of a HOPE-informed change, organizational current use of other strengths-based approaches, the fact that changing organizational culture and individual "mindsets" is challenging when it violates long-held assumptions and approaches, and simple lack of time. Although trainees were enthusiastic about HOPE ideas, there clearly is a gap between aspiration and execution, and further exploration of the barriers to HOPE implementation is recommended. The low response rate to the Three-Month Follow-Up Survey (response rate ranged from 5%-30% within organizations) warrants a cautionary note to drawing strong conclusions from these data. HOPE training attendees who did not respond to the request to complete the Three-Month Follow-Up Survey may have articulated other explanations for the implementation gap than did those who did respond to the survey.

Factors Influencing Ability to Implement HOPE

The variation among respondents to the Three-Month Follow-Up Survey about the level of difficulty they experienced while trying to implement HOPE into their work—ranging from very easy to very difficult, suggests that one's ability to implement HOPE is likely dependent on multiple factors that we could not observe in this evaluation, in part because there were more than 400 workshop attendees who did not respond to our Three-Month Follow-Up Survey. Some of those unknown factors may include one's grasp of the HOPE concepts and their confidence in knowing how to integrate HOPE-informed concepts into their work with families, as well as lack of time, need for additional guidance and HOPE-related resources, and assistance overlaying HOPE's framework with another strengths-based framework to which providers have already committed. Many other factors are worth exploring, such as the importance of support from organizational leadership, buy-in from direct service providers who interact with families, the level of HOPE training required of those who will be implementing HOPE enhancements, and the existence of community, regional, or statewide attention to and funding for HOPE-related concepts such as ACEs, PCEs, and resilience.

HOPE as a Framework Rather Than a Formalized Program

HOPE leaders' decision to present HOPE and its tenets as a framework rather than a more formalized program with specific guidelines and recommendations for policy and practice poses both advantages and challenges. On the one hand, it allows organizations great flexibility and creativity in designing adaptations of the HOPE framework that reflect the nuances of their own program and context. On the other hand, the lack of specificity and articulated steps to implementation may place burden on individuals and organizations that prevent adoption of the framework and translation into practice. Although not without controversy, some have concluded that manual-based interventions (at least in psychology-related fields) are more likely to enhance intended client outcomes and intervention replicability (Goldstein et al., 2013). This may be due to resource scarcity (e.g., many who work in family support roles have few resources)—namely time—to devote to new endeavors, particularly without the buy-in and involvement of other decision-makers in the organization (e.g., the administration). As opposed to implementing a manualized program that has articulated steps and guidance, creating an enhancement "from scratch" requires more time, effort, and intra-organizational coordination than some family-serving providers might have at their disposal.

Implementation Criteria

The lack of specific implementation criteria for HOPE poses evaluation challenges as well, such as not being able to collect and evaluate implementation fidelity metrics across organizations that are using HOPE enhancements, and barriers to determining and identifying sources of implementation efficacy or lack of efficacy. The HOPE framework's successful application in a diversity of family-serving settings might be strengthened by the creation of specific

implementation components created for several different family-serving sectors (e.g., pediatrics, home visiting, early childhood education) that could be incorporated into HOPE's trainings and used to guide implementation and eventually outcomes assessments.

Individual Versus Organizational-Level Change

Undergoing a shift in mindset and practice is a considerable undertaking. Professionals working in fields like medicine that operate within very specific systems of guidelines, protocols, and procedures would need to first be convinced that the effort was important, and directly relevant to their practice and the outcomes of families, if they were going to fully embrace HOPE-informed changes in their work. In particular, instituting an organizational-level change, rather than change only at the individual practitioner level, may require a cultural shift. Both individual and organization-level "buy-in" may be critical to goal attainment. An area for future research is whether organization-wide adaptation of HOPE is necessary for a HOPE-informed enhancement to be successful, and whether individual-level changes that are not supported by or practiced throughout one's organization are sustainable and impactful. For example, there may be an organizational "tipping point" related to proportion of providers, administrators, and policy makers who need to participate in HOPE training in order to achieve successful implementation.

Methodological Considerations

We used multiple methods (surveys, interviews/focus group) to learn about post-workshop implementation. In particular, we urge caution in drawing conclusions from the Three-Month Follow-Up Surveys due to low response rates noted above. Some suggest low response rates increase the chance for sample bias, and that an acceptable survey response rate is much higher than we observed, for example exceeding 40% (Genskow & Prokopy, 2011) or 60% (Fincham, 2008). This information provides important context for interpreting results and drawing conclusions to inform recommendations regarding policy and practice.

Aim 4. Implementation Innovation and Scaffolding: HOPE Innovation Network (HIN)

HOPE leaders launched the inaugural Hope Innovation Network (HIN) in January 2021, envisioning it as (a) a workshop for brainstorming and piloting applications of the HOPE framework from which HOPE leaders could learn about effective implementation approaches and practices and generate new or modified resources to contribute to the HOPE National Resources Center (NRC), and (b) a forum for learning and ideas exchange amongst its members—"the early adopters of HOPE," who would test ideas that they had generated within their organizations about HOPE-informed enhancements in their communities and with the populations they serve.

Evaluation Aim 4: Describe the inagural HOPE Innovation Network (HIN) and its effectiveness in supporting organizations who aim to implement a HOPE enhancement
Evaluation Questions
1. *What did HIN members find valuable about their HIN participation?* 2. *How did participation in the HIN assist its members in moving forward with and sustaining HOPE implementation?* 3. *In what ways could the HIN be improved?*
Data Sources
◦ Interviews with providers and administrators who participated in the inaugural HIN ◦ Observations of HIN meetings ◦ Meetings with HOPE principals

HOPE principals invited individuals from organizations whom they believed to be actively implementing a HOPE-informed enhancement, or to be in the process of planning to do so, to join the HIN. Prospective members submitted applications, and six organizations from around the country committed to participation, including two pediatric practices, a substance use prevention community coalition, a statewide home visiting program, a social service agency, and a community-based organization focusing on child maltreatment prevention. Each organization was encouraged to include all individuals who would be involved in implementing HOPE in HIN meetings. Moreover, the individuals who were spearheading HOPE enhancement efforts within their organizations were generally present at each HIN meeting. For most organizations this meant that one individual attended most or all HIN meetings; one organization had consistent attendance from three to four team members, and several organizations had periodic attendance from staff members who became involved in the enhancement as time went on, or from organizational partners whom they had recruited to be involved in a HOPE enhancement in their own organizations.

The HIN met monthly between January and July 2021 on the Zoom platform (for a total of seven meetings observed by our evaluation team); it was facilitated by the founder of Strengthening Families and a consultant to HOPE, Judy Langford, and attended by HOPE principals and another consultant to HOPE. Meetings were one and a half hours long each. At the beginning of their participation, HIN members were asked to complete an *Organizational Change Recipients' Belief Scale* assessment (Armenikaset al., 2007) in order to evaluate individual and collective readiness to use HOPE-informed approaches and to uncover gaps within their organization that would hinder their ability to create sustainable HOPE-related changes.

The HIN structure for the remainder of monthly meetings included a brief presentation by HOPE principals summarizing HOPE program updates, followed by HIN member organizations' presentations (averaging 5-10 minutes each) outlining a "small test of change" reflecting aspects of the HOPE framework that their organization was implementing. No specific criteria were required for the HOPE-informed test of change, but HOPE principals encouraged the small test of change to have the characteristics of a SMART Aim (i.e., to be specific, measurable, attainable, relevant and time-bound). During their "report out", HIN members were asked to describe their small test of change, who carried it out, what happened when they executed it, what surprised them, whether they plan to make any adjustments based on their implementation effort, and to share a memorable quote or story that came out of their trial.

Based on its goals and structure, we propose that the HIN aspires to be a Community of Practice (CoP), which is defined as a learning and support community for individuals who share overlapping goals and interests, meet regularly, and drawing on a set of common resources, experiences, and approaches, are involved in reciprocal critiquing, collaboration and ongoing learning (Akerson et al., 2009; Naidoo & Vernillo, 2014; Trust & Harrock, 2019). Wenger (1998) outlined three dimensions of Communities of Practice: (1) *Mutual Engagement* involves an "exchange of information and opinions" (p. 75) among members, who come to view one another as having a degree of expertise in the area around which the group has coalesced, and thus have the opportunity to both impart and acquire knowledge and experience; (2) *Joint Enterprise* is a common vision of goals and the work CoPs are engaging in together in their efforts to move in the direction of these goals; (3) *Shared Repertoire* alludes to the resources—knowledge, materials, shared language, norms—that members reference during interactions (Li et al, 2009; Naidoo & Vernillo, 2014; Wenger, 1998).

As this was the inaugural HIN, it was a pilot effort of the HOPE leadership, from which they repeatedly expressed the desire to learn from the first cohort members what worked and what did not work well—knowledge that they intended to apply to future iterations of HIN. Here we consider the alignment and gaps between the inaugural HIN and the three core features of a successful Community of Practice discussed by Wenger (1998): *Mutual Engagement, Joint Enterprise,* and *Shared Repertoire*. For this analysis, in addition to our observations of HIN meetings and discussions with HOPE leaders about the HIN, we draw on interviews and focus groups with ten providers who participated in the HIN.

Mutual Engagement

Several HIN members noted that one thing they found helpful about being in the HIN was learning what other people are doing in their own practice. This allowed HIN members to get ideas for what implementation of the HOPE framework could look like, offering the potential to apply elements of these approaches to their own organization's practice. One member reported thinking during HIN meetings, *"Oh, I wonder what it would look like if we did that here. ...I wouldn't have thought about that."* Another member noted that they have drawn connections between the work of other HIN member organizations and their own, and that they walk away from each HIN meeting they attend with "one idea."Members from two organizations said that they were able to apply ideas they gathered from other HIN organizations' enhancements to their own organization's HOPE enhancement; an example is a handout that one provider created and piloted with families, and then shared with other members in response to their interest about the possible utility of that handout in their own work.

Although HIN meetings were a space for the generation of ideas related to HOPE implementation, the full potential for these ideas to flourish within a CoP may not have been realized. At least one staff member from each of four (out of six) organizations who participated in HIN had taken HOPE training prior to their participation in HIN, between 2017 and 2021; some of these organizations were actively involved with HOPE since their initial training (e.g., had periodic contact with HOPE leaders, followed HOPE National Resource Center activity, and attended more than one event of which HOPE was a part); others attended a single training event during this time period. The two organizations whose participating HIN members had not received HOPE training prior to the launch of HIN had not conceptualized or planned a HOPE-informed enhancement prior to their participation. This meant they had little knowledge of the HOPE framework, which would naturally limit their potential to participate in an exchange of ideas or information with other HIN members who were applying HOPE's framework to an aspect of their organization's practice. One HIN member who had not received prior training noted that other member organizations seemed much more advanced in their fluency with HOPE and that their enhancements seemed more sophisticated.

The monthly "report-out" by members of HIN, which comprised a considerable portion of the monthly meeting, may have impeded the development of mutual engagement by limiting time for interaction between HIN members, such as asking questions or drawing connections between their own work and that about which other organizations were reporting. The structure given to the member report-out component of the HIN meetings (i.e., the small test of change) may have restricted the opportunity for HIN members to "observe" what the organization was doing beyond the small component that fit into this structure. One member commented, "*Sometimes when we're doing the meetings I'm not sure if we're trying to pack too much in, but sometimes it feels a little rushed. ...It would be really nice to go a little bit deeper into what people are talking about...*" This

member further noted that they assumed there was a lot more "richness" to be discovered but that because the member sharing happened in such quick succession, there was insufficient time to generate and pose meaningful questions to one another, to share resources, or to raise and brainstorm solutions to challenges.

With so many people reporting during the short meeting, facilitators had to encourage members to finish up their presentation so that the next group could begin. On select occasions, the HOPE leadership, the HIN facilitator, or other HIN members would offer praise or a point of common ground with one of the presenters, but the virtual Chat function in the Zoom platform was the primary place in which questions, relationship-building, and the exchange of information and opinions could occur. The Chat was lively during the first couple HIN meetings, with members using the Chat (at the encouragement of the meeting facilitator) and expressing enthusiasm about the ideas and implementation strategies shared by other members; this active exchange decreased notably after these initial meetings.

Joint Enterprise

A minority of HIN members indicated that they developed a sense of connectedness to or community with other HIN members throughout the seven months of HIN meetings. Some professional connections were made in the service of advancing HOPE enhancements. Four HIN member organizations reported having contact with other HIN member organizations outside of HIN meetings; two member-to-member interactions occurred once, and for the other two organizations there was more than one meeting reported. The two member organizations who did not receive HOPE training prior to their HIN participation were those that did not report any contact with other HIN members outside of meetings. One individual who reported connecting with another member organization outside of HIN meetings noted the benefit they felt these cross-organization interactions brought to bear on their own thinking about the HOPE work they are doing and the potential of that work to influence families.

In contrast, members of three HIN organizations indicated feeling that the work of their organization was not well-aligned with that of the other HIN organizations, and that therefore it was less likely for them to gain valuable feedback or novel implementation ideas that they could put into practice based on HIN conversations. One member explained, *"we learn from [the report-outs], but we do feel like we're doing a little bit of different work and then there's no feedback [on our work]. So getting a dialogue—so we can move forward through that process—would be helpful for me rather than this one-way sharing out."* Another member agreed, saying, *"being able to take the time in the group to really understand where each other's coming from and how they're doing it would be great. I would love to learn more about what the [social service agency] is doing and the 'why' behind it and where they're coming*

from and their backgrounds and all of that information, so I can completely understand where they're at and why and where they want to go with their vision. Or like for us, you know, this is our vision, this is where we're at, now give us some feedback. Tell us 'What are your ideas?'"

Similarly, one member of the HIN felt a lack of clarity about the motivations of other HIN members for implementing HOPE in their work, as well as why HOPE selected them for inclusion in the HIN. This member also expressed that the end goal of the HIN was not made explicit to the members, and wondered whether there was a larger purpose beyond creating a space where members could learn from one another about their HOPE implementation approaches (e.g., creating a group of HOPE ambassadors). Not having a clear picture of other members' aspirations, ideas about what successful implementation can look like, and the precise nature of the organization's practices around supporting families may hinder joint enterprise. Although this observation was not noted by other HIN members during their interviews, it is possible that other members felt a similar sense of vagueness about what may have tied the various HIN members together. At the first HIN meeting, members were asked to share with the group the "top two reasons they believe in HOPE." This was the only formal opportunity presented by the facilitator or leadership for HIN members to build a foundation of connectedness of purpose with one another. Based on the sentiments of several HIN members, it seems that formal efforts by the HIN facilitator or HOPE leaders to bring the diverse members' joint goals, visions, or common ground to the fore would facilitate the opportunity for social learning—a characteristic of CoPs that enables skill development and knowledge gains via substantial interactions between members (Trust & Harrocks, 2019).

Shared Repertoire

HOPE leaders recruited and selected organizations who represented a range of child-and family-serving sectors to participate in the inaugural HIN. HIN members revealed mixed feelings about the diversity of member organizations. Several members indicated an appreciation for the variety of types of enhancements presented by members of the group, with one noting that in addition to learning about how organizations in different sectors are applying the HOPE framework, they also appreciated the diversity of the types of organizations represented within the HIN, such as statewide versus community organizations. Another member voiced appreciation of the cross-disciplinary organizational membership, describing it as a benefit to have insights into how people think about and work with families in disciplines other than their own. Each of the pediatricians who were involved in the HIN expressed this point of view; this suggests that due to the significant shifts in practice a HOPE-informed approach requires of pediatricians, they may have more to gain from cross-disciplinary interactions than do practitioners from other fields.

For several other HIN members, the diversity of member organizations was a barrier to identifying similarities in the missions, structures, and practices between other HIN member organizations and their own, and therefore members reported difficulty envisioning how the work being done was relevant to their own organizations and target populations. One member said, *"I completely agree that you can learn from everyone and sometimes it's surprising the insights you can get from people who are not doing seemingly similar research or practice, but I do think it has been a little bit more difficult to directly learn from people because they are doing such different things."* Several members expressed a similar sentiment, with one noting, *"...if I were to participate in another one of these, I would find it more beneficial to be with people working in [my field] or [an organization more like ours]."* The nature of the difficulty some members had in finding *"kinship"* with other HIN member organizations may be indicative of a lack of a shared professional repertoire. Even if there were, in reality, more overlap among member organizations than some members perceived, the opportunity to uncover these commonalities within the context of the HIN in the current format was scarce.

One member suggested that if the monthly HIN meeting structure were to continue to involve reports by each member organization, it would be beneficial to focus on one particular aspect of the work each organization is doing in order to reduce repetition and offer skill acquisition for all members. They suggested, for instance, that HOPE could bring a change management expert in to discuss how to respond to challenges or unintended consequences that may come about during implementation. Introducing these learning opportunities in the HIN would begin to establish a shared repertoire among members that may increase a sense of joint enterprise.

Aim 4. Implementation Innovation and Scaffolding: Conclusions and Recommendations

Recruitment and Application Process for Future HIN Cohorts

In order to maximize the potential for HIN to operate as a Community of Practice, demonstrating mutual engagement, joint enterprise, and shared repertoire HOPE has several opportunities to enhance the functioning of future HINs. For example, each of these characteristics might be strengthened by considering how best to comprise a HIN. When recruiting for future HIN cohorts, HOPE leaders should carefully consider the characteristics and qualifications of member organizations. Two prerequisites seem particularly important: (1) having participated in a HOPE training, and (2) having an idea for a HOPE-informed enhancement. Having no foundational knowledge of HOPE when joining the HIN prevents full participation, thereby inhibiting the member organization from experiencing the full potential of the HIN, and constraining the HIN overall because all organizations cannot contribute meaningfully and equally. In the same vein,

organizations who are actively engaged in either conceptualizing or executing a HOPE-informed enhancement will have more to offer during HIN meetings. Having members who are engaged in similar types of enhancements may increase the belief of HIN members in joint enterprise as well as boost the shared repertoire of the group. A carefully constructed application process for the HIN will allow HOPE leaders to maximize the benefits of the group for members, and convey to applicants the commitment expected of HIN members to participate in a CoP where they can make robust contributions to conversations during HIN meetings, and be open to learning and receiving feedback from other professionals. HOPE leaders can continue to explore indicators of individual and organizational readiness to participate in an active CoP that helps facilitate growth and learning for all involved, and consider assessing for these characteristics during the application process. Further, HOPE leaders should clearly outline to prospective applicants the anticipated benefits and constraints to participation in HIN.

HIN Curriculum

A possible alternative to the model HOPE used for the inaugural HIN (i.e., reporting by each organization on a small test of change during each meeting) is one in which each organization gets the spotlight for one whole meeting. The organization could outline their core model of delivering services to families, their goals for a HOPE enhancement, and where they are in their progress toward implementing the enhancement. The spotlighted organization could generate questions for the group based on their piloting of the enhancement or their vision for the next stage, and HIN members could have a chance to share their knowledge, experiences, resources, and ideas. This alternative approach might bring about more lively dialogue and a greater sense of group cohesion.

Scaffolding Around Readiness for Change

HOPE leaders might consider evaluating the HIN curriculum from a developmental point of view. In the current HIN, following a review of the results of the Organizational Change Recipients' Belief Scale assessment (Armenikas et al., 2007) reflected in the responses of HIN members, there was no scaffolding by HOPE principals to support an organization's in-depth assessment, engage in ongoing conversations about various aspects of their readiness, or suggest strategies to address identified areas of need. If readiness for change is believed to be a key indicator of success among those who are undertaking a HOPE-informed implementation effort, more scaffolding and coaching from the HIN leadership in this area is recommended.

The Role of HOPE Leadership in Supporting HIN Organizations

HOPE leadership plays a very important role in the HIN, both substantively and in terms of group process. We encourage the HOPE principals to evaluate their own role and functions in the HIN. HOPE leaders praised members' implementation efforts following their reports of small tests of change, as well as asked for critical responses about HOPE materials and the HIN process from members. However, HOPE leaders did not scaffold members' enhancement efforts during the HIN meetings, nor did they offer members critical feedback. Several members, though, reported having expected HOPE leaders' input on their HOPE-informed work when they had applied for the HIN. These HIN members reported wanting that from the HOPE experts, and also lamented that the HIN felt like a *"one-way street"* on which only they were sharing. In addition to HOPE leaders infusing more analytical feedback during HIN meetings, adding a coaching component to HIN—involving several hours of coaching from HOPE leaders—could benefit organizations who have not yet conceptualized or finalized their idea for an enhancement as well as those who are farther along in the process but are struggling with an aspect of implementation or not seeing anticipated results.

Aim 5. Providers' Perceptions of HOPE's Influences

We used a mixed-methods approach to explore the potential influences of HOPE implementation by asking providers who had implemented any type of HOPE enhancement HOPE to share their views of whether using HOPE in their practice had influenced families, providers, or the interactions and relationships between these groups. While we would hypothesize that the nature and degree of influences would be related to various factors, such as the type, length, and intensity of the enhancement, that type of inquiry was outside of the scope of this evaluation, and would have been premature for HOPE's developmental stage and relative to the number of providers who were actively implementing a HOPE enhancement from 2020 –2021. The focus of this aim was exploratory; we were interested in providers' perceptions of influences that they attributed to the HOPE-informed changes they had implemented. Data sources for this aim included the Provider Three-Month Follow-Up Survey (both open-and close-ended responses) and qualitative data from the interviews and one focus group with the HIN providers as well as with the provider who was not involved in the HIN.

Most providers in this analytic sample (i.e., the respondents to the Three-Month Follow-Up Survey and the interviewees) had been involved in implementing HOPE for a short period of time when they were asked to comment on their perceptions and observations of the impacts of HOPE. With the exception of one interviewee who had been engaged in HOPE implementation for several years, interview and focus group participants had started their HOPE enhancements two to ten months earlier. Respondents to the provider three-month follow-up survey had only received their HOPE training three months earlier. None of the interview or focus group participants were doing formal internal evaluations of their HOPE enhancements, but in qualitative interviews and the focus group some providers spoke about perceived impacts of HOPE-informed approaches on families and providers. Some three-month follow-up survey respondents, when asked, elected to elaborate on how parents have responded to HOPE-informed changes they have made. Here we bring together those responses based on the "intended recipients" (i.e., parents, children, providers), the groups in which impacts were observed.

Evaluation Aim 5: Identify the potential influences of implementing HOPE—on parents, providers, and parent-provider interactions or relationships
Research Questions
1. *Did providers who implemented a HOPE-informed change in practice perceive any changes among parents or providers?*
Data Sources
◦ Provider Three-Month Follow-Up Survey ◦ Provider interviews and focus groups

Reactions of Families, Children, and Parents

Of the 28 respondents who completed a Three-Month Follow-Up Survey and indicated they implemented a HOPE-informed change in their work, 24 answered the question *How do you think the families you work with are reacting to the HOPE-informed changes that you have been incorporating into your interactions with them since the workshop?* Of the 15 of those 24 respondents who work directly with families,[36] six selected *I'm not sure if families are interacting with me any differently than they were before I started implementing HOPE, or if the quality of our relationship has changed;* and nine selected *I have noticed an improvement in the quality of my relationships and my interactions with families since I started implementing HOPE.* These findings suggest both the potential for HOPE to influence providers' interactions with families, and also raise questions about why some of the providers had not (or not yet) observed the desired change.

Qualitative data from open-ended responses as well as interviews and the focus group were informative, suggesting that changing interactions and relationships between providers and families is challenging work *and* that it can have positive benefits for the emotional well-being of families and providers and the potential to shift organizational culture.

For example, a staff member involved in the HOPE enhancement in one of the pediatric clinics reported,

> ***...from what I have seen when I'm shadowing [a doctor] it definitely brings a smile to [the family's] face after you've had a really grim visit about something serious going on health-wise and then you say you know, 'but look you're doing all of these things so well, and because you've provided a safe stable place to live and learn and grow we're able to work on these things, so you should be really proud of yourself,'***
> ***And you can even just tell it, you know, kind of lightens the mood a little bit and makes it feel a little bit less helpless.***

[36] Nine of the 24 respondents reported that they did not directly work with families.

The hospital-owned clinic pediatrician whose HOPE-informed enhancement focused primarily on *Building Block 4* (Social and emotional growth) said that many parents who had practiced the suggested techniques to grow skills for coping with difficult emotions in children reported that children's emotional outbursts and behavioral problems had diminished over the course of several weeks.

An administrator of a home visiting program also perceived positive impacts of HOPE on families, but that there was variability across families. They noted that these impacts were harder to come by for some families, suggesting:

> ***"I think you have to highlight them again and again and again. Because we try and foster a sense of hope and healthy relationships…but that pull is strong, that my parent left me when I was six and I was in foster care, you know. That pull is strong that they didn't care and I had to find food in a dumpster you know. I mean and I'm using those extreme examples, but they're real examples."***

The pediatrician at the hospital-owned clinic reported that the children and youth they worked with directly felt validated that *"their doctor told them that their feelings were important."* A different pediatrician, working in the community clinic, had piloted use of a different strengths-based assessment to guide interactions with families during clinic visits prior to rolling out the enhancement to pediatric residents, and they indicated that parents had a positive response when the doctor made suggestions based on the *4 Building Blocks.* Emphasizing Building Block 1 (Relationships), the physician encouraged the development of a nurturing relationship between parent and child by suggesting activities that involved playing together. They noted that when that suggestion was made to families with children between five and eight years old, the child would respond positively, exclaiming for example, *"Oh, we get to do this together?!"*

Providers who participated in the evaluation emphasized perceived impacts on parents most of all. The community clinic pediatrician indicated that parents responded favorably to receiving feedback about their strengths, saying, *"Parents love hearing that they're doing things well. I've never had a parent not say something akin to, 'Oh my gosh, thank you for saying that. I'm not used to people saying I'm doing something well.'"* In open-ended survey responses, one provider reported that using HOPE increased parents' focus on strengths, writing that HOPE encouraged parents to think about their own strengths, not only their children's strengths. Another respondent indicated that parents are given the opportunity to be *"proud of things they are doing well instead of focusing on areas*

that need improvement. I feel this has increased their willingness to engage and work with me." In the same vein, a third respondent wrote:

> ***I think parents tend to only focus on what is going wrong or what doesn't work in their lives. Many times when I'm talking with a family and I ask them to tell me one of their strengths, they are often stumped. We explore all the small things that are going well, and that often leads to larger accomplishments. Numerous times by the end of the conversations, parents often tend to feel a little more proud of themselves.***

Finally, a fourth respondent noted, *"Parents seem to be more open to sharing what is going on in their lives and asking for assistance."*

Reactions of Providers

Providers also reportedly experienced benefits from embracing the HOPE framework and channeling it during their work with families. They noted both benefits to their own emotional well-being and to the strength of their beliefs in their own practice. The pediatrician from the community clinic reported having received feedback from the residents who were implementing the HOPE enhancement stating that they *"really liked ending visits this way. Like ending on something that is motivating and something that allows the family to kind of walk out of the room with a sense of agency or a sense that the visit ended positively."* Similarly, the pediatrician in the hospital-owned clinic described HOPE as being good for their morale as a practitioner, due to it being more focused on solutions that can improve families' lives. *"Doctors," they said," are trained to look for what's wrong and it's so demoralizing. After a while, you get really tired of looking at everything that's wrong."*

One respondent to the Three-Month Follow-Up Survey described the personal impact they experienced through exposure to the HOPE framework and subsequent enhancement of their strengths-focused implementation efforts: *"I try to bring a strengths-based lens to everything I do. And I try to be a source of strength myself for the young people with whom I work. I think I always did that, to some extent, but it feels more intentional now. The HOPE training validated what I believed in my heart, which helps me feel stronger about what I believe."*

The home visiting program manager commented on what they view as the impact of HOPE on their organizational culture:

> *I think one of the biggest successes for implementing HOPE has just been the culture of seeing families as having enormous potential and strengths already, that are far beyond what the family thinks they have. So I think it's a culture of acceptance, it's a culture of empathy, it's a culture of compassion and understanding. And it's also a culture of potential and accountability, you know that they have, they already have what it takes…*

Development of a Parent Survey

To assess actual effects on families that might be associated with HOPE-informed implementations, pre-and post-implementation measures should be used to assess whether family support providers are effectively incorporating the HOPE framework, and whether doing so has any influence on desired outcomes. Our efforts focused on creating a measure to assess parents' perceptions of their relationship with their providers, perceived parenting stress, perceived ability to create positive experiences for their children and to support their children's social-emotional development, and other outcomes that HOPE anticipates would be associated with incorporating the HOPE Building Blocks into practice. Although HOPE is not a manualized program, the HOPE framework includes critical elements that are intended to be at the core of HOPE-informed implementation efforts, and it is these core elements that we used to create a Pilot Parent Survey. TIER took the first step in developing such a measure, and began pilot testing two versions of a pre-survey in two sectors: healthcare and home visiting. These surveys and our process for testing them are described in detail in Appendix D. Further measurement work and pilot testing would be required before these surveys are ready to disseminate for assessment of impacts.

Aim 5. Providers' Perceptions of HOPE's Influences: Conclusions and Recommendations

Percieved Improvements in Relationships with Families

Although numbers are small (e.g., of trainees who had implemented a HOPE enhancement, worked directly with families, and responded to the Three-Month Follow-Up Survey) some providers perceived improvements in their relationships with families since implementing HOPE in their practice, while others did not. Similarly, some other providers who participated in interviews and the focus group also articulated sometimes substantial improvements in interactions resulting from HOPE implementation. Providers who responded to either the Three-Month Follow-Up Survey or participated in an in-depth interview or focus group had been implementing HOPE for less than one year (some for a few months or less), perhaps not

enough time to change longstanding relationship assumptions and patterns. For the providers who reported no change in interactions and relationships, perhaps perceptions of positive changes might emerge with a longer period of implementation. Particularly among clients with longstanding histories of ACEs, discrimination, and institutionalized racism, changing relationships with people representing such institutions or positions of authority (e.g., hospitals, physicians) may take considerable time and resources.

Emotional Well-Being of Families and Providers

Qualitative analysis indicated that providers perceived a range of different types of influences on families and on providers, including improvements in the emotional well-being of parents, children, and providers themselves. One provider also perceived shift in organizational culture.

Methodological Considerations

Since there was no comparison group (i.e., providers who responded to questions about provider-family relationships who did not implement HOPE) we do not know whether any perceived effects noted are due to the HOPE implementation per se. For example, relationship quality may improve with the passage of time, as families and providers have more "history" together. In addition, the respondents were the providers who themselves had implemented a HOPE-informed enhancement, and not "unbiased" observers; this identity might have influenced their responses. One recommendation would be for neutral observers to view and assess interactions and relationship quality both pre-and post-implementation.

SECTION IV: FINAL REFLECTIONS, RECOMMENDATIONS, AND OPPORTUNITIES

Throughout the report we have provided conclusions and recommendations for HOPE based on our findings for each of the five evaluation aims, aligned with each of the possible stages of the HOPE life cycle. As HOPE continues to use its training and materials to work toward its goal of catalyzing a paradigm shift in "practices, systems, and cultural narrative" (HOPE, 2021) in the direction of recognizing the power of positive childhood experiences (PCEs) to foster well-being in childhood and adulthood, we offer some summative thoughts that underscore the functional role of each of the four stages leading up to the ideal of the outcomes HOPE envisions.

HOPE Training and Materials

Overall, people are enthusiastic and inspired when they learn about the research behind HOPE. Based on feedback from attendees at HOPE trainings and those who are implementing HOPE enhancements, providers want to be a part of a movement that promises to improve outcomesfor children and families—especially those who have experienced ACEs. The HOPE framework is viewed by many as a possible antidote to ACEs; many providers have struggled with how to help families cope—and indeed how to cope themselves—with the troubling realities associated with exposure to multiple ACEs. HOPE also seems to many providers to be accessible in its simplicity. Attendees of the HOPE workshops found the training to be engaging and relevant, an essential first step in laying the groundwork for the possibility of making a fundamental change in providers' underlying assumptions and approach to working with families. And, post-workshop, overall attendees reported greater perceived knowledge of ACEs and PCEs, and greater perceived confidence in knowing how to discuss PCEs with families. Yet HOPE's goals of their training and framework effectuating behavioral change requires more than perceived *knowledge acquisition*, and questions remain for further exploration.

Dosage

What is the ideal "dosage" of HOPE that will enable providers to change their thinking and their practice toward this particular strengths-based approach? Although we were unable to include the more frequently delivered 1-hour trainings in this analysis, comparison of perceived knowledge acquisition from the 2-and -4-hour workshop did not reveal significant differences in respondents' knowledge and confidence. With two additional hours being allotted to knowledge and skill development, differences would be expected. The goals, curricula, proportion of time dedicated to knowledge enhancement, skill-building, and implementation planning during the intermediate (2-hour) and advanced (4-hour) workshop formats, along withother substantive similarities and differences between these training formats (e.g., workshop leaders) would benefit from additional scrutiny.

Sustainabilty of Knowledge Acquisition and Translation to Practice

What changes to HOPE workshops will enhance perceived knowledge retention and confidence? The lower scores in providers' confidence about incorporating PCEs into interactions with families three months after their workshop attendance warrants attention, as confidence (or lack thereof) may be reflected in providers' behaviors toward implementing HOPE in their practice. Some respondents' answers to open-ended questions in the Post-Workshop Survey and Three-Month Follow-Up Survey highlighted their desires and needs for additional guidance from HOPE or refreshers to enable their progression from having gained knowledge of PCEs and the research behind HOPE to implementation of the HOPE framework. HOPE might consider evaluating the need to offer "HOPE Booster" activities or materials post-workshop, or a follow-up workshop focused on applying knowledge of PCEs.

HOPE Implementation

The "theory of planned behavior" (Ajzen, 1991) may be useful in understanding both successes and the challenges in the translation and application of the HOPE framework to policy and practice. According to this theory, human action is guided by three kinds of considerations: (1) *behavioral beliefs* about anticipated outcomes, (2) *normative beliefs* about the expectations of others and the motivation to comply with these expectations, and (3) *control beliefs* or self-efficacy about the perceived presence and power of factors that may facilitate or impede performance of the behavior. Thus, even when an individual provider understands and agrees with (*behavioral beliefs*) the potential benefits of a HOPE-informed approach, these beliefs reside within the context of normative beliefs about others (e.g., within their organizations or even their clients) and their willingness and ability to implement HOPE-informed practices. If a provider believes that others will not share their own enthusiasm or commitment for implementing a HOPE-informed change in practice, they may be less inclined to mobilize the energy, time, and resources to move forward on behalf of such practice. Importantly, *control beliefs* (a person's self-efficacy and beliefs about promotive or impeding conditions—such as organizational barriers to change) may partially explain a gap between endorsement of HOPE tenets and actual implementation in practice. As noted by Ajzen (1991), achieving a goal depends on both intention and behavioral control, including access to resources.

Taken together, the quantitative Three-Month Follow-Up Surveys and the qualitative interviews with members of the HIN provide some insight into a possible implementation gap. Providers who responded to the three-month survey and who had implemented HOPE noted that it was relatively easy for them to do so. Intentions to implement did not always result in actual behaviors, though, as not all providers who intended to implement HOPE had done so during the three-month period post-training, and many providers did not respond to the three-month survey (it is not known whether those who did not implement HOPE were also less likely to respond to the survey.) What, then were the barriers? Do providers perceive that it will be "too heavy a lift" to convince others in their organization that changing practice to include HOPE-informed behaviors would add value to work they are already doing, or be worth their investment of resources? Do they view the endeavor of creating a HOPE enhancement to be a deterrent? Are there structural or other barriers that are unique to their organizations that they believe are insurmountable? Are they using other strengths-based frameworks in their practice and don't perceive unique benefits to adopting HOPE?

Initial knowledge acquisition and enthusiasm for HOPE tenets is a first and essential step, though in most cases it is likely not sufficient to enable providers to create a unique HOPE enhancement for the populations they serve and the structures and policies specific to their organization, and to execute that enhancement. Even the highly motivated "early adopters of HOPE"—members of the inaugural HIN cohort—expressed the desire for more feedback and input from HOPE leadership about their enhancement ideas and efforts, including in the form of handouts and posters for use with families. Most workshop attendees will not have the opportunity to participate in a HIN cohort.

Implementation Guidance

Strengthening implementation guidance could benefit HOPE in addition to benefitting those who are enthusiastic about adopting HOPE-informed strategies, as it gives HOPE the opportunity to ensure that implementation approaches are consistent with the HOPE framework, and to begin to focus on how to create the specific outcomes HOPE might envision being possible for families exposed to HOPE enhancements. Three ideas rose to the surface from the survey, interview, and observation data we collected during this evaluation that HOPE might consider adopting into its formal offerings to consumers of HOPE.

Enhancing Implementation Planning During HOPE Workshops

In our view, building a bridge between HOPE knowledge acquisition and implementation that most attendees can envision crossing with relative ease requires additional input from HOPE. This input is likely necessary during the initial training HOPE provides to attendees, wherein HOPE leaders can build upon attendees' perceived knowledge gains and enthusiasm about the prospect of change by introducing more tangible implementation strategies, tools, and perhaps in the future, sharing successful models of HOPE enhancements that have been implemented. The goal of providing concrete implementation guidance during HOPE trainings would be to alleviate the load on HOPE training attendees to begin at "square one" to develop a HOPE enhancement. For those who have already attended HOPE trainings, and perhaps also for future training attendees, HOPE may consider post-workshop support offerings focused on implementation, perhaps in the form of a "HOPE booster" at a point following training.

Coaching and Mentoring

Adding a coaching or mentoring component to HOPE training may enhance providers' ability to imagine a change in their particular organization or practice and implement the steps necessary to bring it to fruition. Input provided by HOPE training attendees for multiple aims of this evaluation addressed this issue of needing additional guidance in order to take the next step that HOPE intends. Initial coaching could come from HOPE principals and staff during 4-hour workshops, with a set number of hours of coaching offered after workshops. Another consideration might be to develop a peer mentoring model, wherein members of the HIN who have successfully implemented a HOPE enhancement in their organizations could consult with organizations and providers needing assistance in integrating HOPE into their own practice. Successful execution of a peer coaching or mentoring model would require further development of the HIN to incorporate an intentional coaching component provided by HOPE leadership, as well as oversight and support from HOPE and potentially a "credentialing process" for the peer mentors.

Alignment between HOPE and other Strengths-Based Approaches

Outside of the healthcare sector, many programs that serve children and families are already utilizing strengths-based approaches in their practice. Nearly all providers who participated in an evaluation interview or focus group indicated another strengths-based framework that they had already been applying in their work prior to being exposed to HOPE. Some providers had success integrating the two frameworks, and others used an additive approach. Still others mentioned some difficulty reconciling what they were already doing with a HOPE-informed approach and mentioned this as a barrier in their implementation of HOPE. Additionally, during interviews with providers who were involved in HOPE implementation efforts, it is noteworthy that many providers had difficulty articulating the aspects of their strengths-based practice that could be attributed to HOPE versus another strengths-based approach. To be able to take the steps to integrate HOPE into practice, providers should understand the points of overlap with other frameworks, as well as what is unique about the HOPE approach and what it might bring to their practice and the families they work with. We recommend that HOPE conduct a "crosswalk" or mapping of their framework in relation to other strengths-based frameworks. One HIN organization undertook this effort on their own and while they were satisfied with the result, it required considerable effort. If every organization that is interested in implementing HOPE has to take on this endeavor individually, it may be a deterrent to fully embracing HOPE and being able to envision a successful integration of HOPE with a different framework that they already understand well and utilize effectively.

Building Block Conversation Tools

One provider noted that in discussions with families, sometimes reviewing the Building Blocks made families feel like they didn't have many (or any) assets in place which "made them feel worse." Some "anticipatory guidance" around this issue could be part of more specific implementation guidance provided in HOPE workshops and materials. In problem-solving around this and other implementation challenges, two members of the HIN created "conversation tools" to guide providers' conversations about families' assets and reported that families had responded positively to a careful execution of this process. The idea of a conversation tool being used as a HOPE enhancement reflects the HOPE framework in that it conveys to families the importance and the ability of families to create positive experiences. It also reflects HOPE's ideal of promoting collaborative relationships between providers and families because it can facilitate family members sharing their ideas and providers reinforcing those ideas as well as suggesting additional perspectives if appropriate. Finally, it gives providers the opportunity to view their role vis-à-vis families differently, and to experience a positive boost in morale by engaging in these discussions.

HOPE Innovation Network (HIN)

If the HIN is conceptualized as a Community of Practice (CoP) with features of mutual engagement, joint enterprise, and shared repertoire, the inaugural HIN demonstrated greater strength in some areas than in others. Members said they enjoyed the meetings and learned new ideas from other HIN members; however, lack of time at the HIN meetings for mutual brainstorming and resource sharing hampered the ability of HIN to reach its full potential. Unfortunately, most HIN members did not develop a sense of connectedness to each other that characterizes a successful CoP. Conversations with HIN members revealed several potential explanations, including misalignment of different organization characteristics and goals, little understanding of other members' practices and aspirations, and lack of clarity around what successful implementation would look like. Strategic scaffolding of the HIN meetings and "extracurricular" activities by HOPE principals may be necessary to foster the ingredients that would enable HIN to function as a successful CoP.

The other function of the HIN was to serve as a workshop wherein HIN members could develop a repertoire of HOPE enhancement ideas, and to pilot these ideas in the field, thereby providing a stream of ideas to HOPE leaders that presumably could eventually be incorporated into a catalog of tested approaches. As one of the HOPE leaders explained during an early HIN meeting, "All of the real work happens in communities with people who try to figure out how a new idea fits into work being done already. ...This is a way of harvesting what people are already doing." We agree that there is merit to this approach and that there is a lot that could be gained by following the progress of these initial HIN members as they continue piloting their ideas with the populations they work with. In addition, we heard from some HIN members that the process

seemed like a "one-way street," and that something they had hoped to gain from HIN was specific input, direction, and collaboration from and with HOPE leaders. We recommend emphasizing a reciprocal exchange of ideas for future cohorts.

Perceived Influences of HOPE

Some providers who had shared their experiences through the Three-Month Follow-Up Survey or during one-on-one or group interviews and had implemented HOPE to varying degrees reported perceived positive influences of the implementation (e.g., emotional well-being of family members and providers, improved communication with provider, an organizational culture shift toward greater compassion for families). Some respondents had not noticed differences in interactions between families and providers. Given that a shift in behaviors is one of the primary goals of HOPE it is important to consider explanations. Are these programs and providers already using strengths-based approaches and have they not experienced HOPE as "value added"? Are they not (yet) confident in their implementation strategies? Are they working with families with very high ACEs and histories of mistrust of institutions due to social disparities?

It is also noteworthy that some of the core features of the *4 Building Blocks* are systems-level issues that would not be readily malleable based on the efforts of a single provider. A home visitor or a pediatrician, for instance, cannot on their own improve the quality of education available to a child. For one, doing so is outside the scope of their field, and for another it's not within the power of one person to change. HOPE, then, will need to establish realistic, achievable desired outcomes to be tested in the future. Evidencing change in different contexts necessitates different resources and timetables. Depending on their contexts, large—rather than small—acts of change may be necessary to "shift the narrative and behaviors."

Methodological Considerations

Of course, all research and evaluation must be viewed in context, including methodological context. Here we offer some reflections on the findings in this report.

- The small sample sizes available to address some evaluation aims and research questions (e.g., Aim 3: Implementation; Aim 5: Perceived Effects on families and providers) suggest that the "lessons learned" are informative rather than conclusive.
- Survey response rate raises questions about representativeness and generalization to a broader population.
- Because HOPE is in a more "formative" phase as a framework and organization, a process (implementation) evaluation was the appropriate evaluation design for its stage of maturity. Because this design does not include a control or comparison group who did not "receive the intervention," we urge caution about implying causality in attributing findings to HOPE.

Conclusion

It is impressive that HOPE has provided training to thousands of providers who work in family-serving organizations. And it is timely that HOPE invest in program evaluation that provides information about how the HOPE trainings are received and implemented in practice. HOPE can use this knowledge to inform Quality Improvement activities to develop "HOPE 2.0." Understanding how HOPE engages its audience, what child and family-serving individuals and organizations gain from HOPE trainings, and how they intend to adapt and integrate HOPE tenets into their practice—and the barriers to doing so—are critical developmental steps for an organization whose goal is a paradigm shift in "practices, systems, and cultural narrative" (HOPE, 2021) toward child and family health and well-being. Workshop attendees and HOPE early innovators have provided valuable feedback concerning the next steps HOPE can take to enhance their approach as they seek to catalyze a paradigm shift toward recognizing and enabling the power of positive experiences.

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APPENDICES

APPENDIX A: PROVIDER PRE-WORKSHOP SURVEY

Researchers from Tufts Interdisciplinary Evaluation Research (TIER) at Tufts University in Medford are conducting a study to learn how health care providers can best interact with and provide support to families. As part of this project, we would like to invite you to complete this survey about your experiences with your healthcare provider. There are no right or wrong answers to the survey. The survey takes 10-15 minutes to complete.

Your participation in this survey is voluntary—you do not have to complete the survey. Your survey responses will be kept confidential—only Tufts Interdisciplinary Evaluation Research (TIER)—the research group who is evaluating HOPE—and staff members at Healthy Outcomes from Positive Experiences (HOPE) will see your responses; your healthcare provider will not see them. Information will be reported only in aggregate, meaning no answers will be connected with your name. Information we learn from this survey will help healthcare providers improve the services they provide to families. After you fill out this survey, we will ask for your email address separately to send you a $10 Amazon gift card to thank you for your time.

An Institutional Review Board ("IRB") is overseeing this research. An IRB is a group of people who perform an independent review of research studies to ensure the rights and welfare of participants are protected. If you have questions about your rights or wish to speak with someone other than the research team, you may contact:

Tufts Social, Behavioral, and Educational Research IRB
75 Kneeland Street, Suite 623
Boston, MA 02111
617.627.8804
SBER@tufts.edu

If you are willing to participate, please provide your consent.

- ○ I agree to take this survey
- ○ I do NOT agree to take this survey [DIRECTED TO END OF SURVEY VIA SKIP LOGIC]

DIRECTIONS

When answering the questions in this part of the survey, please think about all of the conversations you have had with the healthcare provider who sees your child when they come in for a well-child visit (for example, to receive vaccines). Your healthcare provider refers to your doctor, nurse practitioner (NP), or physician's assistant (PA). Please rate the statements below from 0 (not at all true) to 100 (very true). Draw a line up and down like this | or an X anywhere on the number line to show how you feel about each statement.

Not at all true — Very true

1. I can tell my healthcare provider things that are important about my life.
2. My healthcare provider makes me feel like I have the ability to act on my goals.
3. My healthcare provider talks too much about the negative or hard things in my life.
4. After meeting with my healthcare provider, I feel a sense of hope about changing the things in my life that I can control.
5. My healthcare provider is interested in my ideas about how to make my and my child's life better.
6. When talking about hard things in my life, my healthcare provider helps me see that there are positive things too.
7. My healthcare provider asks me about my own physical and/or mental health during our visits.
8. My healthcare provider has given me ideas about how to make interactions with my child better.
9. My healthcare provider asks me whether I take part in activities or organizations in my community (e.g., library, houses of worship, clubs, etc.).
10. I feel comfortable sharing my cultural beliefs and practices with my healthcare provider because they will respect my beliefs and practices.

11. I think my healthcare provider views my race or ethnicity in a negative way.
12. My healthcare provider is someone I could talk to if I or my child had an experience with discrimination.
13. In the last month I feel like my relationship with my child is going well overall.
14. My healthcare provider gives me information about how to help my child get along with other children.
15. My healthcare provider encourages me to have my child play with other kids.
16. The staff in this office asks me if my child and I feel safe at home.
17. The staff in this office talks with me about positive ways to respond to my child when they misbehave.
18. The staff in this office celebrates the activities my child does at school and in their community.
19. The staff in this office talks about positive relationships my child has or can have with other adults.
20. The staff in this office encourages me to take part in activities or organizations in my community that might be good for me and my family (e.g., library, houses of worship, clubs).
21. The staff in this office has ideas and resources for when my child is struggling with friendships.
22. After meeting with the staff in this office I feel better able to manage stress in my parenting role.
23. The staff in this office shows me ways to help my child express their feelings.
24. The staff in this office helps me respond to my child's feelings of anger, frustration, or sadness in a positive or helpful way.

Next, we will ask you a few questions about yourself.

25. How many children do you bring to get care at this doctor's office?

_____

26. What are the ages of your children you bring to get care at this doctor's office?

_____

27. Your (the parent's or caregiver's) age in years.

_____

28. Your racial identity (Check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

29. Your ethnic identity

- ☐ Hispanic
- ☐ Non-Hispanic

30. Your primary language (Select ONE)

- ☐ Arabic
- ☐ Cantonese
- ☐ Cape Verdean Creole
- ☐ English
- ☐ French
- ☐ Haitian Creole
- ☐ Mandarin
- ☐ Portuguese
- ☐ Somali
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other (please specify):

31. Do you speak another language?

- ☐ Yes
- ☐ No

32. Your second primary language is (Skip if you do not speak another language)

- ☐ Arabic
- ☐ Cantonese
- ☐ Cape Verdean Creole
- ☐ English
- ☐ French
- ☐ Haitian Creole
- ☐ Mandarin
- ☐ Portuguese
- ☐ Somali
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other (please specify):

33. Your gender identity

- ☐ Man
- ☐ Woman
- ☐ Non-binary
- ☐ Not Listed:
- ☐ Prefer not to respond

34. Do you identify as transgender?

- ☐ Yes
- ☐ No
- ☐ Prefer not to respond

Thank you for completing this survey! We need your email address so that we can send you an e-gift card in the amount of $10. By clicking submit to this survey, we will take you to a separate survey where you can fill in your email address. We will only use that email address to send you your e-gift card. We will not connect your email address to your answers on this survey.

Click **here** to continue to fill out the gift card form!

APPENDIX B: PROVIDER PRE-WORKSHOP SURVEY

Researchers from Tufts Interdisciplinary Evaluation Research (TIER) at Tufts University in Medford are conducting a study to learn how home visitors can best interact with and provide support to families. As part of this project, we would like to invite you to complete this survey about your experiences with your home visitor. There are no right or wrong answers to the survey. The survey takes 10-15 minutes to complete.

Your participation in this survey is voluntary—you do not have to complete the survey. Your survey responses will be kept confidential—only Tufts Interdisciplinary Evaluation Research (TIER)—the research group who is evaluating HOPE—and staff members at Healthy Outcomes from Positive Experiences (HOPE) will see your responses; your healthcare provider will not see them. Information will be reported only in aggregate, meaning no answers will be connected with your name. Information we learn from this survey will help home visitors improve the services they provide to families. After you fill out this survey, we will ask for your email address separately to send you a $10 Amazon gift card to thank you for your time.

An Institutional Review Board ("IRB") is overseeing this research. An IRB is a group of people who perform an independent review of research studies to ensure the rights and welfare of participants are protected. If you have questions about your rights or wish to speak with someone other than the research team, you may contact:

Tufts Social, Behavioral, and Educational Research IRB
75 Kneeland Street, Suite 623
Boston, MA 02111
617.627.8804
SBER@tufts.edu

If you are willing to participate, please provide your consent.

- ○ I agree to take this survey
- ○ I do NOT agree to take this survey [DIRECTED TO END OF SURVEY VIA SKIP LOGIC]

DIRECTIONS

When answering the questions in this part of the survey, please think about all of the conversations you have had with your home visitor. Please rate the statements below from 0 (not at all true) to 100 (very true). Draw a line up and down like this | or an X anywhere on the number line to show how you feel about each statement.

1. I can tell my home visitor things that are important about my life.
2. My home visitor makes me feel like I have the ability to act on my goals.
3. My home visitor talks too much about the negative or hard things in my life.
4. After meeting with my home visitor, I feel a sense of hope about changing the things in my life that I can control.
5. My home visitor is interested in my ideas about how to make my and my child's life better.
6. When talking about hard things in my life, my home visitor helps me see that there are positive things too.
7. My home visitor has helped me see how I can create positive experiences for my children.
8. My home visitor asks me about my own physical and/or mental health during our visits.
9. My home visitor has given me ideas about how to make interactions with my child better.
10. My home visitor asks me whether I take part in activities or organizations in my community (e.g., library, houses of worship, club, etc.).
11. My home visitor talks to and treats my child as though they matter.
12. I feel comfortable sharing my cultural beliefs and practices with my home visitor because they will respect my beliefs and practices
13. I think my home visitor views my race or ethnicity in a negative way.
14. My home visitor is someone I could talk to if I or my child had an experience with discrimination.
15. My home visitor asks me if my child and I feel safe at home.
16. My home visitor talks with me about positive ways to respond to my child when they misbehave.
17. My home visitor celebrates the activities my child does at school and in their community.
18. My home visitor talks about positive relationships my child has or can have with other adults.
19. My home visitor encourages me to take part in activities or organizations in my community that might be good for me and my family (e.g., library, houses of worship, clubs).

20. My home visitor has ideas and resources for when my child is struggling with friendships.
21. After meeting with my home visitor, I feel better able to manage stress in my parenting role.
22. My home visitor shows me ways to help my child express their feelings.
23. My home visitor helps me respond to my child's feelings of anger, frustration, or sadness in a positive or helpful way.
24. My home visitor asks me about good things from my own childhood.
25. My home visitor shows me ways to let my child take the lead while we are playing together.

Next, we will ask you a few questions about yourself.

26. How many children are the focus of the home visits you receive?

_____

27. What are the ages of EACH child who is the focus of home visits?

_____

28. Your (the parent's or caregiver's) age in years.

_____

29. Your racial identity (Check all that apply)

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

30. Your ethnic identity

☐ Hispanic ☐ Non-Hispanic

31. Your primary language (Select ONE)

☐ Arabic
☐ Cantonese
☐ Cape Verdean Creole
☐ English
☐ French
☐ Haitian Creole
☐ Mandarin
☐ Portuguese
☐ Somali
☐ Spanish
☐ Tagalog
☐ Vietnamese
☐ Other (please specify):

32. Do you speak another language?

☐ Yes ☐ No

33. Your second primary language is (Skip if you do not speak another language)

- ☐ Arabic
- ☐ Cantonese
- ☐ Cape Verdean Creole
- ☐ English
- ☐ French
- ☐ Haitian Creole
- ☐ Mandarin
- ☐ Portuguese
- ☐ Somali
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other (please specify):

34. Your gender identity

- ☐ Man
- ☐ Woman
- ☐ Non-binary
- ☐ Not Listed:
- ☐ Prefer not to respond

35. Do you identify as transgender?

- ☐ Yes
- ☐ No
- ☐ Prefer not to respond

36. About how long have you worked with your home visitor?

- ☐ Less than 1 month
- ☐ 1-3 Months
- ☐ 4-6 Months
- ☐ 6 months - 1 year
- ☐ More than 1 year

37. How often do you have contact with your home visitor (contact includes visits, phone calls, texts, and email)?

- ☐ Less than 1 month
- ☐ 1-3 Months
- ☐ 4-6 Months
- ☐ 6 months - 1 year
- ☐ More than 1 year
- ☐ Other (please specify)

Thank you for completing this survey! We need your email address so that we can send you an e-gift card in the amount of $10. By clicking submit to this survey, we will take you to a separate survey where you can fill in your email address. We will only use that email address to send you your e-gift card. We will not connect your email address to your answers on this survey.

Click **here** to continue to fill out the gift card form!

APPENDIX C: PROVIDER THREE-MONTH FOLLOW-UP SURVEY

Skip to: End of Survey If Do you agree to complete this survey? = No

Which of the following do you think is the BEST or CLOSEST representation of what HOPE is?

- ○ Hope is focused on children's cognitive development, and how factors such as healthy eating, exercise, and team sports can positively impact cognitive development long-term. HOPE aims to increase providers' focus on these areas of children's and familie's lives.
- ○ HOPE is focused on how Positive Childhood Experiences (PCEs) can improve long-term health and well-being. HOPE aims to increase providers' practices that encourage positive relationships, safe and equitable environments, community engagement, and healthy social and emotional development.
- ○ HOPE is focused on how Adverse Childhood Experiences (ACEs) affect families and how trauma-informed care can help. HOPE aims to increase providers' practices that are related to ACEs and trauma, such as building interactions with parents around adverse events experienced within families.

Have you implemented a HOPE-informed change in your work?

- ○ Yes
- ○ No

Display This Question:

If Have you implemented a HOPE-informed change in your work? = No

Are you planning to implement a HOPE-informed change in your work in the future?

- ○ Yes
- ○ No

Display This Question:

If Are you planning to implement a HOPE-informed change in your work in the future? = Yes

If you are planning to implement a HOPE-informed change sometime in the future, please briefly describe what change you would like to implement.

_____

_____

_____

_____

_____

Display This Question:

If Are you planning to implement a HOPE-informed change in your work in the future? = Yes

Have you set a goal date to implement a HOPE-informed change in your work?

- ○ Yes
- ○ No

Display This Question:

If Have you set a goal date to implement a HOPE-informed change into your work? = Yes

When is your goal date?

- ○ Within the next month
- ○ Within the next 3 months
- ○ Within the next 6 months
- ○ More than 6 months from now

Display This Question:

If Have you implemented a HOPE-informed change in your work? = Yes

Can you briefly describe the HOPE-informed change you have implemented?

Display This Question:

If Have you implemented a HOPE-informed change in your work? = Yes

How would you describe the process of implementing a HOPE-informed change in your work since the workshop?

- Very easy
- Easy
- Somewhat easy
- Somewhat difficult
- Difficult
- Very difficult

Display This Question:

If Have you implemented a HOPE-informed change in your work? = Yes
And How do you think the families you work with are reacting to the HOPE-informed changes that you ha... = I don't notice much of a difference in the quality of my relationships or interactions with families compared to what I was doing before I started implementing HOPE.

OR IF...
Have you implemented a HOPE-informed change in your work? = Yes
And How do you think the families you work with are reacting ot the HOPE-informed changes that you ha... = I'm not sure if families are interacting with me any differently than they were before I started implementing HOPE, or if the quality of our relationship has changed.

OR IF...
Have you implemented a HOPE-informed change in your work? = Yes
And How do you think the families you work with are reacting to the HOPE-informed changes that you ha... = I have noticed an improvement in the quality of my relationships and my interactions with families since I started implementing HOPE.

Can you provide an example of how a parent responded to a HOPE-informed change you have made in your interactions with them?

_____

_____

_____

_____

_____

Display This Question:

If Have you implemented a HOPE-informed change in your work? = Yes

Which of the following accurately describes how you have integrated a HOPE-informed change into your work?

- ○ I have implemented it once, but not again.
- ○ I have implemented it a few times.
- ○ I have tried it and need to work on improving it before I try it again.
- ○ I have incorporated it into my regular practice and will continue to do so going forward.

What have been some barriers you have faced, if any, in trying to integrate HOPE principles into your work (check all that apply):

- ○ I don't have support within my organization to implement the HOPE principles.
- ○ I don't have the funds necessary to implement the HOPE principles.
- ○ I don't have the tools to implement HOPE (e.g., handouts, visuals, sample intake forms).
- ○ I don't know how to translate what I learned about HOPE into practice.
- ○ I don't remember the HOPE principles; I need a refresher.
- ○ I don't think the HOPE principles were realistic to implement or translated well into interactions with families.

- ○ I haven't figured out the type of HOPE-informed change I'd like to implement
- ○ I haven't had time to work out how to implement the HOPE principles yet.
- ○ I was already applying the principles of HOPE in my work before the workshop.
- ○ My organization is already using a different strengths-based approach.
- ○ Other (please specify): _____

What would help you to implement or continue implementing HOPE into your everyday work with families? What do you need to move forward with implementation of HOPE-informed practices?

_____

_____

_____

_____

_____

Rate the following items from 0 (Strongly disagree) to 100 (Strongly agree), the middle (50) means you are neutral

	0 10 20 30 40 50 60 70 80 90 100
I have a good understanding about how Adverse Childhood Experiences (ACEs) influence development. (Examples of ACEs: child abuse and neglect, parental mental illness, & parental substance abuse).	
I have a good understanding about how Positive Childhood Experiences (PCEs) influence development. (Examples of PCEs: feeling safe and protected by an adult at home; feeling supported by friends).	
I feel confident that I know how to incorporate discussions about Positive Childhood Experiences (PCEs) in my work with families.	

APPENDIX D: PILOT PARENT SURVEY REPORT

Section I: Aim and Survey Overview

TIER's one-year evaluation of HOPE was an implementation evaluation, which is described in detail in the main section of this report. A long-term goal of HOPE leaders was to explore potential impacts of HOPE-informed enhancements on their intended beneficiaries—children and parents. In consideration of that pursuit and to begin to understand possible indicators of HOPE-informed implementation success we began the process of developing a measure to be administered to parents in settings where HOPE-informed enhancements are being implemented.

The measure was envisioned as a pre-post design to assess measurable: (1) post-HOPE implementation changes in providers' practice, and (2) impacts of these changes on parents. It includes items that represent: (1) the *4 Building Blocks* of HOPE, in order to examine which of these were being addressed by providers during interactions with families; (2) the quality of the relationship between the provider and the parent; and (3) the parent's perceptions of how they are viewed by the provider. We created two unique versions of the pilot survey, one each to be used in the healthcare and home visiting sectors, to align with the nuances of provider-parent interactions in each service setting. We developed the pilot surveys as the first step in creating a tool that providers who are implementing the HOPE framework in their practice may use to assess their implementation efforts.

Evaluation Aim: To develop and pilot a parent-report survey to assess parents' perceptions of (a) how they are viewed by the provider, (b) the quality of the parent-provider relationship, and (c) the presence of HOPE-related content in their interactions
Evaluation Question
1. Does the Pilot Survey show evidence of internal consistency within subscales?

Creating the Pilot Parent Survey

The Core Elements of HOPE. HOPE is not a manualized program and does not provide trainees with implementation criteria that HOPE-informed enhancements must include or specific programmatic or curricular resources. As such, there are providers from a range of sectors who have been experimenting with creating innovative HOPE-informed enhancements unique to the populations they serve and the goals and features of their organizations. Any instrument intended to detect potential outcomes of HOPE-informed enhancements, then, must focus on common elements that should be exhibited across HOPE-informed enhancements. In the case of HOPE, the common elements are the *4 Building Blocks* of HOPE, and the emphasis on a strengths-based, collaborative (rather than a directive) provider-parent relationship. These core

elements are intended to be incorporated into all HOPE-informed implementation efforts. We summarize them here as described by HOPE in their materials (HOPE, 2021).

Nature of the Parent-Provider Relationship. Although it is not emphasized in their handouts, during HOPE workshop trainings, leaders underscore providers' important role in recognizing and highlighting for families' strengths, as well as how they can grow those strengths, via promotion of the *4 Building Blocks*. Trainers also discuss the importance of providers approaching their interactions with parents in a collaborative way. According to content on the HOPE website, "HOPE can change the relationship between families and their providers." When providers focus on strengths, they say, it "sets the stage for collaborative problem solving based on respect and understanding" (Sege, 2021).

Building Block 1: Nurturing and Supportive Relationships. Building Block 1—Relationships—is described as the presence of nurturing and supportive relationships in children's lives. This includes warm and responsive interactions with caregivers, positive relationships with peers, and having adults outside of one's family who take interest in a child and support positive development.

Building Block 2: Safe, Stable, and Equitable Environments. Building Block 2—Environment—focuses on "safe, equitable, and stable environments for living, playing, and learning at home and in school" (HOPE, 2021, p. 1). This Building Block comprises basic needs such as adequate food, shelter, and healthcare; safety and emotional security at home; and quality education.

Building Block 3: Social Engagement and Sense of Connectedness. Building Block 3— Engagement—emphasizes children's need for opportunities to engage with their communities and develop a sense of belonging, including through activities such as community service, cultural traditions, family traditions, and organized sports.

Building Block 4: Opportunities for Social and Emotional Development. Building Block 4— Emotional Growth—highlights children's need to grow emotional and behavioral self-regulation skills through interactions with adults and other children, which can help them to develop their ability to respond to challenges and improve their communication skills.

Cultural Sensitivity. Although cultural sensitivity is not a core element of HOPE, HOPE leaders have referred to HOPE as an anti-racist framework and developed an online resource[1] on this topic (HOPE, 2021). Based on HOPE's representation of the framework in this way, we included several items meant to assess the parent's perceptions of the provider as culturally sensitive.

[1] https://positiveexperience.org/wp-content/uploads/2021/03/HOPE-as-an-Antiracism-Framework-in-Action.pdf

Exploration of Related Measures. Since HOPE is not a manualized program and does not have specific implementation criteria for providers who adopt its framework, one of the most important functions of the planned pre-post Parent Survey was to assess whether parents receiving services from providers who reported that they were implementing a HOPE enhancement perceived their providers to be incorporating the core elements of the HOPE framework (i.e., that their providers were incorporating content about the *4 Building Blocks*, were interacting with parents in a collaborative manner and a way that emphasized their strengths, and were behaving in a culturally sensitive way). A second important function of the survey is to determine if there would be any measurable shifts in parents' experience with the provider-parent relationship between the pre-and post-implementation period. For the Pilot Survey, the former was the focus, since we hoped to establish internal consistency between the items intended to represent each of the core elements of HOPE, and no enhancements would have been implemented when the Pre-Survey was completed.

There are no surveys known to us that measure all the constructs that make up the HOPE framework (i.e., the *4 Building Blocks* of HOPE, a strengths-focused, collaborative provider-parent relationship, and cultural sensitivity). There are many extant measures that have been created to assess relationships between parents and family support providers in various specialty areas such as Early Intervention (Raspa et al., 2010), foster care (Vanderfaeillie et al., 2016), and mental health (Rileyet al., 2005). HOPE is rooted in health-oriented research about the benefits of PCEs on long-term physical and mental health outcomes. HOPE's founder is a physician by training, and one of the populations HOPE has been most interested in reaching with its trainings is healthcare providers. Thus, when we began the process of creating a measure, one area of exploration was existing instruments about the relationships between healthcare providers and families.

In the measures we reviewed, there was thematic overlap pertaining to the nature of the provider-parent relationship—specifically, whether it was viewed as collaborative by the parent and whether the parent was satisfied with the relationship. Many surveys were interested in collaboration specifically related to medical care, such as parents' understanding of treatment decisions (Coyne et al., 2013; Vasli, 2018) and parent perceptions of care(Raspaet al., 2010; Jashar et al., 2019; Gerkensmeyer & Austin, 2005). The involvement of family members in care and the recognition that parents play a central role in children's lives were components of parent satisfaction with provider relationships across surveys we reviewed (e.g., Vasli, 2018; Khan et al., 2015; Shields & Tanner, 2004; Latour et al., 2011). Involvement in care and collaboration included dimensions such as parents being offered the opportunity to give input (Vanderfaeillie et al., 2016; Coyne et al., 2013; Vasli, 2018), to feel they were being listened to(Gerkensmeyer & Austin, 2005), and to feel their opinion is respected (Vanderfaeillie et al., 2016; Measelle et al., 1998; Shields & Tanner, 2004). HOPE does not explicitly include an intention around the involvement of family members in medical care in its framework. For this survey, we were interested in collaboration pertaining to the providers' role in supporting parents as they expanded their families' exposure to positive experiences.

We identified items in five surveys that included questions that related to the core elements of HOPE we intended to assess in the Pilot Parent Survey. These questions, and our adaptations of them, are included in Table 1.

Table 1. Pilot Parent Survey Questions Adapted from Extant Measures

Measure with Related Item	Original Item from Measure	Healthcare: Adapted Item we Included in Pilot Parent Survey	Home Visiting: Adapted Item we Included in Pilot Parent Survey
Assessment Tool for Cultural Competence (Arthur et al., 2005)	*The staff here listen to me and my family when we talk to them.*	My healthcare provider is interested in *my ideas* about how to make my and my child's life better.	My home visitor is interested in *my ideas* about how to make my and my child's life better.
Iowa Cultural Understanding Assessment (White et al., 2009)	*The staff here respects my religious or spiritual beliefs.*	I feel comfortable sharing my cultural beliefs and practices with my healthcare provider because they will respect my beliefs and practices.	I feel comfortable sharing my cultural beliefs and practices with my home visitor because they will respect my beliefs and practices.
Parent-Caregiver Relationship Scale (parent version) (Elicker et al., 1997)	*Caregiver genuinely cares for child.*		My home visitor talks to and treats my child as though they matter.
Parent Satisfaction Scale (Gerkensmeyer & Austin, 2005)	*I was satisfied with how the staff listened to what I had to say.*		
Physician and Nurse Nighttime Communication and Parents' Hospital Experience (Khan et al., 2015)	*I felt like my doctor valued my input about my child.*	My healthcare provider is interested in *my ideas* about how to make my and my child's life better.	My home visitor is interested in *my ideas* about how to make my and my child's life better.

The Pilot Parent Survey items we arrived included in the Pilot Survey align with the five elements of the HOPE framework (i.e., the *4 Building Blocks* and a collaborative provider-parent relationship) as well as the cultural sensitivity construct, and include items that point to perceived impacts on the parent-child relationship that come about from provider-parent interactions (e.g., *After meeting with the staff in this office I feel better able to manage stress in my parenting role*). The survey was designed as a pre-and post-HOPE-implementation survey to allow for comparison between baseline conditions and changes that come about as a result of HOPE enhancements. However, there was time in this evaluation period to collect pilot data using a single survey from the pre-implementation period. Parent surveys were distributed at one pediatric practice and one home visiting program, as described in detail in Section II. We consulted with HOPE leadership

and a pediatrician who was a member of the HOPE Innovation Network (HIN) on the content of the survey items; their feedback helped us refine our questions to assure that the survey would ask parents to reflect on areas where HOPE leadership would expect to see differences when HOPE is being implemented.

Section II: Method

Survey Descriptions

Pilot Healthcare Parent Survey

Demographic Characteristics. Parents were asked the number of children they bring to receive care at the practice and the age of each child, the parent's own age, the parent's racial and ethnic identity, gender identity, and primary language and secondary language (if any).

For each of the subscales below, parents were asked to rate each item using a visual analog scale (VAS) from 0 to 100, where higher scores indicated greater agreement. For some itemson the Healthcare Survey, parents were asked about their interactions with their healthcare provider[2] whereas other items asked parents about their interactions with other staff in their healthcare provider's office such as a social worker, developmental specialist, mental health provider, community health worker, or nurse. All items included in the Healthcare Survey are included in Table 2.

[2] We defined healthcare provider as doctor, Nurse Practioner (NP), or Physician's Assistant (PA).

Table 2. Items in the Healthcare Survey and the Home Visting Survey by Subscale

Subscale	Healthcare Survey	Home Visiting Survey
Parent Provider Relationship	1. I can tell my healthcare provider things that are important about my life.	1. I can tell my home visitor things that are important about my life.
	2. My healthcare provider makes me feel like I have the ability to act on my goals.	2. My home visitor makes me feel like I have the ability to act on my goals.
	3. My healthcare provider talks too much about the negative or hard things in my life.	3. My home visitor talks too much about the negative or hard things in my life.
	4. After meeting with my healthcare provider, I feel a sense of hope about changing the things in my life that I can control.	4. After meeting with my home visitor, I feel a sense of hope about changing the things in my life that I can control.
	5. My healthcare provider is interested in my ideas about how to make my and my child's life better.	5. My home visitor is interested in my ideas about how to make my and my child's life better.
Building Block 1	6. When talking about hard things in my life, my healthcare provider helps me see that there are positive things too.	6. When talking about hard things in my life, my home visitor helps me see that there are positive things too.
	8. My healthcare provider has given me ideas about how to make interactions with my child better.	7. My home visitor has helped me see how I can create positive experiences for my children.
	13. In the last month I feel like my relationship with my child is going well overall.	9. My home visitor has given me ideas about how to make interactions with my child better.
	21. The staff in this office talks about positive relationships my child has or can have with other adults.	18. My home visitor talks about positive relationships my child has or can have with other adults.
	24. After meeting with the staff in this office I feel better able to manage stress in my parenting role.	21. After meeting with my home visitor, I feel better able to manage stress in my parenting role.
		24. My home visitor asks me about good things from my own childhood.
Building Block 2	7. My healthcare provider asks me about my own physical and/or mental health during our visits.	8. My home visitor asks me about my own physical and/or mental health during our visits.
	18. The staff in this office asks me if my child and I feel safe at home.	15. My home visitor asks me if my child and I feel safe at home.
	19. The staff in this office talks with me about positive ways to respond to my child when they misbehave.	16. My home visitor talks with me about positive ways to respond to my child when they misbehave.
Building Block 3	9. My healthcare provider asks me whether I take part in activities or organizations in my community (e.g., library, houses of worship, clubs, etc.).	10. My home visitor asks me whether I take part in activities or organizations in my community (e.g., library, houses of worship, clubs, etc.).
	16. My healthcare provider encourages me to take part in activities or organizations in my community that might be good for me and my family (e.g., library, houses of worship, clubs).	11. My home visitor talks to and treats my child as though they matter.
	20. The staff in this office celebrates the activities my child does at school and in their community.	17. My home visitor celebrates the activities my child does at school and in their community.
	22. The staff in this office encourages me to take part in activities or organizations in my community that might be good for me and my family (e.g., library, houses of worship, clubs).	19. My home visitor encourages me to take part in activities or organizations in my community that might be good for me and my family (e.g., library, houses of worship, clubs).
Building Block 4	14. My healthcare provider gives me information about how to help my child get along with other children.	20. My home visitor has ideas and resources for when my child is struggling with friendships.
	17. My healthcare provider encourages me to have my child play with other kids.	22. My home visitor shows me ways to help my child express their feelings.
	23. The staff in this office has ideas and resources for when my child is struggling with friendships.	23. My home visitor helps me respond to my child's feelings of anger, frustration, or sadness in a positive or helpful way.
	25. The staff in this office shows me ways to help my child express their feelings.	25. My home visitor shows me ways to let my child take the lead while we are playing together.
	26. The staff in this office helps me respond to my child's feelings of anger, frustration, or sadness in a positive or helpful way.	
Cultural Sensitivity	10. I feel comfortable sharing my cultural beliefs and practices with my healthcare provider because they will respect my beliefs and practices.	12. I feel comfortable sharing my cultural beliefs and practices with my home visitor because they will respect my beliefs and practices.
	11. I think my healthcare provider views my race or ethnicity in a negative way.	13. I think my home visitor views my race or ethnicity in a negative way.
	12. My healthcare provider is someone I could talk to if I or my child had an experience with discrimination.	14. My home visitor is someone I could talk to if I or my child had an experience with discrimination.

Parent-Provider Relationship. To assess the nature of the provider-parent relationship—in particular whether the relationship was viewed as collaborative by the parent, and whether the provider was seen by the parent as empowering the parent to focus on their strengths—parents were asked five questions.

Building Block 1: Nurturing and Supportive Relationships . To assess content covered in provider-parent interactions that relates to Building Block 1, parents were asked five questions. These included two items about their interactions with their healthcare provider.

Building Block 2: Safe, Stable and Equitable Environments. To assess if staff discuss elements of Building Block 2 with families, parents were asked to indicate their level of agreement with three items.

Building Block 4: Opportunities for Social and Emotional Development. To assess whether providers discussed and provided resources about children's social-emotional development in their interactions with parents, parents were asked to indicate their level of agreement with five items on the Building Block 4 subscale. Two of these items were about their healthcare provider.

Cultural Sensitivity. To assess whether parents perceived providers who were implementing HOPE-informed enhancements to be culturally sensitive, we asked parents three items about their perceptions of their healthcare providers.

Response Preference Item. Since this was a pilot survey we asked respondents at the end of the survey whether their preference for responding to surveys was to use a Likert or VAS scale. This question was only included in the Paper Version of the Healthcare version of the Survey.

Pilot Home Visiting Parent Survey. The home visiting version of the Parent Survey is similar to the healthcare version of the survey, but was modified to assess constructs that home visitors, rather than healthcare providers are more likely to discuss with parents. All items included in the Home Visiting Survey are included in Table 2.

Demographic Characteristics. Parents were asked the number of children that are the focus of the home visits they receive and the ages of those children, the parent's own age, the parent's racial and ethnic identity, gender identity, and primary language and secondary language (if any).

Parent-Provider Relationship. To assess the nature of the provider-parent relationship—in particular whether the relationship was viewed as collaborative by the parent, and whether the provider was seen by the parent as empowering the parent to focus on their strengths—parents were asked five questions.

Building Block 1: Nurturing and Supportive Relationships. To assess content covered in provider-parent interactions that relate to Building Block 1, parents were asked six questions.

Building Block 2: Safe, Stable and Equitable Environments. To assess if staff discuss elements of Building Block 2 with families, parents were asked to indicate their level of agreement with three items.

Building Block 3: Social Engagement and Sense of Connectedness. To assess providers' attention to families' engagement in the community in their interactions with parents, parents were asked to rate their level of agreement with four items in this subscale, two of which asked about their healthcare provider.

Building Block 4: Opportunities for Social and Emotional Development. *T*o assess whether providers discussed and provided resources about children's social-emotional development in their interactions with parents, parents were asked to indicate their level of agreement with four items on the Building Block 4 subscale.

Cultural Sensitivity. To assess whether parents perceived providers who were implementing HOPE-informed enhancements to be culturally sensitive, we asked parents three items about their perceptions of their home visitors.

Recruitment

We recruited parents who receive services in two of the sectors HOPE targets for its training –pediatric healthcare and home visiting. We piloted the parent surveys to assess internal consistency of each of the subscales of the constructs the survey is intended to measure, and feasibility of the data collection procedures. Here we describe the Pilot Parent Survey –Healthcare and Home Visiting versions, and how they were distributed. Piloting in both sectors was done during the Summer of 2021.

Healthcare Recruitment and Distribution. For the Pilot Healthcare Parent Survey, parents were recruited from a pediatric practice where one of the pediatricians was a member of the HOPE Innovation Network (HIN)[3] and had attended a HOPE workshop. The pediatrician asked all parents who were attending a well-child visit with a child aged three or older if they were interested in completing the survey before they left the office that day. Most parents were only given the option to complete the survey on paper, however, because we were piloting the survey, we were in regular contact with the provider who was administering the surveys, who

[3] See detailed discussion of HIN in the main section of this report.

gave us feedback that some parents indicated not having time to complete it in the office but would have been willing to do so after leaving the office. In response to this feedback, we gave the provider a flyer including a QR code and allowed the provider to offer the QR code to all parents after this point in time. After this point, parents were given the choice to complete the survey on paper or electronically; it is not known what percentage of parents who were given the QR code chose to complete it online. The pediatrician kept a log of which parents were offered the survey and whether parents participated or not to ensure that parents were not asked to complete the survey again after declining and to ensure that the same parent did not complete the survey more than once. We received a total of 70 completed surveys; most (n = 61) parents completed the survey on paper, with a minority (n = 9)completing it electronically. The pediatrician's office had documented offering the paper version of the surveys to 66 parents, and of those reported one refusal.[4] Upon completion, parents who completed the paper version of the survey sealed their survey in an envelope and returned the envelope to the provider, who mailed unopened envelopes to us. Upon completion, parents received a $10 gift card. Parents were asked to provide their consent before beginning the survey.

Paper Version. For the paper version of the survey, parents were instructed to indicate their answer by drawing an "x" or vertical line on the VAS. Parents were assured that their healthcare provider and any staff at the provider's office would not view their responses. To maintain confidentiality, parents returned their completed survey to the healthcare provider in a sealed envelope, and then the healthcare provider mailed the completed surveys to us.

Electronic Version. Parents who wanted to complete an electronic version of the survey were given fliers with a QR code and link to the survey. Parents completed the survey on their personal devices (e.g., cellphone, tablet, laptop) either at the office, or after they left the office.

Home Visiting Recruitment and Distribution. For the parent-home visiting provider survey, parents were recruited from a home visiting program that was participating in HIN but had not yet participated in a HOPE workshop. Parents (n = 14) completed the survey electronically; home visitors provided a program-owned tablet to parents at in-person visits for the purpose of survey completion, or sent parents a link to complete the survey if they were interacting with parents in a virtual visit setting. We were not able to obtain information about the number of sites that distributed the survey or the number of parents to whom the survey was offered and distributed. Upon survey completion, parents received a $10 gift card.

[4] We were unable to calculate the response rate for the Healthcare Pilot Survey because we received more surveys than the provider's office had documented in the tracking log. This is because only paper surveys that were given to parents were documented on the log, not also QR codes for completing electronic surveys.

Data Quality Control

One member of the research team entered all paper surveys into a secure database. A second member of the research team worked with the member entering all surveys to develop guidelines for how to enter data that were ambiguous or did not conform to the survey instructions[5]; decisions about ambiguous responses were as follows:

- If respondent circled a range of numbers, the median value was used
- If respondent marked an "x" on the line, the value at the crossing of the two lines of "x" was entered
- If the line or "x" marked by the respondent was in between numbers, responses were rounded down to next whole number.

The second member of the research team also checked 10% of paper surveys to ensure that they were entered accurately and found no errors.

Respondent Sample

Pilot Healthcare Parent Survey. Table 3 shows demographic characteristics for parents who completed the Pilot Parent Healthcare Survey. Seventy parents completed the Pilot Parent Healthcare Survey. Overall, most parents (n = 68) reported English as their primary language. Of the four parents who reported speaking another language, two reported speaking French, one Portuguese, and one Tagalog. Most parents identified themselves as a "woman" (n = 60) and did not identify as transgender (n = 67). Ninety percent of parents identified as White, non-Hispanic. The largest group of parents (n = 31) reported that they bring two children to receive care at this practice, followed by one child (n = 20), three children (n =14), and four children (n = 3).

[5] There was one respondent who wrote "strange question" for several items and did not provide a response to these items; these responses were recorded as missing data.

Table 3. Healthcare Survey Respondent Demographics (n = 70)

Characteristics		n	%
Primary Language			
	English	68	100.0%
Speaks a Second Primary Language			
	No	64	91.4%
	Yes	4	5.7%
Second Primary Language			
	French	2	50.0%
	Portuguese	1	25.0%
	Tagalog	1	25.0%
Gender Identity			
	Man	8	11.8%
	Woman	60	88.2%
Transgender Identity			
	No	67	100.0%
Race			
	Asian	3	4.4%
	White	63	92.6%
	Multiracial	2	2.9%
Ethnicity			
	Non-Hispanic	61	98.4%
	Hispanic	1	1.6%
Number of Children Receiving Care at this Practice Per Caregiver			
	1	20	29.4%
	2	31	45.6%
	3	14	20.6%
	4	3	4.4%

As seen in Table 4, parents' average age was approximately 38 years (M = 37.94, SD = 8.18) and the average age of their children was 9 years old[6] (M = 9.01, SD = 4.82).

[6] Children under one year old were coded as 0.

Table 4. Healthcare Survey Respondent Parent and Child Age (n = 70)

	n	*M*	*SD*	*n* of Missing Responses	Minimum	Maximum
Parent age	65	37.94	8.18	5	20.00	57.00
Child age	68	9.01	4.82	2	0.00	19.00

Pilot Home Visitor Parent Survey. Fourteen parents completed the Pilot Parent Home Visitor Survey. Table 5 shows that most parents reported English as their primary language (*n* = 10). Of the five parents who reported speaking a second primary language, three reported that they speak Portuguese, one reported English and one reported "other." More than half of parents identified as White (*n* = 8) and non-Hispanic (*n* = 11). All fourteen respondents identified themselves as a "woman." Almost all parents (*n* = 13) reported that they have one child who is the focus of the home visiting services they receive. Just over half of parents (*n* = 8) reported having contact with their home visitor more than once per month, and five parents reported "other," which included weekly, twice weekly and twice per day.

Table 5. Home Visitor Survey Respondent Demographics (n = 14)[7]

Characteristics		*n*
Primary Language Spoken		
	Cape Verdean Creole	3
	English	10
	Spanish	1
	No	9
	Yes	5
Second Primary Language		
	English	1
	Portuguese	3
	Other	1
Gender Identity		
	Woman	14
Transgender Identity		
	No	14
Race		
	Black or African American	4
	Asian	1
	Native Hawaiian or Pacific Islander	1
	White	8
Ethnicity		
	Non-Hispanic	11
	Hispanic	3
Number of Children Receiving Home Visiting Services		
	1 child	13
	3 children	1
Frequency of Contact with Home Visitor		
	More than Once a Month	8
	Once a Month	1
	Other	5

Table 6 shows that the average age of parents was 21.67 years (SD = 3.34), and children's average age was just over one year old[8] (M = 1.17, SD = 1.17)

[7] We excluded percentages from this table due to the small sample size.
[8] Children under one year old were coded as 0.

Table 6. Home Visiting Survey Respondent Parent and Child Age (n = 14)

	n	*M*	*SD*	*n* of Missing Responses	Minimum	Maximum
Parent Age	12	21.67	3.34	2	16.00	26.00
Child Age	14	1.17	1.17	0	0.00	3.00

As seen in Table 7, of the parents who completed the Pilot Parent Healthcare Survey via Qualtrics (n = 9), the average time to complete the survey was about four and a half minutes (M = 4.46, SD = 2.24). The average time for respondents of the Pilot Parent Home Visitor Survey to complete the survey via Qualtrics (n = 14) was just over eight minutes (M = 8.23, SD = 4.01).

Table 7. Length of Time to Complete Parent Surveys, in Minutes

Survey Version	*n*	*M*	*SD*	Minimum	Maximum
Healthcare	9.00	4.46	2.24	1.03	7.35
Home Visiting	12.00[9]	8.23	4.01	3.42	18.62

Analytic Plan

All analyses were conducted in SPSS (IBM Corp, 2022). We examined whether items and subscale mean scores were normally distributed by examining skewness and kurtosis, whereby data with skewness of 0 and kurtosis between -3 and +3 were normally distributed (Field, 2018). Following conventional guidelines, we deemed a subscale or the overall measure to show evidence of internal consistency, whereby Cronbach's alpha[10] was > .70 and < .91 (e.g., Taber, 2018; Tavakol & Dennic, 2011)[11]. Correlations were statistically significant when p< .05. We used conventional guidelines to determine strength of correlations, whereby absolute magnitudes of 0.00–0.10 were negligible, 0.10–0.39 were weak, 0.40–0.69 were moderate, 0.70–0.89 were strong, and 0.90–1.0 were very strong (Schober et al., 2018).

[9] We excluded two parents when calculating the mean because they spent 1.85 and 1.13 days completing the survey, respectively. Qualtrics allows users to pause survey completion and return to complete the survey within one week.

[10] Cronbach's alpha is a way to examine whether a set of items measure the same construct (Tavakol & Dennick, 2011).

[11] Cronbach's alpha is not considered the "gold standard" in reliability analyses (Sijtsma, 2009); however, preferred methods such as exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) require large sample sizes (Costello & Osborne, 2005). Thus, we used Cronbach's alpha due to sample size.

Scoring. When subscales reached adequate reliability, we computed the mean of the items on the subscale to create a subscale score. We did not create scoring instructions for subscales that did not reach adequate reliability because these subscales should be modified and re-piloted. We computed subscale scores if at least three of the four items were present for parent-provider relationship and Building Block 3 subscales, and if at least three of the five items were present on the Building Block 4 subscale.

Section III: Findings and Recommendations

Pilot Healthcare Parent Survey[12]

To examine whether the Pilot Healthcare Parent Survey showed evidence of internal consistency within subscales and for the measure overall, we ran a series of descriptive analyses for each proposed subscale (i.e., parent-provider relationship, Building Block 1, Building Block 2, Building Block 3, Building Block 4, cultural sensitivity). First, we examined items (e.g., means, standard deviations, whether there were any missing data, etc.), inter-item correlations, and reliability coefficients (i.e., Cronbach's alpha). Second, for subscales that showed evidence of internal consistency, we created subscale mean scores when > 70% of the data were present, examined subscales (e.g., means, standard deviations, etc.), and correlations of subscale means.

Parent-Provider Relationships Subscale. As seen in Table 8 overall, parents reported high agreement on items 1, 2, 4, and 5, and low agreement on item 3. Five parents did not answer item 3. All positively worded items were negatively skewed, and the negatively worded item was positively skewed; kurtosis values were greater than 3. As seen in Table 9, inter-item correlations for items 1, 2, 4, and 5, were significantly positively correlated with one another; magnitude of correlations was moderate to strong. Item 3 was uncorrelated with all items. We computed Cronbach's alpha for the four positively worded items (i.e., 1, 2, 4, & 5) and it was acceptable (α = .90).

[12] Also referred to as Healthcare Survey and Healthcare Pre-Survey throughout the report.

Table 8. Parent-Provider Relationship Subscale Descriptive Statistics (n = 70)

Item	*n*	*M*	*SD*	Minimum	Maximum	*n* of Missing Responses	Skewness	Kurtosis
1. I can tell my healthcare provider things that are important about my life.	70.00	94.89	11.76	40.00	100.00	0.00	-3.27	11.28
2. My healthcare provider makes me feel like I have the ability to act on my goals.	70.00	94.53	10.18	40.00	100.00	0.00	-2.91	11.43
3. My healthcare provider talks too much about the negative or hard things in my life.*	65.00	9.75	24.90	0.00	99.00	5.00	2.95	7.51
4. After meeting with my healthcare provider, I feel a sense of hope about changing the things in my life that I can control.	70.00	91.41	13.12	50.00	100.00	0.00	-1.92	3.23
5. My healthcare provider is interested in my ideas about how to make my and my child's life better.	68.00	95.06	8.90	40.00	100.00	2.00	-3.88	21.38

Note. *item is reverse scored for reliability analysis.

Table 9. Parent-Provider Relationship Subscale Inter-Item Correlations (n = 70)

Item	1	2	3	4	5
1. I can tell my healthcare provider things that are important about my life.	1.00				
2. My healthcare provider makes me feel like I have the ability to act on my goals.	**0.88**	1.00			
3. My healthcare provider talks too much about the negative or hard things in my life.	-0.10	-0.12	1.00		
4. After meeting with my healthcare provider, I feel a sense of hope about changing the things in my life that I can control.	**0.62**	**0.72**	-0.07	1.00	
5. My healthcare provider is interested in my ideas about how to make my and my child's life better.	**0.66**	**0.79**	-0.13	**0.67**	1.00

Note. Boldface indicates significant correlation at $p < .05$. Sample size ranges from 65 to 70 for variables.

Building Block 1 Subscale: Nurturing and Supportive Relationships. As seen in Table 10, overall, parents reported high agreement on items 6, 8, and 13. Parents reported moderate agreement on items 21 and 24. There were some missing data across the five items with most missing data on item 24. All items were negatively skewed, and kurtosis values were >3 for items 6, 8, and 13. As seen in Table 11, inter-item correlations were inconsistent; magnitude of correlations was small to moderate. First, we computed Cronbach's alpha for the five items, and it was unacceptable (α = .62). We removed item 21 because it was only moderately correlated with item 24; we reran Cronbach's alpha and although it increased, it was still unacceptable (α = .66).

Table 10. Building Block 1 Subscale Descriptive Statistics (n = 70)

Item	*n*	*M*	*SD*	Minimum	Maximum	*n* of Missing responses	Skewness	Kurtosis
6. When talking about hard things in my life, my healthcare provider helps me see that there are positive things too.	68.00	94.59	9.54	50.00	100.00	2.00	-2.40	6.98
8. My healthcare provider has given me ideas about how to make interactions with my child better.	67.00	94.41	10.50	40.00	100.00	2.00	-3.51	14.48
13. In the last month I feel like my relationship with my child is going well overall.	68.00	91.60	16.22	29.00	100.00	3.00	-2.55	6.31
21. The staff in this office talks about positive relationships my child has or can have with other adults.	65.00	76.75	33.76	0.00	100.00	5.00	-1.44	0.69
24. After meeting with the staff in this office I feel better able to manage stress in my parenting role.	64.00	78.80	26.94	0.00	100.00	6.00	-1.52	1.90

Table 11. Building Block 1 Subscale Inter-Item Correlations

Item	6	8	13	21	24
6. When talking about hard things in my life, my healthcare provider helps me see that there are positive things too.	1.00				
8. My healthcare provider has given me ideas about how to make interactions with my child better.	**.61**	1.00			
13. In the last month I feel like my relationship with my child is going well overall.	**.31**	**.29**	1.00		
21. The staff in this office talks about positive relationships my child has or can have with other adults.	.21	.22	.10	1.00	
24. After meeting with the staff in this office I feel better able to manage stress in my parenting role.	**.33**	**.33**	.11	**.55**	1.00

Note. Boldface indicates significant correlation at $p < .05$. Sample size ranges from 62 to 68 for variables.

Building Block 2 Subscale: Safe, Stable, and Equitable Environments. As seen in Table 12, overall, parents reported moderate agreement on items 7, 18, and 19. There were some missing data across the three items with most missing data on item 19. All items were negatively skewed, but kurtosis values were in the acceptable range. As seen in Table 13, only one inter-item correlation was significant; thus, Cronbach's alpha was not computed for the three items. The correlation between items 18 and 19 was positive.

Table 12. Building Block 2 Subscale Descriptive Statistics (n = 70)

Item	*n*	*M*	*SD*	Minimum	Maximum	*n* of Missing Responses	Skewness	Kurtosis
7. My healthcare provider asks me about my own physical and/or mental health during our visits.	67.00	88.36	19.15	30.00	100.00	3.00	-1.79	2.21
18. The staff in this office asks me if my child and I feel safe at home.	66.00	82.70	30.44	0.00	100.00	4.00	-1.93	2.52
19. The staff in this office talks with me about positive ways to respond to my child when they misbehave.	65.00	80.11	32.30	0.00	100.00	5.00	-1.66	1.40

Table 13. Building Block 2 Subscale Inter-Item Correlations

Item	7	18	19
7. My healthcare provider asks me about my own physical and/or mental health during our visits.	1.00		
18. The staff in this office asks me if my child and I feel safe at home.	.15	1.00	
19. The staff in this office talks with me about positive ways to respond to my child when they misbehave.	.07	**.56**	1.00

Note. Boldface indicates significant correlation at $p < .05$. Sample size ranges from 64 to 67 for variables.

Building Block 3 Subscale: Social Engagement and Sense of Connectedness. As seen in Table 14, overall, parents reported moderate agreement on items 9, 20, and 22. There were some missing data across the three items with most missing data on item 22. All items were negatively skewed, but kurtosis values were in the acceptable range. As seen in Table 15, inter-item correlations were significant and positive; magnitude of correlations was weak to strong. We computed Cronbach's alpha for the four items, and it was acceptable ($\alpha = .82$).

Table 14. Building Block 3 Subscale Descriptive Statistics (n = 70)

Item	*n*	*M*	*SD*	Minimum	Maximum	*n* of Missing Responses	Skewness	Kurtosis
9. My healthcare provider asks me whether I take part in activities or organizations in my community (e.g., library, houses of worship, clubs, etc.).	66.00	68.20	34.28	0.00	100.00	4.00	-0.86	-0.61
20. The staff in this office celebrates the activities my child does at school and in their community.	65.00	71.38	37.08	0.00	100.00	5.00	-1.01	-0.57
22. The staff in this office encourages me to take part in activities or organizations in my community that might be good for me and my family (e.g., library, houses of worship, clubs).	64.00	67.66	36.88	0.00	100.00	6.00	-0.84	-0.80

Table 15. Building Block 3 Subscale Inter-Item Correlations

Item	9	20	22
9. My healthcare provider asks me whether I take part in activities or organizations in my community (e.g., library, houses of worship, clubs, etc.).	1.00		
20. The staff in this office celebrates the activities my child does at school and in their community.	**.41**	1.00	
22. The staff in this office encourages me to take part in activities or organizations in my community that might be good for me and my family (e.g., library, houses of worship, clubs).	**.72**	**.61**	1.00

Note. Boldface indicates significant correlation at $p < .05$. Sample size ranges from 63 to 65 for variables.

Building Block 4 Subscale: Opportunities for Social and Emotional Development. As seen in Table 16, overall, parents reported moderate agreement on items 14, 17, 23, 25, and 26. There were some missing data across the three items with most missing data on item 17. All items were negatively skewed, and with the exception of item 14, kurtosis values were in the acceptable range. As seen in Table 17, inter-item correlations were significant and positive; magnitude of correlations was weak to strong. We computed Cronbach's alpha for the five items, and it was acceptable ($\alpha = .86$).

Table 16. Building Block 4 Subscale Descriptive Statistics (N = 70)

Item	*n*	*M*	*SD*	Minimum	Maximum	*n* of Missing Responses	Skewness	Kurtosis
14. My healthcare provider gives me information about how to help my child get along with other children.	67.00	87.88	19.24	0.00	100.00	3.00	-2.51	7.61
17. My healthcare provider encourages me to have my child play with other kids	64.00	81.67	27.63	0.00	100.00	6.00	-1.78	2.54
23. The staff in this office has ideas and resources for when my child is struggling with friendships.	65.00	76.08	30.65	0.00	100.00	5.00	-1.34	0.85
25. The staff in this office shows me ways to help my child express their feelings.	66.00	78.80	29.27	0.00	100.00	4.00	-1.47	1.30
26. The staff in this office helps me respond to my child's feelings of anger, frustration, or sadness in a positive or helpful way.	66.00	79.73	29.31	0.00	100.00	4.00	-1.70	2.00

Table 17. Building Block 4 Subscale Inter-Item Correlations

Item	14	17	23	25	26
14. My healthcare provider gives me information about how to help my child get along with other children.	1.00				
17. My healthcare provider encourages me to have my child play with other kids	**.50**	1.00			
23. The staff in this office has ideas and resources for when my child is struggling with friendships.	**.34**	**.44**	1.00		
25. The staff in this office shows me ways to help my child express their feelings.	**.42**	**.55**	**.76**	1.00	
26. The staff in this office helps me respond to my child's feelings of anger, frustration, or sadness in a positive or helpful way.	**.41**	**.50**	**.73**	**.97**	1.00

Note. Boldface indicates significant correlation at $p < .05$. Sample size ranges from 63 to 67 for variables.

Cultural Sensitivity Subscale. As seen in Table 18, overall, parents reported high agreement on items 10 and 12, and low agreement on item 11. There were some missing data across the three items with most missing data on item 11. All items were negatively skewed, and kurtosis values were > 3. As seen in Table 19, only one inter-item correlation was significant. The correlation that was significant was positive. Because only one inter-item correlation was significant, Cronbach's alpha was not computed for the three items.

Table 18. Cultural Sensitivity Subscale Descriptive Statistics (N = 70)

Item	*n*	*M*	*SD*	Minimum	Maximum	*n* of Missing Responses	Skewness	Kurtosis
10. I feel comfortable sharing my cultural beliefs and practices with my healthcare provider because they will respect my beliefs and practices.	65.00	90.88	15.06	40.00	100.00	5.00	0.30	3.34
11. I think my healthcare provider views my race or ethnicity in a negative way.	63.00	2.79	14.63	0.00	100.00	7.00	0.30	35.97
12. My healthcare provider is someone I could talk to if I or my child had an experience with discrimination.	66.00	87.29	23.42	0.00	100.00	4.00	0.30	4.88

Table 19. Cultural Sensitivity Subscale Inter-Item Correlations

Item	10	11	12
10. I feel comfortable sharing my cultural beliefs and practices with my healthcare provider because they will respect my beliefs and practices.	1.00		
11. I think my healthcare provider views my race or ethnicity in a negative way.	.11	1.00	
12. My healthcare provider is someone I could talk to if I or my child had an experience with discrimination.	**.29**	.09	1.00

Note. Boldface indicates significant correlation at $p < .05$. Sample size ranges from 62 to 66 for variables.

Means for subscales that showed evidence of internal consistency. As seen in Table 20, the mean level of agreement across the three reliable subscales (i.e., parent-provider relationship, Building Block 3, and Building Block 4) was moderate to high. Means were not computed if more than one item was missing in each subscale. Most of the missing data were for Building Block 3. The parent-provider relationship and Building Block 4 subscales were both negatively skewed, and only the parent-provider relationship subscale had a kurtosis value > 3. Table 21 shows that two correlations were significant; parent-provider relationship was weakly positively correlated with Building Block 4, and Building Block 3 and Building Block 4 were strongly positively correlated. Cronbach's alpha was computed using all items from the three reliable subscales. We only included responses from participants for whom we were able to calculate a mean score (i.e., they were not missing more than one item per subscale). Cronbach's alpha was within the acceptable range ($\alpha = .90$).

Table 20. Descriptive Statistics for Subscales that Showed Evidence of Internal Consistency, Healthcare Survey

Subscale	*n*	*M*	*SD*	Minimum	Maximum	*n* of Missing Responses	Skewness	Kurtosis
Parent-Provider Relationship	70.00	94.00	9.73	42.50	100.00	0.00	-2.84	11.00
Building Block 3	64.00	69.65	29.24	0.00	100.00	6.00	-0.84	-0.40
Building Block 4	66.00	80.70	22.42	19.80	100.00	4.00	-1.37	1.11

Table 21. Subscales Inter-Item Correlations

Subscale	PPR	BB3	BB4
Parent-Provider Relationship (PPR)	1.00		
Building Block 3 (BB3)	.17	1.00	
Building Block 4 (BB4)	**.39**	**.73**	1.00

Note. Boldface indicates significant correlation at $p < .05$. Sample size ranges from 63 to 70 for variables.

Pilot Home Visiting Parent Survey[13]

We could only examine whether inter-item correlations were at least moderate (i.e., > .40) but could not examine reliability coefficients due to the small sample size (n = 14)[14] (Yurdügul, 2008). We examined the Pilot Home Visiting Parent Survey using a series of descriptive analyses for each proposed subscale (i.e., parent-provider relationship, Building Block 1, Building Block 2, Building Block 3, Building Block 4, cultural sensitivity). Descriptive analyses included means, standard deviations, range, missing data, skew, kurtosis, and inter-item correlations.

Parent-Provider Relationship Subscale. As seen in Table 22, parents reported high agreement on items 1, 2, 4, and 5. Item 3 had a lower mean, greater variability, and more missing responses than the other four items. All items were negatively skewed and kurtosis values were > 3. Table 23 shows that all items except for item 3 have statistically significant strong positive correlations.

[13] Also referred to as Home Visiting Survey and Home Visiting Pre-Survey throughout the report.
[14] Reliability analyses are not recommended for samples smaller than *n* = 30 (Yurdügul, 200).

Table 22. Parent-Provider Relationship Subscale Descriptive Statistics (n = 14)

Item	*n*	*M*	*SD*	Minimum	Maximum	*n* of Missing Responses	Skewness	Kurtosis
1. I can tell my home visitor things that are important about my life.	14.00	97.29	9.33	65.00	100.00	0.00	-3.70	13.74
2. My home visitor makes me feel like I have the ability to act on my goals.	14.00	97.36	9.60	64.00	100.00	0.00	-3.74	13.97
4. After meeting with my home visitor, I feel a sense of hope about changing the things in my life that I can control.	14.00	95.57	9.59	73.00	100.00	0.00	-2.10	3.11
5. My home visitor is interested in my ideas about how to make my and my child's life better.	14.00	97.57	6.22	79.00	100.00	0.00	-2.65	6.58

Table 23. Parent-Provider Relationship Inter-Item Correlations

Item	1	2	4	5
1. I can tell my home visitor things that are important about my life.	1.00			
2. My home visitor makes me feel like I have the ability to act on my goals.	**1.00**	1.00		
4. After meeting with my home visitor, I feel a sense of hope about changing the things in my life that I can control.	**0.66**	**0.65**	1.00	
5. My home visitor is interested in my ideas about how to make my and my child's life better.	**0.90**	**0.86**	**0.64**	1.00

Note. Boldface indicates significant correlation at $p < .05$. Sample size was 14 for all variables.

Building Block 1 Subscale: Nurturing and Supportive Relationships. As seen in Table 24, parents reported high levels of agreement for items 6, 7, 9, 18, and 21, and moderate levels of agreement for item 24 on the Building Block 1 Subscale. None of the items had missing data. Items 6, 7, 9, 18, and 21 were negatively skewed, and had kurtosis values > 3. Table 25 shows that items 7 and 21 were moderately positively correlated, as were items 9 and 24. Items 6 and 21 and items 7 and 9 were almost perfectly positively correlated with each other.

Table 24. Building Block 1 Subscale Descriptive Statistics (n = 14)

Item	*n*	*M*	*SD*	Minimum	Maximum	*n* of Missing Responses	Skewness	Kurtosis
6. When talking about hard things in my life, my home visitor helps me see that there are positive things too.	14.00	98.71	3.75	86.00	100.00	0.00	-3.47	12.35
7. My home visitor has helped me see how I can create positive experiences for my children.	14.00	99.43	1.40	95.00	100.00	0.00	-2.88	8.63
9. My home visitor has given me ideas about how to make interactions with my child better.	14.00	96.64	9.97	63.00	100.00	0.00	-3.42	12.03
18. My home visitor talks about positive relationships my child has or can have with other adults.	14.00	96.79	8.12	70.00	100.00	0.00	-3.19	10.72
21. After meeting with my home visitor, I feel better able to manage stress in my parenting role.	14.00	98.93	2.97	89.00	100.00	0.00	-3.32	11.42
24. My home visitor asks me about good things from my own childhood.	14.00	70.29	29.59	9.00	100.00	0.00	-0.47	-0.73

Table 25. Building Block 1 Subscale Inter-Item Correlations

Item	6	7	9	18	21	24
6. When talking about hard things in my life, my home visitor helps me see that there are positive things too.	1.00					
7. My home visitor has helped me see how I can create positive experiences for my children.	0.49	1.00				
9. My home visitor has given me ideas about how to make interactions with my child better.	0.37	**0.98**	1.00			
18. My home visitor talks about positive relationships my child has or can have with other adults.	0.13	0.19	0.19	1.00		
21. After meeting with my home visitor, I feel better able to manage stress in my parenting role.	**1.00**	**0.54**	0.42	0.14	1.00	
24. My home visitor asks me about good things from my own childhood.	-0.10	0.52	**0.54**	0.31	-0.06	1.00

Note. Boldface indicates significant correlation at p< .05. Sample size was 14 for all variables.

Building Block 2 Subscale: Safe, Stable, and Equitable Environments. As seen in Table 26, parents reported high levels of agreement for all items on the Building Block 2 subscale. There was low variability among responses to each item. Additionally, there were no missing data, all items were negatively skewed, and had kurtosis values > 3. Table 27 shows that items 5, 8, and 16 were strong to very strongly positively correlated with each other. Item 15 was not significantly correlated with any other items.

Table 26. Building Block 2 Subscale Descriptive Statistics (n = 14)

Item	*n*	*M*	*SD*	Minimum	Maximum	*n* of Missing Responses	Skewness	Kurtosis
5. My home visitor is interested in my ideas about how to make my and my child's life better.	14.00	97.57	6.22	79.00	100.00	0.00	-2.65	6.58
8. My home visitor asks me about my own physical and/or mental health during our visits.	14.00	99.36	1.65	94.00	100.00	0.00	-3.09	9.98
16. My home visitor talks with me about positive ways to respond to my child when they misbehave.	14.00	99.14	2.38	91.00	100.00	0.00	-3.55	12.91

Table 27. Building Block 2 Subscale Inter-Item Correlations

Item	5	8	16
5. My home visitor is interested in my ideas about how to make my and my child's life better.	1.00		
8. My home visitor asks me about my own physical and/or mental health during our visits.	**0.79**	1.00	
16. My home visitor talks with me about positive ways to respond to my child when they misbehave.	**0.90**	**0.93**	1.00

Note. Boldface indicates significant correlation at $p < .05$. Sample size was 14 for all variables.

Building Block 3 Subscale: Social Engagement and Sense of Connectedness. As seen in Table 28, parents reported high levels of agreement for all items on the Building Block 3 subscale. There was more variability in parents' responses to these items than for other items on other subscales, and there were some missing data on item 11. All items except for item 10 were negatively skewed. Only item 11 had a kurtosis value > 3. Table 29 shows that items 10 and 19 were significantly and strongly positively correlated, but no other items were correlated.

Table 28. Building Block 3 Subscale Descriptive Statistics (n = 14)

Item	*n*	*M*	*SD*	Minimum	Maximum	*n* of Missing Responses	Skewness	Kurtosis
10. My home visitor asks me whether I take part in activities or organizations in my community (e.g., library, houses of worship, clubs, etc.).	13.00	85.77	17.13	53.00	100.00	1.00	-0.84	-0.79
11. My home visitor talks to and treats my child as though they matter.	10.00	88.40	31.27	0.00	100.00	4.00	-3.09	9.63
17. My home visitor celebrates the activities my child does in our community.	13.00	88.15	19.24	50.00	100.00	1.00	-1.26	-0.06
19. My home visitor encourages me to take part in activities or organizations in my community that might be good for me and my family (e.g., library, houses of worship, clubs).	14.00	87.29	20.97	48.00	100.00	0.00	-1.43	0.25

Table 29. Building Block 3 Subscale Inter-Item Correlations

Item	10	11	17	19
10. My home visitor asks me whether I take part in activities or organizations in my community (e.g., library, houses of worship, clubs, etc.).	1.00			
11. My home visitor talks to and treats my child as though they matter.	-0.27	1.00		
17. My home visitor celebrates the activities my child does in our community.	0.35	-0.16	1.00	
19. My home visitor encourages me to take part in activities or organizations in my community that might be good for me and my family (e.g., library, houses of worship, clubs).	**0.86**	-0.27	0.15	1.00

Note. Boldface indicates significant correlation at $p < .05$. Sample size ranged from 10 to 14 for variables.

Building Block 4 Subscale: Opportunity for Social and Emotional Development. Table 30 shows that parents indicated high levels of agreement for all items for the Building Block 4 subscale, and there was little variability among their responses. There were no missing data on Building Block 4 items. All items were negatively skewed and had kurtosis values > 3. As seen in Table 31, only items 22 and 23 were significantly positively correlated and the correlation was strong.

Table 30. Building Block 4 Subscale Descriptive Statistics (n = 14)

Item	*n*	*M*	*SD*	Minimum	Maximum	n of Missing Responses	Skewness	Kurtosis
20. My home visitor has ideas and resources for when my child is struggling with interactions with other children.	14.00	95.93	13.32	50.00	100.00	0.00	-3.65	13.49
22. My home visitor shows me ways to help my child express their feelings.	14.00	98.93	3.45	87.00	100.00	0.00	-3.67	13.62
23. My home visitor helps me respond to my child's feelings of anger, frustration, or sadness in a positive or helpful way.	14.00	98.00	4.91	85.00	100.00	0.00	-2.35	4.29
25. My home visitor shows me ways to let my child take the lead while we are playing together.	14.00	97.14	6.96	74.00	100.00	0.00	-3.26	11.17

Table 31. Building Block 4 Subscale Inter-Item Correlations

Item	20	22	23	25
20. My home visitor has ideas and resources for when my child is struggling with interactions with other children.	1.00			
22. My home visitor shows me ways to help my child express their feelings.	0.03	1.00		
23. My home visitor helps me respond to my child's feelings of anger, frustration, or sadness in a positive or helpful way.	-0.03	**0.75**	1.00	
25. My home visitor shows me ways to let my child take the lead while we are playing together.	-0.10	0.17	0.14	1.00

Note. Boldface indicates significant correlation at $p < .05$. Sample size was 14 for all variables.

Cultural Sensitivity Subscale. As seen in Table 32, parents reported high levels of agreement for items 12 and 14 and moderately high agreement for item 11. Item 11 in particular has a considerable amount of variability and more missing data than other items. All items were negatively skewed and had kurtosis values > 3. Table 33 shows that none of these items were significantly correlated with each other.

Table 32. Cultural Sensitivity Subscale Descriptive Statisitcs (n = 14)

Item	*n*	*M*	*SD*	Minimum	Maximum	*n* of Missing Responses	Skewness	Kurtosis
12. I think my healthcare provider views my race or ethnicity in a negative way	5.00	78.20	43.89	0.00	100.00	9.00	-2.19	4.84
13. I feel comfortable sharing my cultural beliefs and practices with my home visitor because they will respect my beliefs and practices.	14.00	99.71	0.61	98.00	100.00	0.00	-2.17	4.25
14. My home visitor is someone I could talk to if I or my child had an experience with discrimination.	13.00	99.31	1.55	95.00	100.00	1.00	-2.36	5.07

Table 33. Cultural Sensitvity Subscale Inter-Item Correlations

Item	11	12	14
12. I think my healthcare provider views my race or ethnicity in a negative way	1.00		
13. I feel comfortable sharing my cultural beliefs and practices with my home visitor because they will respect my beliefs and practices.	0.22	1.00	
14. My home visitor is someone I could talk to if I or my child had an experience with discrimination.	0.17	-0.15	1.00

Note. Sample size ranged from 5 to 14 for variables.

Section IV: Conclusions and Recommendations

- The Parent-Provider Relationship, Building Block 3, and Building Block 4 subscales showed evidence of internal consistency on the Pilot Healthcare Parent Survey for the current sample as measured by Cronbach's alpha.
- The Building Block 1, Building Block 2, and Cultural Sensitivity subscales for the Healthcare Survey need to be modified or recreated. Through a review of correlations and Cronbach's alpha, these subscales do not show evidence of internal consistency for the current sample.
- Once the Building Block 1, Building Block 2, and Cultural Sensitivity subscales are modified or recreated, the entire Healthcare Survey should be re-piloted with a larger and more diverse sample. Having a larger sample will allow for more sophisticated measurement work. Having a more diverse sample will allow for generalization of the findings across a broader population.
- A larger sample is also needed for examining whether responses differed by whether a participant filled out the paper vs. the Qualtrics survey.
- For the Pilot Home Visiting Parent Survey, a larger pilot study should be conducted so that at minimum, Cronbach's alpha can be computed for each subscale.
    - Items that were correlated on the Parent-Provider Relationship and Building Block 2 subscales could be retained but should be tested with a larger sample and analyzed using more sophisticated statistical tests.
- For the Home Visiting Survey, Building Block 1, 3, and 4, and the Cultural Sensitivity subscales should be recreated or modified and re-piloted.
- More sophisticated measurement work is needed for both the Healthcare and Home Visiting versions of the survey, including exploratory factor analysis and confirmatory factor analysis to examine whether a set of observed variables (i.e., items) is measuring an underlying construct (i.e., parent-provider relationship). Measurement invariance work is also needed if the intention is to combine samples from different sectors (i.e., respondents who reported on their healthcare providers vs. respondents who reported on their home visitors).
- If the revised measures are intended to be used more than once (i.e., pre and post), test-retest reliability needs to be assessed.
- Validity of the revised measures must also be tested (i.e., content validity, criterion validity, discriminant validity).

- We would caution against the use of negatively worded items (e.g., *I think my healthcare provider views my race or ethnicity in a negative way; My healthcare provider talks too much about the negative or hard things in my life)* as these items were not significantly correlated with other items in their respective subscales.
- Only parents who completed the paper version of the Healthcare Survey were asked how they preferred to respond to survey items—using the VAS or a Likert scale. Most parents who completed the paper version preferred the Likert scale (1 = Almost never true and 5 = Almost always true), with eight parents indicating they preferred the VAS scale.

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PILOT PARENT HEALTHCARE SURVEY

Researchers from Tufts Interdisciplinary Evaluation Research (TIER) at Tufts University in Medford are conducting a study to learn how home visitors can best interact with and provide support to families. As part of this project, we would like to invite you to complete this survey about your experiences with your home visitor. There are no right or wrong answers to the survey. The survey takes 10-15 minutes to complete.

Your participation in this survey is voluntary—you do not have to complete the survey. Your survey responses will be kept confidential—only Tufts Interdisciplinary Evaluation Research (TIER)—the research group who is evaluating HOPE—and staff members at Healthy Outcomes from Positive Experiences (HOPE) will see your responses; your healthcare provider will not see them. Information will be reported only in aggregate, meaning no answers will be connected with your name. Information we learn from this survey will help home visitors improve the services they provide to families. After you fill out this survey, we will ask for your email address separately to send you a $10 Amazon gift card to thank you for your time.

An Institutional Review Board ("IRB") is overseeing this research. An IRB is a group of people who perform an independent review of research studies to ensure the rights and welfare of participants are protected. If you have questions about your rights or wish to speak with someone other than the research team, you may contact:

Tufts Social, Behavioral, and Educational Research IRB
75 Kneeland Street, Suite 623
Boston, MA 02111
617.627.8804
SBER@tufts.edu

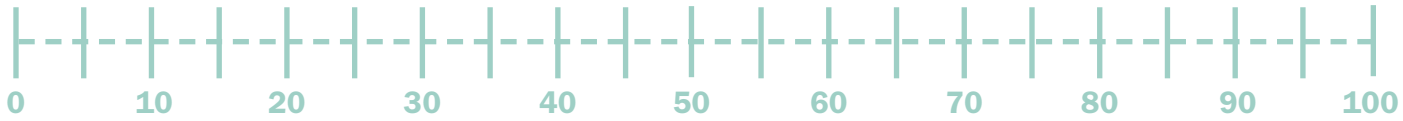
If you are willing to participate, please provide your consent.

- ○ I agree to take this survey
- ○ I do NOT agree to take this survey [DIRECTED TO END OF SURVEY VIA SKIP LOGIC]

DIRECTIONS

When answering the questions in this part of the survey, please think about all of the conversations you have had with the healthcare provider who sees your child when they come in for a well-child visit (for example, to receive vaccines). Your healthcare provider refers to your doctor, nurse practitioner (NP), or physician's assistant (PA). Please rate the statements below from 0 (not at all true) to 100 (very true). Draw a line up and down like this | or an X anywhere on the number line to show how you feel about each statement.

Not at all true — Very true



1. **I can tell my healthcare provider things that are important about my life.**
2. **My healthcare provider makes me feel like I have the ability to act on my goals.**
3. **My healthcare provider talks too much about the negative or hard things in my life.**
4. **After meeting with my healthcare provider, I feel a sense of hope about changing the things in my life that I can control.**
5. **My healthcare provider is interested in my ideas about how to make my and my child's life better.**
6. **When talking about hard things in my life, my healthcare provider helps me see that there are positive things too.**
7. **My healthcare provider asks me about my own physical and/or mental health during our visits.**
8. **My healthcare provider has given me ideas about how to make interactions with my child better.**
9. **My healthcare provider asks me whether I take part in activities or organizations in my community (e.g., library, houses of worship, clubs, etc.).**
10. **I feel comfortable sharing my cultural beliefs and practices with my healthcare provider because they will respect my beliefs and practices.**

11. I think my healthcare provider views my race or ethnicity in a negative way.
12. My healthcare provider is someone I could talk to if I or my child had an experience with discrimination.
13. In the last month I feel like my relationship with my child is going well overall.
14. My healthcare provider gives me information about how to help my child get along with other children.
15. My healthcare provider encourages me to have my child play with other kids.
16. The staff in this office asks me if my child and I feel safe at home.
17. The staff in this office talks with me about positive ways to respond to my child when they misbehave.
18. The staff in this office celebrates the activities my child does at school and in their community.
19. The staff in this office talks about positive relationships my child has or can have with other adults.
20. The staff in this office encourages me to take part in activities or organizations in my community that might be good for me and my family (e.g., library, houses of worship, clubs).
21. The staff in this office has ideas and resources for when my child is struggling with friendships.
22. After meeting with the staff in this office I feel better able to manage stress in my parenting role.
23. The staff in this office shows me ways to help my child express their feelings.
24. The staff in this office helps me respond to my child's feelings of anger, frustration, or sadness in a positive or helpful way.

Next, we will ask you a few questions about yourself.

25. How many children do you bring to get care at this doctor's office?

_____

26. What are the ages of your children you bring to get care at this doctor's office?

_____

27. Your (the parent's or caregiver's) age in years.

_____

28. Your racial identity (Check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

29. Your ethnic identity

- ☐ Hispanic
- ☐ Non-Hispanic

30. Your primary language (Select ONE)

- ☐ Arabic
- ☐ Cantonese
- ☐ Cape Verdean Creole
- ☐ English
- ☐ French
- ☐ Haitian Creole
- ☐ Mandarin
- ☐ Portuguese
- ☐ Somali
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other (please specify):

31. Do you speak another language?

- ☐ Yes
- ☐ No

32. Your second primary language is (Skip if you do not speak another language)

- ☐ Arabic
- ☐ Cantonese
- ☐ Cape Verdean Creole
- ☐ English
- ☐ French
- ☐ Haitian Creole
- ☐ Mandarin
- ☐ Portuguese
- ☐ Somali
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other (please specify):

33. Your gender identity

- ☐ Man
- ☐ Woman
- ☐ Non-binary
- ☐ Not Listed:
- ☐ Prefer not to respond

Do you identify as transgender?

- ☐ Yes
- ☐ No
- ☐ Prefer not to respond

Thank you for completing this survey! We need your email address so that we can send you an e-gift card in the amount of $10. By clicking submit to this survey, we will take you to a separate survey where you can fill in your email address. We will only use that email address to send you your e-gift card. We will not connect your email address to your answers on this survey.

Click **here** to continue to fill out the gift card form!

PILOT PARENT HOME VISITING SURVEY

Researchers from Tufts Interdisciplinary Evaluation Research (TIER) at Tufts University in Medford are conducting a study to learn how home visitors can best interact with and provide support to families. As part of this project, we would like to invite you to complete this survey about your experiences with your home visitor. There are no right or wrong answers to the survey. The survey takes 10-15 minutes to complete.

Your participation in this survey is voluntary—you do not have to complete the survey. Your survey responses will be kept confidential—only Tufts Interdisciplinary Evaluation Research (TIER)—the research group who is evaluating HOPE—and staff members at Healthy Outcomes from Positive Experiences (HOPE) will see your responses; your healthcare provider will not see them. Information will be reported only in aggregate, meaning no answers will be connected with your name. Information we learn from this survey will help home visitors improve the services they provide to families. After you fill out this survey, we will ask for your email address separately to send you a $10 Amazon gift card to thank you for your time.

An Institutional Review Board ("IRB") is overseeing this research. An IRB is a group of people who perform an independent review of research studies to ensure the rights and welfare of participants are protected. If you have questions about your rights or wish to speak with someone other than the research team, you may contact:

Tufts Social, Behavioral, and Educational Research IRB
75 Kneeland Street, Suite 623
Boston, MA 02111
617.627.8804
SBER@tufts.edu

If you are willing to participate, please provide your consent.

- ○ I agree to take this survey
- ○ I do NOT agree to take this survey [DIRECTED TO END OF SURVEY VIA SKIP LOGIC]

DIRECTIONS

When answering the questions in this part of the survey, please think about all of the conversations you have had with your home visitor. Please rate the statements below from 0 (not at all true) to 100 (very true). Draw a line up and down like this or an X anywhere on the number line to show how you feel about each statement.

1. I can tell my home visitor things that are important about my life.
2. My home visitor makes me feel like I have the ability to act on my goals.
3. My home visitor talks too much about the negative or hard things in my life.
4. After meeting with my home visitor, I feel a sense of hope about changing the things in my life that I can control.
5. My home visitor is interested in my ideas about how to make my and my child's life better.
6. When talking about hard things in my life, my home visitor helps me see that there are positive things too.
7. My home visitor has helped me see how I can create positive experiences for my children.
8. My home visitor asks me about my own physical and/or mental health during our visits.
9. My home visitor has given me ideas about how to make interactions with my child better.
10. My home visitor asks me whether I take part in activities or organizations in my community (e.g., library, houses of worship, club, etc.).
11. My home visitor talks to and treats my child as though they matter.
12. I feel comfortable sharing my cultural beliefs and practices with my home visitor because they will respect my beliefs and practices
13. I think my home visitor views my race or ethnicity in a negative way.
14. My home visitor is someone I could talk to if I or my child had an experience with discrimination.
15. My home visitor asks me if my child and I feel safe at home.
16. My home visitor talks with me about positive ways to respond to my child when they misbehave.
17. My home visitor celebrates the activities my child does at school and in their community.
18. My home visitor talks about positive relationships my child has or can have with other adults.
19. My home visitor encourages me to take part in activities or organizations in my community that might be good for me and my family (e.g., library, houses of worship, clubs).

20. My home visitor has ideas and resources for when my child is struggling with friendships.
21. After meeting with my home visitor, I feel better able to manage stress in my parenting role.
22. My home visitor shows me ways to help my child express their feelings.
23. My home visitor helps me respond to my child's feelings of anger, frustration, or sadness in a positive or helpful way.
24. My home visitor asks me about good things from my own childhood.
25. My home visitor shows me ways to let my child take the lead while we are playing together.

Next, we will ask you a few questions about yourself.

26. How many children are the focus of the home visits you receive?

_____

27. What are the ages of EACH child who is the focus of home visits?

_____

28. Your (the parent's or caregiver's) age in years.

_____

29. Your racial identity (Check all that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

30. Your ethnic identity

☐ Hispanic ☐ Non-Hispanic

31. Your primary language (Select ONE)

☐ Arabic
☐ Cantonese
☐ Cape Verdean Creole
☐ English
☐ French
☐ Haitian Creole
☐ Mandarin
☐ Portuguese
☐ Somali
☐ Spanish
☐ Tagalog
☐ Vietnamese
☐ Other (please specify):

32. Do you speak another language?

☐ Yes ☐ No

33. Your second primary language is (Skip if you do not speak another language)

- ☐ Arabic
- ☐ Cantonese
- ☐ Cape Verdean Creole
- ☐ English
- ☐ French
- ☐ Haitian Creole
- ☐ Mandarin
- ☐ Portuguese
- ☐ Somali
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other (please specify):

34. Your gender identity

- ☐ Man
- ☐ Woman
- ☐ Non-binary
- ☐ Not Listed:
- ☐ Prefer not to respond

35. Do you identify as transgender?

- ☐ Yes
- ☐ No
- ☐ Prefer not to respond

36. About how long have you worked with your home visitor?

- ☐ Less than 1 month
- ☐ 1-3 Months
- ☐ 4-6 Months
- ☐ 6 months - 1 year
- ☐ More than 1 year

37. How often do you have contact with your home visitor (contact includes visits, phone calls, texts, and email)?

- ☐ Less than 1 month
- ☐ 1-3 Months
- ☐ 4-6 Months
- ☐ 6 months - 1 year
- ☐ More than 1 year
- ☐ Other (please specify)

Thank you for completing this survey! We need your email address so that we can send you an e-gift card in the amount of $10. By clicking submit to this survey, we will take you to a separate survey where you can fill in your email address. We will only use that email address to send you your e-gift card. We will not connect your email address to your answers on this survey.

Click **here** to continue to fill out the gift card form!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Tufts Interdisciplinary
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