Exploring Feasibility and Frontline Insight: Provider Perspectives on the Precision-Based Adaptation of the SafeCare Model

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Introduction

Home-visiting programs have long served as a foundational public health strategy to support family well-being, particularly for those navigating socioeconomic hardships or other challenges that place them at higher risk for negative outcomes (Sweet & Appelbaum, 2004). These programs are designed to provide structured, evidence-based guidance in areas such as parenting, child safety, and health promotion. Agencies can choose from dozens of home-visiting models, many of which share common features: they primarily serve families with young children, participation is voluntary, and services are delivered in the home or another preferred location (U.S. Department of Health and Human Services, n.d.) However, these models also differ in their purpose, service providers, visit frequency and duration, and levels of evidence supporting their effectiveness. Selecting the right model involves considering community needs, available resources, and potential implementation challenges, as a strong fit increases the likelihood of successful adoption and impact.

Among the many evidence-based home-visiting models, SafeCare is an established and effective intervention to reduce child maltreatment and improve parental skills (Lutzker & Bigelow, 2002). SafeCare provides caregivers with a structured, skills-based curriculum that focuses on enhancing parent-child interactions, maintaining a safe home environment, and managing child health concerns. While SafeCare has demonstrated strong evidence for effectiveness across diverse populations, there is an increasing recognition of the need for a more flexible, precision-based model that accounts for the unique circumstances and evolving needs of each family. SafeCare is particularly interested in increasing family engagement, recognizing that improved engagement correlates with stronger adherence, retention, and ultimately, better outcomes (Casillas et al., 2016). By shifting towards a precision-based approach, SafeCare aims to tailor its intervention strategies more effectively, ensuring that resources are used efficiently while promoting stronger relationships between providers and families.

This capstone project explores the feasibility of an adapted approach to SafeCare delivery, Precision-Based SafeCare (PBSC), that was developed by experts at t the National SafeCare Training and Research Center at Georgia State University. By partnering with a state (Oklahoma) that is currently implementing SafeCare statewide in prevention and child protection settings, this project aims to collect feedback on the feasibility of the recently designed precision-based approach, which tailors' intervention delivery to individual caregiver needs based on an initial comprehensive assessment. The findings will contribute to further design and development of the curriculum, with the ultimate goal of enhancing parent engagement by better tailoring SafeCare program components to align with the unique needs of families, increasing their participation, retention, and outcomes.

What Impacts Family Engagement in Evidence-Based Home Visiting Programs?

Understanding the factors that contribute to family disengagement in home visiting programs is important for developing strategies that promote sustained participation and program retention. Research indicates that parent program engagement is impacted by a variety of barriers, which can be broadly categorized into structural, relational, and individual-level factors (U.S. Department of Health & Human Services, Administration for Children &

Families, Office of Planning, Research & Evaluation, 2022). These categories encompass the external, interpersonal, and personal challenges that influence families' ability to access and fully participate in home visiting services. By identifying these factors, researchers can better understand the barriers to engagement and develop more effective approaches to support families throughout their program matriculation.

Structural barriers stem from external factors that make it difficult for families to access or fully participate in home visiting programs. Many families experience logistical obstacles such as transportation difficulties, unpredictable work schedules, or housing instability, which can prevent them from consistently engaging with home visitors (Kaye, et. Al, 2024). Limited access to technology can also pose a significant challenge, particularly for families who rely on virtual visits. Additionally, childcare responsibilities may interfere with caregivers' ability to focus on the program, particularly in households with multiple young children requiring attention. These systemic obstacles often create unintended barriers for families who might otherwise benefit from participation. McCurdy and Daro (2001) highlight that structural factors, such as program accessibility and the alignment of services with families' real-life needs, play a critical role in shaping engagement, and addressing these barriers requires flexibility in how programs are designed and delivered.

Relational barriers arise from trust issues, cultural differences, and concerns about privacy or stigma. Some families may hesitate to allow home visitors into their personal space due to fear of judgment or prior negative experiences with social services. There may also be concerns about how personal information is used, particularly among marginalized communities with histories of surveillance or systemic discrimination (Stevens et al., 2005). Furthermore, cultural and linguistic barriers can make engagement challenging. If home visiting services are not culturally responsive or available in a family's primary language, caregivers may feel misunderstood or disconnected, reducing their willingness to participate. McCurdy and Daro (2001) emphasize that provider attributes, including their ability to establish rapport, demonstrate empathy, and respect cultural differences, are critical in encouraging family engagement and overcoming relational barriers. Additionally, frequent home visitor turnover can exacerbate these challenges by disrupting established relationships and making it harder for families to build new connections with incoming providers (Harnett et al., 2024).

Individual-level barriers are rooted in the personal circumstances and perceptions of caregivers, which can influence their engagement in home visiting services. Mental health challenges, high levels of stress, or ongoing crises can make it difficult for caregivers to prioritize participation, even if they recognize the program's potential benefits. Additionally, some families may not perceive home visits as relevant to their needs or may struggle to see their immediate value. If a program's structure or content does not align with its expectations or pressing concerns, engagement may wane over time (Stevens et al., 2005). Addressing these barriers requires a personalized approach that acknowledges each family's unique circumstances and motivations. According to McCurdy and Daro (2001), individual characteristics, such as personal beliefs, attitudes, and prior experiences, significantly impact a caregiver's decision to engage in support programs, making it essential to tailor services to address these factors.

By recognizing these barriers at multiple levels, home visiting programs can develop tailored strategies to enhance accessibility, build trust, and ensure families feel valued and

supported throughout their participation. This foundation sets the stage for exploring evidence-based approaches to improving family engagement and sustaining participation in home visiting services.

How could Precision-Based Home Visiting be a Solution for Parent Engagement Challenges?

Precision-based home visiting is an emerging model that seeks to optimize intervention delivery by customizing services based on family-specific characteristics, needs, and risk levels. Unlike traditional home-visiting programs that implement a standardized curriculum for all participants, precision-based approaches use data-driven assessments to determine the most appropriate intensity, duration, and focus of services for each family (Supplee et al., 2021). This approach draws from principles used in precision medicine, which tailors treatment plans based on genetic, environmental, and lifestyle factors unique to an individual. Similarly, in home visiting, precision-based models rely on ongoing evaluations, behavioral analytics, and caregiver feedback to adjust interventions dynamically. The goal is to ensure that families receive the right support at the right time, minimizing unnecessary interventions while maximizing program effectiveness (Duggan et al., 2018). In a precision-based home-visiting model, intervention plans are tailored to individual family circumstances rather than following a one-size-fits-all curriculum. Programs integrate assessment tools and data tracking to refine service delivery and anticipate needs, adjusting the intensity and focus of home-visiting sessions as families progress.

Precision-based home-visiting models rely on data-driven decision-making and personalized intervention strategies to improve program outcomes. Rather than delivering the same curriculum to all families, these models assess family-specific factors such as risk profiles, strengths, cultural background, and engagement levels to determine the most appropriate intensity and content of services (Supplee et al., 2021). This approach allows for more efficient resource allocation, ensuring that caregivers receive the level of support they need without unnecessary redundancy. One of the primary motivations for adopting a precision-based model is the recognition that traditional home-visiting frameworks, while beneficial at the population level, may not yield optimal results for every family. Some caregivers may need extended coaching and support, while others might be able to progress through the curriculum more quickly. Additionally, advances in technology, predictive analytics, and behavioral assessment tools create new opportunities to refine service delivery and ensure that families receive targeted support (Duggan et al., 2018)

A Precision-Based Approach Applied to the Family Spirit Model

The Family Spirit program, a home-visiting intervention designed specifically for Native American communities, has been a leader in integrating precision-based approaches into its model. Family Spirit has successfully used adaptive intervention strategies that personalize the timing, intensity, and content of services based on family characteristics and risk factors (Barlow et al., 2021).

A study detailing Family Spirit's adaptation process highlights how the program identifies "active ingredients", key program components that drive positive outcomes, and "pivot points",

moments when interventions should be adjusted based on individual family needs. Active ingredients in Family Spirit include the relationship between home visitors and clients, structured lessons on child safety and development, parent-child communication strategies, and goal setting. Pivot points involve key factors such as whether the caregiver is a first-time parent, has a history of substance abuse, has a child at risk for obesity, or has specific reproductive health concerns (Barlow et al., 2021).

By utilizing these insights, Family Spirit has seen increased engagement, better retention, and improved child health and developmental outcomes. These successes demonstrate the potential of precision-based home visiting to refine implementation strategies while maintaining fidelity to core program structures. SafeCare can draw valuable lessons from Family Spirit in developing assessment tools, integrating digital monitoring, and implementing adaptive intervention strategies to enhance family engagement and service efficiency.

The SafeCare Model

SafeCare® is an evidence-based home-visiting program designed to support caregivers in three core areas: parent-infant interactions or parent-child interactions, home safety, and child health (Lutzker & Bigelow, 2002). It is implemented by trained professionals who guide caregivers through lessons using behavioral strategies such as modeling, role-playing, and performance feedback. The program has been widely adopted both nationally and internationally, demonstrating effectiveness in reducing child neglect and improving parenting skills (Gershater-Molko, Lutzker, & Wesch, 2003). The SafeCare model has been successfully scaled to meet the needs of diverse populations and is used in various countries, demonstrating its adaptability and effectiveness across cultural contexts (Guastaferro et al., 2012).

The SafeCare model consists of three structured modules that target key areas of child well-being. The Parent-Child Interaction (PCI) module teaches caregivers how to engage positively with their children, focusing on responsive parenting, communication, and appropriate discipline. For caregivers with children under 18 months, the Parent-Infant Interaction (PII) module emphasizes bonding and early developmental support. The Health module educates caregivers on identifying and responding to common child illnesses and injuries, ensuring appropriate use of healthcare services. This module also addresses home safety-related health risks, such as poisoning or burns. The Safety module focuses on injury prevention by helping caregivers identify and remove hazards in the home and providing checklists and guidance for maintaining a safe environment over time. Research has shown that the model's multifaceted approach leads to significant improvements in caregiver skills and reductions in child maltreatment (Guastaferro et al., 2019; Guastaferro et al., 2012).

SafeCare is designed for caregivers of children ages 0 to 5 years old, particularly those at risk for child maltreatment, neglect, or unsafe home conditions. The program is delivered through trained home visitors, such as social workers or public health professionals. Sessions typically range from 18 to 20 visits, though duration may vary based on family needs. While the structured curriculum ensures fidelity to the model, it does not fully accommodate the varying risk levels, learning preferences, and specific needs of different families. Some caregivers may require more intensive coaching in certain areas, while others may already demonstrate strong competencies and benefit from a modified approach. The SafeCare model’s adaptability is one

of its most significant strengths, as it can be tailored to the individual needs of families to optimize engagement and outcomes (Guastaferro et al., 2019). Moreover, the program's effectiveness in addressing barriers to service participation has been demonstrated in its successful implementation with high-risk populations, including families involved in child protective services (Gershater-Molko et al., 2003).

Purpose of Project

The National SafeCare Training and Research Center is interested in examining a possible precision-based approach to SafeCare program delivery with the goal of enhancing both program efficiency and family engagement through a more targeted, responsive approach. By incorporating a precision-based approach, SafeCare hopes to improve family engagement and retention by making services more relevant and responsive to individual needs. The model also enhances the efficiency of resource allocation, ensuring that support is directed where it is most needed, ultimately increasing overall program effectiveness by delivering interventions that align with specific family characteristics and circumstances.

The NSTRC leadership and training team drafted an adapted SafeCare curriculum that aligns with the best practice recommendations for a precision-based delivery approach. The purpose of this capstone project is to vet the adapted curriculum in a focus group with SafeCare Trainers, coaches, and Providers from the state of Oklahoma to collect information on the strengths, challenges, and feasibility of this approach. Focus groups were selected as the next step in program adaptation because they allow for a collaborative and interactive way to gather detailed feedback from those who have firsthand experience with the program (Gill, 2008). This method helps to identify specific needs and challenges, ensuring that the adapted curriculum is practical, culturally relevant, and feasible for implementation. Additionally, focus groups provide an opportunity to explore participants' perceptions, helping to refine the curriculum to better align with the realities of home visiting practices and maximize its effectiveness (Rosen, 2018).

Focus Group Methods

Participant Recruitment

We invited trainers and providers from SafeCare agencies in Oklahoma to participate in a focus group discussion to gather feedback on the Precision-Based SafeCare model. Recruitment was conducted via email, with invitations sent to state leaders in the Oklahoma SafeCare implementation, who went on to select a representative group of external trainers, coaches and providers from agencies across the state of Oklahoma. The decision to start this evaluation with Oklahoma partners is because this is the longest ongoing statewide implementation of SafeCare, and the leadership team has engaged in several highly innovative adaptations to SafeCare to make the program more relevant to Oklahoma families. Thus, the NTRC team believed that providers engaged with the implementation in that state would be able to offer constructive feedback on the PBSC approach and could think critically about implementation related tasks. Participants were selected to ensure diverse perspectives from individuals with direct experience delivering SafeCare services to families.

Focus Group Format

The focus group was conducted in a virtual setting and lasted approximately 60 minutes. Prior to the session, participants were emailed virtual and physical copies of the Precision-Based SafeCare manual two weeks in advance, ensuring they had ample opportunity to review the materials and form initial thoughts and opinions. This approach allowed participants to come into the discussion with a foundational understanding of the adapted model.

The discussion was structured around five key areas, each introduced by open-ended questions designed to prompt detailed feedback on various aspects of the adaptation. Aspen Humes led the focus group discussion and guided participants through each topic. Supporting the discussion were two directors from the National SafeCare Training and Research Center: JoAnne Bielecki, the Director of Training and Implementation, and Shannon Self-Brown, the Co-Director of the National SafeCare Training and Research Center. They provided additional facilitation, offering their expertise and inputs as needed. The session encouraged open dialogue, allowing participants to share insights, ask clarifying questions, and engage in discussion about the feasibility, implementation, and impact of the Precision-Based SafeCare model.

Discussion Topics and Questions

The focus group discussion was designed to assess five core areas related to the Precision-Based SafeCare model:

1. General Impressions of the Precision-Based Model (10 minutes)
    - What are your initial impressions of the Precision-Based Model adaptation after reviewing the manual?
    - What aspects of the model stand out as promising or innovative?
2. Feasibility and Implementation (15 minutes)
    - How would the Precision-Based SafeCare fit into your current SafeCare delivery work with families?
    - What challenges do you anticipate when implementing with families?
    - Do you foresee any barriers to adopting this approach? (e.g., training, resources, time constraints)
    - What supports or resources would help providers successfully implement this adaptation?
3. Family Engagement & Accessibility (10 minutes)
    - How do you think families will respond to this adaptation of SafeCare?
    - Are there particular families that may benefit more from this model?
    - Are there particular families that may struggle with this approach? If so, why?
    - How does this Precision-Based SafeCare compare to traditional SafeCare in terms of family engagement?
4. Training & Provider Readiness (10 minutes)
    - Based on the manual, do you feel the training materials are clear and sufficient for preparing providers?
    - Are there any gaps or missing elements in the manual that should be addressed?
    - What additional training or support would you need to feel confident in delivering services using the Precision-Based model?

5. Recommendations & Final Thoughts (10 minutes)
    - What important next steps should NSTRC consider before implementing the Precision-Based approach with families?
    - Would any of you be willing to pilot the approach with one family?
    - What adjustments would you suggest before this model is implemented?
    - Is there anything else you'd like to share that we haven't covered?

Participation

Following the focus group session, the number and characteristics of participants were documented, including their roles within SafeCare agencies. The participant breakdown is as follows:

- Total number of participants: 8 participants
- Roles:
    # of Trainers: 5
    # of Providers: 1
    # of Coaches: 2
- Agency representation: OUHSC Center on Child Abuse & Neglect, Family & Children Services of Tulsa, Northcare, Latino Community Development Agency

Focus Group Themes

Participants had a mix of positive reactions and concerns about the new model, highlighting both its potential benefits and areas needing further refinement. Many appreciated its clarity and flexibility, particularly in streamlining Health and Safety topics, while also emphasizing the importance of maintaining SafeCare's core parenting components. The ability to adjust pacing based on family needs was seen as a strength, but questions arose about how best to balance structure with adaptability. Additionally, participants discussed the practical implications for providers, including workload, capacity, and the role of baseline assessments in guiding engagement. Conversations also centered on the challenge of standardizing the model while allowing for individualized support, as well as the need for clear decision-making tools to ensure consistency across implementation. These key themes provide insight into both the strengths of the adapted curriculum and the considerations necessary for its effective delivery.

Balancing Structure with Flexibility

A key strength of the Precision-Based SafeCare model lies in its flexibility, which enables providers to tailor each session based on a family's unique needs. This flexibility allows providers to adapt their approach, focusing on areas that require additional support and streamlining those that families have already mastered. Such customization enhances efficiency by ensuring that providers use their time effectively, prioritizing what matters most to each family. Given that families enter the program with varying levels of experience and understanding, this level of flexibility is particularly valuable. It allows providers to respond to each family's specific situation and create a more personalized and engaging experience. One focus group member pointed out that the ability to adjust the pace and content of sessions is crucial in managing session time effectively:

“It allows you more freedom to spend that extra time on those other modules because we do have a timeline and a limit for how long we want them involved with the program. So, to be able to say, ‘Hey, we're gonna spend more time on this module, and this one will be shorter’—that’s a lot more freedom for the provider as well.”

Providers also welcomed the addition of a ‘success’ measurement to baseline assessments, noting that it offers a more nuanced and comprehensive way to evaluate families’ understanding of key concepts beyond the traditional mastery framework. Many felt that this approach allows for a more accurate assessment of where families stand, capturing progress that might otherwise go unrecognized. By incorporating this additional measure, providers can better tailor their support and interventions to meet families’ specific needs. This new approach was already being applied in some settings, with positive feedback from both staff and providers. A provider who had recently implemented the change, shared:

“The fact that it now includes success on baselines as opposed to just mastery—we have implemented that already with resounding positive feedback from staff.”

While most agreed that this flexibility could enhance engagement and efficiency, some providers expressed concerns about maintaining structure and accountability within the model. A key worry was that too much adaptability could lead to inconsistencies in implementation or unintentional shortcuts in session delivery, ultimately impacting the fidelity of the program. One focus group member, drawing on her extensive field experience, cautioned that without clear boundaries and guidance, some providers might take advantage of the model’s flexibility, resulting in rushed sessions or inaccurate baseline assessments. She emphasized the importance of ensuring that baseline measurements truly reflect a family’s starting point rather than being assumed, stating:

“Sometimes you open that door for an easy way out, and if staff can shorten a session, they will. I want the baselines to be accurate, not just assumed.”

This discussion highlighted the challenge of balancing adaptability with maintaining fidelity to the model. Ensuring that providers have enough flexibility to meet families where they are can enhance engagement and make sessions feel more relevant, but it also requires strong training and oversight to prevent inconsistencies in implementation. Participants acknowledged that while adaptability can be beneficial, it must be carefully managed to avoid rushed sessions or assumptions about families’ progress.

Another focus group member noted that the streamlined approach helped simplify SafeCare delivery while preserving its essential components. Many providers agreed that flexibility, when paired with clear implementation guidelines, structured training, and ongoing support, could strengthen the program rather than weaken it. Ultimately, there was broad consensus that striking this balance is critical to ensuring that SafeCare remains both effective and responsive to the diverse needs of families.

The Role of Baseline Assessments in Parent Engagement

Many recognized the value of baseline sessions, acknowledging them as essential tools for measuring progress and tailoring support to families. However, providers also raised concerns about the potential for overwhelming both caregivers and themselves, particularly when working with families who may not be familiar with in-home visits or structured assessments. A key challenge was the time and cognitive load that the extended, comprehensive baseline assessment of PBSC could place on families, especially those who are new to the program. Providers pointed out that these sessions might be especially taxing for caregivers who aren't accustomed to the structure and intensity of the assessments.

A focus group participant discussed time constraints as a significant practical concern, particularly given that many providers are limited in how much time they can spend with a family during each visit. She emphasized that completing the three baseline assessments as outlined in PBSC session 1 She stated:

"Time constraints around getting those three assessments done with the modules might take longer than the hour, hour and a half that some of our providers are staying with the family and keeping their attention long enough to get through all of that."

Beyond the logistical challenges, establishing trust and comfort in the home environment was also a critical consideration. Another group participant emphasized that for many families, this session represents one of the first times a provider is entering their home, which can lead to discomfort and hesitation. She stressed that building rapport and creating a sense of security is essential for successful implementation of the assessments:

"It can be very overwhelming for the provider and for the family, especially because this is one of the first times that you're in their home as a provider. A lot of the time, they're not super comfortable, so you may need to break it into chunks because they may not be ready for you to walk around those three rooms in their home."

In light of these concerns, some providers recommended breaking the baseline assessments into multiple visits to prevent caregiver overload and improve engagement. One participant emphasized the importance of adapting the structure of visits to avoid overwhelming families. He noted that the baseline session doesn’t need to be confined to a single visit, and, in some cases, longer sessions may need to be split across two visits, which would allow for more manageable timeframes and better family engagement.

Another key insight shared was that NSTRC may consider a combined approach of SafeCare and PBSC. A discussion ensued about the majority of parents benefitting from the full PCI module. A suggestion was made that the program could start with PCI to allow for a more gradual, relationship-building approach, followed by the comprehensive assessment of Safety and Health to determine a PBSC approach to those modules.

Ultimately, while baseline assessments are valuable for measuring family progress and tailoring support, providers emphasized the need to introduce them in a way that feels manageable and respects families' comfort levels. Strategies such as breaking sessions into smaller parts, offering flexibility in scheduling and structuring visits, and prioritizing relationship-

building before assessments were suggested as ways to enhance engagement and improve the overall effectiveness of the process. These approaches ensure that baseline assessments achieve their intended goals while considering the realities of family dynamics and provider capacity.

Provider Workload & Capacity Concerns

A recurring concern among providers was the potential increase in workload and strain resulting from the requirement to conduct a structured baseline assessment for all three SafeCare modules: Parent-Child Interaction (PCI) or Parent-Infant Interaction (PII), Health, and Safety within a single session. While many acknowledged the value of establishing clearer benchmarks for family progress, some worried that consolidating all three assessments into one sitting could place an additional burden on providers. Ensuring that this approach remained feasible without contributing to provider fatigue or compromising the quality-of-service delivery was a key point of discussion.

For instance, one participant described that providers are responsible for more than just SafeCare during their visits. In addition to delivering the program, they often take on case management tasks to address urgent family needs, ensuring families receive the support and resources necessary for their well-being:

“What I see with a lot of providers is that they don't only just do safe care. Most of the providers take a few minutes to do case management. You know, especially those, we serve really high-risk families. There's a lot of needs. So, I feel like It's a lot for one, one session at least.”

She expressed concern that introducing a structured baseline assessment for all three modules in a single session could add stress not only for providers but also for families, particularly those facing complex challenges. Given that many providers work with high-risk families, she noted that they frequently dedicate time during visits to check in on pressing concerns beyond SafeCare, making it essential to consider how this added requirement might impact both provider workload and family engagement.

This reality highlights a broader concern regarding provider capacity. For many providers, SafeCare sessions extend beyond the curriculum itself; they often involve addressing families' wider needs, connecting them to necessary resources, and helping navigate complex social or economic challenges. Providers are already balancing multiple tasks, and the added demand of the PBSC comprehensive session 1 structured assessments may strain their ability to provide comprehensive support to families while maintaining the quality of SafeCare sessions. Some participants noted that the added demands could make it difficult to maintain the quality and consistency of sessions.

To address these challenges, several providers suggested that additional guidance, training, or adjustments to workload expectations may be necessary to ensure that the changes do not lead to provider burnout or result in rushed, less effective sessions. Ensuring that providers have the support they need to manage these new expectations will be critical to maintaining the overall effectiveness and sustainability of the program.

The Need for Additional Decision-Making Tools

A recurring theme in the discussion was the need for clearer guidance in decision-making, particularly when it comes to tailoring PBSC to the unique needs of families. While the model is lauded for its flexibility, providers voiced concerns about navigating the complexities of individualized care without structured decision-making tools. Many expressed that, while the flexibility of PBSC allows for customization, the lack of formalized guidance can lead to inconsistencies in implementation, which could ultimately impact the quality and effectiveness of service delivery. Without clear frameworks to guide their decisions, providers were unsure how best to adapt the program to ensure it met the needs of each family, potentially leading to variations in the intervention's impact.

One issue raised by a provider was the challenge of modifying session structures based on a family's needs. There was a clear desire for more direction on when and how to appropriately condense or extend sessions depending on factors such as family engagement, progress, and external constraints:

"I would think that an additional training specifically in terms of, hey, this is how we could combine, or this is how the baseline would look, like a precision-based training in addition to training on the modules would be an important element for providers."

Without a standardized set of criteria or a structured framework for making these adjustments, providers expressed difficulty in balancing the need for personalization with the requirement to maintain fidelity to the program. Developing clear guidance or additional trainings in this area would help providers make these decisions more confidently, ensuring that each family receives the appropriate level of support while preserving the model's integrity.

Another area of uncertainty revolved around the question of when to choose PBSC versus traditional SafeCare. Since PBSC introduces a more flexible, needs-driven approach, providers found it challenging to determine which families would benefit most from this model and which might be better suited to the more structured, sequential format of traditional SafeCare. There are many factors that can influence this decision, including a family's prior experience with parenting programs, their engagement level, and the complexity of their needs. However, without a clear decision-making framework, providers were often left to rely on their judgment, which could lead to inconsistent assessments and possibly place families in a model that doesn't align with their specific needs. Establishing guidelines for making these decisions would enable providers to more accurately assess and match families to the appropriate program, ensuring that families receive the most effective intervention.

A final area of concern that emerged during the discussion was whether returning families should automatically complete a new baseline assessment. Some providers saw value in reassessing families to capture any changes in their circumstances or needs, while others raised concerns about the redundancy of this process, particularly if the family's situation had not significantly changed. There was a consensus that a structured approach to re-evaluation would help ensure that returning families are provided with targeted support without subjecting them to unnecessary repetition. At the same time, such an approach would give providers valuable insights into any shifts in the family's situation, allowing them to tailor services more

effectively. Clear guidelines for this process would help prevent both redundant assessments and missed opportunities to address emerging needs.

To address these challenges, providers emphasized the importance of developing formal decision-making tools that offer clear, practical guidance for navigating the complexities of the PBSC model. A well-defined framework would provide providers with the confidence they need to make informed decisions about session adjustments, program placement, and re-assessment, ensuring that families receive the most effective and personalized support possible. This would not only improve the consistency and quality of service delivery but also enhance providers' ability to implement the program with greater precision, ultimately benefiting families and improving outcomes.

Conclusions and Recommendation for Next Steps in Development of Precision-Based SafeCare

The discussions and feedback from providers highlight both the strengths of Precision-Based SafeCare (PBSC) and the areas that require further development before full implementation. While the model has been well received for its adaptability and potential to enhance family engagement, several key concerns must be addressed to ensure its effectiveness in real-world application.

One of the most significant themes that emerged was the challenge of balancing standardization and individualization with the PBSC model. Many providers appreciated the structured baseline assessment and saw it as valuable for identifying family needs early in the process. This standardized approach allows providers to establish a foundation for service delivery and ensure families receive targeted support and meet their most pressing needs. However, concerns were raised about whether all families should undergo the same structure for the initial baseline assessment. Some providers worried that a rigid structure might inadvertently create an additional burden for families already managing time constraints, while others felt that standardization was necessary to ensure consistency and effectiveness.

Another key concern centered on provider workload and the level of support necessary for successful implementation. While some providers expressed confidence in their teams' ability to integrate PBSC with minimal additional guidance, others emphasized the need for more structured training and ongoing coaching. The introduction of new structured activities and a clearer distinction between PBSC and traditional SafeCare led many to suggest that additional hands-on learning resources, such as case-based training, peer support, or interactive workshops, could strengthen provider readiness and confidence.

Additionally, decision-making emerged as an area requiring more explicit guidance. Providers sought clarity on when it would be appropriate to condense or extend sessions, how to determine whether a family is better suited for PBSC versus traditional SafeCare, and whether returning families should automatically complete a new baseline assessment. Without a clear framework, providers may struggle to make consistent and informed choices that best support families. Establishing a structured decision-making guide will help ensure that providers have the tools they need to navigate these critical questions effectively.

The potential of PBSC as a tool for engagement and retention was another major point of discussion. Several providers saw this model as an opportunity to better engage families who already possess strong skills and may disengage from a more rigid, structured curriculum. PBSC's adaptability could make it a useful strategy for keeping these families involved by tailoring sessions to their specific needs. Additionally, providers highlighted the potential benefits for mandated families who often face strict time constraints and may be more receptive to a streamlined, precision-based approach.

However, a challenge that emerged was how to address families who regress after completing SafeCare or those who are re-referred. Without a clear reimplementation strategy, these families may not receive the support they need in a way that is both efficient and purposeful. Developing a structured approach to re-engagement will be essential in ensuring that families who need continued support are not left without an appropriate pathway forward.

To address the concerns raised during provider discussions and optimize the implementation of Precision-Based SafeCare (PBSC), several key recommendations emerged.

Recommendation 1. Establish Protocols for PBSC Eligibility and Family Reassessment

NSTRC should establish clear protocols for determining which families would benefit most from PBSC versus traditional SafeCare, taking into account variables like prior parenting experience, engagement level, and the complexity of the family's needs. A primary consideration is avoiding the blanket application of PBSC to all families, as some may require the full SafeCare model. In such cases, implementing the extended PBSC baseline unnecessarily could lead to assessment fatigue and reduced engagement on the part of the caregiver. The creation of such a decision-making framework would equip providers with the tools necessary to make consistent, informed choices, ensuring that the model is implemented with fidelity and effectiveness.

Building on this, the development of a structured decision-making guide would offer providers clear, practical criteria for navigating the complexities of PBSC in everyday practice. This guide should include specific guidance for when and how to modify session structures, helping providers determine appropriate adjustments to session lengths based on family engagement, progress, and external constraints. Together, these tools would support a more responsive and tailored implementation of PBSC, grounded in consistency, flexibility, and the unique needs of each family.

Recommendation 2. Expand Provider Training for PBSC with Case-Based and Ongoing Support

While some providers expressed confidence in their ability to integrate PBSC into their practice with minimal guidance, others noted the importance of hands-on training to increase their readiness and confidence. Therefore, expanding provider training should include case-based learning, peer support, and interactive workshops to offer practical experience and develop a deeper understanding of how to navigate the complexities of the PBSC model. These types of resources will help providers develop the skills and knowledge necessary to implement PBSC effectively, even in situations that may be more challenging or outside their initial

expertise. Ongoing coaching and access to supplemental resources would also support providers as they continue to refine their skills and integrate PBSC into their work with families.

Recommendation 3. Create a Targeted Reimplementation Strategy for Returning Families

Instruction on how to apply PBSC with returning families.ne of the most significant challenges discussed was the issue of families who regress after completing SafeCare or those who are re-referred for additional support. To address this, a structured reimplementation strategy should be developed, with clear criteria for when and how families should re-engage with PBSC. This strategy should ensure that families who may have experienced setbacks or require additional support are not left behind. However, it is also essential that the re-engagement process avoids unnecessary repetition, offering families a more targeted and efficient path to regaining progress. By defining the level of additional support needed and offering families a clear roadmap to follow, PBSC can be adapted to ensure that families in need of continued support are properly served. A well-structured reimplementation strategy would also help providers allocate resources effectively, ensuring that they focus their efforts on families with the most pressing needs while preventing redundancy and burnout.

Recommendation 4. Introduce a Flexible, Modular Structure for PBSC Baseline Assessments

NSTRC should consider adopting a flexible, modular structure for the PBSC baseline assessment that maintains consistency in data collection while allowing providers to complete it across multiple sessions when needed. While many providers valued the structured assessment for helping identify family needs early on, some expressed concern that completing it in a single session could be overwhelming for families already managing competing demands.

To promote engagement and reduce potential burden, the PBSC model should include clear guidance on how to break up the baseline assessment without compromising quality or fidelity. This would allow providers to tailor the assessment process to each family's unique circumstances while still following a consistent framework.

Developing a provider-facing implementation guide would support this approach by outlining when it is appropriate to segment the assessment, how to prioritize its components, and strategies for keeping families engaged throughout the process. Incorporating flexibility in this way would help ensure that PBSC remains both effective and responsive to the realities of family life and provider workflow.

Recommendation 5. Pilot PBSC Implementation Before Broad Rollout

Before scaling PBSC to a larger group of families, it is recommended that a pilot phase be conducted to assess the feasibility, engagement levels, and overall impact of the model. This pilot phase would allow providers to gather real-time feedback from a small group of families, which could inform any necessary adjustments or refinements to the model. Additionally, piloting PBSC with a select group of families would help identify potential barriers to successful implementation and provide valuable insights into the model's effectiveness in real-world settings. A pilot phase will also give providers the opportunity to test different modifications and evaluate the overall feasibility of PBSC before committing to a broader implementation. This process of continuous feedback and improvement will ensure that PBSC is optimally adapted to meet the needs of both providers and families, increasing the likelihood of long-term success.

Summary

In summary, implementing these recommendations will allow PBSC to reach its full potential as a flexible and effective model for family-centered care. By developing a decision-making guide, expanding provider training, piloting the model with a small group of families, clarifying the role of the parenting component, and creating a reimplementation strategy for families who regress, PBSC can be refined and tailored to meet the diverse needs of families and providers. These steps will increase provider confidence, enhance family engagement and retention, and ultimately ensure that PBSC can become a sustainable and impactful tool in the field of home visiting and family support services. Through ongoing collaboration, continuous feedback, and provider-driven improvements, PBSC has the potential to make a lasting impact on family support services, ultimately contributing to the well-being of families and children.

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