Home Visiting Programs in Alameda County

Program Review and Evaluation

Executive Summary

April, 2011

RESEARCH STUDY FUNDED AND SUPPORTED BY:

Alameda County Public Health Department

FIRST 5 ALAMEDA COUNTY every child counts

REPORT PREPARED BY:

ASR APPLIED SURVEY RESEARCH

P.O. Box 1927, Watsonville, CA 95077 • 831.728.1356 •
991 West Hedding St., Suite 102, San José, CA 95126 • 408.247.8319 •
www.appliedsurveyresearch.org •

Executive Summary

PROJECT BACKGROUND

In August 2010, the Alameda County Public Health Department (ACPHD) and First 5 Alameda County (F5AC) commissioned Applied Survey Research (ASR) to conduct a review of ten perinatal/early childhood home visiting programs in the county. The broad goal of the project was to support the work of several county working groups – including the Building Blocks Collaborative/Life Course Initiative and the 0-8 Convergence – by assisting this group of programs in moving from a loosely organized "community" of home visiting programs toward a more intentional system of services that effectively address the needs of the county's at-risk families.

To that end, this report collectively and individually describes the set of ten perinatal/early childhood home visiting programs, including whom each one serves, what services and interventions each provides, and the intended and demonstrated outcomes associated with participation in each program. These descriptions are embedded in the larger context of what is known about effective home visiting programs and how these programs are positioned with regard to the recent federal legislation designating new funding for home visiting programs. This report is intended as a source of program information for understanding these programs individually, comparatively, and collectively, and it serves as a resource for ongoing analysis and action as the group continues to work on improving services for those at need.

HOW THE REPORT IS ORGANIZED

After a brief **review of home visiting research**, this report presents the following:

- Some of the **key population needs among Alameda County residents**, with particular focus on data relating to perinatal and early childhood home visiting programs.
- **Cross-program summaries and analysis** of the populations, services and supports offered, along with expected and demonstrated outcomes of the ten home visiting programs in this review.
- A set of **recommendations for enhancing the home visiting services** for at-risk county residents, along with possible actions within each recommendation.

Finally, Appendix 1 provides a **more focused individual look at each one of the ten home visiting programs** included in this report, including more detailed program summaries and data from each program's most recent fiscal year.

Although this Executive Summary includes a great deal of general, summary information about the ten home visiting programs, readers are encouraged to look to the full report for a richer discussion and analysis of the programs and the recommendations described here.

HOME VISITING PROGRAMS REPRESENTED

It is important to note that the ten perinatal/early childhood home visiting programs described in this report by no means represent all – or even most – of the home visiting programs offered county-wide. Specifically, these programs include a subset of home visiting programs that operate through or are associated with ACPHD or F5AC. There were no fixed criteria for inclusion or exclusion in this group of programs being reviewed, except that they serve pregnant, interconceptional, or parenting women and their young children, and they have agreed to collaborate in this project to better serve Alameda County's neediest populations. Indeed, it is hoped that representatives from other programs and agencies join in the ongoing work of the original group as they continue to work on issues related to improving home visiting and related services in Alameda County.

The names and brief descriptions of each of the ten participating perinatal/early childhood home visiting program are provided in the figure that follows. A more complete program-by-program summary – along with available program service and outcome data from each one's most recently completed fiscal year – is included as Appendix 1.

Figure A. Summary of Perinatal/Early Childhood Home Visiting Programs in This Review

Program name	Program description
Improving Pregnancy Outcomes Program (IPOP)	Originally federally funded as the Oakland Healthy Start program in the early 1990's, IPOP aims to reduce infant mortality and morbidity by providing culturally competent case management and health education services to pregnant and inter-conceptional African American women, their children and male partners in order to improve perinatal risk factors such as low birth weight, late entry into perinatal care, pre-term births, perinatal depression and maternal substance use. The program has aligned its case management services with the Life Course Perspective and recognizes the importance of improving inter-conceptional health risk factors that might negatively impact subsequent pregnancies
Black Infant Health (BIH)	Home visiting, outreach and social support services are provided to pregnant and parenting African-American women and their families. The program objectives are to decrease African-American infant mortality and morbidity in Alameda County and to eliminate the persistent disparities in Maternal, Child, and Adolescent Health (MCAH)-related health indicators for this population. African Americans have more than twice the infant mortality rate and by far the highest percentage of LBW and VLBW babies of any other ethnic group in the county.
Maternal Access and Linkages for Desired Reproductive Health (MADRE)	MADRE is a bilingual, bicultural health linkage and access to care program designed to improve the interconception and maternal health of high risk low income women in order to achieve an optimal pregnancy outcome . MADRE serves low income women of childbearing age with one or more of the following: history of fetal or infant loss, previous low or very low birth weight baby, previous premature delivery, history of multiple miscarriages, pregnancy with a non-viable fetal diagnosis i.e. anecephaly, hydrocephaly, genetic disorders, congenital (fetal) anomalies. MADRE provides bio-psychosocial assessment, administrative case management, care coordination, assistance with linkages & access to health care, bereavement support, field visits by staff, education & outreach, and MSW internships. MADRE targets the largest Medi-Cal population in Alameda County.
Perinatal Hepatitis B Program (Perinatal Hep B)	A case management program working with new moms identified through hospital records as HBsAg positive. At least one home visit by Public Health is conducted with additional referrals to community supports to address factors impacting child's health outcomes. Newborns are followed at 12-18 months to ensure appropriate vaccinations.
Public Health Nursing	Multicultural and multilingual targeted case management, outreach and care coordination for low income, high-risk families, via family support and home visiting contracts and partnerships with F5AC, CHDP and MPCAH programs. PHN has a long history of providing intensive family support services to mothers who present at delivery having had no prenatal care, as well as those who give birth to babies with positive toxicology screens. For purposes of this report, CHDP participants and information are not included in Public Health Nursing descriptions.
Pregnant & Parenting Teen Program	Two community-based organizations that provide teens with home-based family support services from prenatal period until the parent is 25 years or until the child is 5 years.
Your Family Counts	Perinatal Home Visiting (partnership with AC Public Health Department Family Health Services): up to 1 year of home-based family support for high risk pregnant and families with newborns provided by a multi-disciplinary team.
Special Start	A public/private partnership between ACPHD Family Health Services and Children's Hospital and Research Center Oakland. The program provides up to 3 years of home-based family support for infants discharged from the neonatal intensive care units with medical and social risks.
Another Road to Safety	A collaboration between F5AC, Social Services Agency (SSA) and CBOs, now overseen by SSA, that provides home-based family support services for families up to 9 months who have entered the child welfare system.
Homeless Families Program	Comprehensive case management and support services that includes transitional and permanent housing assistance. Family Case Management is the core of Homeless Families Program and is a requirement in order to receive transitional or permanent housing assistance, as well as other support services.

A PROFILE OF POPULATION NEEDS IN ALAMEDA COUNTY

As Alameda County begins to consider moving toward a deliberate and coordinated system of home visiting services, it is important to more broadly quantify different needs in the county population as a whole. There is, of course, an enormous amount of data that can facilitate analysis of what the most pressing needs are that should be addressed by Alameda County's home visiting programs. Three types of information were used to summarize the population needs in the county, including the following:

- A summary of county data from the statewide needs assessment recently submitted by the California Department of Public Health, Maternal, Child and Adolescent Health Program (CDPH/MCAH) as part of the state's application for Health Resources and Services Administration (HSRA) and Administration for Children and Families (ACF) home visiting program funds.
- More specific data comparing groups of residents within Alameda County, as well as additional indicators for school readiness and homelessness, which are particularly relevant to Alameda County's home visiting programs but were not part of the statewide needs assessment report.
- A summary of what Alameda County home visiting program administrators have indicated are their greatest challenges in delivering their programs to the county residents they serve.

Findings from the California Statewide Needs Assessment

The CDPH/MCAH statewide needs assessment provides information on 21 indicators relating to home visiting services. The focus of this data presentation is on the relative performance of different California counties (or multi-county regions, depending on the data available).

Findings from this report suggest that relative to other counties, Alameda County as a whole is generally doing well. Of the 21 indicators reported, Alameda County performed above the state median on 17 and fell below the state median on only four. Of those four indicators, the one with the most direct relevance to home visiting programs is the percentage of low birth weight infants. On this indicator, Alameda County ranks as the tenth worst county of the 50 California counties with data for this indicator. (Interestingly, this datapoint is inconsistent with the other birth outcome data for the county, which are generally stronger.) Other indicators on which Alameda County was worse than the state median involved substance use or abuse (i.e., marijuana use and nonmedical use of pain relievers) and crime rates. The latter is significant in that it demonstrates one of the social determinants of health that is most challenging for Alameda County residents. Crime is an indicator that must be considered both as a negative influence on the overall health and well-being of county residents and as a distal outcome that can be improved through prevention and early intervention efforts such as home visiting programs.

Taking a Closer Look at Populations Within Alameda County

The county-level statistics reported in the statewide needs assessment have some limited utility because the emphasis in the statewide needs assessment is on comparing different counties' relative risks, rather than assessing absolute risk within counties. Moreover, the fact that data are only presented at the county level means that the needs of some at-risk subpopulations within counties may be masked. Finally, there are a few key indicators that were not included in the statewide assessment that provide important information about particular community needs and issues in Alameda County.

Thus, to supplement data from the statewide needs assessment, additional indicators for Alameda County residents were examined (with subgroup data included when it was available).

This more targeted look within Alameda County revealed needs in several key outcome areas that home visiting programs typically attempt to impact:

- **Child health:** On birth outcomes, African American mothers are not meeting Healthy People 2020 targets for birth weight, preterm births, and infant mortality; teen mothers have needs in the area of early prenatal care; and all county residents have needs for enhancing vaccination rates in early childhood.
- **Child development and school readiness:** Latino and African American students are particularly at risk based on English-Language Arts proficiency at third grade; non-representative school readiness data suggest students in San Lorenzo Unified and Oakland Unified may be starting school with low readiness levels.
- **Child maltreatment:** African American families in Alameda County have maltreatment rates that exceed Healthy People 2020 targets.
- **Maternal health:** African American and multi-ethnic women are not well-connected to a usual source of health care; other groups within the county may be at-risk on this measure as well.
- **Economic self-sufficiency:** There are more than 2,000 homeless adults with one or more minor children living with them.

What Do Program Administrators Report to Be Their Biggest Service Gaps and Unmet Needs?

A crucial source of information about the unmet needs of Alameda County residents – particularly those who enroll in (or attempt to enroll in) home visiting programs – comes from the administrators of the ten home visiting programs included in this project. Their perspective reflects direct experience with the populations in need. Even though they work with disparate at-risk populations at different points in the perinatal timelines, eight of the ten participating home visiting programs indicated that either they were unable to enroll all of the clients who needed their services, or the clients they have are unable to receive help for as long as they need it.

POPULATIONS SERVED BY PERINATAL/EARLY CHILDHOOD HOME VISITING PROGRAMS[1]

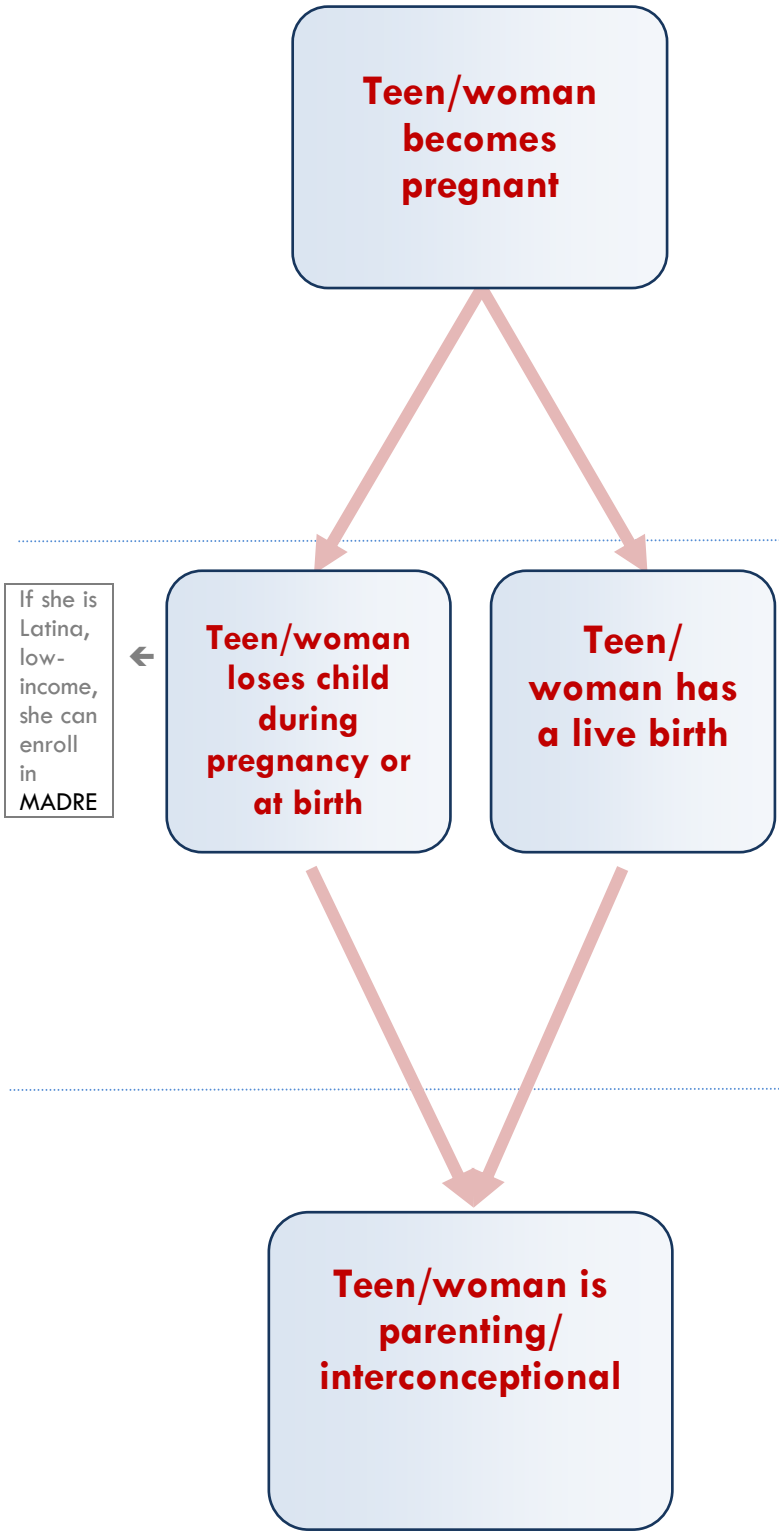
Who is served by the home visiting programs in Alameda County, and how many are served overall? When and how do people get enrolled in the programs? Which populations are targeted by the programs? This section describes the profile of participants who are served by the ten home visiting programs examined in this report.

[1] Please note that in this report, when we refer to perinatal/early childhood home visiting programs, we refer only to the set of ten programs that were examined as part of this project.

Eligibility and Connection Points

The figure on the following page shows when participants can enter each of the home visiting programs, based on the extent to which they meet the various program criteria. As the figure shows, most of the home visiting programs have multiple possible entry points. Seven programs enroll teens and/or women as early as their first pregnancy, but most of them (all but Perinatal Hepatitis B) also enroll participants at later points in time – postnatally or interconceptionally.

Figure B. Program Eligibility and Points of Entry



If she …		She can enroll in …
Is African-American, low-income	→	BIH
Is African-American, low-income, in 1 of 9 zip codes in Fruitvale, W. Oakland, E. Oakland , N. Oakland, Emeryville	→	IPOP
Is a teen	→	Pregnant & Parenting Teen Pgm
Is Hepatitis B positive	→	Perinatal Hep-B Pgm
Is medically and/ or socially at-risk for poor pregnancy outcome	→	Public Health Nursing, Your Family Counts
Is in Path 2 CPS and lives in W. Oakland, E. Oakland, Hayward	→	Another Road to Safety

If she …		She/child can enroll in …
Is African-American, low-income	→	BIH
Is African-American, low-income, in 1 of 9 zip codes in Fruitvale, W. Oakland, E. Oakland , N. Oakland, Emeryville	→	IPOP
Is a teen	→	Pregnant & Parenting Teen Program
And/or infant is medically and/or socially at-risk	→	Public Health Nursing, Your Family Counts
Has an infant in NICU with extreme medical/social risk	→	Special Start

If she …		She/child can enroll in …
Is African-American, low-income, in 1 of 9 zip codes in Fruitvale, W. Oakland, E. Oakland , N. Oakland, Emeryville	→	IPOP
Is a teen	→	Pregnant & Parenting Teen Pgm
Had a previous fetal/ infant loss, pregnancy w/ terminal fetal dx, LBW, preterm delivery	→	MADRE
Is in Path 2 CPS and lives in W. Oakland, E. Oakland, Hayward	→	Another Road to Safety
Is homeless	→	Homeless Families Program

Program Reach

Program reach across the ten home visiting programs in this report is described in two ways: (1) the total number of active participants in each program over a twelve-month period[2]; and (2) the number of new cases enrolled during that twelve-month period. Each number provides important information about the capacity of programs to serve the needs of the community.

The total number of active cases across all programs quantifies the total amount of home visiting intervention that was being delivered to county residents during a twelve-month period. In all, 4,393 **participants were touched by one of these ten home visiting programs in Alameda County over a twelve month period.**

This number is less appropriate for estimating the capacity of home visiting programs to address county need, however. Because many programs provide services to participants for more than a year, knowing the number of new cases may be particularly helpful in determining the gap between the amount of need among residents and the available services to meet those needs. In the most recent fiscal year, the total number of new clients served by the set of home visiting programs was 2,921. This means that across the ten programs, about 66 percent of the cases were new, and 34 percent were continuing from the previous fiscal year.

Data presented in the full report show that the bulk of the home visiting services in this set of programs – 39 percent of all those who receive home visits over a twelve month period – are provided by Public Health Nursing, a fairly low-intensity home visiting program (short participation period with moderately frequent visits).

Two other programs each serve more than 500 clients per year. After Public Health Nursing, the next largest program is Special Start, which, even though it serves 680 participants per year, is somewhat different from the Public Health Nursing program in that it is much more intensive and serves perhaps the most at-risk populations of any of the ten home visiting programs examined. The Pregnant and Parenting Teen Program is the third largest program in terms of number of participants served in a twelve-month period.

There are several mid-size programs serving less than 500 clients yearly, including Another Road to Safety, Your Family Counts, IPOP, Perinatal Hepatitis B, and Black Infant Health. The two smallest programs are MADRE and the Homeless Families Program, serving 62 and 25 clients over a twelve-month period, respectively.

Participation Profiles

By summing across all of the programs, we can begin to get a picture of who has been served in home visiting programs county-wide. Figure C shows the race/ethnicity, preferred language, and age for the set of newly enrolled cases across the programs. As the figure shows:

- Over half (54%) of all newly enrolling program participants are Hispanic/Latino, and about one fifth (21%) are African American.

[2] Programs provided information for their most recent fiscal year (2009-10); thus, the start and end dates differed somewhat.

- Fifty-nine percent of participants speak English as their preferred language, and 32 percent speak Spanish. Small numbers of participants speaking Chinese (Mandarin or Cantonese), Vietnamese, and Tagalog were represented as well.
- Teen participants make up about one quarter of the participants in these programs (24%).

Figure C. Key Demographics – Summing Across Home Visiting Programs

Participant Characteristics	Percent of new program participants
Race/ethnicity	
Hispanic/Latino	53.7%
African American	20.8%
Asian/Pacific Islander	11.3%
Caucasian	3.1%
Other/Multi-ethnic	11.1%
Preferred language	
English	59.2%
Spanish	31.7%
Chinese	4.3%
Vietnamese	1.3%
Tagalog	< 1%
Other	3.0%
Age	
Younger than 20	24.1%
20 or older	75.9%

Source: Individual program data.

Note: Sample sizes are as follows: race/ethnicity = 2,731; language = 2,292; age = 2,224.

DELIVERY OF HOME VISITING PROGRAM SERVICES

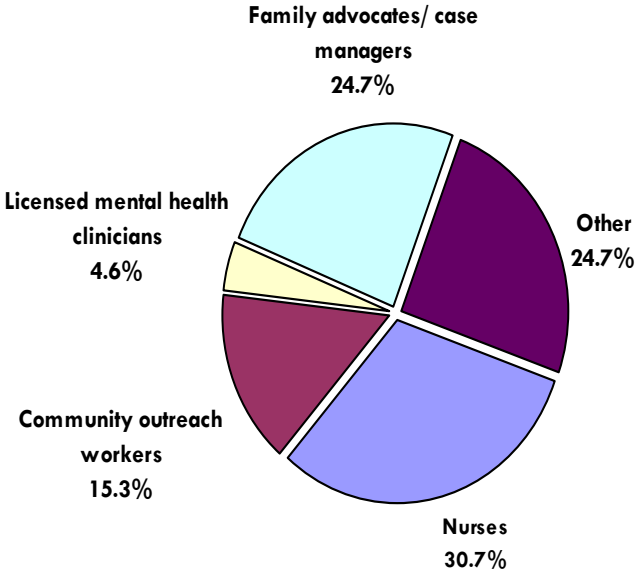
What does it mean to participate in one of these home visiting programs? Who is delivering services? What do programs offer, and what is the intensity of those services?

Staffing

The figure that follows summarizes the types of home visiting staff employed across all ten programs. Nearly one-third of all staff are nurses. About one in four are described as family advocates or case managers, a category that includes primarily bachelor's-level employees. Fifteen percent of home visiting staff are community or community health outreach workers. Mental health experts are rare as program

staff; these individuals more often tend to be consultants to the programs rather than primary staff, or participants are referred to outside mental health services when they are in need of them.[3]

Figure D. Summary of Staffing Across All Home Visiting Programs



Source: Administrator survey of home visiting programs and administrator telephone interviews.

What Do Programs Offer?

Although the models of care, program intensity, and target populations of the home visiting programs vary, many of the programs offer similar services to their participants. **Medical case management**, **health education** (general and specific to certain issues), **information and referrals to social services**, and **assistance with benefits enrollment** are core elements of each of the ten programs. Almost all of the programs also offer assistance with **transportation** needs related to medical visits.

With regard to **mental health needs**, all ten home visiting programs examined refer participants to services if they are in need of mental health care, and First 5-funded programs and Homeless Families Program have resources to provide short-term treatment for acute mental health needs. First 5- funded programs, as well as IPOP and Black Infant Health, also screen for maternal depression using the Edinburgh Postnatal Depression Scale (although program data indicate that not all participants are routinely screened).

Three programs use the ASQ and ASQ-SE for **developmental screening of children;** both IPOP and Black Infant Health use the Denver Developmental Screening Test for developmental screenings.

Support groups provide another way to assist participants in addressing their psychological and emotional needs, and IPOP, Black Infant Health, and MADRE are the only programs that directly offer support groups, although other providers will connect participants with support groups as needed.

[3] F5AC has additional in-house mental health clinicians that work with BIH, IPOP, YFC, Special Start and Pregnant and Parenting Teen programs.

Home visitors in several programs provide **parent education and/or parenting skills training** to participants, including IPOP, Black Infant Health, Pregnant and Parenting Teen Program, Your Family Counts, and Special Start. Another Road to Safety home visitors help parents who need this service to get connected with resources related to parenting.

Basic needs are provided in several programs that serve some of the most financially needy participants, including Pregnant and Parenting Teen Program, Another Road to Safety, and Homeless Families Program. More specific items related to infant and childcare needs are provided through IPOP, Black Infant Health, Perinatal Hepatitis B, and Your Family Counts.

Finally, several programs provide **assistance to fathers** as well. IPOP and Black Infant Health provide several types of services specifically offered to assist fathers. MADRE provides connections to several resources. Pregnant and Parenting Teen Program, Your Family Counts and Special Start include fathers in their case management, and Another Road to Safety assist fathers as part of their family services.

This summary-level table provides an overview of the services offered across the programs; however, this is only a first step in understanding what these programs offer. There is certainly a great deal of variability in how these services are administered, including both the quantity and quality of the services provided across the programs. Although detailed descriptions of how these services are delivered are beyond the scope of this summary, future collaborative work across these programs can employ this summary table as a tool for identifying common program offerings, sharing best practices, and moving closer to adoption of consistent high-quality standards for delivering services across the set of home visiting programs.

Program Intensity: What Is the Dosage of the Home Visiting Interventions?

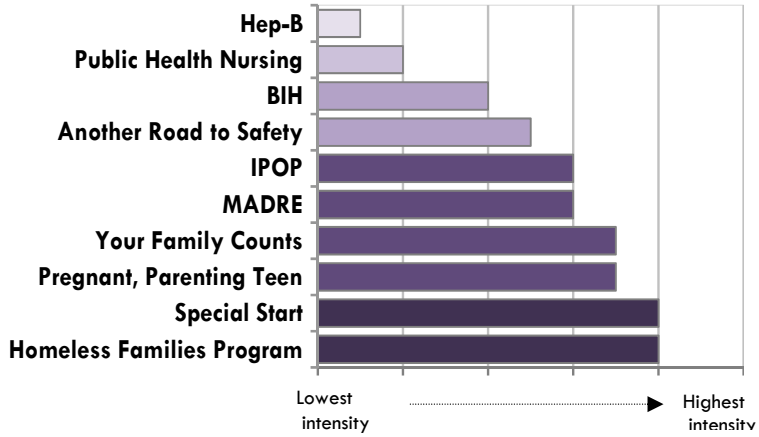
Program intensity refers to a combination of the frequency of home visits offered through a program and the length of participation in that program. According to multiple reviews of the home visiting research literature, a consistent finding is that program models of higher intensity tend to be more effective than those of lower intensity.

As the previous section indicates, many of the home visiting programs examined offer very similar services. However, the services may be more or less effective depending in part on how intensively home visitors can work with program participants to foster a trusting relationship, deliver useful information (such as health or parenting information), and accurately identify clients' needs and offer the right types and amount of support and resources.

The figure that follows displays the each program's intensity, according to the combined frequency of visits and program length. The figure show the average intensity for each program, acknowledging that every home visiting program has some variability in the program intensity that is driven by individual participants' needs and commitment to the program.[4]

[4] A note of caution is offered in the interpretation of this information: Specifically, the program's intended length and frequency of services is generally somewhat greater than what is actually observed in the program participation data. Because some programs did not have service data available for reporting, this figure displays intended program intensity.

Figure E. Summary of OVERALL Home Visiting Program Intensity: Combined Frequency x Length



Source: Administrator survey of home visiting programs and administrator telephone interviews.

The most intensive programs work with participants for both a long period of time and have visits at a weekly or nearly-weekly frequency; in the context of the broader home visiting literature, these programs would generally be considered to be of high intensity. The Homeless Families Program and Special Start – two programs that work with participants who are perhaps the most likely to have broad and highly-complex needs – are the highest-intensity programs among this set.

Several programs fall into a category of moderately-high intensity. This category includes programs such as the Pregnant and Parenting Teen Program (which lasts two or more years) and Your Family Counts (a one-year program) which have weekly to twice-monthly visits. In addition, MADRE and IPOP also are included in this category, but they are both of slightly lower intensity than the other two programs, based on combined frequency and program length measures.

Another Road to Safety is a moderate-intensity program overall. It is somewhat unlike any of the others, in that visits are quite frequent, but last for a fairly short period of time (about six months, in some cases up to nine months). Consistent with this model, administrators of this program describe its primary function as being a connector for participants – to ensure that they are linked up with agencies and services they need, but otherwise providing little in the way of direct intervention.

Black Infant Health is also a moderate-intensity program, with a one-year participation period and visits that are about on a monthly schedule. Public Health Nursing is a low-intensity program, with a fairly short participation period and, monthly visits. Finally, with its highly targeted focus on ensuring appropriate Hepatitis B-related health behaviors, the Perinatal Hepatitis B program is the least intense of the programs. It has just one home visit with longer monitoring of appropriate immunizations.

EXAMINING PROGRAM OUTCOMES

Without a clear representation of what a program intends to change as the result of people participating in it, it is difficult to determine whether the resources and efforts that go into its operation are justified. This section provides a summary of the core outcomes that each program believes it is impacting, as well as existing data that inform programs' progress in achieving changes in those outcome areas. Using

information from the home visiting literature as well as the ten home visiting programs in this review, core home visiting program outcomes were divided according to six general categories, as follows:

- Child health
- Child development and school readiness
- Child maltreatment/exposure to violence
- Maternal health
- Parenting skills/parent-child interactions
- Economic self-sufficiency

Expected and Demonstrated Program Outcomes

What are the specific outcomes that these programs expect to be impacting by offering home visiting services? And, importantly, to what extent are programs achieving these expected outcomes? The figure on the following two pages summarizes both the programs' expected and demonstrated outcomes.

Expected outcomes are represented on the figure by the shading of different cells in the grid. The darker shading designates the primary outcomes of each of the programs, i.e., the "must-have" impacts that are essential to a program's goals. The lighter, striped shading designates secondary program outcomes – those that the program believes it is also impacting, but that are less central to the program's mission. Because the ten programs included in this community of home visiting services offer many of the same interventions to their participants (albeit through different models and among different populations), there is significant overlap in the extent to which they expect to be impacting various outcomes. However, the programs also work with different populations and at different points along the perinatal timeline, so there is also not perfect correspondence across the set.

Inserted into these cells is the available program data that shows each program's progress in achieving their primary and secondary outcomes. (See Appendix 1 for more specific program outcome data.)

It should be noted that the purpose of this figure is to provide a high-level summary of both the data that are available across programs as well as collective program outcomes. **Because these programs serve different populations, intervene at different points along the perinatal timeline, and serve clients with very different risk profiles, it is not appropriate to use the figure to evaluate a particular program's effectiveness relative to another, even if the programs have similar expected outcomes.**

As the figure shows, where data are available, there are some promising outcomes to report. For example, the number of infant mortalities among the two programs that target African American populations in Alameda County suggests that these programs may be improving birth outcomes on this indicator. Immunization rates and possession of a medical home among children are generally strong across the programs that provide these data, even though these outcomes have been reported to be difficult to impact in other home visiting programs.

However, this figure also underscores that there are many more opportunities for programs to enhance the data that they collect to evaluate their effectiveness on many of their expected outcomes. Additionally, if programs want to draw conclusions about outcomes across the set of home visiting services in the county, there are opportunities for standardizing the measurement of common outcomes tools across programs as well.

Figure F. Summary of Demonstrated Outcomes, by Home Visiting Program

		PROGRAM									
	Outcome	IPOP	BIH	MADRE	Hep-B	Pub Hlth Nursing	Pregnant/ Parenting Teens	Your Family Counts	Special Start	Another Road to Safety	Homeless Families Program
CHILD OUTCOMES	**Child health**										
	Reduced infant mortality (up to one-year post-birth)	0 deaths (2 deaths of 429 served over 5 yrs)	0 deaths (1 deaths of 349 served over 5 yrs)								
	Healthy birth weight (not LBW, VLBW)	90%	93%								
	Full-term at birth		90%								
	Current on immunizations		96%	64%	100% Hep B series		98%	94%	98%	99%	
	Has a medical home	86%	82%	91%			98%	99%	100%	99%	
	Child development and school readiness										
	Developmentally on target		99% on target (DDST)				44% had no concerns (ASQ)	42% had no concerns (ASQ)	17% had no concerns (ASQ)		
	Child maltreatment/exposure to violence										
	Reduced maltreatment allegations/substantiations						3% opened CPS case during pgm	5% opened CPS case during pgm	3% opened CPS case during pgm	11% opened CPS case during pgm	
	Child is not exposed to violence in the home										
	Child is living with birth parent(s)						2% in foster care during pgm	2% in foster care during pgm	2% in foster care during pgm	1% in foster care during pgm	

(Figure continues on next page)

Demonstrated Outcomes (cont'd)		PROGRAM									
Outcome		IPOP	BIH	MADRE	Hep-B	Pub Hlth Nursing	Pregnant/ Parenting Teens	Your Family Counts	Special Start	Another Road to Safety	Homeless Families Program
MATERNAL/PARENT/ FAMILY OUTCOMES	**Maternal health**										
	Has a medical home	94%	96%	100%							
	Can advocate for family health care needs										
	Are linked to needed mental health supports	100% were screened for depression	100% were screened for depression				69% were screened for depression	69% were screened for depression	84% were screened for depression	69% were screened for depression	
	Reduced maternal depression										
	Delay subsequent births										
	Engages in healthier behavior	74% prenatal care in 1st trimester	79% prenatal care in 1st trimester				46% breastfed > 6 mos.	46% breastfed > 6 mos.	54% breastfed > 6 mos.		
	Has increased health knowledge										
	Parenting skills/Parent-child interactions										
	Parents have improved parenting knowledge, skills						90% read daily to children	71% read daily to children	89% read daily to children	75% read daily to children	
	Economic Self-Sufficiency										
	Complete high school education						65% in school or graduated				
	Are in school or working						39% employed				33% had income from employment
	Are economically stable										92% (n=11) had income source at exit; 33% (n=4) had perm. hsing at exit

Note: All data are from most recent program fiscal year, except where noted. All data are based on percent of known respondents. Solid, darker shading designates primary outcomes; striped, lighter shading designates secondary outcomes.

RECOMMENDATIONS FOR FUTURE EFFORTS

Supplemented with findings and perspectives from the home visiting research literature, a set of five broad recommendations was developed to help move this group of home visiting programs closer to their goal of becoming a coordinated, deliberate system of services for at-risk Alameda County residents. Please see the full report for a more comprehensive description of each recommendation.

Recommendation 1

Develop a process for: (1) identifying (and then monitoring) the level of county need over time; and (2) coordinating services and ensuring that those in need are matched to the right home visitation programs.

The Issue

One of the biggest challenges faced by programs serving at-risk populations involves accurately quantifying the need that exists in the communities they serve, and then determining the extent to which the need is being met by the services that are available to help people. This challenge is compounded when multiple programs are attempting to work together to address community needs, as the different programs serve some unique and some common target populations within the larger set of at-risk individuals, and programs vary in intensity and services offered. To ensure that those with needs for assistance are matched to programs that are most likely to benefit them, programs (and systems) must communicate with each other and develop a coordinated system to serve clients – all in a way that minimizes expenditures and limits overlap in program participation

Suggested actions

- Decide on a set of key county-level indicators that the group would like to track over time to describe county needs.
- Identify and invite other partners to participate in county-wide coordination efforts.
- Develop guidelines for determining which county residents should be matched to which home visiting programs.
- Develop coordinated outreach efforts to engage clients in the community of service providers and the community at large.
- Once identified and secured, conduct regular monitoring and updating of the portrait of Alameda County needs.

Recommendation 2

Enhance the quality of this community of home visitation programs, both individually and collectively.

The Issue

A precise understanding of which home visiting program features lead to positive outcomes for participants is still evolving; there is little evidence that can be considered to be both strong and consistent across the body of research studies examining what works in home visiting programs. Available evidence does suggest that using highly trained, well-qualified staff leads to better program outcomes. Programs of higher-intensity (greater frequency and longer duration of visits) also tend to be associated with better outcomes, particularly among high-risk populations. Outcomes such as enhanced parenting skills are frequently demonstrated, as are (somewhat less strongly) benefits for children's developmental progress. Less easy-to-impact outcomes are found among child and infant health outcomes and maternal mental health outcomes. Moreover, across all studies of home visiting program effectiveness, a warning emerges about program implementation: there is often wide variability in the extent to which home visitors are actually delivering the program to participants as it is intended to be delivered.

Suggested Actions

- Develop appropriate and consistent approaches to staffing.
- Encourage staff retention within programs.
- Develop consistent approaches to initial and ongoing staff training and development.
- When possible, create coordinated standards of practice among programs doing similar work.
- Review each program design as intended versus as delivered.

Recommendation 3

Finalize and implement a measurement system that gathers clear and relevant data that will help to determine whether the community of home visitation programs is successful.

The Issue

Each program in this community of home visiting programs serves a slightly different target population, using varied home visiting program models to impact outcomes – outcomes that are sometimes shared by other programs and are sometimes unique to a particular program. Moreover, each program has different funder reporting requirements, different data collection tools and protocols, database systems, and different data use "cultures," i.e., how (and whether) staff use data to inform how they run their programs. Despite this substantial variability, it is useful to have some consensus in data collection practices and core data elements across programs. It is recognized that each program will have some data collection requirements and needs that are unique to their own program that make complete standardization neither possible nor desired; however, to become a more intentional system, there must be a core set of data elements that are collected across the set of diverse programs.

Suggested Actions

- Develop common, cross-program data elements to collect about participants, services, and outcomes.
- Establish protocols for gathering feedback from program participants to better understand the program from their perspective.
- Consider use of a single electronic database – or compatible databases – to facilitate merging of data across programs.
- Foster a culture that sees the value of collecting data.
- Develop a high-level summary communication that can simply display your efforts and outcomes.

Recommendation 4

Ensure commitment to the ongoing work of this community of programs by developing and implementing processes to help sustain it.

The Issue

The stated goal of this group of home visiting programs is an ambitious one: To move from being a loosely-organized community of home visiting programs to a deliberate system that serves the needs of Alameda County. The recommendations in this report to advance that goal are fairly complex, and they involve multiple, coordinated, and sustained efforts to achieve them. How does the group stay organized, coordinated, and successful?

Suggested Actions

- Continue meeting regularly.
- Establish subcommittees so that important work gets done in between larger collaborative meetings.
- As a group, rank the recommendations and actions according to whether they are high, medium, or low priority.
- Use your data dashboard to guide your work together.

Recommendation 5

Once program quality and treatment fidelity have been solidified, each program should enhance its routine data collection practices and also consider conducting a one-time, rigorous program evaluation to become more competitive for funding that has an "evidence-based" standard.

The Issue

The Patient Protection and Affordable Care Act of 2010 (ACA) was signed into law on March 23, 2010. One of the provisions of that act included the creation of the Maternal, Infant, and Early Childhood Home Visiting program, which will provide $100 million in early 2011 to states to fund home visiting programs.

With annual increases over five years, it is expected that the total amount of funds to be distributed to home visiting programs will be $1.5 billion by 2014.

The grant program specified that most of the funding would be used to support evidence-based home visiting program models, and information was subsequently provided describing the requirements that would have to be met for a program to be considered to be evidence-based.

Among the programs in this report, only IPOP is based on a model that has been rigorously tested (Healthy Start), with mixed results and not within Alameda County. It is helpful to look at what the key considerations are in conducting high-quality program evaluations, as well as some examples of different research designs that can range from highly rigorous to much less rigorous.

Suggested Actions

- Be informed about issues to consider in planning program evaluation research studies.
- When program staffing and design issues have been addressed and preliminary data show that implementation is "true" to program design, invest in a high-quality research study and commit to enhanced ongoing data collection.