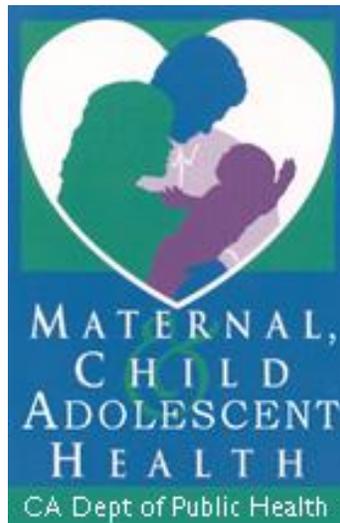


**Affordable Care Act
Maternal, Infant and Early Childhood Home Visiting
Program**

**Supplemental Information Request for the Submission
of the Updated State Plan for a
State Home Visiting Program**



**Maternal, Child and Adolescent Health Program
Center for Family Health
California Department of Public Health**

June 2011

[Type text]

TABLE OF CONTENTS

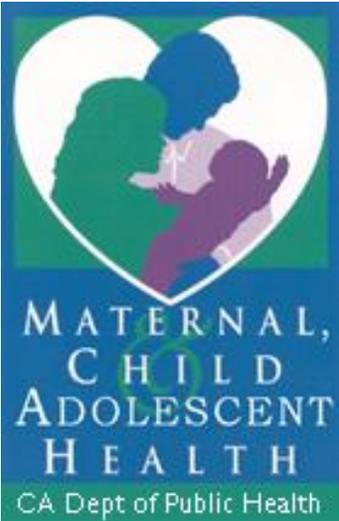
EXECUTIVE SUMMARY	7
Background	7
Overview of the Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program	7
Development of the California Home Visiting Program.....	8
Methods.....	9
Challenges.....	9
Conclusion.....	10
SECTION 1. IDENTIFICATION OF THE STATE’S TARGETED AT-RISK COMMUNITIES.....	12
1. Background.....	12
2. Methods to Identify the State’s Targeted At-Risk Communities	14
3. Summary of Results for Refining At-Risk Communities.....	21
4. Requirements for Responding to Section 1 of the Second SIR	25
5. Detailed Information for Each At-Risk Community Selected for Funding Beginning in Phase 1	30
SECTION 2. HOME VISITING PROGRAM GOALS AND OBJECTIVES.....	94
1. Mission, Goals and Objectives.....	94
2. Comprehensive, High-Quality Systems in California to Promote Maternal, Infant, and Early Childhood Health	96
3. California Strategies for Program Integration.....	97
4. Logic Model	98
SECTION 3. SELECTION OF PROPOSED HOME VISITING MODELS AND EXPLANATION OF HOW THE MODELS MEET THE NEEDS OF TARGETED COMMUNITIES.....	101
1. Selection of the California Home Visiting Models	101
2. Description of How Models Meet the Needs of Targeted Communities	102
3. Communities Selected for Funding Beginning in Phase 1	102
4. At-Risk Communities Not Selected for Funding Beginning Phase 1	103
5. How Models Meet the Needs of Targeted Communities.....	104
6. California’s Current or Prior Experience with Implementing the Selected Models and Current Capacity to Support the Model	124
7. Implementation of Quality and Program Assurance to Maintain Model Fidelity	128

8. Anticipated Challenges and Risks to Maintaining Quality and Fidelity and Proposed Response to Issues Identified.....	133
9. Anticipated Challenges/Risks of Selected Program Models with Proposed Responses and Anticipated Technical Assistance Needs	135
SECTION 4. IMPLEMENTATION PLAN FOR PROPOSED STATE HOME VISITING PROGRAM	139
1. Process for Engaging the At-Risk Communities	139
2. Methods to Identify the State’s Targeted At-Risk Communities	139
3. Identifying Organizations, Institutions, and Other Groups Consulted.....	140
4. CDPH/MCAH Approach to Policy and Standards	141
5. CHVP Approach to Policy and Standards.....	143
6. Plan for Working with National Model Developers: Description of Technical Assistance and Support.....	144
7. Timeline for Obtaining Curricula or Other Materials	146
8. Initial and Ongoing Training and Professional Development Activities	148
9. A Plan for Recruiting, Hiring, and Retaining Appropriate Staff for all Positions	150
10. Subcontracts.....	151
11. Assurance of High Quality Clinical Supervision and Reflective Practice....	151
12. Estimated Number of Families Served.....	152
13. Identifying and Recruiting Participants.....	153
14. Minimizing Attrition Rates for Participants Enrolled in the Program	157
15. Estimated Timeline to Reach Maximum Caseload	160
16. Coordination Between the Proposed Home Visiting Programs and Other Existing Programs and Resources in Those Communities	163
17. Obtaining or Modifying Data Systems for Ongoing Continuous Quality Improvement (CQI)	165
18. CHVP Approach to Monitoring, Assessing, and Supporting Implementation with Fidelity to the Chosen Models and Maintaining Quality Assurance.....	166
19. Anticipated Challenges to Maintaining Quality and Fidelity, and the Proposed Response to the Issues	168
20. Collaborative Public and Private Partners.....	168
21. Assurance that the California Home Visiting Program is Designed to Result in Participant Outcomes as Noted in the Legislation.....	169
22. Assurance that Individualized Assessments will be Conducted of Participant Families and that Services will be Provided in Accordance with those Individual Assessments	170

- 23. Assurance that Services will be Provided on a Voluntary Basis 170
- 24. Assurance that California will comply with the Maintenance of Effort Requirement 170
- 25. Assurances that Priority will be given to Eligible Participants 170
- SECTION 5. PLAN FOR MEETING LEGISLATIVELY-MANDATED BENCHMARKS 173**
 - 1. Process for Developing Proposed Benchmark Construct Measures 173
 - 2. Coordination with Other Relevant State or Local Data Collection Efforts 174
 - 3. Defining Measures of Improvement 174
 - 4. Identification and Measurement of Constructs 175
 - 5. Benchmarks 176
 - 6. Data Collection Plan 196
 - 7. Data Management Infrastructure 196
 - 8. Data Management and MIS 197
 - 9. Staff Qualifications and Plan for Data Safety and Monitoring 198
 - 10. Data Quality Assurance 199
 - 11. Plan for Analyzing Data at the Local and State Level 200
 - 12. Benchmarks and Continuous Quality Improvement 201
 - 13. Barriers and Challenges to Benchmark Reporting 201
- SECTION 6. PLAN FOR ADMINISTRATION OF STATE HOME VISITING PROGRAM 204**
 - 1. Public and Private Partners 204
 - 2. California Home Visiting Program Management Strategy 211
 - 3. Coordination and Referrals Across Models 212
 - 4. Related Evaluation Efforts of Home Visiting Programs in California 212
 - 5. Leadership and Organizational Capacity 213
 - 6. Coordination Efforts 215
 - 7. Monitoring of Fidelity 216
 - 8. Prerequisites for Implementation 217
 - 9. Strategic Planning Efforts 218
 - 10. Collaborations with California Early Childhood Initiatives 219
- SECTION 7. CONTINUOUS QUALITY IMPROVEMENT 225**
 - 1. The California Home Visiting Program Continuous Quality Improvement Plan 225
 - 2. California’s Plan for Fidelity Monitoring and Quality Improvement 226

- 3. Role of the Local Program in Fidelity and Quality Improvement 229
- 4. Role of the LHJ in Fidelity and Quality Improvement 230
- 5. Role of CHVP in Fidelity and Quality Improvement 230
- SECTION 8. TECHNICAL ASSISTANCE..... 233**
- SECTION 9. REPORTING REQUIREMENTS 236**
- 1. CHVP Goals, Objectives and Logic Model..... 236
- 2. CHVP Promising Program Update..... 236
- 3. Implementation of Home Visiting Program in Targeted At-Risk Communities..... 237
- 4. Progress Towards Meeting Legislatively Mandated Benchmarks 237
- 5. CHVP Continuous Quality Improvement Efforts 237
- 6. Administration of State Home Visiting Program 238
- 7. Technical Assistance Needs..... 238

EXECUTIVE SUMMARY



EXECUTIVE SUMMARY

Background

The Maternal and Child Health (MCH) Services Block Grant (Title V of the Social Security Act) has operated as a Federal-State partnership since 1935, when the Social Security Act was passed. The Federal Government, through Title V, pledged its support of State efforts to extend health and welfare services for mothers and children. States and jurisdictions use Title V funds to design and implement a wide range of maternal, adolescent and child health programs that meet national and State needs. In California Maternal Child and Adolescent Health (MCAH) Program and California Children's Medical Services (CMS) coordinate the Title V Block Grant Program.

Title V is frequently amended to reflect changing national approaches to maternal and child health and welfare issues. On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA amended Title V of the Social Security Act (42 U.S.C. 701 et. seq.), by adding Section 511, which establishes the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV).

Overview of the Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program

The ACA MIECHV program provides an opportunity for collaboration at the federal, state and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs. U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF) intend that the funds will result in a coordinated system of early childhood home visiting in every state that has the capacity and commitment to ensure high-quality, evidence-based practice. The new program plays a crucial role in a national effort to build quality, comprehensive, statewide early childhood systems. Ultimately these systems will improve health and developmental outcomes for pregnant women, parents and caregivers, and children from birth to eight years of age.

The ACA MIECHV program is designed to:

- Strengthen and improve programs and activities carried out under Title V
- Improve coordination of services for at-risk communities
- Identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. At risk-communities are defined in the legislation as those with a high concentration of risk factors for premature birth; low birth weight; infant mortality; poor maternal, newborn and child health; poverty; crime; domestic violence; high rates of high school dropouts; substance abuse; unemployment; and child maltreatment.

States are required to utilize evidence-based home visiting programs in an effort to promote improvements in maternal and prenatal health, infant health, and child health and development; increased school readiness; reductions in the incidence of child maltreatment; improved parenting related to child development outcomes; improved family socio-economic status; greater coordination of referrals to community resources and supports; and reductions in crime and domestic violence.

Development of the California Home Visiting Program

The California Department of Public Health, Maternal, Child and Adolescent Health (CDPH/MCAH) was designated in 2010 by former Governor Arnold Schwarzenegger as the single State entity authorized to apply for and administer HRSA and ACF home visiting program funds on behalf of California. The following steps are required to complete the FY 2010 ACA MIECHV program application:

1. Submission of an Application for Funding in Response to Federal Funding Opportunity (FOA) Announcement: The FOA was issued on June 10, 2010; state applications were due July 9, 2010. The application included plans for completing a statewide needs assessment and an initial plan for program development to meet legislative criteria. CDPH/MCAH received a response on July 27, 2010 which served as the basis for obligating FFY 2010 funds for development of a statewide MIECHV program.
2. Submission of a Statewide Needs Assessment in Response to the First Federal Supplemental Information Request (SIR-1): states were required to complete a needs assessment as a condition of receiving payment of FFY 2011 Title V Block Grant funds, regardless of whether the State intended to apply for a grant to provide home visiting services. SIR-1, published August 19, 2010, provided guidance for completing the Needs Assessment; California submitted the response on September 20, 2010. SIR-1 required California to:
 - Determine how it would identify at-risk communities
 - Identify the quality and capacity of existing early childhood home visiting programs
 - Discuss California's capacity to provide substance abuse treatment and counseling services
3. Supplemental Information Request 2 (SIR-2) Submission of an Updated State Plan for a State Home Visiting Program: SIR-2 for the Updated State Plan was released February 8, 2011. Guidance was provided for defining targeted at-risk communities, updating and providing a more detailed needs and resources assessment, and creating a specific plan for home visiting services tailored to address those identified needs. SIR-2 also identified criteria for establishing evidence of effectiveness of home visiting models and provided a listing of evidence-based models known to meet those criteria. SIR-2 provided a rolling 90-120 days for submission of the Updated State Plan.

CDPH/MCAH utilized the guidance provided by the SIR-2 as an opportunity to develop a strategic implementation plan for the California Home Visiting Program (CHVP) which defines a comprehensive, high-quality early childhood system within California. SIR-2 requires detailed responses for nine sections which are based on an assessment of needs and existing resources in the at-risk communities.

Methods

The preparation of the California Updated State Plan for a State Home Visiting Program, based on the SIR-2 guidance from HRSA, involved collaborative efforts with public and private partners to develop cohesive strategies and to ensure program quality and effectiveness. To ensure the creation and implementation of an effective statewide home visiting program in California, CHVP worked in conjunction with the Needs Assessment results from SIR-1, which identified all 61 Local Health Jurisdictions (LHJ) in California as having at-risk communities, to develop the Request for Supplemental Information (CHVP-RSI) in response to SIR-2 guidance. The CHVP-RSI gathered additional information on the needs of the at-risk communities and provided information on existing home visiting models within the communities, referral resources currently available and services which would be needed in the future to support a home visiting program. To provide justification for the selection of the targeted at-risk communities within California, CHVP utilized a multi-pronged approach which included qualitative and quantitative data collection and analysis utilizing sub-county level data, as well as advanced statistical methods. Information gathered from the local partners was vital for the analysis which led to the identification of 13 at-risk communities who will receive funding for the expansion or development of a home visiting program under the FFY 2010-2011 ACA MIECHV. An additional 19 communities may be considered for funding if future FFY funding allows.

CHVP also performed rigorous analysis on the evidenced-based home visiting models that would best address the needs of the families, as well as the particular risks, of the overall targeted communities. CHVP ultimately selected the Nurse-Family Partnership (NFP) and Healthy Families America (HFA) home visiting models to address the needs of the targeted at-risk communities. Of the 13 communities selected for funding, three will implement HFA and 10, including one consortium, will implement NFP.

Challenges

CHVP ensures that the level of commitment and collaboration with federal, state and local partners will remain strong as the implementation process for a home visiting program unfolds. The staff at CHVP has found the process for creating the Updated State Plan to be challenging and informative, and has provoked much discussion on the best path for implementation of the overall home visiting program. While there have been many successes with the writing of the plan, there have also been challenges; some which have been addressed, while others may be addressed through the HRSA technical assistance process. Specifically, CHVP challenges included:

- The directive that States were not allowed to gather pertinent information from 58 California counties via a Request for Application (RFA) process and due to the lack of prior notification that a RFA process would not be allowed, CHVP lost valuable time by having to create a separate Request for Supplemental Information (RSI) to gather qualitative and quantitative information from the county level.
- Difficulty in obtaining specific information from NFP in the absence of a contract. NFP noted on several occasions that proprietary information would not be shared until contractual agreements were in place; however this lack of information made it challenging to write sections of the plan.
- Difficulty in defining benchmark measurements due to lack of clarity in SIR-2 guidance and the inability to obtain the necessary information from NFP to measure Benchmarks.
- The Technical Assistance provided throughout the application process was not received until very late in the process. This impacted California's overall planning timeline.

Conclusion

The mission of the California Home Visiting Program is to provide leadership for integrated, collaborative, high-quality maternal and early childhood interventions across multiple systems of health and human services to address the complex needs of diverse families throughout California. California's investment to empower pregnant women and families with children will positively impact maternal health and childhood development, which leads to improved health and well-being over the life course, and ultimately cultivates resilient communities. To achieve this mission, CHVP will continue to work closely with federal, state and local partners in addition to the various stakeholders to implement a comprehensive, evidence-based home visiting program. CHVP ensures that the level of commitment and collaboration with these partners will remain strong as the implementation process for a home visiting program unfolds.

SECTION 1.

IDENTIFICATION OF THE STATE'S TARGETED AT-RISK COMMUNITIES



SECTION 1. IDENTIFICATION OF THE STATE'S TARGETED AT-RISK COMMUNITIES

This section describes the process utilized by the California Department of Public Health/Maternal, Child and Adolescent Health (CDPH/MCAH) program to make the final designation of at-risk communities in fulfillment of SIR-2 requirement for Section I; also included is a detailed description of each of the targeted at-risk communities including an assessment of needs and existing resources, a plan for coordination among existing programs and resources in those communities, and local and State capacity to integrate the proposed home visiting services into an early childhood system of care. A list of California communities that were identified as being at-risk but are not being selected for initial implementation of the California Home Visiting Program (CHVP) due to limitations on available FFY 2010-2011 funding is also included.

1. Background

How California Identified “At-Risk Communities” in Response to SIR-1

The process for identifying California’s “At-Risk Communities” began in response to the first Supplemental Information Request 1 (SIR-1). To identify at-risk communities, California had to determine how it would define “community.” The SIR-1 guideline for defining “community” stated that *“Each State should describe its understanding of the term “community” in accordance with the unique structure and make-up of the State.”* CDPH/MCAH determined census tracts and Medical Service Study Areas (MSSAs) to be the units of analysis best suited for representing the *“unique structure and make-up of the State”* particularly for the purpose of conducting a needs assessment to identify disparities and unmet need. However, due to a number of factors, particularly the limited availability of data at a sub-county level for many variables required by the SIR-1 and time constraints for responding to SIR-1, analyses of data at the census tract or MSSA level were not feasible in response to SIR-1. Therefore, California defined “community” as county for the initial Needs Assessment.

CDPH/MCAH then identified its “at-risk communities.” SIR-1 provided a definition of “at-risk community” whereby “an ‘at-risk community’ is a community for which indicators, in comparison to statewide indicators, demonstrate that the community is at greater risk than is the State as a whole. The distinction was based on a comparison of statewide data and data for the community identified as being “at-risk.” California considered “at-risk” counties to be those with a rate or percentage worse than the statewide median value for any one of the included indicators. CDPH/MCAH designated all 58 Counties as “at-risk communities” for the purposes of the initial Needs Assessment based on the data illustrating a level of need for the included indicators in all of California’s 58 Counties, and knowing that the federal SIR-2 would allow California to further refine the “at-risk community” definition with the use of sub-county data.

How California Identified the Quality and Capacity of Existing Early Childhood Home Visiting Programs in Response to SIR-1

In California early childhood home visiting programs are operating at the local level. To learn more about these programs, CDPH/MCAH disseminated a Capacity Assessment Home Visiting Survey that was sent to MCAH Directors in August 2010. To lessen the potential burden to county-level MCAH Directors, the survey focused on eight nationally recognized home visiting models. The survey provided a snapshot of select home visiting programs throughout California and was the basis for the information presented in the initial Needs Assessment about the quality and capacity of existing programs and initiatives for early childhood home visiting in California's at-risk communities.

Step-Wise Needs Assessment Process

The Needs Assessment was one step in a process to develop and implement a Statewide Home Visiting Program. Given the size, diversity, and complexity of California's geography and population, this process required a comprehensive approach. As part of SIR-2, HRSA allowed States to refine the Needs Assessment including the final designation of targeted at-risk communities and the quality and capacity of existing home visiting services in those communities. With this in mind, California's planned approach for submission of the Updated State Plan was to supplement results from the initial Needs Assessment to include further data to pinpoint the highest at-risk populations in communities with unmet need or gaps in services, and to incorporate a framework for leveraging local expertise. Although all 58 counties in California had areas of identified need based on the Needs Assessment, it was recognized that CDPH/MCAH would need to identify those areas in the state with the greatest need and potential for impact because available funds are limited, future funding is not guaranteed, and the state must meet strict and challenging legislatively mandated benchmarks.

The Need for Supplemental Information: California's Home Visiting Program Request for Supplemental Information (CHVP-RSI)

During the months that followed completion of the Needs Assessment, CDPH/MCAH undertook extensive efforts to further refine the results in preparation for the submission of the Updated State Plan. Specifically, CDPH/MCAH explored multiple different sub-county indicators for potential use in further refining "At-Risk Communities," conducted additional analyses, and developed a plan to solicit the expertise of its local partners, building on the information already collected from the Capacity Assessment Home Visiting Survey. In addition, CDPH/MCAH staff conducted a more extensive internal review and assessment of various home visiting models.

See Section 3. Selection of Proposed Home Visiting Models and Explanation of How the Models Meet the Needs of Targeted Communities for further information on model selection.

California selected two evidence-based home visiting models for implementation: the Nurse-Family Partnership (NFP) and Healthy Families America (HFA) based on findings of the Home Visiting Evidence of Effectiveness Review (HomVEE) Study which distinguished NFP and HFA as having the most favorable ratings for primary and secondary outcomes in the benchmark areas and the internal review. It was also recognized that the federal SIR-2 would require additional information about local areas not asked for as part of federal SIR-1. This need for local input prompted CDPH/MCAH to develop a Request for Supplemental Information (CHVP-RSI) to build upon the information already provided to CDPH/MCAH in responding to the Home Visiting Capacity Assessment Survey as part of the Needs Assessment.

2. Methods to Identify the State's Targeted At-Risk Communities

CDPH/MCAH developed a multi-pronged approach including both quantitative and qualitative data collection and analysis to make the final designation of at-risk communities. Specifically, CDPH/MCAH utilized newly released sub-county level data to complete a geospatial hot-spot analysis. The CHVP-RSI provided qualitative information from the Local Health Jurisdictions (LHJs) about the community(ies) and population(s) that local officials believe have the highest need, and identified the evidence-based model that would best meet the identified needs. Following is a detailed description of how the quantitative data analyzed by CDPH/MCAH were combined with the qualitative information submitted from local partners to identify the highest need communities in California where the home visiting programs, when implemented, would have the greatest impact and likelihood of success.

Use of Poverty Indicator to Help Refine At-Risk Communities

The process developed to identify the targeted communities for home visiting funding included a quantitative comparison of all areas across the state. The variable selected for this comparison was families living below 185% Federal Poverty Level with any children under age 5, from the United States Census American Community Survey (ACS), 2005 – 2009 5-Year Aggregate data (<http://www.census.gov/acs/www/>). This variable was selected because data are available at the sub-county level and because Census data are official United States government statistics.

Poverty is associated with other stressors affecting health including inadequate nutrition and food insecurity, unsafe housing, homelessness, and lack of access to health and social services.^{1,2} Poverty can also increase children's risk of exposure to alcohol and other drugs, abuse, neglect, and violence in the home or community.^{3,4} Children living

¹ American Psychological Association. Effects of Poverty, Hunger and Homelessness on Children and Youth. <http://apa.org/pi/families/poverty.aspx?item=2>. Accessed September 8, 2010.

² Davis R, Nageer S, Cohen L, Tepperman J, Biderman F, Henkle G. FIRST STEPS: Taking Action Early to Prevent Violence. Oakland, Calif: Prevention Institute; 2002.

³ American Psychological Association. Effects of Poverty, Hunger and Homelessness on Children and Youth. <http://apa.org/pi/families/poverty.aspx?item=2>. Accessed September 8, 2010.

in economically deprived communities are at greater risk for a variety of negative outcomes from low birth weight, poor nutrition, increased chance of academic failure, and emotional distress.⁵ Poverty is an indicator that demonstrates associations with the prioritized populations in the federal SIR-2 guidance whose outcomes can be improved from home visiting services.

It was important, however, to examine the relationship between the ACS poverty indicator for families with children under age five and the indicators reported in the initial Needs Assessment to determine if the poverty measure represents the intended home visiting target population specified in the federal legislation. A correlation analysis conducted using Statistical Analysis Software (SAS) revealed that the poverty indicator was highly correlated with indicators that were included in the Needs Assessment, with p-values ranging from <0.001 to 0.022. This analysis confirmed that the five-year ACS poverty indicator was a good proxy measure for identifying at-risk families who are most in need of home visiting services.

Development of the California Home Visiting Program Request for Supplemental Information (CHVP-RSI)

The availability of the ACS poverty indicator at the sub-county level allowed CDPH/MCAH to distribute the CHVP-RSI to all 58 California counties and the three municipal areas that together make up California's 61 LHJs. The CHVP-RSI, released on March 14, 2011, requested information about need, cross agency coordination and collaboration, current infrastructure, timeline for program implementation, strength of referral systems, data experience, and continuous quality improvement. The CHVP-RSI was composed of two parts: PART A focused at the LHJ Level; and PART B focused at the Community Level. PART B provided LHJs (individually or as part of a consortium⁶) the opportunity to: (1) identify and describe the community(ies) and population(s) that have the highest need; and (2) identify the evidence-based home visiting model, either NFP or HFA, that, based on LHJs first-hand knowledge, would best meet the identified needs and fill any gaps in early childhood services. Some LHJs have established NFP, HFA or other evidence-based home visiting programs. They were encouraged to submit a CHVP-RSI to expand on existing sites, build upon an existing infrastructure, or to implement new programs that supplement but not supplant current operations.

Supporting Materials of the CHVP-RSI

The state provided LHJs supportive quantitative information in the form of County Profiles and geospatial maps to complement local community knowledge in identifying

⁴ Davis R, Nageer S, Cohen L, Tepperman J, Biderman F, Henkle G. *FIRST STEPS: Taking Action Early to Prevent Violence*. Oakland, Calif: Prevention Institute; 2002.

⁵ Child Trends. Children in Poverty. www.childtrendsdatabank.org/?q=node/221. Accessed September 8, 2010.

⁶ California's population centers range from dense metropolitan areas to sparsely populated frontier regions. CDPH-MCAH gave LHJs with smaller populations the opportunity to form a consortium with one or more LHJs who might otherwise be unable to fulfill administrative needs or meet the minimum enrollment criteria for the geographic area served.

their at-risk communities. Information was provided via the CDPH/MCAH Home Visiting Program website

(www.cdph.ca.gov/programs/mcah/Pages/RequestforSupplementalInformation.aspx).

These materials included:

- 1) Summary of Home Visiting Needs Assessment Indicators for Each County: The Needs Assessment included a set of indicators reported at the state, county, and/or regional levels. These indicators were reported in Section I and Section III of the Statewide Needs Assessment, and included data for the following domains: newborn/infant health, child health, maternal health, family characteristics, community characteristics, and substance abuse. Each county was categorized as being in one of four quartiles for each of these indicators: 0-49th percentile; 50th-74th percentile; 75th-89th percentile; and 90th percentile and above. CDPH/MCAH assembled this data into County Profiles that were uploaded to the Home Visiting website. Each LHJ had access to their profile displaying their quartile ranking for each of the initial Needs Assessment indicators.
- 2) Estimation of Clients Likely to Enroll in Nurse Family Partnership (NFP) and Healthy Families America (HFA): To fully equip LHJs with information on their ability to sustain the NFP and HFA programs, numbers of clients that were likely to enroll for both programs were listed on their County Profiles. CDPH/MCAH estimated clients using the 2009 Birth Statistical Master File with methods provided by NFP and HFA. NFP's criteria accounts for first time mothers, the percent likely to be offered services, and finally the mothers likely to enroll in the program. HFA's estimation takes into account the mothers likely to screen positive for services, mothers screened positive that are offered services, and those likely to enroll in the program. A minimum enrollment of 100 families per program is required for the CHVP. Communities with less than an estimated 100 families would likely find it difficult to reach a full caseload and sustain a program.
- 3) Geospatial and Thematically Mapped Data: CDPH/MCAH completed a geospatial hot-spot analysis of the ACS poverty indicator of families with children under 5 years old below 185% Federal Poverty Level. Geospatial hot-spot analyses identify clusters that statistically are significantly different than the statewide mean for that particular indicator. Significance was determined as being either above or below the statewide mean. Since comparisons are made to the statewide mean, statistically significant clusters are identifying areas that differ across the entire state; these analyses are not attempting to identify areas that differ within each county.

CDPH/MCAH also developed several thematic choropleth maps⁷ of families with children under five years old living in families below 185% Federal Poverty Level, estimated number of NFP clients, and estimated number of HFA clients. A separate map was generated for each indicator and each LHJ. These choropleth maps

⁷ A choropleth map uses various color shading to illustrate different categories of a variable thematically. In this case poverty was displayed on the map.

feature counts by MSSAs. MSSAs are geographic boundaries developed by the California Office of Statewide Health and Planning Development (OSHPD) with the input of local stakeholders to best display health disparities and reflect recognized neighborhoods. MSSAs encompass one or more census tracts and are an ideal unit for highlighting community differences at the sub-county level given California's diverse population.

All LHJs were asked to submit PART A of the CHVP-RSI to report requisite information about current home visiting capacity at the LHJ level. PART B of the CHVP-RSI was only required if the LHJ wanted to be considered for Home Visiting Program funds beginning in Phase 1. Each LHJ participating in a consortium was asked to submit PART A and PART B of the CHVP-RSI to describe their individual role in the collaboration. LHJs were asked to submit a maximum number of communities for PART B, ranging from one to three communities. CDPH/MCAH determined the number of communities each LHJ could propose as a targeted community for funding based on the estimated number of births for 2009 and the number of clients likely to enroll in the selected home visiting program. For instance, heavily populated Los Angeles could propose up to three communities. Based on this determination, there was a potential of 73 communities that could be proposed and considered for funding.

CHVP-RSI Technical Assistance

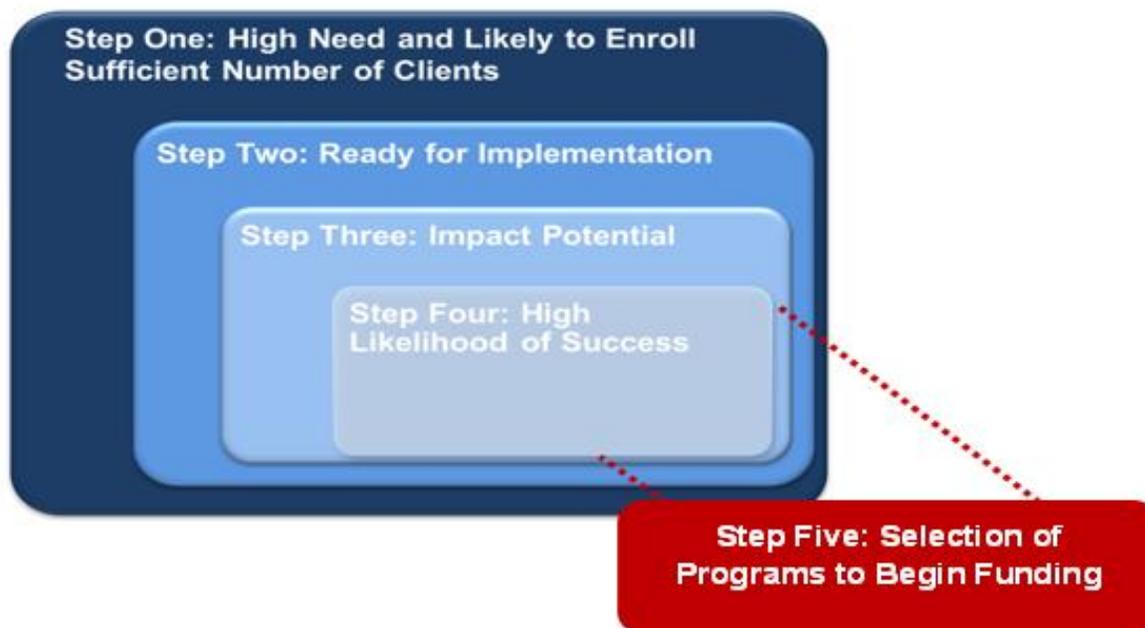
CDPH/MCAH was engaged with LHJs throughout the entire CHVP-RSI completion period. A special website was established specific to home visiting, and CDPH/MCAH staff corresponded with LHJs via phone and email on a daily basis. Technical assistance conference calls for completing the CHVP-RSI were held with Maternal, Child and Adolescent Programs on March 16, 2011 and again on March 28, 2011. This was an opportunity for CDPH/MCAH to communicate updates, address frequently asked questions received prior to the call, as well as field questions from LHJs concerning the CHVP-RSI and California's Home Visiting Program in general. After each conference call, a document summarizing all the questions and responses was posted on the California Home Visiting Program website.

Process of Reviewing and Categorizing At-Risk Communities: Combining Quantitative Results from Hot-Spot Analysis with Qualitative Results from the CHVP-RSI to Identify "At-Risk Communities" for Funding Beginning in Phase 1

All of the communities identified by LHJs through the CHVP-RSI are considered by CDPH/MCAH as at-risk. However, the funding available and the need to achieve specific federal requirements by year three necessitated CDPH/MCAH to identify those communities with the greatest potential for impact and likelihood of success. At-risk communities targeted for funding were identified using a five step process of reviewing and categorizing qualitative information from responses to the CHVP-RSI with quantitative data from the hot-spot analysis. Communities with attributes indicating higher need and higher likelihood of success continued onto subsequent steps of the review process. The steps of the review and categorization process are shown in Figure 1 and include:

- Step One: Review of Need and Minimum Enrollment Estimates Within the Community
- Step Two: Review of Readiness and Timeline to Implement
- Step Three: Potential Impact of Home Visiting Program
- Step Four: Review of Capacity Within the Community and Local Health Jurisdiction
- Step Five: At-Risk Communities for Funding Beginning in Phase 1

Figure 1. Steps of the Review and Categorization Process



Step One: Review of Need and Minimum Enrollment Estimates Within the Community

All communities were placed into higher or lower need categories based on geospatial “hot-spots” of need and likelihood of meeting minimum enrollment for a home visiting program. Using the LHJs description of the geographic area targeted for a home visiting program, CDPH/MCAH determined if the target community fell within a poverty “hot-spot.” Each community was assessed on the likelihood of meeting California’s minimum requirement of 100 families per home visiting program using methods provided by HFA and NFP. Based on the review of need and minimum enrollment, communities were placed into four groups, as shown in Figure 2.

Figure 2. Need and Enrollment Minimum

		Community is a “Hot-Spot”	
		Yes	No
Meet Minimum Enrollment	Yes	High Need 1a	Moderate Need 1b
	No	Lower Need 1c	Lowest Need 1d

Step Two: Review of Readiness and Timeline to Implement

The ACA legislation requires states to demonstrate improvement in four of the six benchmark areas by year three of the home visiting program. Therefore, community readiness to implement a home visiting program on a short timeline is of paramount importance. Community readiness was assessed using information provided by the LHJ/community on the existence of an infrastructure to support expansion or implementation of NFP or HFA, the length of time to hire staff, access to target populations for referrals into the home visiting program, established resource connections within the community, the existence of systems and/or frameworks for collaboration and referrals, and the presence of existing home visiting programs. Timelines provided by LHJs were evaluated relative to realistic timelines provided by HFA and NFP. Based on the review of community readiness and timeline, identified communities were placed into the four groups shown in Figure 3.

Figure 3. Readiness and Timeline to Implement

		Timeline to Required Caseload	
		Short	Long
Readiness to Implement HV	More	More Readiness/ Short Timeline 2a	More Readiness/ Long Timeline 2b
	Less	Less Readiness/ Short Timeline 2c	Less Readiness/ Long Timeline 2d

Step Three: Potential Impact of Home Visiting Program

Results from Step One ‘*Review of Need and Enrollment Minimum*’ and Step Two ‘*Review of Readiness and Timeline to Implement*’ were combined to identify communities where the proposed home visiting program would have the greatest potential for impact and likelihood to meet ACA requirements. Communities were categorized into one of four *Potential for Impact* categories based on their cell location in Steps 1 and 2 (Figure 4). For example, the cell labeled “Greatest Impact” represents communities that were identified in *Step 1* as High Need (cell 1a, from Figure 2) AND also identified in *Step 2* as High Readiness to implement (cell 2a, from Figure 3). Communities from the Greatest, Significant, and Potential Impact groups moved on to Step 4 of the review process. Moreover, results from the *Potential for Impact* categories

were used at the end of the review and categorization process when selecting communities for funding beginning in Phase 1. When establishing the order for funding communities, efforts were made to select one community from the ‘Significant Impact’ or ‘Potential Impact’ category for funding beginning in Phase 1 for every three communities from the ‘Greatest Impact’ category. This approach was used in order to increase the likelihood of funding communities without an existing home visiting program and communities that may not have been in an identified “hot-spot”. This approach will also allow CDPH/MCAH to establish best practices and lessons learned for implementing home visiting programs in areas with less existing infrastructure.

Figure 4. Categories for Potential for Impact Based on Need and Readiness

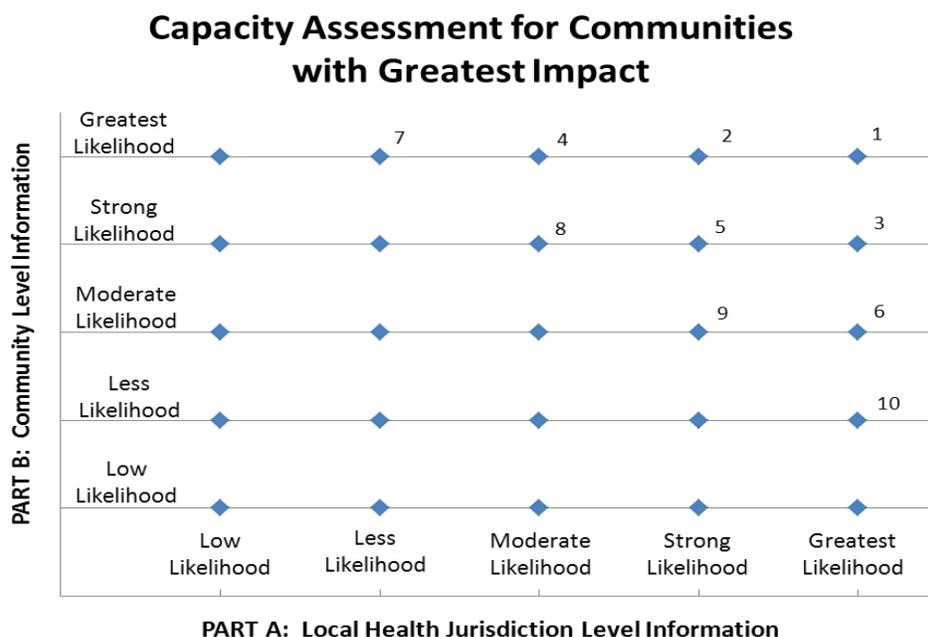
	High Readiness	Moderate Readiness
High Need	Greatest Impact (cells 1a and 2a)	Significant Impact (cells 1a and 2b)
Moderate Need	Potential Impact (cells 1b and 2a)	Less Potential for Impact (cells 1b and 2b)

Step Four: Review of Capacity Within the Community and Local Health Jurisdiction

Two independent review panels conducted a comprehensive assessment of the capacity of both the LHJs and the corresponding identified communities from Step 3. Capacity was measured based on data management and analytic capacity, completion of rigorous program evaluation, implementation of continuous quality improvement, staff training and supervision, and maintenance of high level coordination and collaboration with partner agencies. In addition, community strengths and needs and the ability to fully implement the program with limited up-front delays were taken into consideration. The two review panels used a Likert scale to categorize separately the community and the corresponding LHJ as having either ‘Greatest Likelihood’, ‘Strong Likelihood’, ‘Moderate Likelihood’, ‘Less Likelihood’ or ‘Low Likelihood’ to Succeed when implementing a Home Visiting program. The categorizations assigned by the two independent review panels were reconciled to assure objectivity. Each review panel included a staff person with knowledge specific to the proposed model (NFP or HFA), an epidemiologist, a health program specialist who works directly with LHJs in their implementation of Title V funded programs, and a person from contracts or budgeting.

Once the Likert scale category was assigned to the LHJ and a separate category assigned to the identified community, these were plotted on an x and y axis with the x-axis representing the likelihood to succeed based on LHJ-level information and the y-axis representing the community level information. An example of this plot is shown in Figure 5. Communities graphed at point “1” represent those communities with the greatest likelihood for success at both the LHJ and Community levels. Communities at point “2” have the greatest likelihood for success on the Community level and a strong likelihood of success on the LHJ level. These point designations reflect the order that at-risk communities were selected for funding beginning in Phase 1.

Figure 5. Plot of the Likert Category for Community and Local Health Jurisdiction Capacity



Step Five: At-Risk Communities Selected for Funding Beginning in Phase 1

Communities were selected for funding first starting at point “1” in Figure 5. After all communities at point “1” were selected for funding, other communities were selected for funding sequentially at point “2”, then point “3”, and so on as funding levels permitted and bearing in mind efforts to maintain the 3:1 funding ratio described in Step 3 (one community from the ‘Significant Impact’ or ‘Potential Impact’ category selected for funding for every three communities from the ‘Greatest Impact’ category).

3. Summary of Results for Refining At-Risk Communities

CDPH/MCAH received 44 uniquely defined communities from 44 LHJs in response to the CHVP-RSI. Four of the proposed communities were consortia made up of two or three LHJs. Of the LHJs that could have submitted multiple communities, only Sacramento and Los Angeles elected to identify more than one community (2 and 3, respectively). 13 LHJs declined the opportunity for a home visiting program in Phase 1 but provided LHJ capacity information that will be considered for future funding years. The following provides a quick summary of the review and categorization results.

Step 1 results: There were 42 communities that fulfilled the minimum enrollment requirements; of these, 25 communities overlapped with an identified “hot spot” and 19 were not part of a “hot-spot” area.

Step 2 results: Of the 42 communities that proceeded to Step 2, 34 demonstrated readiness to implement the proposed home visiting program while achieving it in a short

timeline. A total of 8 communities had the infrastructure and capacity to implement the proposed program with a longer than desired timeline to reach the required caseload.

Step 3 results: With rare exception, a great many of the communities demonstrated high need, met minimum client enrollment requirements, and showed a readiness to implement their program on a short timeline. Of the 34 communities that moved forward to Step 3, 13 were categorized as having the “Greatest Impact,” 14 as having “Potential Impact,” three as “Significant Impact,” and two with “Less Potential for Impact.” 32 communities fell in the Greatest, Significant, or Potential Impact groups and thus moved on to Step 4 of the review process.

Step 4 results: Through the review and categorization process, CDPH/MCAH identified 32 at-risk communities with considerable need and the best likelihood to improve health outcomes of families targeted with home visiting services. In Step 4, the 32 at-risk communities were further reviewed and categorized to reflect the order that at-risk communities were selected for funding beginning in Phase 1.

Step 5 results: Thirteen at-risk communities were selected for funding beginning in Phase 1 bearing in mind efforts to select one community showing “Potential Impact” or “Significant Impact” for every three communities categorized as having the “Greatest Impact.” The home visiting programs to be implemented beginning in Phase 1 include 10 NFP sites (four of which are new) and three HFA sites (two of which are new). A consortium of three rural northern counties was among those selected. The end result of this process is a set of communities with diverse population needs representing nearly all regions of California.

The remaining 19 of the 32 at-risk communities demonstrating considerable need and the best likelihood of success will be considered for subsequent years of federal Home Visiting funding *after* the first 13 at-risk communities selected for funding beginning in Phase 1 have received funds *and* pending availability of funds.

Feedback from the review and categorization process will be given to the LHJs on a case-by-case basis. CDPH/MCAH will continue to provide technical assistance to LHJs that are not a part of the initial 32. Based on responses to the CHVP-RSI, it was determined that these communities did not meet minimum enrollment requirements, did not have sufficient readiness for implementation of a home visiting program and/or required a lengthier timeline to establish their program and begin enrollment. The goal of CDPH/MCAH is to ensure that opportunities are identified to address the many needs that remain within these at-risk communities and all 58 at-risk counties in California. Providing technical assistance will help identify appropriate programs for those communities unable to meet minimum enrollment numbers for NFP or HFA, and will further the readiness of communities and LHJs to receive future funding under the California Home Visiting Program.

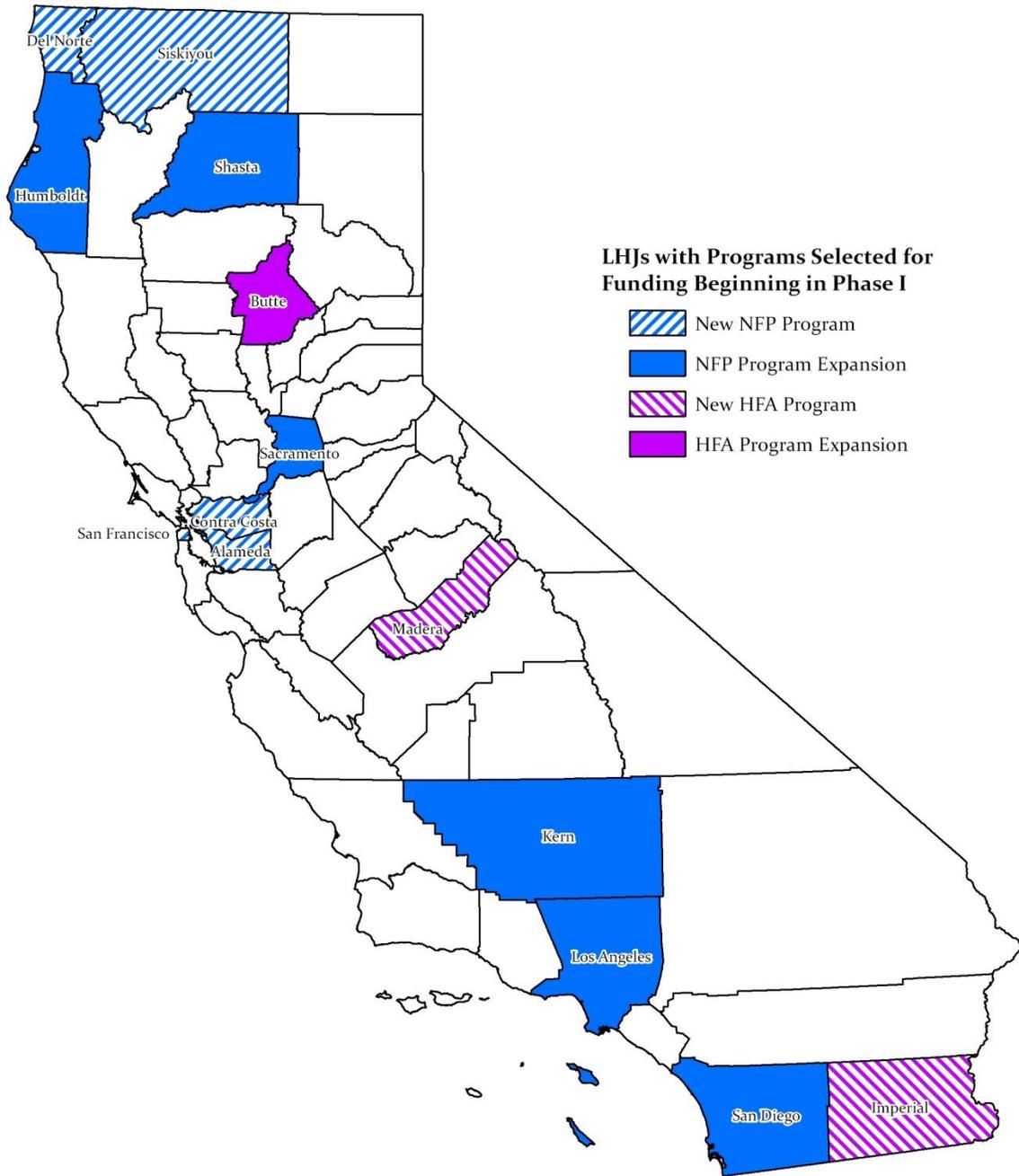
See Section 8. Technical Assistance for details regarding technical assistance needs

Communities Selected for Funding Beginning in Phase 1

The communities are presented below in the order they will be funded beginning in Phase 1. This selection reflects the efforts made to maintain a 3:1 funding ratio described previously where one community from the 'Significant Impact' or 'Potential Impact' category was selected for funding for every three communities from the 'Greatest Impact' category.

- Los Angeles Unified School District (LAUSD)
- Butte (Paradise Ridge/Southern Butte)
- Los Angeles Service Planning Areas or LA-SPA [SPA 2 (San Fernando Valley); SPA 3 (San Gabriel Valley); SPA 7 (East L.A.)]
- Contra Costa (East/West/Central)
- San Diego (North Inland-Coastal Expansion (NICE) - Oceanside/Vista/San Marcos/Escondido/Carlsbad)
- Imperial (El Centro/Imperial/Holtville/Seeley/Heber)
- Kern (Countywide)
- Madera (Western Madera County or WMC)
- Shasta (Shasta Lake/Redding/Anderson/Burney)
- North Coast Tri Consortium (Del Norte/Humboldt/Siskiyou County)
- Alameda (East/West Oakland)
- San Francisco (Bayview Hunter's Point)
- Sacramento (South Sacramento Communities)

Local Health Jurisdictions Selected for Funding Beginning in Phase 1 by Home Visiting Program Model (Nurse-Family Partnership or Healthy Families America) and Type (New or Expansion)



At-Risk Communities Not Selected for Funding Beginning in Phase 1

Once all 13 at-risk communities selected for funding beginning in Phase 1 have received funds, the following 19 LHJs/communities will be funded, in the order presented, based on future funding availability:

- Merced (Countywide)
- Fresno (Southeastern Fresno)
- Northern Los Angeles SPA 1 (SPA 1- Antelope Valley)
- Sacramento (North Sacramento communities)
- Nevada (Countywide)
- Stanislaus (Countywide)
- San Mateo (North/ Central/ South Counties)
- Solano (Countywide)
- Riverside (Perris/Moreno Valley)
- Tehama (Countywide)
- Yolo (Countywide)
- Sonoma (Sonoma County Hwy 101 Corridor)
- Santa Clara (Countywide)
- Santa Cruz (Countywide)
- Long Beach (The City of Long Beach)
- Marin (San Rafael/ Novato/ Marin City)
- Santa Barbara (North County)
- Northern Tri Consortium (Colusa/Glenn/Tehama County)
- Orange (Countywide)

4. Requirements for Responding to Section 1 of the Second SIR

Requirements for responding to SIR-2 specify that the following information be provided for each selected at-risk community:

- Community strengths and risk factors
- Characteristics and needs of participants
- Any existing home visiting services in the community including the number, type, and models used
- Existing mechanisms for screening, identifying and referring clients

- Referral resources currently available and needed in the future
- A plan for coordination among existing programs and resources
- Local and State capacity to integrate the proposed program into an early childhood system of care

Community Strengths and Risk Factors/Characteristics and Needs of Participants

The CHVP-RSI provided an opportunity for LHJs to describe the populations in need within their identified at-risk community. A detailed description of each at-risk community selected for funding beginning in Phase 1 and their populations in need, risk factors, and community strengths is provided in Section I. The populations identified and factors placing them at risk were extensive and most often included first time mothers, poverty, pregnant teenagers, foreign born or those with immigration related needs, high drop-out rates or education problems, crime, child maltreatment, substance use, domestic violence, and delayed initiation of or limited access to prenatal care.

See Section 3. Selection of Proposed Home Visiting Models and Explanation of How the Models Meet the Needs of Targeted Communities for detailed descriptions of each community

Existing Home Visiting Services in the At-Risk Community

The Capacity Assessment Home Visiting Survey, sent to MCAH Directors in August 2010, and the CHVP-RSI provided an opportunity for each county/LHJ to identify all existing and recently discontinued home visiting programs both within their county/LHJ and within the identified At-Risk Community. A cross-sectional summary of existing home visiting programs and initiatives operating within the at-risk communities selected for funding beginning in Phase 1 is provided in Table 1. For additional information about home visiting programs implemented in the county/LHJ, please refer to the Needs Assessment.

Table 1. Existing or Recently Discontinued Home Visiting Programs in Communities Selected for Funding Beginning in Phase 1

Selected At-Risk Community	Name of Home Visiting Program in Selected At-Risk Community	Evidence-Based (per HomVEE Study)	Name of Model if Evidence-Based	Number of Families Served in the At-Risk Community in Most Recent 12-Month Period
Alameda (East/ West Oakland)	Improving Pregnancy Outcomes Program			255
	Maternal Access and Linkages for Desired Reproductive Health	No		62
	Special Start	No		680
	Your Family Counts	No		171
	Unity Council Early Head Start	Yes	Early Head Start	295
Butte (Paradise Ridge/ Southern Butte)	Butte Baby Steps	Yes	Healthy Families America	48
	E-Center Early Head Start	Yes	Early Head Start	27
	Parents As Teachers	Yes	Parents as Teachers	22
Contra Costa (East/ West/ Central)	Prenatal Care Guidance Program	No		350 ^a
	Lift Every Voice	No		63 ^a
	Medically Vulnerable Infant Program	No		230 ^a
	Public Health Clinic Services	No		8000 ^a
	Welcome Home Baby	No		995 ^a
	Hand to Hand	No		119 ^a
	Early Head Start	Yes	Early Head Start	150 ^a
Imperial (El Centro/ Imperial/ Holtville/ Seeley/ Heber)	Imperial Valley Regional Occupational Program, Project Nenes	Yes	Home Instruction for Parents of Preschool Youngsters	64
	Imperial County Office of Education Early Head Start Program	Yes	Early Head Start	16
Kern (countywide)	Kern County Nurse Family Partnership	Yes	Nurse Family Partnership	102
Los Angeles Service Planning Areas or LA-SPA [SPA 2 (San Fernando Valley); SPA 3 (San Gabriel Valley); SPA 7 (East L.A.)]	Nurse-Family Partnership	Yes	Nurse Family Partnership	127
	Early Head Start	Yes	Early Head Start	Unknown
	HOPE-SFV Best Babies Collaborative	No		147
	San Gabriel Valley Best Babies Collaborative	No		78
	Heart of the City Best Babies Collaborative	No	Piloting Parents as Teachers	155
	Norwalk LaMirada Unified School System Project ABC	No		47 ^a
	Project ABC	No		10
Los Angeles Unified School District (LAUSD)	County MCAH: NFP-LA	Yes	Nurse Family Partnership	50
	Safe Schools/ Healthy Students - "Project WIN" (Washington Investing in Neighborhoods)	Yes	Nurse Family Partnership	20
	Ready for School Visitation Program - Cudahy	Yes		25
	LAUSD Asthma Program	Yes		100
	LA Best Babies Collaborative	No		100
	Early Head Start	Yes	Early Head Start	100 ^{ab}

(Table continued on next page)

(Continued)

Selected At-Risk Community	Name of Home Visiting Program in Selected At-Risk Community	Evidence-Based (per HomVEE Study)	Name of Model if Evidence-Based	Number of Families Served in the At-Risk Community in Most Recent 12-Month Period
Madera (Western Madera County)	First Parents Program	No		146
	Migrant Head Start (defunded)	No		15
	Safe Kids California Project	Yes	SafeCare	15
North Coast Tri Consortium				
Del Norte	Del Norte County Early Head Start	Yes	Early Head Start	35
Humboldt	Humboldt County Nurse Family Partnership	Yes	Nurse Family Partnership	96
	Northcoast Children's Services Head Start/ Early Head Start	Yes	Early Head Start	178
	American Indian Infant Health Initiative	No		25-35
	Alternative Response Team	No		201
Siskiyou	Siskiyou Early Head Start	Yes	Early Head Start	200
	Shasta Early Head Start	Yes	Early Head Start	20
	Modoc Early Head Start - Tulelake	Yes	Early Head Start	23
Sacramento (South Sacramento communities)	Nurse-Family Partnership	Yes	Nurse Family Partnership	367 ^a
	Early Head Start	Yes	Early Head Start	229
	Healthy Start	No		Unknown
San Diego (North Inland-Coastal Expansion (NICE) - Oceanside/ Vista/ San Marcos/ Escondido/ Carlsbad)	Public Health Nursing	Yes	Nurse Family Partnership	545
	MAAC Head Start	Yes	Early Head Start	300 ^b
San Francisco (Bayview Hunter's Point)	Early Head Start	Yes	Parents as Teachers	185
Shasta (Shasta Lake/ Redding/ Anderson/ Burney)	Shasta Head Start	Yes	Parents as Teachers & Early Head Start	206 ^b
	Shasta County Children and Family Services - SafeCare	Yes	SafeCare	100
	Parent Partners	No		730

a. Either unspecified whether the number of families served is limited to the targeted community or LHJ was unable to distinguish

b. Not specified if number of families served received home-based services and/or center-based services

Existing Mechanism for Screening, Identifying, and Referring Clients

California does not have an existing statewide home visiting program and no centralized statewide mechanism for identifying, screening and referring potential clients is in place. The model for integrating existing programs and services will follow procedures established by the home visiting model's curriculum and the Strengthening Families Framework. At the local level there are numerous existing mechanisms for screening, identifying, and referring clients. Local area mechanisms are specific to the particular region and reflect the diversity that exists within the at-risk communities.

See Section 3. Selection of Proposed Home Visiting Models and Explanation of How the Models Meet the Needs of Targeted Communities for detailed descriptions of how

the Strengthening Families Framework will contribute to California's overall operational plan

Referral Resources Currently Available and Needed in the Future

The CHVP-RSI asked each LHJ to identify existing referral resources for each of the following domains: health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services, and to provide an operational plan for coordinating among these referral resources for referring clients to and from the newly established home visiting program. LHJs were also asked to identify future needs to support families residing in the community.

See Section 4. Implementation Plan for Proposed State Home Visiting Program for detailed descriptions of referral resources

See Section 5. Plan for Meeting Legislatively-Mandated Benchmarks for data collection and utilization relating to referrals

Coordination of Early Childhood System of Care

Coordination and collaboration among existing programs and resources is a key component at the LHJ and state levels of CHVP. CHVP is seen as a component of a larger comprehensive, coordinated and high quality maternal and early childhood system, contributing to the maternal, infant, and early childhood health, safety and development of strong parent-child relationships. Local and state stakeholders believe there is greater support and resources available for effective home visiting if it is viewed as one component of a larger cross-agency maternal and early childhood service system. This perspective provides opportunities for leveraging community and state infrastructure such as workforce and professional development, family outreach, policy reform and sustainability of innovative programs. CHVP will build on and align a number of state and community initiatives already underway.

CDPH/MCAH identified organizations, institutions, and individuals to begin discussions on the implementation of a California Home Visiting Program. The process includes consultation and collaboration with stakeholders, local MCAH Directors, and CDPH partner programs such as California Department of Education (CDE), California Department of Social Services (CDSS), the California Department of Health Care Services (CDHCS), Alcohol and Drug Programs (ADP), as well as public health educators and organizations concerned with the well-being of California's at-risk communities. Members of the Collaborative will continue to meet and their activities will be aligned with the work of the California ECCS Advisory Council, the California Early Learning Advisory Council, the California Statewide Screening Collaborative and California Project LAUNCH and Help Me Grow. These initiatives will engage in strategic planning to create an administrative structure that encourages stronger collaboration across health and early care and education settings. Through this coordinated structure, agencies will be better positioned to promote a common set of

outcomes for young children, enhancing efforts to track outcomes through improved data linkages.

CHVP will utilize the Strengthening Families framework, centered on five protective factors for working with children and their families. The five evidenced-based protective factors are known to be linked to the reduction of child abuse and neglect, and an increase in the optimal development of children. CHVP will use this protective factors approach to serve as an overarching frame for building collaborations across the maternal and early childhood system. At a local level, many individual programs serving children and families are already adopting the Strengthening Families approach. Using Strengthening Families as a common frame for programmatic purposes will help California create a way for different types of local programs to share a unifying language and approach. Additionally, there are numerous other programs and initiatives at the local level that already contribute to a coordinated maternal and early childhood system of care.

See Section 2. Home Visiting Program Goals and Objectives for a detailed description of the Strengthening Families framework as it will be applied to the CHVP

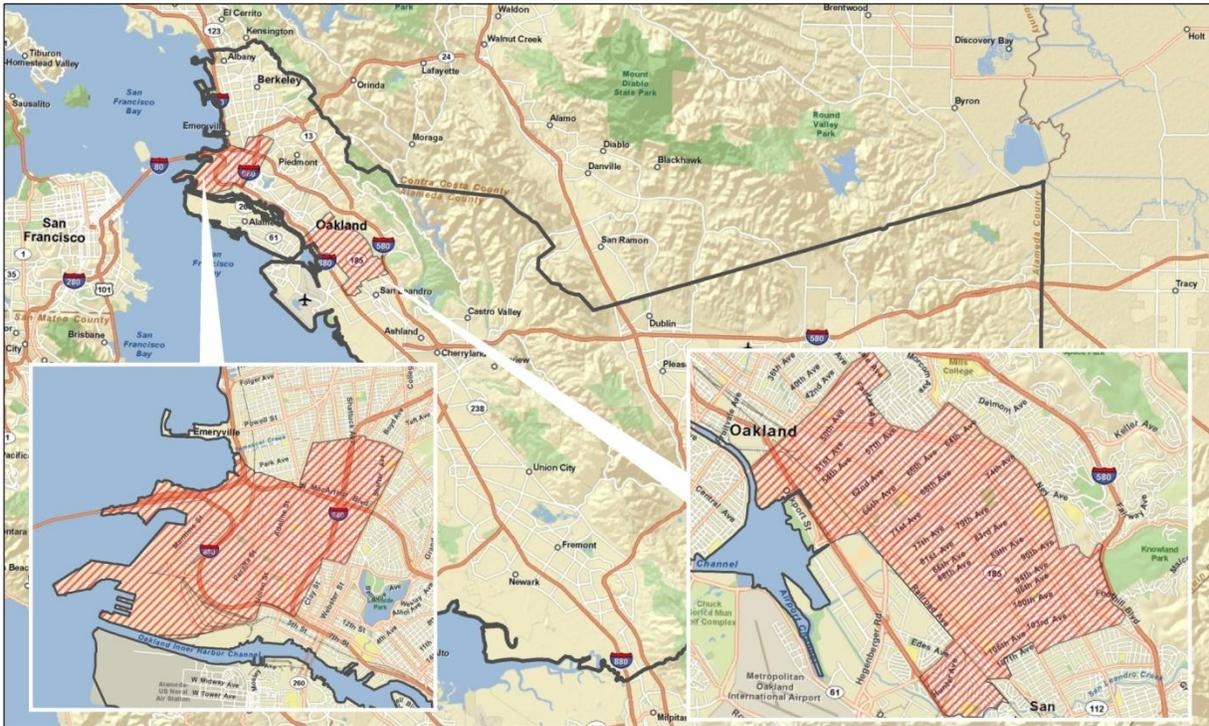
See Section 4 Implementation Plan for Proposed State Home Visiting Program for a detailed description of programs and initiatives described for each at-risk community selected for funding beginning in Phase 1.

5. Detailed Information for Each At-Risk Community Selected for Funding Beginning in Phase 1

The following information was provided by the LHJs in response to the CHVP-RSI. The responses, however, have been truncated by CDPH/MCAH in fulfillment of SIR-2 federal reporting requirements. The community boundaries of the maps are approximations made by CDPH/MCAH.

Alameda (East/ West Oakland)

The designated at-risk community is East/West Oakland and encompasses Bay census tracts 401-4019, 4021-4027 (West Oakland) and 4073-4076, 4084-4089, 4091-4097, 4101-4104 (East Oakland). Approximately 120,000 people live in East/West Oakland, of which over 80% are African American or Latino. East/West Oakland and their African American and Latino residents experience a disproportionate burden of morbidity and mortality.



Characteristics and Needs of Participants and Risk Factors

In any given year, there are approximately 800 first time births in East/West Oakland with 42% of these births to women under the age of 21 and 63% of these births paid by Medi-Cal. East and West Oakland contain the highest concentration of census tracts in Alameda County where 60% or more of the families with children under age 5 live below 185% of the federal poverty level.

First time mothers in East/West Oakland have among the highest rates in the county of low infant birth weight. In particular, 13.2% and 10.5% of infants born to African American mothers in East and West Oakland, respectively, are born at low birth weight, compared to 8% in the County as a whole.

Oakland Unified School District has the highest dropout rate in the County. In 2008-09, the four-year adjusted dropout rate in Oakland was 40% with the highest dropout rates among African American youth (49%) and Latinos (39%).

In Alameda County, about 12% of all births to first-time mothers are to teens ages 15-19 years. In Oakland, the overall percent is higher with 18% of first-time mothers who are teenagers and particularly high in East/West Oakland with almost a third (32%) between the ages of 15-19.

Substance use screening and assessment data collected from participating Comprehensive Perinatal Services Program (CPSP) sites indicate that African American pregnant women have among the highest rates of both marijuana and tobacco use in the county.

Oakland had the highest number of families living in high crime areas and the highest homicide rate with 25.5 deaths per 100,000 population - 2.4 times higher than the Alameda County rate. Oakland had the highest violent crime rate with 1,871 crimes per 100,000, more than double the county average and it had among the highest property crime rates with 6,396 reported per 100,000. Between 2004 and 2009, there were 114,055 incidences of misdemeanor and felony crimes, 11,449 incidents of violent crime, and 8,490 incidents of domestic violence in the two neighborhoods.

Community Strengths

The designated East/West Oakland community includes some of the most racially and ethnically diverse neighborhoods in the country. The areas are rich in culture, housing people from all over the world, both newcomers and multi-generational residents, with more than 44 languages spoken among the population. While the communities experience profound and persistent health inequities across geographical borders and population subgroups, tremendous efforts are underway to address these disparities. Historically, the East and West Oakland communities have successfully mobilized to address issues such as better food access for children, cleaner air and water, reduced violence, and greater economic opportunities for residents.

Currently, the Alameda County Public Health Department (ACPHD) is an active participant in several multi-partner initiatives to increase health and wellness in East/West Oakland. Through these initiatives, the ACPHD has developed working partnerships with people and organizations with dedicated resources that directly address the social and health inequities experienced by the target population. Three such initiatives include:

- The School-Based Health Centers that bring together schools, families and the community in underserved neighborhoods to ensure that students succeed in school and in life. These Centers serve as a hub to provide a range of services to students and their families.
- The Building Blocks Collaborative, a partnership of county wide, multi-sector community organizations committed to promote health equity and improve the overall wellbeing of the community and the people who live in it.
- East Oakland Building Healthy Communities (EOBHC), a 10-year program funded by the California Endowment, East Oakland is one of 14 communities across the

state taking action to make communities healthier. Over 4,000 community members, government agencies and community based organizations have already engaged in EOBHC.

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

Because Alameda County already has successful home visiting programs in place, formal linkages between home visitation services and other programs in the community already exist. Currently, many of the home visiting programs in Alameda County are connected through a county-wide database which allows staff from programs within the county to see whether their clients are being served by other home visiting programs and/or to make referrals to other programs within the system. The functionality of this data system is being enhanced and efforts are underway to build the system out so that it can accommodate more programs.

In addition, information about the home visiting program will be provided to local obstetricians and clinics serving pregnant Medi-Cal clients, school programs serving pregnant teens, the local Social Service Agency, juvenile justice programs serving pregnant teens, Women, Infants and Children's (WIC) Programs, and probation officers. Public Health Department outreach workers will also let pregnant women know about the service. The First 5-funded Hospital Outreach Coordinators (HOCs) will be informed about the program and will make referrals through the ECChange system using a collaboratively developed universal referral form. Recruitment will also be done at community events and will make use of the counties many coalitions and collaborations to inform the public about the program and assist with recruitment of clients.

Referral Resources Currently Available to Support Families Residing in the Communities

Referral resources currently available in Alameda County include the following (by domain):

- **Health:** Federally Qualified Health Centers (West Oakland Health Council, Life Long Medical Care, La Clinica de la Raza), Highland Hospital
- **Mental Health:** Alameda County Behavioral Health Services, FQHCs (West Oakland Health Council, La Clinica de la Raza Casa del Sol), Asian Community Mental Health Services
- **Early Childhood Development:** First 5 Alameda County, The Link to Children, City of Oakland and Unity Council Early Head Start, Oakland Unified School District Child Development Centers (including Acorn Woodland, Santa Fe)
- **Substance Abuse:** Alameda Medical Center - Highland Hospital Substance Abuse Program, Second Chance-Women's Phoenix Program, Solid Foundation Women's Center, West Oakland Health Council, Inc. – Options for Recovery, Horizon Services –Chrysalis, East Bay Community Recovery Project /Project Pride

- Domestic Violence Prevention: Alameda County Family Justice Center (including County law enforcement agencies, Bay Area Legal Aid, Bay Area Women Against Rape, Family Violence Law Center)
- Child Maltreatment Prevention: Alameda County Social Services, Alameda County Child Abuse Prevention Council, Oakland Children's Services, City of Oakland Head Start, Center for Child Protection-Children's Hospital Oakland, CALICO Center
- Child Welfare: Alameda County Social Services, Child Protective Services, CASA
- Education: City of Oakland and Unity Council Head Start, Oakland Unified School District, Peralta Community College District
- Other Social and Health Services: Alameda County Community Food Bank, Alameda County Homeless Action Center, Bay Area Immigrant & Refugee Services, Bay Area Legal Aid, Building Futures With Women & Children, Catholic Charities, East Oakland Community Project , Seneca Center, Spectrum Community Services, West Coast Children's Clinic

Referral Resources Needed to Support Families Residing in the Communities

In individual interviews with the administrators of existing home visiting programs in Alameda County, providers all identified the need for increased services capacity. In some form, providers 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.

Other identified needs include:

- Increased coordination of service systems
- Housing supports
- Job training and employment services
- Financial supports
- Child care services
- Early childhood programming
- Education opportunities and supports
- Substance abuse and mental health services
- Translation services
- Transportation
- Support with health insurance enrollment
- Support navigating the social service and health care system

Plan for Coordination Among Existing Programs and Integration into an Early Childhood System

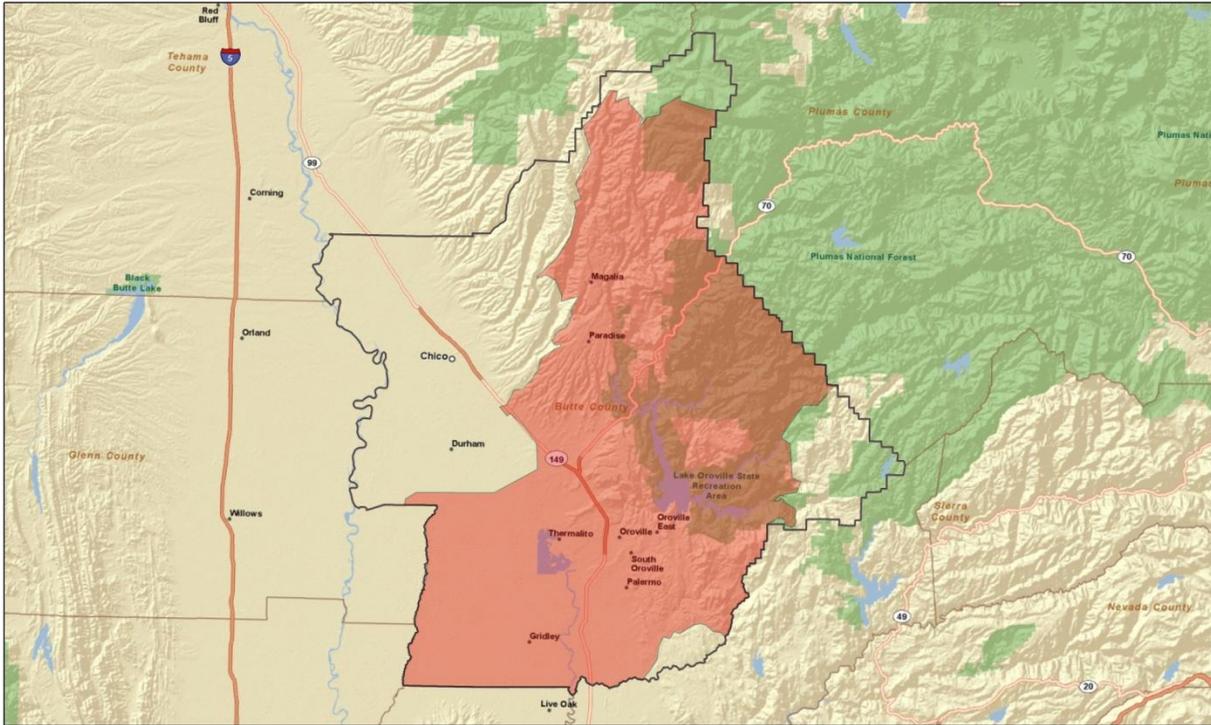
Alameda County has a strong focus on systems building for early childhood services. First 5 in collaboration with the ACPHD and other county agencies have worked closely together over the past 10 years to create integrated systems for young children and their families. Many of the home visiting and other programs are using EC Change.

These systems building efforts are currently merging with a larger county effort called the 0-8 Convergence Initiative, a multi-disciplinary think-tank composed of decision-makers from county-wide coalitions and programs addressing children's health and well-being. It aims to streamline and improve services for children aged 0-8, and their families, through cross-departmental planning and governance that builds on existing initiatives and services. The goal is to make sure that all services are continuous for children – particularly those with special needs – from birth to third grade, and that services are connected across the spectrum: from health to mental health to developmental services to education. One area of focus for the group has been to ensure that families can easily transition between home visiting and early childhood programs. Through this effort, the county will be developing common outcomes across service systems and implementing an outcomes-based Children's Budget providing the ability to track investments in early childhood over time.

The Interagency Children's Policy Council (ICPC) has been charged with improving outcomes for Alameda County's vulnerable children and families by fostering cross-departmental collaboration. The ICPC is composed of a broad range of county decision-makers and community stakeholders, all of whom are united around the cause of ensuring the availability and effectiveness of children's services in Alameda County. Alameda County proposes to convene an ICPC subcommittee as the new home visiting program's community advisory board.

Butte (Paradise Ridge/ Southern Butte)

The identified at-risk community area for Butte County includes zip codes 95914; 95916; 95917; 95930; 95940; 95948; 95965; 95966; 95966; 95968; and 95974; 95969; and 95954.



Characteristics and Needs of Participants and Community Risk Factors

Butte County was ranked sixth out of 58 counties for “Percentage of Residents of All Ages Living in Poverty” in the California Home Visiting Statewide Needs Assessment, placing Butte in the > 90th percentile for poverty. Review of the hot spot analysis, the communities of Paradise and Magalia indicate they are high in poverty, while the Southern Butte County area is high to very high in concentration of families living in poverty.

Butte also ranks between the 75th and 89th percentile for the indicator for child maltreatment. Butte County’s rate of substantiated cases of child maltreatment for 2009 was 17.0 per 1,000 children. This rate is significantly higher than California’s rate of 9.1. Additionally, Butte County ranked 4th with a rate of 13.1 for Children Ages 0-17 in Child Welfare Supervised Foster Care per 1,000 children, as opposed to the state rate of 6.0 per 1,000 children.

The Butte County profile ranks Butte at >90th percentile for illicit drug use, 75th-89th percentile for binge alcohol use and non-medical pain reliever use, and 50th-74th for Marijuana use.

Butte County women under age 25 giving birth, 32.3% received less than adequate prenatal care, based on the Kessner Prenatal Care Index. The Butte County Profile ranks Butte at the 75th to 89th percentile for children with special needs. Butte County ranked 11th out of 58 counties with a rate of 12.4% compared to the state's 10.4%.

Community Strengths

Butte County has the following community and social services to serve the community:

- Feather River Hospital (FRH) operates the “Healthy Mothers Program.” Healthy Mothers (HM) is the CPSP program with a case management approach to prenatal services, and a high success rate of enrollment with Medi-Cal mothers.
- Youth For Change, a community non-profit, offers a wide variety of programs and resources to The Ridge community, including counseling, family reunification services, group home services, Parent Child Interaction Therapy, and the Paradise Ridge Family Resource Center.
- The Boys and Girls Club of Butte County operates afterschool programs at the elementary schools and a Teen Center in downtown Paradise.
- The Ridge faith community actively reaches out to families and provides free meals and other ongoing and as-needed assistance.
- Care Net is a non-profit community program that provides support and assistance to young pregnant mothers that can earn education credit in the store to purchase baby and maternity items.
- Public Health provides the Targeted Case Management program county-wide.
- The Greater Oroville Family Resource Center offers programs, classes and groups for teens, adults and seniors; and partners with Oroville Hospital to provide health education regarding diabetes, stroke, Parkinson's disease and grief.
- The South Oroville Community Center hosts the Boys and Girls club of the North Valley for afterschool programming.

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

The comprehensive assessment and identification of target participants include establishing an MOU to detail the partnership and collaborative efforts of BBS and Healthy Mothers who come from parenting classes and CPSP services. BBS will work closely with the OB/GYNs and midwives in the community to ensure they are referring partners. Relationships with these providers have already been established through other programs and services provided by the BBS parent agency. For post-natal families, referrals for screenings may come from Community partners, pediatricians offices, hospitals, and postnatal providers. BBS will continue to use the Parent Survey (Kempe) as a comprehensive and effective assessment tool which is the recognized standard of best practices by Healthy Families America.

Referral Resources Currently Available to Support Families Residing in the Communities

- **Health**: CHDP, CPSP, Family PACT, CMSP, Medi-Cal, Denti-Cal, Children's Mobile Dental Clinic, Perinatal Care Guidance Pregnancy Education Program, Better Babies, Healthy Mothers, Feather River Midwifery, Sweet Success, Feather River Hospital, Feather River Family Health Center, Oroville Hospital, Oroville Family Practice, Oroville Family Health, Oroville Family Dentistry, Feather River Tribal Health, Feather River Tribal Dental Clinic, OB physicians, Pediatric providers, California Children's Services.
- **Mental Health**: Group Counseling, Case Management for chronically mentally ill, medication support, Crisis Support Unit, Mobile Crisis Team, Youth for Change Play Therapy and Parent Child Interactive Therapy, Feather River Behavioral Health outpatient counseling services.
- **Early Childhood Development**: E Center Head Start, Butte County Office of Education Child Development, Parents as Teachers, Palermo Children's Center, Palermo Preschool, state and private preschools, First Five School Readiness programs, Childcare Resource and Referral, Valley Oak Children's Services, Ridgeway Continuation High School, Prospect High School, Early Intervention Program - Far Northern Regional Center.
- **Substance Abuse**: Alcohol and Drug Recovery and Relapse Prevention services, Stepping Stones Perinatal Program, Drug Court, Esther's Hope, Salvation Army Adult Rehabilitation Center, Aegis Medical Systems, Alcoholics Anonymous, Butte County Behavioral Health, BCBH Cal Works, Cherokee Restoration Fellowship, Feather River Tribal Health, Second Step, Skyway House, Tri County Treatment Center.
- **Domestic Violence Prevention**: Catalyst Domestic Violence Services- Safe Housing, Drop In Center, Legal Advocacy Services, Counseling and 24 hour hotline; Rape Crisis; Victim Witness.
- **Child Maltreatment Prevention**: Child Abuse Prevention Council, Youth for Change, Butte County Public Health Department Targeted Case Management, Parents as Teachers, Parenting Classes, Butte County Behavioral Health, Nurturing Parents, Adolescent Family Life Program, Cal Learn, WIC, Children's Services Division, Parent reunification programs.
- **Child Welfare**: Children's Services Division, Foster Care, Foster Care Training, Options for Recovery, Foster Care Public Health Nurses, Independent Living Services, Parenting classes and programs, Nurturing Parenting program.
- **Education**: Oroville Elementary School District, Thermalito Union School District, Butte County Office of Education, Paradise Unified School District, Oroville Adult Education, Butte Junior College, GED Preparation Classes, Work Training Center.
- **Other Social and Health Services**: HOPE Center, Salvation Army, Rescue Mission, Family Preservation and Support Program, Family Paradise Network, Children's Services Coordinating Council, Paradise Family Resource Center, Greater Oroville

Resource Center, Southside Resource Center, Community Health Alliance of Oroville.

Referral Resources Needed to Support Families Residing in the Communities

Unmet mental health needs of pregnant and postpartum women: The unmet needs include both lack of referral sources for women experiencing depression and other mental health conditions as well as a lack of mental health professionals who can adequately treat women during pregnancy. There is a need to establish a system of continuing education to support both mental health and medical providers.

Lack of substance abuse treatment options: Detox, inpatient and outpatient services are desperately needed, as well as substance abuse counseling and support. Additional training opportunities for medical, mental health and social services providers are also a priority.

Ineffective education/outreach efforts: Inclusion of media outreach campaigns such as Text4Baby would provide an additional education point for pregnant and new mothers.

Inadequate perinatal programs: The current perinatal services are not comprehensive enough to adequately meet the needs of many women in the county. The Gridley community desperately needs Ob/Gyn resources because currently there are none. Gridley and Oroville both need resources for Spanish and Hmong speaking families. Gridley and Oroville would also benefit from increased perinatal educational and support opportunities.

Plan for Coordination Among Existing Programs and Integration into an Early Childhood System

Butte County Public Health (BCPH) Department is the lead agency for the Perinatal Council (PNC) which is dedicated to improving maternal health and birth outcomes. The PNC includes members from all three birth hospitals, a local pediatric clinic as well as multiple agencies including our local AFLP affiliate, Butte Baby Steps, State Adoptions, the FAS Diagnostic Center, local midwives, Department of Social Services and Behavioral Health Department.

BCPH actively participates in the Child Abuse Prevention Council, the Children's Services Coordinating Council, Strong Starts Infant/Child Mental Health Collaborative and is a member of the Healthy Families America/Butte Baby Steps Advisory Committee. These groups have representation from a broad spectrum of child health, child care and mental health services which make them the ideal setting to discuss issues related to child health, safety and service needs. BCPH's Director of Public Health and Health Officer are members of the Butte County First 5 Commission. The commissioners represent a broad array of services within Butte County including Department of Social Services, a local CBO, Chico State University, a local school district, Childcare Resource and Referral agency and parents of young children/recipients of services.

Contra Costa (East/ West/ Central)

The designated area for this At-Risk Community in Contra Costa includes zip codes: 94801 and 94804 (Richmond), 94806 (San Pablo), 94520 (Concord), 94565 (Pittsburg and Bay Point), 94509 (Antioch), 94561 (Oakley), and 94513 (Brentwood). The eight key ZIP codes represent 40.3% of Contra Costa's population. Contra Costa County has the ninth largest population of all California counties, with an estimated population of 1,042,804 (2007),⁸ an increase of 9.9% since 2000.⁹ In 2007, people of color comprised 43.3% of the county's population.⁸



Characteristics and Needs of Participants and Community Risk Factors

Although Contra Costa County's overall teen birth rate is 23.5 per 1,000, the teen birth rate is significantly higher in five communities: San Pablo (67.4 per 1,000), Bay Point (60.2 per 1,000), Richmond (54.0 per 1,000), Pittsburg (47.2 per 1,000) and Antioch (39.0 per 1,000). There are disproportionate rates among Hispanic (49.7 per 1,000) and Black (43.6 per 1,000) teens which together accounted for 75% of teen births. From 2006-2008, San Pablo (84.5 per 1,000), Richmond (56.5 per 1,000), and Pittsburg (43.9 per 1,000) had teen birth rates that were significantly higher than the county rate, and accounted for 43% of all teen births.

⁸ State of California, Department of Finance. Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento (CA); July 2007.

⁹ 2000 U.S. Census

Pregnant women residing in Bay Point (76.3 per 100 live births), Pittsburg (79.1 per 100 live births), Antioch (82.4 per 100 live births) and Concord (80.5 per 100 live births) had lower rates of first trimester prenatal care than the county overall (86.1 per 100 live births). African American (81.4 per 100 live births) and Hispanic women (80.3 per 100 live births) had lower rates of early prenatal care compared to women in the county overall.

African American women had the highest rate of low birth weight (LBW) infants (12.4 per 100 live births); a rate nearly two-fold greater than the overall County rate (6.7 per 100 live births). African American mothers had the highest rates of LBW in San Pablo (15.2 per 100 live births), Richmond (14.4 per 100 live births), Pittsburg (12.8 per 100 live births), Concord (12.3 per 100 live births), and Antioch (11.4 per 100 live births). Communities with the most LBW infants were Richmond (382), Concord (321), Antioch (315) and Pittsburg (239).

African Americans had the highest rate of fetal deaths (11.9 per 1,000 live births and fetal deaths), which was almost two-fold higher than the County rate (5.7 per 1,000 live births and fetal deaths) and higher than any other racial/ethnic group listed.

Illicit drug use is estimated for Contra Costa County at approximately 71,000 users. Substance-abuse treatment admissions suggest that methamphetamine use may be high, with alcohol as the second most common reason for admission, followed by marijuana.

Concord had the highest number of arrests for domestic violence (1893), followed by Antioch (1476). The cities of Antioch, Concord, and Oakley had significantly higher rates of domestic violence arrests than the county overall.

Community Strengths

Contra Costa has many services and organizations available to serve the community including:

- The Contra Costa Health Services (CCHS) integrated health care delivery system; full-scope medical clinics; and prenatal care at Planned Parenthood.
- The Contra Costa Food Bank
- The First 5 Contra Costa Family Resource Centers
- The Bay Point Career Center, EASTBAY Works One-Stop career centers, and City of Richmond One-Stop career center
- Brighter Beginnings, a local non-profit organization, operates the Adolescent Family Life Program (AFLP) services and Black Infant Health (BIH) contracts.
- English as a Second Language classes at adult education programs and childcare programs at high school sites

- The Life Course Initiative, including the Building Economic Security Today (BEST) project
- Bridges to Care gives health care providers practical tools to engage alcohol-using pregnant women in prenatal care.
- Lift Every Voice for pregnant women and teens in County detention facilities
- Photovoice to engage community members in assessing the community's health needs
- Mobile School-Based Health Clinics
- Families Thrive, a partnership of Contra Costa County's Zero Tolerance for Domestic Violence systems change initiative
- Building Blocks for Kids, a partnership of more than 30 agencies in West Contra Costa County to support the healthy development and education of all children and self-sufficiency of all families by engaging the community, block by block.

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

The primary strategy will be to develop referral plans and MOUs with prenatal provider networks to identify eligible pregnant women. This plan will include establishing referral relationships with community agencies, and participating in CCHS's Healthy Start Case Conference Sessions.

Staff will develop a presentation package about the program, and identify a list of agencies and programs in the community and arrange times to provide a program overview. Agencies will be provided with referral information to provide to eligible pregnant women.

Contra Costa's new program will be a part of the CCHS system and will take full advantage of the many services that are part of this system, including: Healthy Start Prenatal Clinics; the Contra Costa Regional Medical Center; the Contra Costa Health Plan; WIC; Mental Health; Alcohol and Other Drug Services; Homeless Programs; and Public Health Clinic Services. The new program will work closely with the Comprehensive Perinatal Services Program (CPSP).

Medically Vulnerable Infant Program (MVIP) and Public Health Clinic Services (PHCS) are additional programs under CCHS that provide nurse home visitation. MVIP and PHCS receive more referrals than they have the capacity to serve. Currently, MVIP and PHCS have processes in place for referral coordination.

Referral Resources Currently Available to Support Families Residing in the Communities

Referral resources currently available in Contra Costa County include the following (by domain):

- Health: Healthy Start Prenatal Clinics; Contra Costa Regional Medical Center; Health Care for the Homeless; Immunization Program; Child Health and Disability Prevention Program; California Children’s Services; Children’s Oral Health Program; Public Health Clinic Services; Medically Vulnerable infant Program; Contra Costa Health Plan; Healthy and Active Before 5; Prenatal Care Guidance; WIC; Public Health Homeless Programs; Peer Counselor Breastfeeding Support Program; Lift Every Voice; Life Course Initiative; Building Economic Security Today (BEST); Brookside Community Health Center; Planned Parenthood Shasta Pacific; La Clínica de la Raza; Alta Bates Medical Center; Children’s Hospital Oakland; John Muir Health’s Ronald McDonald Care Mobile; Kaiser Permanente; dental providers; Contra Costa Dental Society; Brighter Beginnings Adolescent and Family Life Program and the Black Infant Health Program
- Mental Health: Depression to Wellness Network; Adult and Children’s Mental Health; Contra Costa Crisis Center; Early Childhood Mental Health Program; Lynn Center; We Care
- Early Childhood Development: Head Start and Early Head Start; First 5 Centers; Building Blocks for Kids; Regional Center of the East Bay; Child Care Council
- Substance Abuse: Alcohol and Other Drugs Division; Born Free; Ujima Family Recovery Services; New Connections; Wollam House
- Domestic Violence Prevention: Richmond Police Department; Families Thrive; STAND Against Domestic Violence; West Contra Costa Family Justice Center; Latina Center
- Child Maltreatment Prevention: EHSD Path 1 Partner Programs; Child Abuse Prevention Council
- Child Welfare: Employment and Human Services Department (EHSD)
- Education: Los Medanos Community College; Contra Costa College; Contra Costa County Office of Education; School based clinics; Crossroads Continuation School; “Y” Team Teen parent Program
- Other Social and Health Services: Monument Community Partnership; Richmond and Bay Point Family Services Centers; Housing Authority; Great Richmond Interfaith Programs Homeless Service Center; Family Economic Security Partnership (FESP); Contra Costa Crisis Center; Hand to Hand – home visiting; Welcome Home Baby- home visiting; Through the Looking Glass; SparkPoint Centers in Richmond and Bay Point; Food Bank of Contra Costa and Solano County; Contra Costa Interfaith Coalition; Shelter Inc.; Bay Area Legal Aid; Civic Organizations; Familias Unidas; Community Financial Resources – staff

Referral Resources Needed to Support Families Residing in the Communities

There remains a need for broad and sustained efforts to create supportive systems that strengthen families. The following resources will ensure that families are supported in building on strengths and creating long term changes:

- A high quality accessible and culturally appropriate health care system that responds to the needs of the population
- A responsive child welfare system that includes families and supports as part of the solution
- Early childhood programs that support parent-child attachment and child development
- A mental health system that provides a broad spectrum of services
- A network of public and private community-based agencies that supports families
- Resources for teens
- Home visiting nursing support during pregnancy and early childhood

Plan for Coordination Among Existing Programs and Integration into an Early Childhood System

Two primary theoretical frameworks, the New Spectrum of Prevention and the Life Course Perspective have informed Contra Costa Family Maternal and Child Health (FMCH) Programs collaboration with other organizations and sectors.

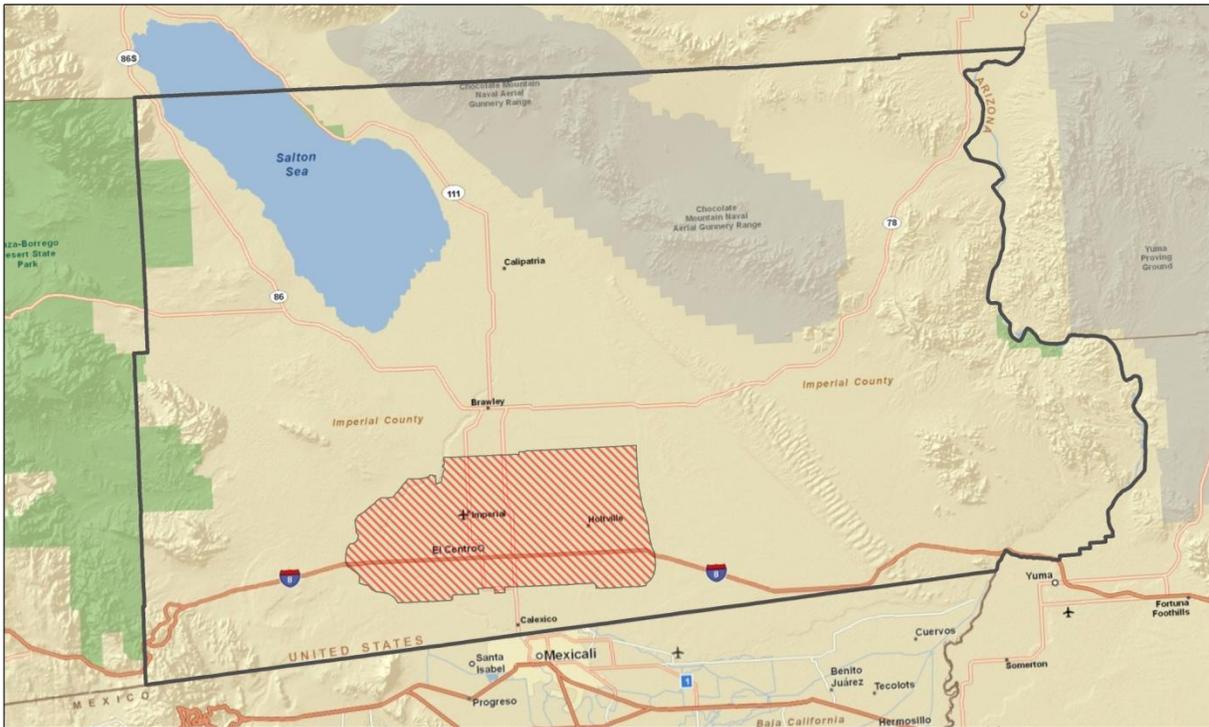
The eight interrelated bands of the New Spectrum of Prevention address multiple determinants of health and can be used to develop a comprehensive, coordinated approach to public health issues. These bands are: 1) Assuring access to quality health care, 2) Strengthening individual knowledge and skills, 3) Promoting community education, 4) Educating providers, 5) Fostering coalitions and networks, 6) Changing organizational practices, 7) Mobilizing neighborhoods and communities, and 8) Influencing policy and legislation. The fifth item in the framework, “Fostering coalitions and networks,” was the original foundation for FMCH Programs and CCHS work in collaboration with other organizations and sectors.

In 2005, FMCH Programs learned about the Life Course Perspective (which added a new layer onto the existing framework of the New Spectrum of Prevention. FMCH Programs Life Course Initiative, launched in 2005, is a 15-year initiative to reduce inequities in birth outcomes and change the health of the next generation in Contra Costa County. In 2008, FMCH Programs launched Building Economic Security Today (BEST), an asset development pilot project that utilizes innovative strategies to reduce inequities in health outcomes for this and future generations of low-income Contra Costa families by improving their financial security and stability. BEST addresses scientific evidence that wealth is the strongest determinant of health across the life course.

The innovative nature of the Life Course Initiative and BEST has led FMCH Programs into several new collaboratives outside traditional maternal and child health work, connecting with sectors other than public health and medicine.

Imperial (El Centro/ Imperial/ Holtville/ Seeley/ Heber)

The at-risk community selected for Imperial County is contained in the Medical Service Study Area (MSSA) made up of the incorporated cities of El Centro, Imperial, and Holtville, and unincorporated communities of Seeley and Heber.



Characteristics and Needs of Participants and Community Risk Factors

An estimated 1,500 to 2,999 families in the targeted high-risk community are living in poverty. This MSSA has a statistically higher percentage of families with children under age 5 living below 185% Federal Poverty Level compared to California overall and more families living in poverty than any other area in Imperial County. Unemployment rates ranged from 18.7% in the City of Imperial to 40.9% in Heber, among the highest in California. Imperial County also has a higher overall crime rate (3,769.0 per 100,000 population) than the statewide rate (3,319.9).

The communities in the targeted MSSA have significantly higher percentages of first-time mothers on Medi-Cal. The high-risk community is also impacted by high teen birth rates: El Centro, the largest city in the targeted MSSA, consistently reports among the highest number of teen births, including those to mothers under 15 years old, of all areas in Imperial County. In 2009, nearly 17% (147) of all births in El Centro were women under 20 years of age.

Other risk factors that could impact this population include Imperial County's high rate of women with short birth intervals (less than 24 months), compared to California as a

whole. In 2008, 14.4% of all births to women aged 15-44 had a previous birth less than two years before, a slightly higher percentage than the statewide median. Imperial County has one of the lowest rates of prenatal care initiation during the first trimester (59.7% compared to 82.4% statewide).

Imperial County has a higher rate of substantiated child maltreatment cases (9.9 per 1,000 children) than California as a whole (9.1 per 1,000 children). In 2008, Imperial County's Children and Family Services received 2,042 calls involving 5,370 children. This translated to 1,411 families requiring intervention for investigation of allegations of abuse and or neglect. The highest concentration of referrals was in El Centro (32%).

Community Strengths

Locally provided programs and services are well attended. There is a strong sense of community and connectedness between families, neighbors, schools, and other support systems. Seeley residents are benefitting from a recent major park renovation at Sunbeam Lake that now offers fishing, boating, and lighted playing fields for youth and families. Imperial has Market Days during summer and family events in the park that include movies, entertainment and other family-oriented activities. Holtville Athletic Club sponsors an annual Rib Cook-off that attracted 16,000 attendees in 2010. All money raised by the event supports youth activities and equipment. El Centro is building a new Community Center that will include an indoor pool, courts, and possibly a skate park, a refuge during the extreme summer heat. Other resources are offered through churches and faith-based organizations, social service organizations, Salvation Army, Food Bank, and community outreach efforts including community health workers or Promotores who are trained to provide linguistically and culturally appropriate education and assistance.

Among the resources available to address the needs of this population are the Imperial County Office of Education support programs, the County Departments of Social Services, Behavioral Health, and Public Health. The Public Health Department offers AFLP, Child Health and Disability Program, along with outreach and education that focuses on nutrition and obesity prevention, immunization, and pregnancy testing. The Department of Social Services funds Family Resource Centers for domestic violence referrals and counseling. Annual immunization clinics exceed attendance expectations every year. Behavioral Health Department's Nurturing Parenting Program planned for 200 children and families but exceeded enrollment with 256 families. The annual World's Largest Baby Shower was attended by 391 mothers, children, and support people.

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

Participant identification and screening will occur systematically and in concert with existing referral systems and local organizations such as community clinics and the MCAH advisory board. A strategy will be used to re-screen "screened out" participants. The HFA program staff will rescreen all families that were previously screened out. Participant recruiting plan includes development of a targeted media campaign using

flyers, billboards, PSAs, print/radio media, etc. Local agencies such as the Women Infants and Children Program, medical providers, Imperial County Office of Education, school campuses, Cal-SAFE programs, Family Resource Centers, and faith communities will be involved in advertisement of the program. In addition, MCAH Advisory Board will serve as a vehicle to help promote the HFA Program via agency meeting and provide a 5-10 minute presentation on the HFA program.

Referral Resources Currently Available to Support Families Residing in the Communities

- Health: Imperial County Public Health Department (ICPHD).
- Mental Health: The California Department of Mental Health's Prevention and Early Intervention.
- Early Childhood Development: three Child Development centers that are located in Imperial County.
- Substance Abuse: Imperial County Behavioral Health Services, Alcohol & Drug Programs (ICBHS-ADP).
- Domestic Violence Prevention: Centers for Families Solutions
- Child Maltreatment Prevention: The CAP Council offers Little /Giant STEPS, a parent education program.
- Child Welfare: Imperial County Children and Family Services.
- Education: Cal- Safe education programs.
- Other Social and Health Services: Pioneer Memorial Healthcare District - Diabetes Education and Support Group; El Centro Regional Medical Center Breastfeeding Support Group; Women, Infants and Children (WIC).

Referral Resources Needed to Support Families Residing in the Communities

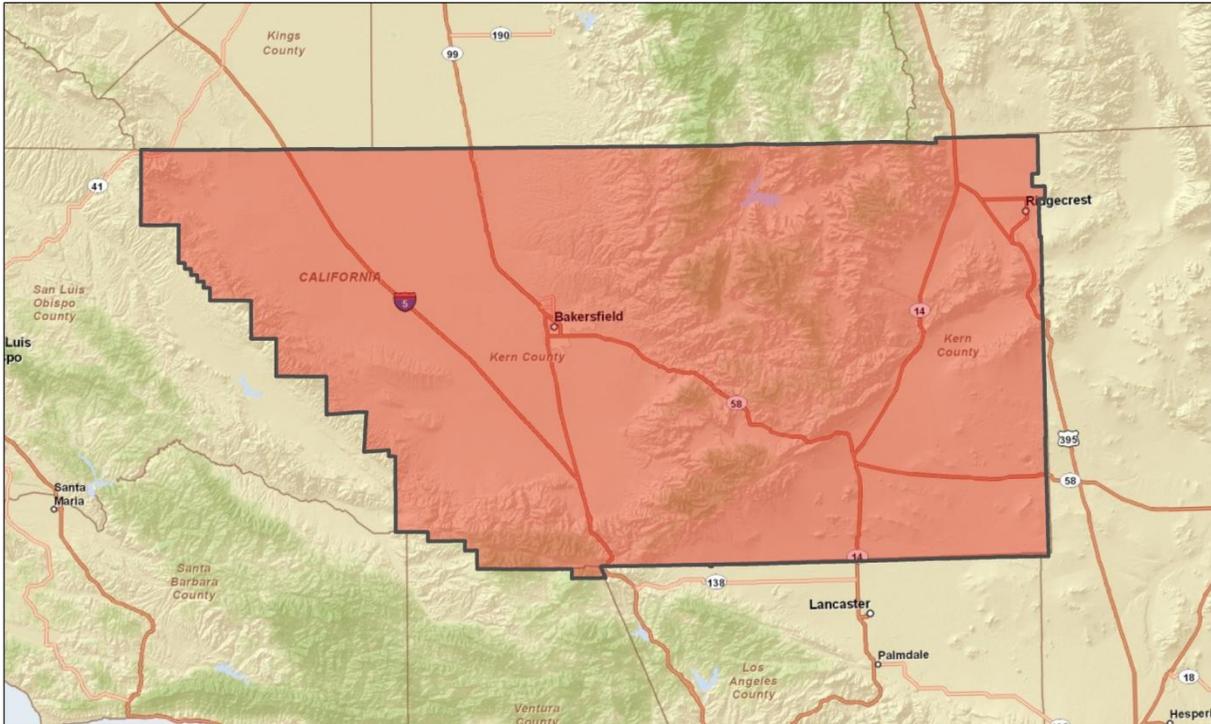
Resources that will be needed in the future include basic living skills, breastfeeding education, support, and referrals; understanding immunization schedules and when appropriate immunizations need to be administered; alternative and temporary shelter services, and/or hotel vouchers; monetary assistance for housing, clothing, baby supplies, transportation, utilities; assistance with Cal-Fresh (food assistance); access to medical providers for well child checks and the identification of medical homes to minimize unnecessary emergency room visits; creative options for parents (teens) to achieve their high school diploma; options to pursue higher education, specifically at a local level, and appropriate financial aid assistance; job placement, and interviewing skill development; additionally, resources that focus on supporting parent-child interaction, child development, and goal setting.

Plan for Coordination Among Existing Programs and Integration into an Early Childhood System

Imperial County continues to integrate the following local services and organizations to enhance the currently existing early childhood system: The Imperial County Children and Families First Commission (ICCFCC), the local First 5, The Riverside County Office of Education Migrant Head Start (MHS), The San Diego Regional Center (SDRC), California Children's Services (CCS), and The Imperial County Office of Education-Early Care and Education. Some collaborative effort projects between the local agencies include: California Early Start, a program that ensures eligible infants and toddlers and their families receive evaluation and assessment of current functioning and coordinated services early to make a difference in development. Imperial Valley Child Asthma Project; Healthy Children; Healthy Lives, an obesity prevention project; Parent Education and Enrichment Program; and Imperial County Immunization Coalition. Other notable local coalitions that were established based on multi-agency collaborative efforts aim to enable low-income individuals and families (with emphasis on those with children aged 0-5) to adopt healthy eating and physical activity patterns as part of a healthy lifestyle, to control tobacco use, raise awareness and change policies and practices to reduce the burden of asthma in Imperial County, and develop multi-disciplinary prevention, intervention, and treatment services to improve breastfeeding initiation and community acceptance.

Kern (Countywide)

The designated high risk population is first time, low income, high risk pregnant women and their children from birth to age 2 and their families countywide.



Characteristics and Needs of Participants and Risk Factors

Kern County is geographically the 3rd largest county and encompasses valley, mountain, and desert regions. The county's demographics are changing and the Hispanic/Latino population is growing faster than other segments of the population. According to the California Census Data, in 2009, the Hispanic population in Bakersfield was 139,406 (43.0%) in comparison to 132,712 White (40.9%) and 25,997 African American (8.0%).

The U.S. Census American Community Survey ranked Kern County 20th out of counties across the United States in overall poverty levels over a 12-month period. During 2008, the Census Bureau reported Kern County's median income for families with children was \$43,183, a decrease of \$1,286 from the previous year and well below California's average of \$64,155 and national average of \$60,944. According to the 2008 American Community Survey, 27 percent of Kern County children (63,718) lived in families with incomes below the federal poverty level. The percentage of births paid for by Medi-Cal ranged from 46.6% in Western Kern to as high as 82.7% in Southern Kern.

Kern County had the 38th worst unemployment rate among the state's 58 counties. Kern County's unemployment rate jumped from 9.8 percent in 2008 to 14.4 percent in

2009. From December 2009 to January 2011, 9,400 farm jobs vanished (Bakersfield Californian, 2011).

Community Strengths

Kern County has many programs, resources and organizations available to service the community including:

- A spectrum of MCAH programs such as the Perinatal Outreach Program and the Black Infant Health (BIH) Program.
- The MCAH Resource Manual provides a list of phone numbers and addresses for various community resources such as Parenting Classes, Dental, Family Planning, and medical providers and is available online.
- The Greater Bakersfield Legal Assistance Incorporated (GBLA) offers free legal services in civil matters to eligible low-income persons residing in Kern County.
- The 2-1-1 Kern County provides comprehensive information and referrals to services such as food, transportation, rent/financial aid, utility assistance, child care and clothing, 24 hours a day, seven days a week.
- The Search and Serve provides services to children with a disability that has the potential to adversely impact the child's ability to learn. Services are provided from birth to age 21 at no cost to the family.
- The Alliance Against Family Violence and Sexual Assault's 24-hour hotline and other program and support services.

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

The recruitment strategy will involve a combination of outreach activities focused on referrals from other providers/agencies, staff outreach such as participation at community health fairs and other events, and self-referral.

The home visiting program team will continue to promote the program to various collaboratives, community agencies, and medical providers by conducting presentations and sharing success stories and healthy delivery outcomes. Through outreach efforts, Kern expects to receive referrals from a number of agencies including: Health and Human Services, WIC, Community Based Organizations (e.g., Clinica Sierra Vista, National Health Services Inc., and Community Action Partnership of Kern), and various medical providers and hospitals. In addition, a strategy will be developed to receive referrals from community partners that are not yet referral sources such as Family Resource Centers, high schools and colleges.

Participants who meet the eligibility criteria will be contacted by a Public Health Aide who is responsible for informing the potential participants about the program. If the potential participant is interested in the program and meets the eligibility criteria, then the referral will be given to the PHNs. The PHN will then contact the potential

participants and utilize the Public Health Nursing Acuity Scale tool. Because there is currently a waiting list in the NFP program, PHNs will use the scale to determine acuity levels (low, moderate or intensive) of the potential participants.

Referral Resources Currently Available to Support Families Residing in the Communities

- Health: Kern County Public Health Services Department (MCAH, California Children's Services, Immunization, CHDP), Community Based Organization (Clinica Sierra Vista, National Health Services Inc. and Community Action Partnership of Kern), Comprehensive Perinatal Services Program Providers, medical/private providers and county and private hospitals, Breastfeeding Coalition, Children's Health Initiative
- Mental Health: Kern County Mental Health Adults System and Children System, Drug and Alcohol Administration, Kern County Mental Health Crisis Unit, Clinica Sierra Vista, National Health Services and Ebony Counseling Center, H.W. Child Guidance Clinic
- Early Childhood Development: Kern County Superintendent Of Schools (KCSOS), Children Assessment Center, Henrietta Weills, Child Guidance Clinic Kern Regional Center, Kern Early Head Start Coalition, Kern Regional Center Early Start, Kern SELPA, Coordinating Council for Child Care
- Substance Abuse: Drug Residential Homes, Kern County Mental Health System, Mental Health Adult System and Children System, Turning Point Rehab Services
- Domestic Violence Prevention: Alliance Against Domestic Violence, Law Enforcement, Adult Protective Service
- Child Maltreatment Prevention: Haven Counseling, Kern Child Abuse Prevention Council, Kern County Department of Human Services--Voluntary Maintenance, Family Maintenance and Differential Response, Kern County Network for Children, Child Death Review Team, Kern County Juvenile Probation
- Child Welfare: Kern County Department of Human Services (Child Protective Service, Foster Care Program, Public Health Unit), Medically Vulnerable Infant Program
- Education: KCSOS, Bakersfield City School District, Kern High School District, SELPA, Bakersfield Adult School, County-wide rural school districts, Community Connection for Child Care
- Other Social and Health Services: Kern County Child Support, Kern County Network for Children, Medi-Cal Managed Care (Health Net and Kern Family Health Care), Adolescent Family Life Program

Referral Resources Needed to Support Families Residing in the Communities

In Kern County, 25 CPSP sites are using Dr. Chasnoff's 4 P's Plus to screen pregnant women in their prenatal providers' offices, educate them about the dangers of alcohol,

tobacco and drugs during pregnancy, and to link them to community resources and treatment services when appropriate. However, it was noted that while women were provided information about the risks of prenatal substance use, there were very limited resources to access in their community if one needed them. Similarly, by utilizing the Edinberg Depression Scale, MCAH staff is screening more women suffering postpartum depression. And while a referral to Kern County Mental Health Crisis Unit, Clinica Sierra Vista or National Health is provided to the mothers, it is up to the mother to follow-up on that referral.

Thus, as Kern County increases its screening efforts for postpartum depression and prenatal substance use, stronger links to and availability of mental health and substance abuse services will be needed to ensure that women receive the support they need.

Plan for Coordination Among Existing Programs and Integration into an Early Childhood System

All PHNs including the Supervisor are assigned to attend all existing community collaboratives. By attending collaboratives in various community areas such as East Bakersfield Collaborative, Southeast Neighborhood Partnership, 34th Street Neighborhood Partnership, Oildale Community Collaboratives and the many rural county Family Resource Centers, it enables the PHNs to be aware of community resources available in the area, how families can engage in community activities, and how community agencies work together to make Kern County a safe and nurturing environment for children and families.

Kern MCAH program will continue to collaborate with early childhood development organizations such as Kern Child Abuse Prevention Council, Superintendent of Schools and Kern Early Start Advisory Committee (Caring Corner, Darlyn's Darlings: Child Care for Children with Special Medical Needs).

Finally, the Kern County Nurse Family Partnership Advisory Committee brings together community partners to promote program quality and sustainability, provide a support system to the program, and recommend new prevention strategies. The members include Kern County Network for Children, law enforcement, medical providers, private attorneys and Kern managed care organizations (Health Net and Kern Family Health Care). The NFP Advisory Board will continue to grow and extend its membership to other agencies.

Los Angeles Service Planning Areas or LA-SPA [SPA 2 (San Fernando Valley); SPA 3 (San Gabriel Valley); SPA 7 (East L.A.)]

The designated area for this At-Risk Community in Los Angeles is Service Planning Areas (SPAs) 2, 3 and 7. SPA 2 includes the San Fernando Valley, SPA 3 consists of the San Gabriel Valley, and SPA 7 is the East Los Angeles area. Together SPAs 2, 3, and 7 account for over 36,000 births each year to women who are pregnant for the first time and living in poverty.



Characteristics and Needs of Participants and Community Risk Factors

SPA 2 has a population of 559,233. Located in the northwest section of Los Angeles, the population is noted for their high crime areas, high poverty (16% of children live below the FPL) and large numbers of undocumented Hispanics. SPA 2 had 28,229 live births in 2008 of which 48% (13,471) were to first-time mothers receiving prenatal care that was Medi-Cal funded. There were 135 infant deaths. In this area of Los Angeles, adult residents were two times less likely to hold a high school diploma compared to the rest of the County. SPA 2 recorded 1,0001 homeless children in 2008.

SPA 3 is located in the Pomona and San Gabriel Valleys and is one of the largest service planning areas, home to 29 cities, 32 separate school districts and a population of great diversity. SPA 3 had 24,927 live births of which 46% (11,448) were to first-time mothers on Medi-Cal funded prenatal care. There were 142 infant deaths. Nearly ninety percent of residents age 5 years or older speak a language other than English at home; and over one-quarter of the population is children and youth under age 17 years old.

SPA 7 is a mosaic of 21 independent cities and five unincorporated areas east of the Los Angeles River and city limits. Its southeastern communities border Orange County. This area has pervasive poverty, high crime rates, numerous gangs and large number of children in foster care; its' resources are very limited. In this area, 126 homicides were reported in 2006, 21 committed by children 10-17 years old. SPA 7 recorded the highest number of felony arrests for children 1-17 (2,722) of all the designated SPAs. Over 21% of the children live below the FPL. SPA 7 had 20,834 live births of which 57% (11,900) were to first-time mothers using Medi-Cal funded prenatal care. The rate of low birth weight births is 68.8 per 1,000 births and there were 104 infant deaths. Latinos represent the majority of children and Asians are the largest racial/ethnic group in many SPA 7 cities.

Using 2007 data--the most current available--California ranks 41st in the nation with a high school graduation rate of only 62.7%, dropping 10% lower than the 2002 level of 71.3%. The high school graduation rate in SPA 2 is 55.9%, SPA 3 is 76.% and 61.4% in SPA 7.

SPAs 2, 3, and 7 have pockets of high crime areas where many pregnant youth are living. During the last five years, there were over 23,000 verified violent gang crimes in the City of Los Angeles, including 784 homicides, nearly 12,000 felony assaults, approximately 10,000 robberies and just under 500 rapes. In 2008, SPA 2 recorded 5776 misdemeanor arrests of 10-17 year olds, 4052 in SPA 3, and 3098 in SPA 7; felony arrests were 2690 in SPA 2, 2617 in SPA 3, and 2722 in SPA 7.

As of February 2011 data from the Los Angeles County Department of Children and Family Services (DCFS), there were 34,225 children receiving protective services, and 18,889 were in out-of-home/ foster placement. It is estimated that of the 7,773 children ages 8-18 years old who are in protective out-of-home care (as of February 2011), over 900 are at the highest risk of pregnancy in Los Angeles each year.

Community Strengths

Recent efforts to bring family resource centers into SPA 2 have been successful, especially in building a local job market; still, the needs for pregnant youth far outweigh available resources. SPA 2 is a proud community and has developed several local community centers, some with County-level support and participation. The SPA also contains resources from Los Angeles Universal Preschool providing a high number of licensed child care seats. The Valley College opened a family resource center and has a variety of programs designed to build the early care workforce and support families with children under age three.

The Edelman's Children's Court is located in SPA 3 and represents the first children's court in the nation designed and dedicated to the health and welfare of abused and neglected children and their families. Strengths of SPA 3 include the Los Angeles City's recent "Gang Reduction Program" that brought community resources (e.g., individuals, agencies, and county/city departments) together to address the large number of Homeboy Industries, Inc., the gang diversion program run by Father Greg Boyle is

located in SPA 4 but serves the entire County. An existing NFP program works with several community programs, such as the Promotora programs run by the Citrus Valley Health Care Partners, and collaborates with the Pasadena Health Department and their BIH program; participation in the WIC program is higher than elsewhere in Los Angeles.

SPA 7 is a very vocal community and advocates voraciously for equal services and their fair share of public health, medical and police support. Los Angeles budget cuts have removed many governmental services from this area, and the community is eager to receive any support in dealing with their community needs and helping them achieve better neighborhoods. An existing NFP program is working closely with many County and private agencies in this SPA, such as St. John's Well Child and Family Center and the County Department of Public Health's newly developing Health Clinic that will serve this area.

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

The new Home Visiting program will outreach to the higher risk pregnant youth, such as those in foster care, on probation, or battling mental disease. Outreach efforts will utilize an existing community screening/referral tool that clearly indicates who should and should not be referred. This tool also assists staff to make referrals to other programs when client's cannot be accepted. The referral can be electronically sent or faxed to program headquarters, and each referring party is given a summary of the status and outcome of their referral. As of this date, there is no centralized mechanism to coordinate referrals of high risk families to the program or other home visiting agencies.

Referral Resources Currently Available to Support Families Residing in the Communities

- Health: Communication pathways are currently open between the county prenatal clinics, community health centers, FQHCs, and several other private hospital providers. In addition, the new program will share headquarters office space with the Department of Public Health's Comprehensive Perinatal Services Program (CPSP) that provides instant linkages to individual prenatal providers.
- Mental Health: The existing NFP-LA program has a MOU with the Department of Mental Health that allows the Nurses to utilize their System Navigators to access contracted mental health agencies within L.A. for NFP clients. NFP-LA has excellent relationships with the LAUSD school based mental health services and peer support groups that can be accessed without difficulty.
- Early Childhood Development: The existing NFP-LA program has established connections to the Early Head Start (EHS) programs and their coordinator who assist NFP clients in utilizing these services that vary across the SPAs. In addition, the NFP-LA Administrator participates as Co-Chair of the Early Identification & Intervention (EII) Collaborative. The EII has senior level managers AND field staff from Regional Centers, Early Head Start, child care providers and schools who

participate in meetings directed toward strengthening child development services and assessments throughout Los Angeles. The EII provides a quick, high-level access into other systems that can help with developmental issues.

- Substance Abuse: Substance Abuse Prevention and Control contracted agencies are accessed through internal channels via the Department of Public Health.
- Domestic Violence Prevention: The Los Angeles County USC Medical Center Violence Intervention Program (VIP) is used for difficult cases for determination of abuse and intervention.
- Child Maltreatment Prevention: NFP-LA has worked closely with both the DCFS Prevention Initiative Demonstration Project (PIDP) that supports families at risk of child abuse, and the First 5 Partnership for Families (PFF) that also attempts to strengthen families to prevent entry or re-entry of children into protective services. NFP-LA has also gained the support of the Los Angeles Commission for Children and Families that is facilitating access to high risk foster children and TAY youth who are pregnant.
- Child Welfare: NFP-LA has partnered with several other agencies serving the residents of SPAs 2, 3 & 7. The Friends of the Family Resource Center in SPA 2 works with families to improve their economic conditions and improve parenting techniques. Linkages to Early Head Start services exist in all of the designated SPAs. NFP-LA also works closely with the Family First Project in SPA 3, a reunification program.
- Education: NFP-LA has an ongoing agreement to supervise and oversee the one NFP nurse currently employed by and working within the LA Unified School District (LAUSD). This effort has helped to establish sound NFP linkages to helpful resources within the largest school district in Los Angeles. In addition, NFP is in the process of building linkages to the LA County Office of Education and their many Early Head Start and Head Start Programs.
- Other Social and Health Services: NFP-LA coordinates with several other community support agencies based upon the geographical areas served. For example, in SPA 2, NFP has linkages to LABBN's Best Baby Collaborative. In all the SPAs, NFP has linked with several WIC centers for referral resources. In SPAs 3 & 7, the members of the Gang Reduction Program provide a source of social support for gang involved youth living in and around these SPAs.

Referral Resources Needed to Support Families Residing in the Communities

In all of the designated communities, employment for those who are unemployed is most needed. NFP-LA has been fully involved and participatory in building the new Magnolia Place in SPA 4 that offers employment referrals, day care, medical services and space for classes and peer support groups, and will work toward building similar resources in all County communities. SPA 2 has recently established their own Resource Center that assists residents with health and social issues and employment opportunities for their residents.

Plan for Coordination Among Existing Programs and Integration into an Early Childhood System

Los Angeles County has numerous efforts underway that coordinate across existing programs and resources; these include:

- **Prevention Initiative Demonstration Project (PIDP):** Builds on existing community capacity to address the full spectrum of child abuse prevention. PIDP was designed to fill gaps in local family support and service delivery systems by highlighting social connections and economic opportunities for families and encouraging partnerships with existing services to increase access to community services and resources. PIDP builds relationships between leaders of DCFS Regional Offices and leaders of public and community-based networks serving families and children by encouraging joint planning to fill local gaps in services, joint problem solving and ongoing communication.
- **Linkages:** A statewide initiative currently sponsored by the Child & Family Policy Institute of California with the goal of effectively integrating CalWORKs and Child Welfare Services. Linkages is designed to address common barriers that limit parents ability to parent and their ability to work from a prevention and intervention perspective.
- **Magnolia Place Network:** The mission is to unite the county, city, and community to strengthen individual, family, and neighborhood protective factors by increasing social connectedness, community mobilization, and access to needed supports and services. The Network consists of approximately 70 organizations.
- **Children’s Council of Los Angeles County:** A community-based nonprofit organization that works as a broker and champion for children, youth, and families. The Council is now focusing on establishing a regional network of neighborhood groups with selected “Best Start LA” communities.
- **LA Partnership for Early Childhood Investment:** A collaborative of over 35 members including some of the country’s largest private foundations, a number of family foundations, and leading private- and public-sector funders of early childhood development issues, programs, and services. The Partnership supports and promotes the lifelong health and wellbeing of children, aged prenatal to 5. It is currently focusing its efforts on supporting Strengthening Families initiatives
- **First 5 LA:** The forthcoming transition from initiative-based grant making to a place-based approach will be implemented through the two primary mechanisms of Family Strengthening and Community Capacity Building but will also include a countywide approach when dealing with countywide systems, such as health and human services departments, economic systems, policy environments, and public will.
- **Best Babies Collaboratives:** The seven Best Babies Collaboratives are comprised of over 45 separate agencies.

Community Strengths

The NFP-LA program has been an important referral source for LAUSD, especially with helping pregnant and newly delivered teens to complete high school. During the last 3 years, through a partnership with LA County MCAH and assistance of the Nurse Manager of LA-NFP, LAUSD hired one NFP Nurse Home Visitor using a Safe Schools/Healthy Students grant.

LAUSD provides Foster Care counselors who provide case management and counseling services to students and their families; work with children's social workers to ensure school stability; expedite and assist with prompt school enrollment and transfer of student records; participate in case-conferences, Individual Education Plans, and other educational meetings; consult and train Local District and school staffs and other community partners; assist in locating district services and community resources available to at-risk students; and engage in research and data.

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

- LAUSD-NFP will reach out to higher risk pregnant youth, such as those in foster care or on probation using the NFP-LA developed community screening/referral tool adapted for LAUSD. It can be electronically sent or faxed to the LAUSD-NFP headquarters, and each referring party will be given a summary of the status and outcome of their referral.
- LAUSD NFP will assist in locating an alternative program if the person referred does not meet the intake criteria or refuses to voluntarily participate for the required 2 1/2 years.
- LAUSD will partner with NFP-LA to conduct outreach activities, develop referral resources, and form connections to other home visiting programs and agencies.
- LAUSD-NFP will provide informational training district-wide to school nurses, attendance counselors, PSWs, health educators, administrators, and staff in option schools.

Referral Resources Currently Available to Support Families Residing in the Communities

- Health: the school district (especially school nurses, school physicians, attendance counselors), Psychiatric Social Workers (PSWs) and school-based health centers, many of which are Federally Qualified Healthcare Clinics (FQHC) health providers, WIC centers, the county and NFP-LA.
- Mental Health: LAUSD School Mental Health, the County Department of Mental Health, NFP-LA, community agencies such as LA Child Guidance and El Nido Family Services.

- Early Childhood Development: Early Head Start, Early Childhood Education Programs (6am to 6 pm, M-F), Infant Care Programs and Special Education Preschool and services, Early Identification & Intervention (EII) Collaborative.
- Substance Abuse: School Mental Health providers and health teachers, preventative programs and curriculum, such as Impact, LAUSD-NFP nurse, Cedar-Sinai Psychological Trauma Center.
- Domestic Violence Prevention: The LAC-USC Medical Center Violence Intervention Program (VIP).
- Child Maltreatment Prevention: review of child abuse case reporting by LAUSD school nurses, PIPE (Partners in Parenting Education) curriculum, Department of Children & Family Services (DCFS), and the Child Protection Hotline.
- Child Welfare: Healthy Start coordinators, LAUSD counselors, the Pregnant and Parenting Teen Program.
- Education: LAUSD, City of Angels Independent Studies, Community Day Schools, Continuation Schools, Adult Education, Schools for Pregnant/Parenting Teens, peer support groups and GED/Special Education Programs, after school activities (YMCA, SOS Mentor, Boys and Girls Club), and Parent Centers.
- Other Social and Health Services: programs focused on youth empowerment, peer advocacy, leadership development, and health career promotion.

Referral Resources Needed to Support Families Residing in the Communities

Coordination of the LAUSD-NFP within the LAUSD will take place through established channels of communication among all programs serving youth who are at risk of or who are pregnant. Resources vary from school to school. LAUSD has resource centers in some schools, especially those with a Healthy Start Coordinator. School Nurses work with the school community to find health and social resources. Some schools have COST teams which share resources to assist particular students; school health personnel who work together to find community agencies to meet needs. However, with severe cuts in school staff, there will be a greater need to develop community referral systems composed of schools, public and private agencies, and faith-based organizations. Web-based referral systems may need to be developed.

Plan to Integrate Home Visiting Services into an Early Childhood System

The Los Angeles County Home Visitation Advisory Committee (LAC HVAC) was developed to provide oversight, direction and foster collaboration among the multiple agencies providing home visitation and other child development services in Los Angeles County. LAC HVAC is working on a more rapid referral process between all home visiting agencies/programs in LA County.

The Early Identification and Intervention (EII) Collaborative, consisting of private and public sector individuals and organizations, advocates to improve and expand timely identification of, and intervention for, children with or at risk of delays, disabilities and

other barriers. The EII is comprised of more than 250 organizations and agencies and 500 individuals.

The Infant Development Association of California is a multi-disciplinary organization of parents and professionals committed to optimal developmental, social and emotional outcomes for infants, birth to three, with a broad range of special needs, and their families.

Los Angeles County's Prevention Initiative Demonstration Project builds on existing community capacity developed over the last decade to address the full spectrum of child abuse prevention. The Department of Children and Family Services funded initiatives in collaboration with Department of Mental Health, Department of Public Social Services, First 5 LA's Partnership for Families, School Readiness, Family Literacy and other networks; City of LA Family Resource Centers, Gang Reduction and Youth Development Zones.

Linkages is a statewide initiative currently sponsored by the Child & Family Policy Institute of California with the goal of effectively integrating CalWORKs and Child Welfare Services. Los Angeles Linkages is designed to address common barriers that limit parents' ability to parent and their ability to work from a prevention and intervention perspective.

The mission of the Magnolia Place Network is to unite the county, city, and community to strengthen individual, family, and neighborhood protective factors by increasing social connectedness, community mobilization, and access to needed supports and services. The Network consists of approximately 70 community organizations. The MP "community" consists of nearly 100,000 residents living in the 5-square-mile 500-block area surrounding West Adams, Pico Union, and the North Figueroa Corridor.

The Children's Council of Los Angeles County a community-based nonprofit organization works as a broker and champion for children, youth, and families across our region's varied and diverse neighborhoods. The Council continues to implement a Community Level Change Model of Relationship Based Organizing that builds on the strengths and assets of individuals rather than on needs and services.

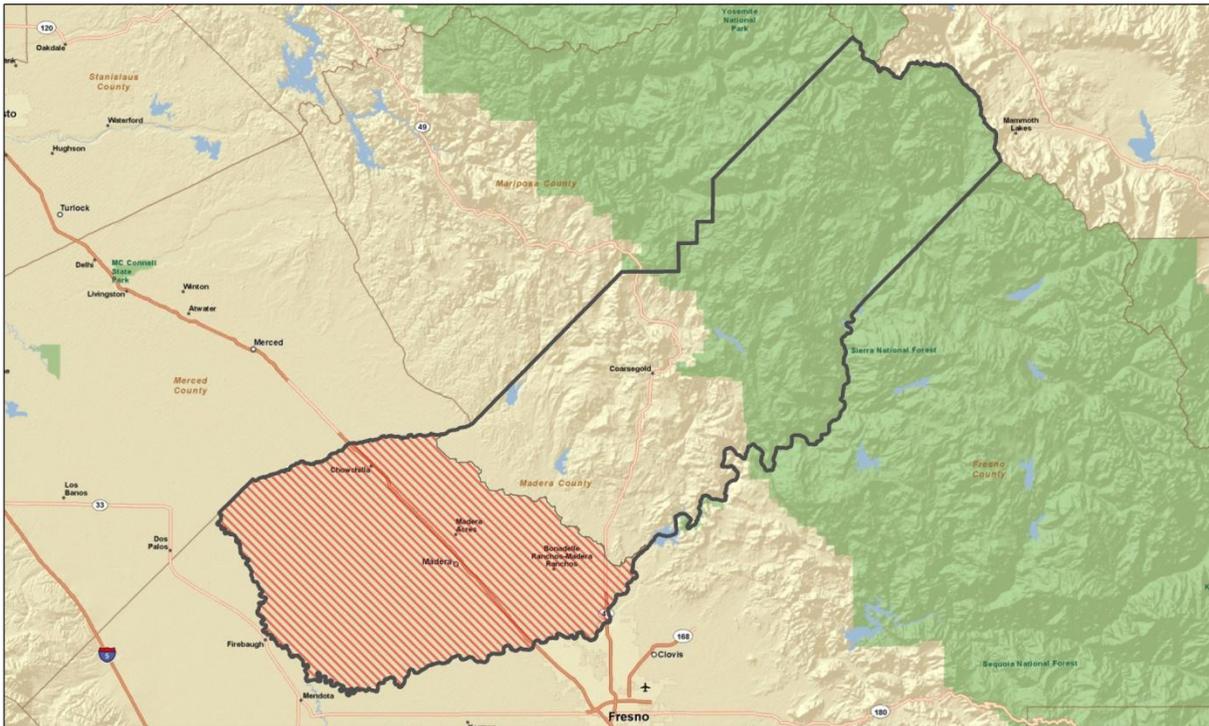
The Partnership is a collaborative of over 35 private- and public-sector members that supports and promotes the lifelong health and wellbeing of children, aged prenatal to 5. It is currently focusing its efforts on supporting Strengthening Families initiatives, leveraging state and federal investments for prenatal-to-5 programs in LA County, and building support for prenatal-to-5 investment in the business sector.

With its 6-year strategic plan, First 5 LA joins a movement of public and private funders who are transitioning from initiative-based grant making to a place-based approach and focus on long-term change. The Place-Based Approach Plan will be implemented through the two primary mechanisms of Family Strengthening and Community Capacity Building but will also include a countywide approach.

The seven Best Babies Collaboratives are comprised of over 45 separate agencies. The LA Best Babies Network, serves as the coordinator and technical support provider for the seven collaboratives. Each BBC established a steering committee, and systems for internal communication and accountability between partners.

Madera (Western Madera County)

The identified at-risk community for Western Madera County (WMC) includes State Highway 99 (SH 99); the area west of SH 99; and area east of SH 99 to a width of approximately 7-12 miles. The 2 largest cities Madera and Chowchilla are also included in WMC.



Characteristics and Needs of Participants and Community Risk Factors

In 2008 the estimated percentage “California Residents of All Ages Living in Poverty” in Madera County was 18.2% compared to the State 13.3%. Madera had 13.7% (50th-74th percentile) unemployment compared to California 11.9%. Per Employment Development Department the current rate of unemployment in MC is 16.4% (February, 2011) compared to California 12.3%.

In 2008 Madera shared the 5th highest ranking for preterm births; 11.9% of Madera County births were preterm (>90th percentile) compared to California 10.7% and the State median 9.8%.

The 2008 teen birth rate for ages 15-19 years was 56.9 per 1000, ranking MC 4th highest for teen births in CA. All 10-14 year old births for 2005-2008 were to Hispanic

mothers. In 2008 and 2009, Madera County AFLP served 39 teens under age 15. Effective June 30, 2011, Cal-Learn will be discontinued; Madera will be reduced to serving 90 teens per month instead of 150.

According to the US Census Bureau 65.4% of Madera County persons age 25 years or more have a high school diploma or equivalent compared to 76.8% of all Californians. Only 12% of Madera County persons age 25 years or more had a bachelor's degree or higher compared to 26.6% of Californians.

Domestic violence clients served face-to-face in 2008 were 23.6 per 10,000 residents. This is less than the California rate 26.3 and significantly less than the State median 52.3. Madera County percentile ranking was 50th–74th for child maltreatment. For substantiated cases of child maltreatment, the Madera County rate per 1,000 children was 11.8 ranking Madera 22nd (from high to low). This is higher than California 9.1 and the State median 9.75.

Community Strengths

Agencies are interconnected through a multistrand network of professionals that attend, participate in and direct a variety of multidisciplinary teams and coalitions; the network is flexible but strong. There is a general tendency for agencies to be transparent with each other, to place the child and the family at the center of the problem solving circle then go out from there. This attitude and behavior results in creative problem solving that goes across agency and fiscal lines helping to work out of agency silos. Agencies have internal expertise and there is a willingness among professionals to collaborate.

Madera County professionals emphasize strength based approach to family problem solving. Families also tend to commit to change for the benefit of their children. With deep pockets of poverty as there are in WMC there is also a sense for the need to help each other and pull together; this results in a familial sense of community. WMC community has many migrant and immigrant families who came to the U.S. to have a better life and that is strongly felt for their children and translates to a commitment to making life better.

Children's Hospital Central California (CHCC) located in Madera County is a state-of-the-art hospital with more than 450 physician specialists. The 338 bed facility is one of the 10 largest children's hospitals in the nation. CHCC was the first children's hospital West of the Rockies to receive Magnate Nursing Designation, the highest nursing benchmark in the world.

City of Madera community members have developed the Vision Madera 2025 (VM 2025) which serves as a scorecard to evaluate the implementation of the VM 2025 Action Plan. The Action Plan includes 4 focus areas: a well-planned city; a strong community and great schools; good job and economic opportunities; and, a safe and healthy environment.

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

Referral networks already exist in Madera County. Primary referring partners include: Comprehensive Perinatal Service Providers, all public or private medical/obstetrician offices/clinics; hospitals; First 5 MC which receives many new parent referrals and also routes them into MCPHD MCAH HVP; schools including the CalSAFE Programs; counselor or school nurses at Madera High School and two middle schools, and staff at several alternative schools; Planned Parenthood; Department of Social Services (DSS) Child Welfare Services, Cal-Learn; WIC. Birth certificates will be reviewed so as to identify any potential clients who weren't previously referred into MCPHD MCAH HVPs. Eligible clients not identified with the referral process could be identified through birth certificate review within the first two weeks after birth.

Determining eligibility will be a two step process: First a positive screen either by referral or birth certificate review; then a family assessment carried out by the Family Assessment Worker utilizing the standardized Family Stress Checklist.

Recruiting HFA participants: Services are offered voluntarily and with positive persistent outreach efforts in order to build family trust. MCPHD MCAH HVPs have policies and procedures regarding "Establishing and Maintaining Trust" and "Standards and Guidelines for Case Management Excellence." Creative outreach to families to encourage participation is ongoing for 3 months.

Referral Resources Currently Available to Support Families Residing in the Communities

- Health: hospitals that include OB/GYN providers, family primary and specialty care clinic, reproductive health clinic, pediatricians, Denti-Cal providers, Optometrists.
- Mental Health: Outpatient Mental Health (MH) services for Medi-Cal eligible clients.
- Early Childhood Development: One stop, county-wide Child Care Resource and Referral System. The Local Planning Council and Family Resource Centers HVP First Parents Program managed through MCPHD.
- Substance Abuse: Alcohol and other drug (AOD) prevention program.
- Domestic Violence Prevention: 1-800 Domestic Violence prevention hotline available 24 hours per day/7 days per week and Victims Services programs.
- Child Maltreatment Prevention: California Youth Connection and Child Abuse Prevention Council.
- Education: Head Start, Migrant Head Start, State Pre-School and private education programs, K-12th grade, Adult Education, a Community College campus, First Parents Program, Healthy Beginnings Program.
- Other Social and Health Services: Food bank and food service programs for those in poverty; the Madera Rescue Mission, the Madera Ministerial Association, the Madera & Chowchilla public transportation hubs, Madera Housing Authority, Madera

& Chowchilla parks & recreation, Coalition for Community Justice, Economic Development Commission, Arts Council, Historical Society, athletic, fitness and exercise centers; and Farmers Market.

Referral Resources Needed to Support Families Residing in the Communities

WMC economic base is agriculture. Agriculture is reliant on migrant agricultural workers and their families who follow the crops. There is constant movement of very poor people in and out of WMC; as a result there needs to be improved resource access and improved assistance for navigating community resource systems. Also, resources change as they are funded, defunded and refunded; this issue needs an improved tracking system.

Other than Migrant Head Start Center Programs and Family Resource Center activities, WMC has few supports for parents of toddlers and currently no HVP support. Case Managers (CM) for MCPHD MCAH Programs do not have Behavioral Health Services backgrounds. Programs are seeing more depressed persons; CMs could use more support with MH issues.

Other resource needs include: Parents supporting and mentoring parents; improvements in communication and sharing between agencies and professionals or agencies and policy makers (or vice versa), and public transportation in rural areas.

Plan for Coordination Among Existing Programs and Integration into an Early Childhood System

Previous collaborative efforts existed among local agencies with successes in providing various education programs for high risk families with children 0-5. Madera County has on-going efforts to strengthen the following local services and organizations into an integrated early childhood system: Migrant and Regional Head Start; Central Valley Regional Center; Healthy Beginnings Program, Cal-SAFE Program, PAI Subcommittee for Special Needs Children; Guild's Child Abuse Prevention and Treatment Center; and the Child Death Review Team.

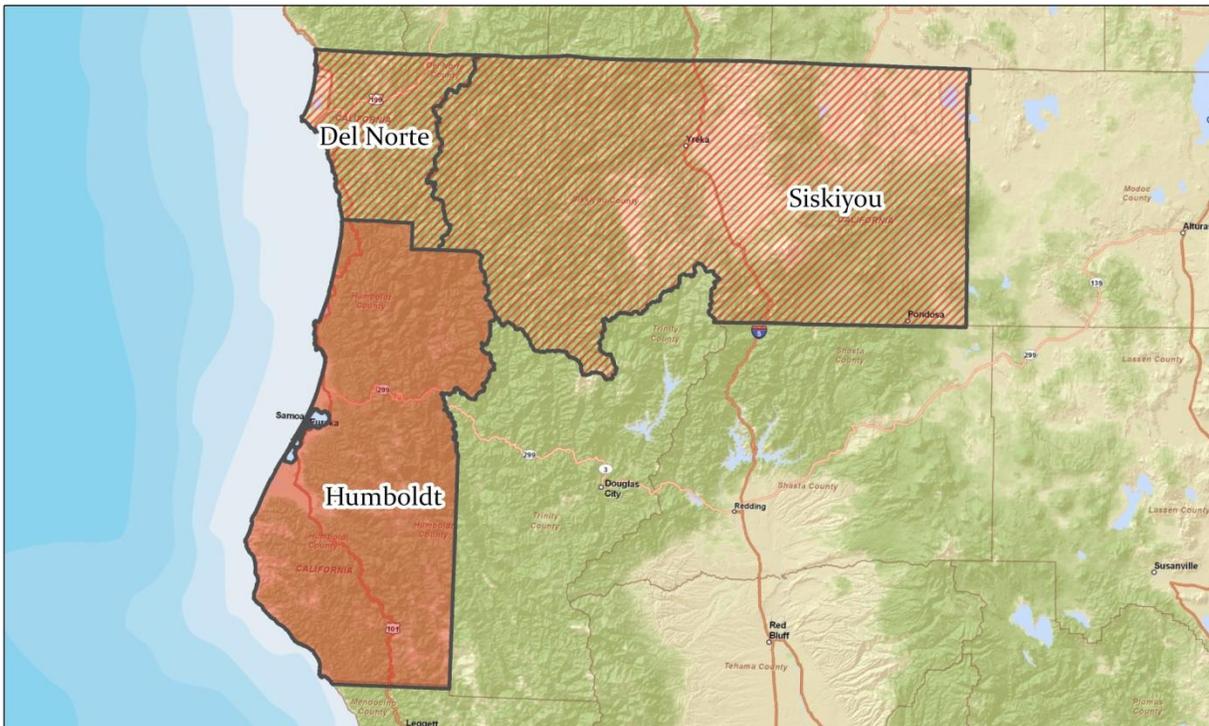
First 5 Madera County Initiatives were established to: 1) Integrate early childhood education with high quality pre-K programs; 2) Workforce development; 3) All 3 and 4 year olds access high quality, content-rich, developmentally appropriate pre-K curricula; 4) Stable and continuous funding for quality, affordable and accessible Pre-K programs; 5) Facility capacity matches demand; facilities are well-maintained and provide high quality, accessible and safe environment.

Madera County has a Local Child Care Development and Planning Council, which aims to foster collaboration of consumers, providers, public agencies and community members: determine local priorities for child care/development (CCD) services; develop and maintain child care resource and referral system; seek and advocate for funding; maximize CCD resources through coordination and collaboration; promote public awareness of CCD issues as an essential part of family support services; advise Board

of Supervisors and Superintendent of Schools on issues affecting CCD; and promote and enhance CCD services through public and provider education.

North Coast Tri Consortium (Del Norte/Humboldt/Siskiyou County)

The high risk community for the Del Norte/Humboldt/Siskiyou consortia will consist of all low-income, first time mothers eligible for Nurse Family Partnership, who live within the boundaries of Humboldt, Del Norte or Siskiyou counties. Priority will be given to those mothers who: have substance use or mental health issues, are homeless, have experienced domestic violence or have difficulty accessing health care.



Characteristics and Needs of Participants and Community Risk Factors

As per the Home Visiting Needs Assessment, Humboldt, Del Norte and Siskiyou counties were found to have indicators above the 90th percentile in the areas of perinatal substance use, children with special needs, juvenile crime, illicit drug use, prenatal care, foster care, short birth intervals, domestic violence child maltreatment, poverty, premature births, and low birth weight.

Del Norte County, which has a high poverty rate, far exceeds the state rate of reported and substantiated cases of child abuse and neglect. Drug and alcohol abuse and lack of access to mental health/ family support services are also contributing factors. Entries into foster care for the children of Del Norte County are more than twice the rate for the state for all age groups.

According to the 2010 County Health Status Profiles, Del Norte County, years 2006-2008, ranked # 57 in the state for late or no prenatal care.

According to the Del Norte County Economic and Demographic Profile 2009-10, approximately 26 percent of the population was eligible for Medi-cal programs in 2008.

Humboldt County, according to 2006-2008 data taken from the Office of Statewide Health Planning and Development, ranks 4th in the State for prenatal drug use.

Humboldt County ranked in the 75th to 89th percentile in maternal depression as per the Statewide Home Visiting Needs Assessment. Data from Infant Risk Summary forms completed at the three local birthing hospitals demonstrates a moderate to high incidence of reported "depression" at the time of delivery.

Humboldt County ranks 10th in the State for residents of all ages living in poverty. In 2009, 58.5% of the births in Humboldt County were to women on Medi-Cal. According to the California Center for Rural Policy report, Rural Community Vital Signs-2006, 21.8% of children under the age of 5 were living in poverty in Humboldt County compared to 19.3% in the State and 13.8% of households with children reported food insecurity.

Humboldt County ranks in the 50th to 74th percentile in crime. In 2009, violent crime in Humboldt County rose to 17% with the number of homicides more than doubling from 3 in 2008 to 8 in 2009.

An estimated 17.9 percent of Humboldt County adults were current smokers in 2005. This was higher than the State average, which was 14.3 percent for that same year.

Siskiyou County is extremely frontier, impacting service delivery efficiency. The Siskiyou County profile ranks Siskiyou at >90th percentile for illicit drug use, 75th-89th percentile for binge alcohol use and non-medical pain reliever use, and 50th-74th for Marijuana use.

The Siskiyou County profile ranks Siskiyou greater than 90th percentile for the indicator of foster care. Additionally, Siskiyou County's rate of substantiated child maltreatment in 2009 was 19.3/1000 children, the 10th highest rate in the State.

Siskiyou County's profile ranks > 90th percentile in families with a history of domestic violence.

Yreka Union High School had a dropout rate of 29% in 2007-08 and in 2008-09 the rural community of Dorris had an extremely high dropout rate of 44.2% that year.

Siskiyou County ranks in the greater than 90th percentile for the number of low birth weight infants and premature infants born.

Community Strengths

Del Norte County has strong collaboration efforts to promote service gap solutions for families with children ages 0-5. They include Strengthening Families offered at First 5 and the county Perinatal Drug and Alcohol program. This includes an outpatient drug and alcohol program, parenting classes and on-site child care. Other relevant community partnerships/collaborations include the Board of Supervisors Safe and Healthy Families Committee, First 5 of Del Norte, Sunset High Alternative Parenting Teen and Infant Program, Redwood Coast Regional Center, Community Health Alliance, Children Health Initiative Coalition, Sutter Coast Hospital, DHSS Mental Health Branch, DHSS Social Service Branch, Open Door Community Clinic, Community Assistance Network, Baby Steps and Cal-Learn Programs. Early Start, Early Head Start, United Indian Health Services.

Humboldt has First 5 Humboldt and St. Joseph Health System sponsored family resource centers and play groups. Humboldt County DHHS' Mobile Engagement Vehicle and Street Outreach Services van provide information, referral and support to those who are homeless and/or living in remote areas. The existing NFP program serves clients throughout Humboldt County as does the Alternate Response Team (ART), Head Start/Early Head Start, Field Nursing and the American Indian Infant Health Initiative (AIHI).

Siskiyou County has a network of early childhood advocates who work together to promote service gap solutions for families with children 0-5. Siskiyou Perinatal Professionals and Siskiyou Early Childhood Team (SECT) are working together to promote timely referrals. Nurturing Parenting classes are offered throughout our county at 10 family resource center sites. The Siskiyou Substance Abuse Coalition is implementing a county wide substance abuse prevention grant for Siskiyou youth. Another resource for families is the county's Perinatal Drug and Alcohol program that is offered for pregnant women. In addition to case coordination and appropriate referrals, the Siskiyou LHJ has a robust workforce that includes community partners: Siskiyou First 5, Domestic Violence and Crisis Center, the Local Planning Council network of preschool providers, all county Head Start Services, SECT, Human Services key staff, foster care agencies, and perinatal professional.

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

Del Norte County will work with current programs and the consortium to develop a plan for recruitment, and identifying and screening participants.

Humboldt County NFP has an existing plan for identifying and screening participants. Recruitment is currently accomplished through collaborative meetings, ongoing outreach and communication with OB provider offices, inter-departmental referrals from the Prenatal Care Guidance Program, Alternative Response Team, Field Nursing, and WIC. A relationship has been developed with Northcoast Children's Services Head Start/Early Head Start program to refer first time mothers. A relationship is developing

with the Native community and referrals are increasing in the Eastern Humboldt area and through United Indian Health Services. The MCAH program director performs outreach on behalf of NFP program to Social Services Branch-MediCal Eligibility, OB providers and family resource centers. Humboldt County's NFP is also receiving a number of self-referrals from "friends" of current clients.

Siskiyou County has identified the following plan:

- (1) Start-up - During the subcontract period with Humboldt, Siskiyou County MCAH will inform Siskiyou County Human Service and Public Health entities, all perinatal professionals, medical centers, school nurses, and the Siskiyou Early Childhood Team.
- (2) Outreach process - A simple program brochure describing referral criteria and referral form will be developed and distributed to partners.
- (3) Waiting List - Will be created to help prioritize assessments of eligible participants.
- (4) Notify Referral Partners of Program Start-Up Date
- (5) MCAH Director/Coordinator participates in monthly collaborative meetings to accept and solicit NFP eligible referrals.
- (6) First time pregnant women referred to the Public Health's MCAH Prenatal Care Guidance program will be screened for interest in the NFP program during the phone intake process.
- (7) Referral process: Will accept referrals from any source including self-referrals.
- (8) Referrals meeting criteria, residing in Del Norte, Siskiyou or Humboldt Counties will be referred to NFP PHN in closest proximity to their residence.
- (9) Referrals meeting criteria will be received from Consortium partners, for mothers residing in Siskiyou County.
- (10) Referrals will be screened for risk, utilizing a tool that will be developed to facilitate this process. Those with the highest risk will be given priority.
- (11) Outreach to eligible, prioritized referrals will be initiated as soon as possible and following the NFP model.
- (12) Face-to-face contact will be made preferably through a home visit.

Referral Resources Currently Available to Support Families Residing in the Communities

Between Del Norte, Humboldt, and Siskiyou counties the following referral resources exist:

- **Health:** CHDP, Family PACT, CMSP providers, Sutter Coast Hospital, Del Norte Community Health Center, OB providers, Sutter Coast Community Clinic, optometrists, United Indian Health Services, UIHS, CHDP clinics, pediatric providers, Early - Head Start/Head Start, Open Door Health clinics, K'ima:w Medical Center and United Indian Health Services (UIHS), St. Joseph Health System, Redwood Memorial Hospital, Mad River Community Hospital, family practice providers, dental providers, home birth community-midwives/doulas, WIC, DHHS-Public Health Branch, California Children's Services, Northcoast AIDS Project, Family PACT, Mercy Mt. Shasta Medical Center, Fairchild Medical Center. Local OB providers, Family practice, and eye doctors.
- **Mental Health:** Strengthening Families parenting classes, family resource centers, , Remi-Vista, Healthy Moms (DHHS MHB), Open Door Health clinics, Changing Tides, Humboldt Family Services Center, UIHS, K'ima:w Medical Center, Hope Center, parenting classes, County Behavioral/mental health services, private mental health specialists.
- **Early Childhood Development:** Early Head Start/Head Start, Strengthening Families Parenting Classes, Early Start, Del Norte Child Care Council, State and private preschools, 1 continuation high school with a child care center, Redwood Coast Regional Center, Incredible Years parenting classes, Changing Tides, First 5 playgroups and family resource centers, Parent Child Interactive Therapy, Nurturing Parenting Classes, Siskiyou Child Care Council, State and private preschools, Siskiyou County Office of Education child care centers at continuation high schools.
- **Substance Abuse:** County alcohol and other drug program, perinatal substance abuse program, services through the community health center, DHHS Mental Health Branch-AOD, Healthy Moms, DHHS Public Health Branch-Health Education-AOD, Tobacco Free Humboldt, Narc-Anon, AA, County of Siskiyou Human Services Department.
- **Domestic Violence Prevention:** Victim Witness program through the DA's office, Harrington House domestic violence shelter, DHHS-PHB-Family Violence Prevention Program, DHHS-Children and Family Services, North Coast Rape Crisis Team, Adult Protective Services, Women and Children in Southern Humboldt, Victim's Witness, Two Feathers, Tribal Victim Assistance, Raven Project, Emma Center, UIHS, Humboldt Women for Shelter, Humboldt Domestic Violence Services, Multiple Assistance Center, Arcata House, MEND/WEND (therapy and intervention), Victim Witness program through the DA's office, Domestic Violence crisis intervention and sheltering.
- **Child Maltreatment Prevention:** Child Abuse Prevention Council, WIC, Strengthening Families parenting classes, Remi-Vista, Child Care Council, DHHS-Children and

Family Services, Alternative Response Team, DHHS-PHB-NFP and Field Nursing, Child Abuse Coordinating Council, family resource centers, Community Services Council (Child abuse prevention council), Nurturing Parenting classes at 10 family resource centers. Northern Valley Catholic Social Services, Environmental Alternatives.

- Child Welfare: Foster care public health nurse at DHSS, DHHS-Children and Family Services, CASA, MAC, Arcata House, DHHS-PHB, Foster care public health nurse, foster care LVN at Human Services Department, College of the Siskiyous (Foster Kinship training program).
- Education: Del Norte County Office of Education, primary and secondary schools, special education services, charter schools, College of the Redwoods, Northcoast Children's Services Head Start/Early Head Start, Tribal Head Start, Humboldt County Office of Education, First 5 Humboldt, Changing Tides, Siskiyou County Office of Education, primary and secondary schools special education services, GED preparation, charter schools, College of the Siskiyous Community College.
- Other Social and Health Services: Cal-Works, Victim Witness, WIC, Redwood Coast Regional Center, food banks, after school programs administered through the school district, Community Assistance Network, Rural Human Services, Pregnancy Care Center, Mission, Arcata House, MAC, Redwood Community Action Agency, Paso a Paso, DHHS-PHB-Prenatal Care Guidance Program, DHHS Mobile Engagement Vehicle, injury prevention car seat and bicycle/skater helmet programs, Far Northern Regional Center, Food banks, after school programs administered throughout the Siskiyou County Office of Education.

Referral Resources Needed to Support Families Residing in the Communities

Del Norte, Humboldt, and Siskiyou counties have identified the following resources needed:

- Increased access to public transportation
- Safe and affordable housing
- An improved economy and job market
- Increased access to family planning services and medical providers
- Continued after school programs and day care providers
- Continued perinatal substance abuse prevention programs
- Increased mental health services for low income adults and children
- Substance abuse recovery programs
- Employment training and opportunity
- Dental providers who accept adults on MediCal

Plan to Integrate Home Visiting Services into an Early Childhood System

In Del Norte County, the PHN is an active participant in the monthly Early Intervention team meeting and the Northcoast Health Services Advisory Committee meeting. Relevant community partnerships include Safe and Healthy Families, Sunset High School Alternative Parenting Teen and Infant program, Redwood Coast Regional Center, Community Health Alliance, Children Health Initiative Coalition, Sutter Coast Hospital, DHHS Mental Health Branch, DHHS Social Service Branch, Open Door Community Clinic, Community Assistance Network, Friday Night Live, Baby Steps and Cal-Learn programs.

The local MCAH program functions within Del Norte County Department of Health and Human services. Within the public health branch are substance abuse and tobacco prevention services, CCS, CHDP, Immunizations, public health nursing, and emergency preparedness programs.

DHSS works collaboratively with community partners such as Early Head Start/Head Start, First 5, Early Start, Sunset High School Alternative Parenting teen and infant program, and Cal-learn, Child Protective Services, to address the needs of the local MCAH population.

In Humboldt County, DHHS is receiving national attention as a model for integrating Public Health, Mental Health and Social Services into one department. DHHS formed a new branch in 2010, Children and Family Services, which includes representatives from the three branches and focuses on the needs of at risk children and families.

NFP staff members collaborate with the Independent Living Skills Program staff to provide care to pregnant and parenting foster care youth. A mental health practitioner from Healthy Moms, alcohol and drug addiction treatment program, meets with NFP staff on a regular basis to debrief clients with dual diagnoses, substance use and post-traumatic stress disorders. The NFP supervising PHN participates on the Humboldt County Domestic Violence Coordinating Council.

First 5 supports NFP through PHB-DHHS, Paso a Paso (pregnancy and parenting support for Latino families), a “Spanish Speaking” initiative, the Children’s Health Initiative, Circle of Smiles, and the Hoopa School Readiness. Support is also given to the Community Transition Teams facilitating the transition of young children into school.

MCAH and other members of the Public Health team participate on the Northcoast Children’s Services (Head Start/Early Head Start) Advisory Committee.

Programs in Humboldt’s MCAH Division of Public Health Branch include: Nurse Family Partnership, Field Nursing, Child Health and Disability Prevention Program, California Children’s Services, Medical Therapy Unit, Alternative Response Team and Children’s Medical Services/Foster Care Nursing. MCAH Division supervisors meet on a monthly basis to discuss program updates and outcomes. Humboldt County’s Public Health, Social Services and Mental Health branches are integrated under the Humboldt County

Department of Health and Human Services that allows for communication between branches through regularly scheduled meetings.

Community based partners include Redwood Community Action Agency/Youth Services Bureau, Raven Project, MARZ Project, Mental Health Branch, Nurse Family Partnership and Planned Parenthood.

Representatives from the Family Resource Centers (FRC's) and play groups participate on many of the MCAH facilitated collaboratives. DHHS hosts a quarterly meeting with FRC leaders to provide an opportunity for communication exchange.

In Siskiyou County, the MCAH Coordinator and Director are leaders and active participants within multiple early childhood collaborations including: Siskiyou County Dental Task Force, SECT, Siskiyou Local Planning Council, Siskiyou Perinatal Professional Team, Siskiyou Breastfeeding Task Force, Siskiyou First 5, Siskiyou FRC network, Early Childhood Education Advisory Board and Siskiyou Community Services Council. The collaboratives are composed of early childhood professionals, dental, medical providers, early childhood advocates and leaders of community based organizations who serve children and families from 0-5.

Siskiyou First 5 has developed a network of family resource centers in 10 communities throughout the county providing family centered services. Five years ago First 5 funded the current MCAH coordinator as a certified Partners in Parenting Education (PIPE) regional trainer. Siskiyou First Five received a Ford Family Foundation grant to train partners countywide in the Nurturing Parenting curriculum in 2006.

In October of 2010 the County Department of Behavioral Health Services merged with Human Services (HS) to become the Siskiyou Human Services Agency. The reorganized Human Services Department works closely with MCAH to promote early identification of perinatal substance abuse.

MCAH leads the Dental Task Force (DTF), a collaborative that includes: Siskiyou County Office of Education Health Services, Siskiyou First 5, all Siskiyou Head Start programs, local dental professionals, Siskiyou Federally Qualified Clinics, local pediatrician, and other community organizations. The DTF collaborative has developed and implemented several prevention/screening projects.

SECT has established a Multi-Disciplinary Team protocol to assist providers and case managers develop a service plan for high risk families. Members include Siskiyou Human Services staff, Next Step Perinatal Drug and Alcohol Supervisor, a local Pediatrician, Local Planning Council Director, all Early Head Start Directors including the Karuk Tribe, Shasta and Siskiyou Head Start programs, Siskiyou First 5/ FRC Network Director, Siskiyou County Office of Education Infant Toddler Program Director, and a Far Northern Regional Center representative.

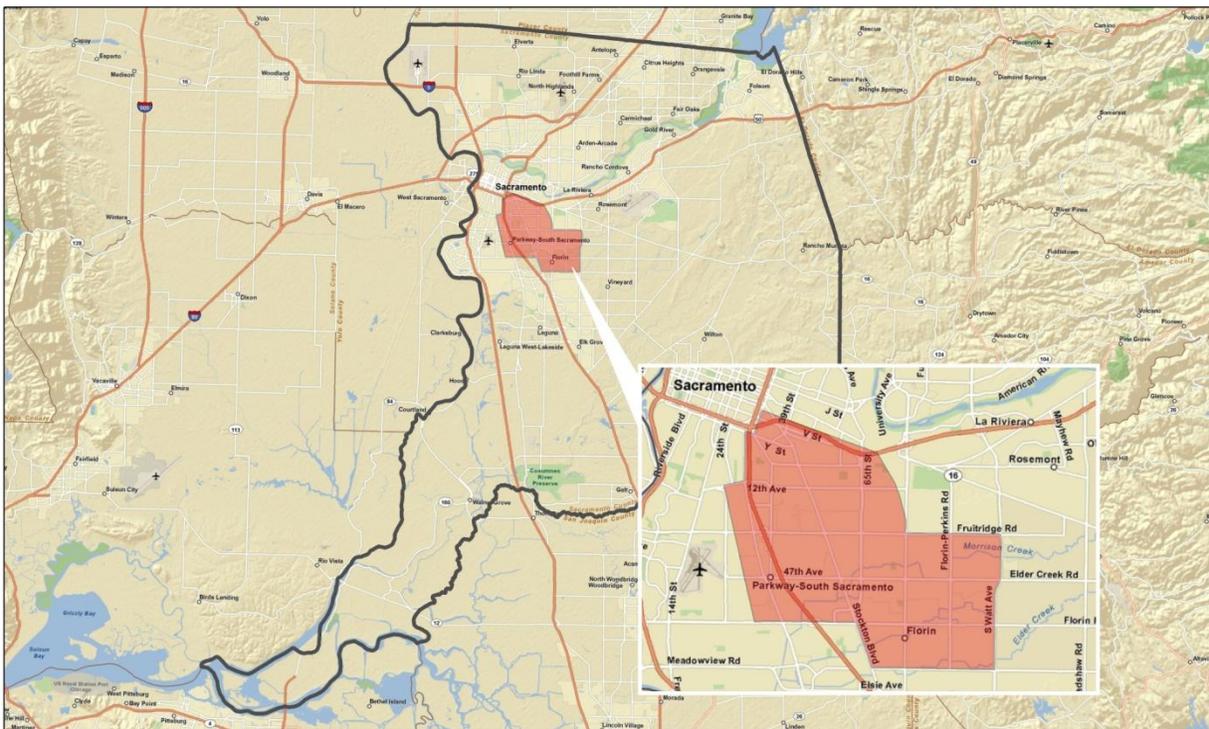
The Siskiyou Local Planning Council and the Siskiyou Child Care Council together promote early childhood education for preschools and licensed childcare facilities in the

LHJ. Both organizations are participants in SECT and have worked to develop a link between Early Childhood Education providers and services to their families at risk.

The MCAH program has been the primary convener to begin new work in perinatal substance abuse prevention. Meetings with medical providers have used video conferencing to bridge professionals with on-call travel limitations to promote improved service delivery.

Sacramento (South Sacramento communities)

The At-Risk Community in the Sacramento LHJ includes the South Sacramento communities of Florin, Fruitridge, Oak Park, Parkway and South Sacramento.



Characteristics and Needs of Participants and Community Risk Factors

The population of the South Sacramento Communities is significantly more racially and ethnically diverse compared to Sacramento County overall. During the year 2000, the racial composition of this region was 41.1% Caucasian, 29.9% Hispanic, 18.6% Asian and Pacific Islander, 15.3% African-American and 1.7% American Indian. The majority of residents in this community are between the ages of 18 and 65 years (56.3%), followed by residents aged 18 years or less (32.4%).

In 2008, there were 1496 first time mothers in these South Sacramento Communities. Medi-Cal was the payment source for 843 (56.4%) first time mothers, a rate 35.5% higher than the rest of Sacramento County. The 2008 prematurity rate in this region was 13.7% higher than the rate for Sacramento County. During the same year,

approximately 307 (7.5%) live births were of low birth weight; a rate 15.4% higher than the rate for Sacramento County. The teen birth rate for teens aged 15 to 19 years was 37.8% higher than the teen birth rate for Sacramento County.

The California Department of Public Health ranked Sacramento County as having the second highest incidence of Gonorrhea and the third highest incidence of Chlamydia in the State. In 2010, the incidence rate in South Sacramento Communities for all sexually transmitted diseases was 47.8% higher than the rate for Sacramento.

During 2004 to 2008 a total of 590 infant deaths occurred in Sacramento County. Of these infant deaths a total of 129, or 21.8%, occurred in the South Sacramento Communities. The Sacramento Bee recently acknowledged zip code 95820 among the top 10 for highest infant mortality rate in California. Sacramento County Public Health analyses revealed Oak Park as the third highest infant mortality rate compared to California zip codes with at least 20 deaths.

According to the California Department of Justice in 2008, Sacramento County had the highest average yearly crime rate in California and was 25% higher than the statewide rate. From 2004 to 2008, 512 homicides occurred in Sacramento County; 152 (29.6%) occurring in the South Sacramento Communities. The homicide rate for these communities was 80% higher than the homicide rate for Sacramento County.

Of the 123,031 South Sacramento Community residents, 26.2% are at 100% of the federal poverty level compared to 13.9% in all of Sacramento County. During the 2008 to 2009 school year compared to all school districts in Sacramento County, the Sacramento City Unified School District (SCUSD) had the second highest high school dropout rate for grades 9-12 (6.9%).

Community Strengths

The South Sacramento Communities have numerous organizations and associations providing services and support to the communities, including:

- Organizations to provide multi-cultural services to the diverse population. These organizations include: La Familia Counseling Center, Asian Pacific Community Counseling, Asian Resources, Hmong Women's Heritage Association, My Sister's House, Southeast Asian Assistance Center, United Lu-Mien Community, Inc., Sacramento Hmong Mediation, and Sacramento Asian American Minority Inc.
- Business and neighborhood associations
- The University of California - Davis (UCD) Medical Center and medical school; and a student run clinic in the Oak Park Community Center
- The California Endowment Sacramento Building Healthy Communities (BHC)
- Three Family Resource centers
- The Effort Oak Park Community Health Center

- Sacramento Food Bank Services
- Lutheran Social Services
- Department of Human Assistance provides Medi-Cal services and Cal-Works services
- Women Escaping a Violent Environment (WEAVE) and My Sister's House
- County of Sacramento Department of Health and Human Services Alcohol and Other Drugs (AOD) Program

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

Referrals from Obstetric providers have proven to be a successful and efficient referral system that will continue. Referral forms, program information, and client brochures will be mailed on a regular basis to providers. Other outreach efforts include government agencies such as the Departments of Human Assistance, Mental Health, Probation, Foster Care and Adoption Agencies. Recruitment plans also include outreach to agencies such as community-based organizations including community centers, Resource centers, pregnant minor school programs, pregnancy testing centers, school nurses, counselors and WIC offices. Program staff will provide follow-up visits to community providers to network and identify key gatekeepers in the office who are more likely to make referrals.

The program will utilize an existing centralized system in processing referrals whereby a supervisor reviews, screens and assigns as appropriate. The program referral is also available electronically which offers an easy access option to potential referral sources. The Supervisor refers non-eligible clients to other programs and resources in the community, thereby enhancing the collaboration with other community partners while ensuring the client receives appropriate intervention and services.

The Community Planning Council's 211 line and the Sacramento County DHHS toll free baby line already provide a variety of referrals and linkages to community resources.

A Community Advisory Council (CAC) to support the new Home Visiting program will be developed as a program enhancement. The role of the CAC will be to provide community input to help ensure that the local program remains culturally and programmatically relevant to families being served, and to increase community connectedness and support.

Referral Resources Currently Available to Support Families Residing in the Communities

- Health: Community physicians including: Obstetricians, Comprehensive Perinatal Service Providers (CPSP), and Pediatricians. Another referral source is the Women, Infants and Children Program (WIC).
- Mental Health: Sacramento County Mental Health Services; the ACCESS team; The Child and Family Integrated System of Care; Sacramento County Mental Health Treatment Center and the Minor Emergency Response Team (MERT).
- Early Childhood Development: Seta Head Start and Early Start; existing outreach to area schools with a process for referrals.
- Substance Abuse: The Sacramento County Alcohol and Drug Division's System of Care.
- Domestic Violence Prevention: Women Escaping A Violent Environment (WEAVE)
- Child Maltreatment Prevention: Sacramento County Child Protective Services
- Education: CalSafe; outreach activities to local High Schools and Alternative Schools regarding available services; the Adolescent Family Life Program (AFLP)
- Other Social and Health Services: The Black Infant Health Program (BIH); Birth and Beyond Family Resource Centers; Job Corp; programs to assist with housing options including Tubman House, Love them Both, and Bishop Gallegos Maternity Home; Juvenile Court and Probation Departments

Referral Resources Needed to Support Families Residing in the Communities

Although housing options exist in Sacramento County, there continues to exist an increasing need for affordable and safe housing. The existing affordable and safe housing programs have their own limitations including long waiting lists.

There also exists a need for programs targeting fathers, specifically programs that promote positive parental involvement, and support to fathers and their families. Many clients have histories of being raised in the foster care system or by a single parent with an absent father.

Subsidized payment programs for pre-schools and child care centers exist in Sacramento County, but the need for these type programs also continues to exist. The lists for subsidized programs are long and some centers may have their own eligibility requirements, such as income, location and student/employment status.

Transportation continues to be a challenge especially in South Sacramento Communities. Residents of this region are required to make frequent and multiple transit transfers to get to school, places of employment, shopping and medical appointments. This soon becomes a barrier for services especially for those with low incomes and other transportation limitations.

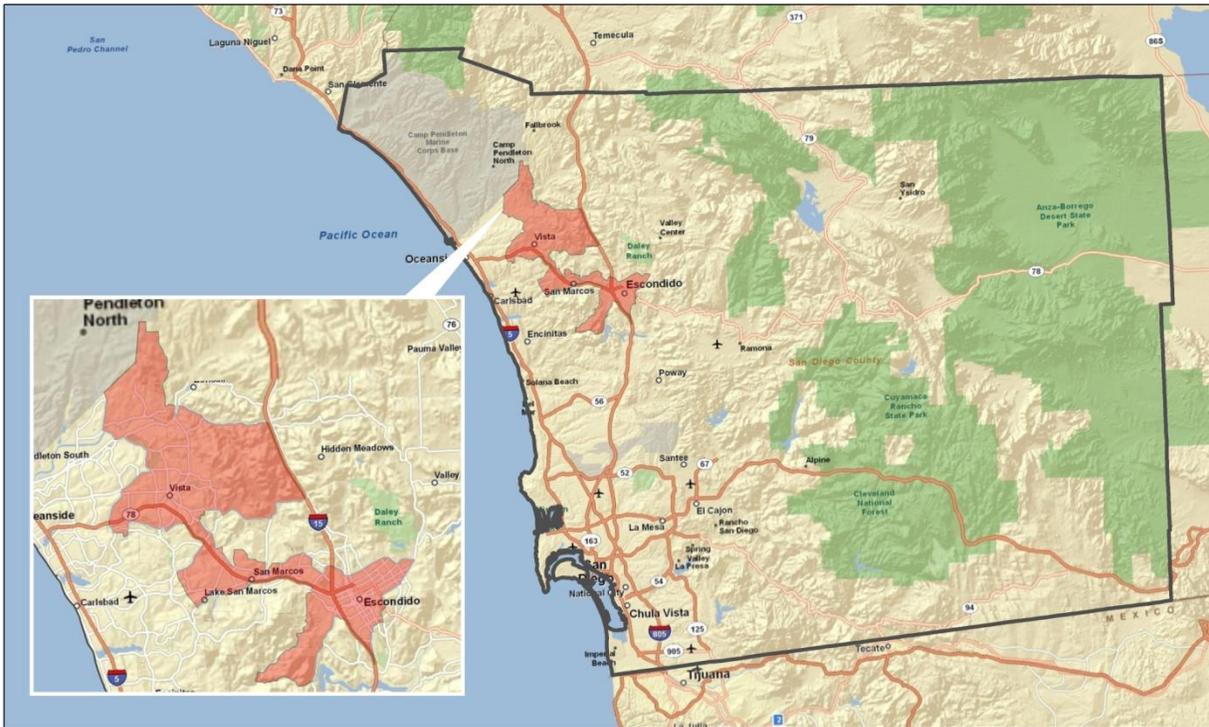
Plan for Coordination Among Existing Programs and Integration into an Early Childhood System

The primary partners for coordinating the new Program with existing services include:

- California Children's Services (CCS): Provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21. CCS has a long-standing relationship with the existing home visiting program and has received referrals and jointly managed.
- Child Protective Services: Refers first-time pregnant teens in foster care to the existing home visiting program. Care plans are shared and discussed to ensure efficient coordination of services.
- The Black Infant Health Program (BIH): BIH identifies pregnant African-American women and provides services through support group intervention models. Eligible client referrals are made between programs and service plans and resources are coordinated.
- The County of Sacramento Mental Health Services Agency: Through the Mental Health Access Team, screening and assessments are provided to determine the level of service needs of a person; and services are then coordinated for women in need of mental health services.
- The Department of Human Assistance: provides Cal Works benefits and Medi-Cal services to pregnant, low-income women; and refers pregnant, eligible clients to the existing home visiting program.
- Women, Infants and Children (WIC): The existing home visiting program refers eligible clients to WIC; and pregnant clients seeking WIC services are assessed for eligibility and referred to the home visiting program.
- ALTA California Regional Center (ALTA): Public Health Nurses screen children for developmental delays at frequent structured intervals, referring potentially eligible children to ALTA for assessment. ALTA works to support persons with developmental disabilities and children at-risk for these disabilities.

San Diego (North Inland-Coastal Expansion (NICE) - Oceanside/ Vista/ San Marcos/ Escondido/ Carlsbad)

The identified at-risk community for San Diego County includes Medical Service Study Areas (MSSAs) 156d and 156e (The North Inland-Coastal Expansion (NICE)).



Characteristics and Needs of Participants and Community Risk Factors

Using the NFP income eligibility limit, 2005 to 2009 American Community Survey estimates show nearly half of all families with children under age five (48.5%) is below 185% of poverty (compared to 32.1% countywide). There are also pockets of concentrated poverty throughout the large rural and frontier areas and in neighborhoods in suburban communities. One in five NICE families (21.4%) is headed by a single mother and almost a third of these families live in poverty (31.6%).

Averaging 2007 through 2009 data in NICE, a quarter of infants were born to young mothers each year – 554 were to girls under 21 and 436 (78.7%) of these were to first-time mothers. More than half the births (56.6%) to NICE residents were to mothers with only a high school diploma or less; nearly a third were to moms who did not even have a diploma (31.6%). About half the area's births (49.6%) were to mothers who were foreign-born. And more than one in four (27.0%) NICE residents at least 5 years of age speak English less than “very well”. Between 2007 and 2009, nearly one out of four babies (24.8%) was born to a mother who did not receive prenatal care until after the first trimester.

According to 2008 law enforcement statistics, there were 1,007 reports of domestic violence in NICE, or 15.6 reports per 1,000 households (14.7 countywide). From 2009 to 2010, the County's Child Welfare Services substantiated an average of 621 cases of child abuse and neglect each year; this is equivalent to 10.9 cases per 1,000 children ages 0 to 17 (9.4 countywide). In 2008, the age-adjusted rate for assault hospitalizations was 57.2 per 100,000 among Latinos, compared to 40.8 among whites. Even more alarming, in 2007, the age-adjusted homicide rate was 4.9 per 100,000 for Latinos, more than twice the rate among whites, which was 2.1.

Community Strengths

Local agencies within the NICE target community are committed to joint action, integrating and coordinating services to build capacity, and strategizing to address barriers. These partnerships are built on the belief that relationships and networks are the foundation for long-term sustainability in making a difference in the health and prosperity of the community. Public and private alliances have brought diverse representation to the table (government, education, health care, faith-based, grass-root, councils, schools, and other associations). Coordinated efforts have created innovative programs and strategies to deliver comprehensive services directed towards issues such as, unemployment, lack of transportation, access to healthy foods, medical/dental services, affordable housing, and other concerns.

The NICE community has an integrated health care system comprised of two community clinics, two hospitals, and other private providers working together to ensure the medical/dental needs of families are coordinated. Professionals are well informed of systems and knowledgeable of resources in the community to refer families appropriately.

There is a strong sense of community in the target area that builds on the strengths of the diverse population. Residents are engaged and committed to solving problems, share risk, and work together. NICE community is comprised of multi-generational families with rich cultural traditions, beliefs and strong support systems. This deep-rooted connection provides for a solid foundation that helps families thrive and cope with life's challenges.

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

NFP NICE will use its existing relationships with healthcare providers and other community partners to access and engage NFP clients living in the targeted community to participate in the NFP program. NICE will utilize the expertise of the HealthLink Nurse, as well as two other PHNs that are very familiar with the NICE community and have strong working relationships with referral sources in engaging clients into PHN services.

First 5 and SANDAPP (San Diego Adolescent Pregnancy and Parenting Program) refer all teens prior to their 29th week of pregnancy to NFP. NICE will use staff meetings and

individual meetings between the supervisor and each staff person to practice introducing NFP and getting a commitment to participate. We intend to invite the supervisors and/or highly skilled PHNs from other regions to share their success stories and best practices with the NICE staff.

NICE plans to use the County's Training Center to provide specialized training to assist staff in understanding the culture of the diverse groups and how to engage and support clients with different cultural norms related to pregnancy, child birth, parenting, family roles and health care services. The Standardized PHN Orientation currently under development will include a skit demonstrating positive and negative ways to engage clients and enroll them in NFP services.

Referral Resources Currently Available to Support Families Residing in the Communities

- Health: North County Health Services, Vista Community Clinic, Neighborhood Healthcare, Central Medico, County Maternal, Child and Family Health Services toll-free phone line.
- Mental Health: North County Health Services, Vista Community Clinic, Neighborhood Healthcare, Postpartum Health Alliance, Mental Health Systems, Palomar Family Counseling Services, Exodus Recover Inc., North County Lifeline.
- Early Childhood Development: YMCA Childcare Resource Services, North County Community Services, Escondido Community Child Development Center, First 5 – Healthy Development Services, Project Early Head Start Program, San Diego Regional Center, Project Hope.
- Substance Abuse: Serenity House, Aurora Hospital, Alcoholics Anonymous, Narcotics Anonymous, Pregnancy Risk Information Line, Smokers' Helpline.
- Domestic Violence Prevention: Center for Community Solutions, North County Lifeline, Palomar Family Counseling and Women's Resource Center.
- Child Maltreatment Prevention: North County Lifeline.
- Child Welfare: Escondido Family Resource Center, Oceanside Family Resource Center.
- Education: California State University San Marcos, Palomar Community College and adult education programs, Project Head Start, Project Early Head Start Program, San Diego Adolescent Pregnancy and Parenting Program (SANDAPP), Escondido Education Compact, Regional Occupation Program.
- Other Social and Health Services: Interfaith community Services, Salvation Army, US Department of Housing and Urban Development, Treasure Box, Hope Food, Women Infants and Children.

Referral Resources Needed to Support Families Residing in the Communities

Information listed below was obtained from the San Diego MCAH Home Visiting Team, community organizations that provide services in the targeted community and from the Community Health Improvement Partners Charting the Course VI Needs Assessment.

Health

- Increase number of culturally and linguistically competent health care providers
- Increase culturally competent health educators and health education materials
- Access to more mental health providers (culturally competent)
- Training of medical staff regarding health literacy
- Increase funding social media related to mental health

Environmental

- Access to and supply of affordable healthy foods
- Increase in adequate and efficient public transportation
- Improve public safety – (more police presence in community)
- Access to quality and affordable housing
- Address how the environment impacts health (e.g., asthma, heart disease and other health issues)
- More parks and improved walking and bike paths to decrease sedentary lifestyles and increase physical activity
- Increase number of community centers to bring families together and decrease isolation

Social/Education

- Improved economic growth to support jobs for our families
- Increase resources to assist families with basic needs for infants and children – (e.g., portable cribs, baby clothes, diapers, formula, food, etc.)
- Increase funding for schools

Political

- Endorsement and concrete support from politicians at the city and county level for supporting evidence prevention models
- Increase health and social services funding to help with maintaining infrastructure and key staff positions

Plan for Coordination Among Existing Programs and Integration into an Early Childhood System

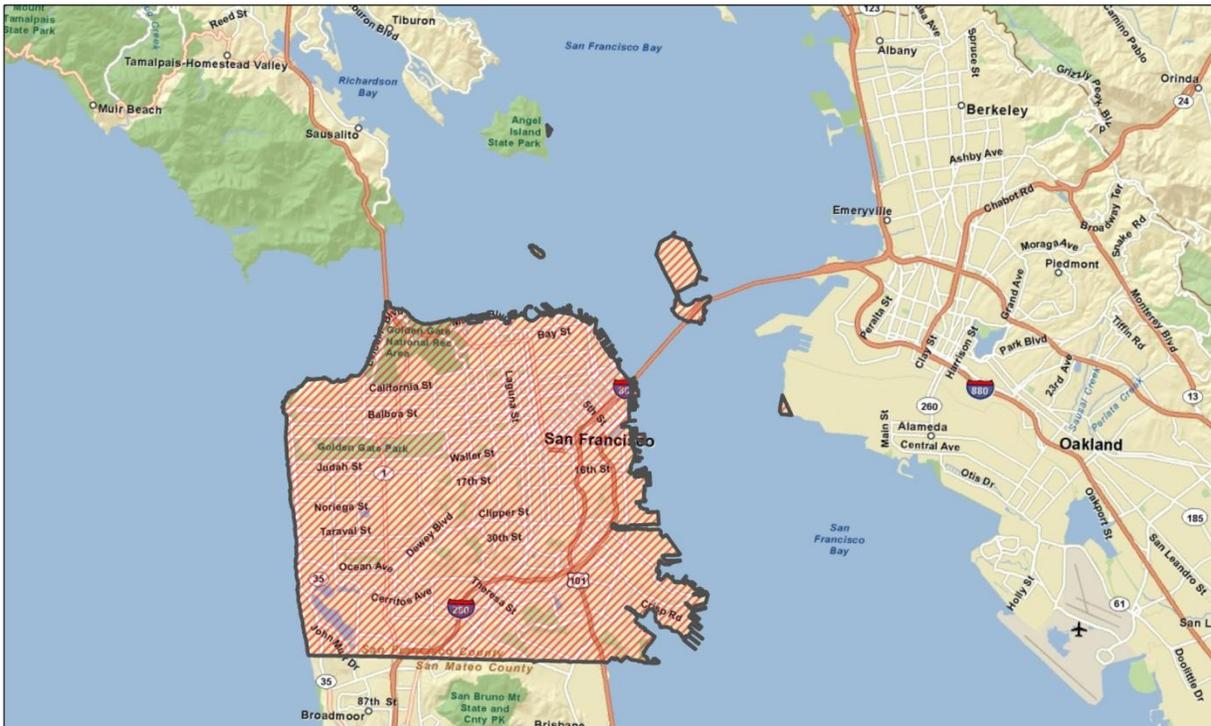
San Diego has previously established partnerships with local programs and community stakeholders to integrate a county wide early childhood system and continues to strengthen this collaboration. The following activities highlight some of the achievements done by the established partnerships between San Diego Health Department Services, CWS, Behavioral Health Services, MCAH, Probation, Regional Center, Juvenile Court, Hospital Association of San Diego, and SDCOE.

A wide array of programs and activities established by the local agencies include development of a coordinated child developmental screening, assessment, referral and treatment system;

provision of health-oriented services to children ages birth-5 years relating to development screening, assessment, treatment; speech and language services; distribution of the Welcome Baby Kit to new mothers; continuing the effort to meet goals established in the San Diego's Live well San Diego Strategy Agenda to maintain and build community strengths; devoting efforts to provide information about the new WIC guidelines about the identification, brief intervention, referral and treatment of overweight and obese women.

San Francisco (Bayview Hunter's Point)

The unique geography of San Francisco with its diverse and dense population makes it possible to identify the entire city and county as the geographic area for the new NFP. Priority will be given to low income first time mothers with the following additional risk factors: age under 21 years; history of domestic violence; history of substance abuse; non-English speaking; residence in a high crime area; and unstable housing.



Characteristics and Needs of Participants and Community Risk Factors

There were 8,437 births to San Francisco mothers in 2010, of which over half (53%) were to first-time mothers. Nearly a quarter (22%) of first-time mothers were insured through Medi-Cal. In regard to race and ethnicity, 85% of these women were of four non-white groups: Hispanic (41%), Asians (28%), Black (11%), and Pacific Islander (5%), 14% of the women were White.

Domestic violence is prevalent in San Francisco. In 2009, 911 dispatchers fielded 7,311 domestic violence calls. In 34% of the calls, callers indicated that an assault occurred. Another 56% indicated a fight or dispute with no weapons.

The Child Abuse Unit received 564 felony child abuse cases in FY09-10; 515 (91%) merited investigation. This represents a 3-year high for felony child abuse cases, up 13% from FY08-09. The most common types of abuse have been general neglect (30%) and physical abuse (29%).

Over a third (37%) of San Francisco residents are foreign-born, compared to 26% statewide, according to the 2000 Census. San Francisco has an estimated 76,986 legal permanent residents and 41,546 undocumented immigrants.

A family of three on CalWORKs public assistance has just 14% of the income necessary to live securely in San Francisco. Of the approximately 4800 CalWORKS families, 14% of families are homeless or inadequately housed, and over 20% live in public housing.

Public housing serves populations disproportionately affected by race, poverty, and lack of economic opportunity. While children comprise only 15% of the total San Francisco population, children represent 31% of San Francisco's public housing residents.

Community Strengths

San Francisco is a unique city with a high-level of political activism, community advocacy, and social awareness. Its vast diversity of local governmental programs and community-based organizations provide innovative resources that promote the health and well-being of its residents. Many low income, first time mothers have already been connected to some type of social service prior to their pregnancy. Social services – from direct case management, healthcare services, public benefits, to neighborhood family resource centers - are generally very high quality and culturally-sensitive.

The City and County of San Francisco provides a wide array of governmental programs, particularly through the Human Service Agency, Community Behavioral Health Services, the Department of Public Health, Department of Children, Youth and Families, and a network of primary health clinics. There are many innovative community-based non-profit organizations that provide highly effective programs. Some children's programs receive funding through the local Children's Fund; the current annual Children's Fund is approximately \$70 million.

Finally, San Francisco is also the home of outstanding research and teaching universities and a powerful financial and technology economy. These resources are valuable partners in evaluating, supporting, and expanding innovative public health programs.

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

The existing MCAH —Field Nursing unit within the City and County of San Francisco paired with its long-standing collaboration with community agencies and hospitals to create a strategy identifying eligible home visiting candidates. The referral system would include the following:

- Identification: Eligible prenatal patients can be identified through the following sources: community prenatal clinics, CPS workers, Medi-Cal workers, Private OB offices who take low-income patients, high schools, Perinatal Public Health Nurse Liaisons, MSWs, and Mental Health agencies, and additional community agencies.

- Recruitment: San Francisco will make use of the marketing material available from the NFP National Service Office including brochures, statistical sheets, handouts, and a DVD highlighting the many benefits of the program. This material will be made available to the above-mentioned referral sources as well as partner agencies and programs. The home visiting team will create a subcommittee designed to make community presentations.
- Screening: San Francisco has identified the target population as high risk first time moms (no previous live births) with complex psycho-social issues. To simplify the screening process, a section can be added to the initial referral form that identifies risk factors and any additional criteria necessary to adhere to the home visiting model.

Referral Resources Currently Available to Support Families Residing in the Communities

- Health: The Child Health Project of the Department of Public Health, the San Francisco Healthy Kids program, the High Risk Infant Interagency Council, Multi-Disciplinary Assessment Center at SFGH, Prenatal to Three, CPMC Specialized Services
- Mental Health: Early Childhood Mental Health Consultation Initiative
- Early Childhood Development: Preschool for All initiative, Infant Toddler Sustaining Grants, Kinder Transition Camps, Early Literacy Program.
- Substance Abuse: Jelani House Perinatal Residential, Jelani Kirkwood Family Residential, Epiphany Center Masonic Street House, Latino Commission Aviva House, Walden Hope House, FACET Perinatal Opiate Treatment program, Iris Center, Asian American Recovery Lee Woodward Program.
- Domestic Violence Prevention: (no resources identified by the LHJ in response to the RSI)
- Child Maltreatment Prevention: Talkline, SafeStart.
- Child Welfare: Family Resource Center Initiative
- Education: (no resources identified by the LHJ in response to the RSI)
- Other Social and Health Services: (no resources identified by the LHJ in response to the RSI)

Referral Resources Needed to Support Families Residing in the Communities

A central database for clients receiving services from multiple providers would assist the NFP program and stakeholders to identify progress of clients reaching measurable goals.

Transportation for clients, for example, bus or taxi vouchers would be a benefit to clients in accessing health and social service appointments. Homeless families in particular

would benefit from transportation assistance and would be able to be visited by NFP PHNs at an alternate location if necessary.

Plan for Coordination Among Existing Programs and Integration into an Early Childhood System

San Francisco has a long successful history of early childhood collaboration. San Francisco created the Early Childhood Interagency Council convening all key early childhood stakeholders, including families for policy and planning. The SF Family Support Network grew out of the Starting Points Initiative, and is currently very active in promoting family support, family economic success and school readiness.

San Francisco was one of 58 Local Interagency Coordinating Agencies (LICA) responsible for planning the implementation of Early Start Prop C of IDEA legislation. The LICA created the High Risk Infant Interagency Council, whose mission is to improve access and the service delivery system for young children with special needs and their families.

Established in 1998, the First 5 Commission has cross sector representation and has been a key convener and participant in several interdepartmental and interagency early childhood collaboratives, including: The Child Care Planning and Preschool Advisory Committees; Early Childhood Mental Health Network; High Risk Infant Interagency Council; Early Childhood Inclusion Collaborative with SFUSD Child Development Department; Special Education and Head Start, and the PreK to Third grade initiative. First 5 SF partnered with SF DPH MCAH and convened the Home Visiting Collaborative.

Over the past 6 years, First 5 SF, SF Department of Children, Youth and Families, and the SF Human Service Agency have collaborated and jointly funded early childhood development programs with the goal of strengthening programs, increasing access, involving families and caregivers, supporting the early childhood workforce, building the quality of care, and streamlining reporting. The joint funders meet monthly and have built several key initiatives including projects with SF Department of Public Health: Early Childhood Mental Health Consultation and Childcare Health Screening, Consultation and Linkage.

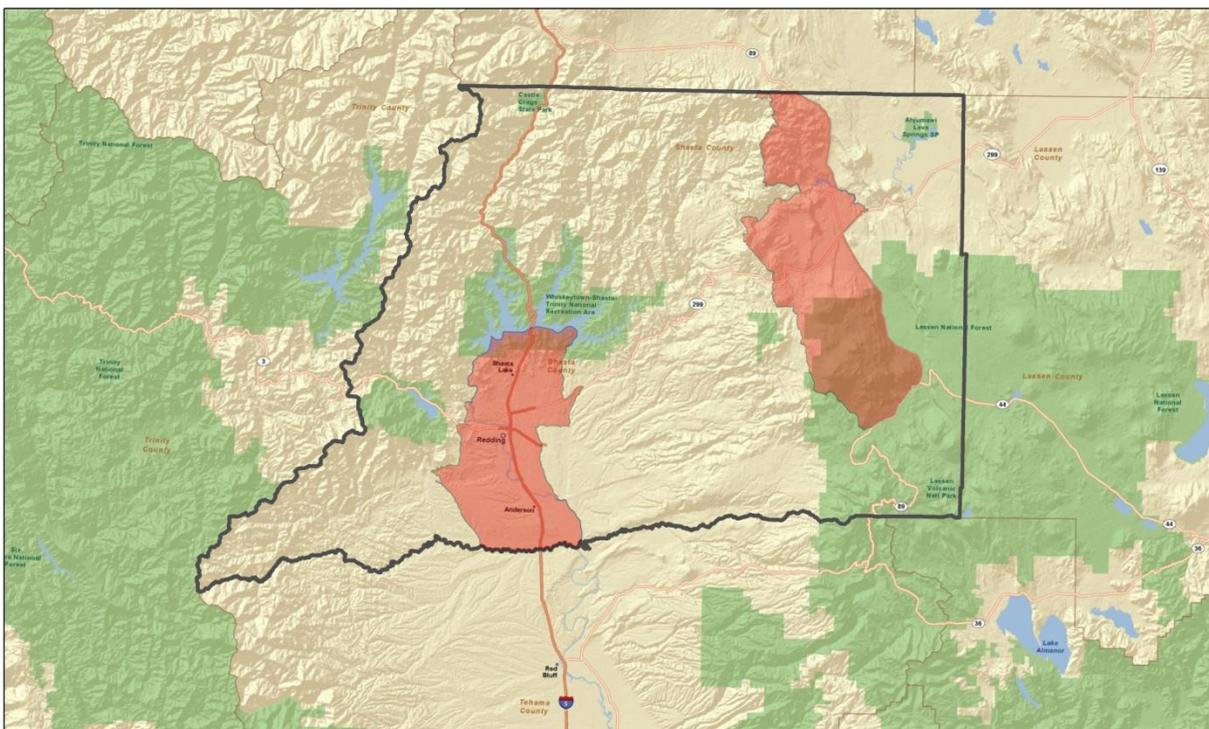
SF MCAH implements the First 5 funded Child Care Health Screening, Consultation and Linkage Project. The project provides health and safety consultation and outreach to under-served children and child care centers, family resource centers and shelter sites throughout the city and county, and facilitates MediCal enrollment and linkage of children ages 0-5 years to needed health services, medical and dental homes.

In addition, San Francisco has several important initiatives that have early childhood components including HOPE SF, the nation's first large-scale public housing transformation effort, and Bridge to Success, a partnership aiming to double the number of low-income youth who receive post-secondary credentials.

First 5 San Francisco, Department of Public Health, Department of Children Youth and Families and Human Service Agency are committed to the vision and goals of the national Strengthening Families Through Early Care and Education Initiative to prevent child abuse and neglect and its strategies have been implemented in neighborhoods throughout San Francisco. The Strengthening Families approach and language has been incorporated into San Francisco's Preschool for All (PFA) Program guidelines, which serves as the overarching vision for high quality early childhood programs.

Shasta (Shasta Lake/ Redding/ Anderson/ Burney)

The high risk community targeted for the home visiting program is defined as census tracts 101-118, 120-123.03, and 127.01, which covers the most populated areas of Shasta County. This high risk community encompasses 86% of the county's population, 89% of the women who gave birth in 2009, and 90% of the county's women of childbearing age.



Characteristics and Needs of Participants and Risk Factors

In 2009, more than two-thirds (68%) of the births within Shasta's high risk community were to women who received WIC services during their pregnancy, paid for prenatal care with Medi-Cal, and/or listed Medi-Cal as the expected principal source of payment for delivery. Additionally, from 2005-09, 28% of the families with children under age five in this community had incomes below the poverty level compared to 18% statewide.

Many of the births, and especially first births, are to moms who are young, single, and with low educational attainment. In 2009, 39% of births to residents in this community were to first time mothers and 16% were to women under age 21. In 2006 42% of Shasta County's births were to unmarried moms, compared to 38% statewide.

From 2006-08, the rate of women with a diagnosis of alcohol or drug use in Shasta county was more than four times the statewide rate (54.3 per 1,000 labor and delivery hospital discharges versus 11.9 per 1,000) and was the second highest among all the counties in California.

Shasta County had a rate of 19.9 substantiated cases of child maltreatment per 1,000 children in 2009, more than twice the statewide rate of 9.3 per 1,000. The county's foster care entry rate was 7.3 per 1,000 children, also more than twice the statewide rate of 3.2 per 1,000.

The rate of juvenile arrests at 8,200.0 per 100,000 population is much higher than the statewide rate of 4,972.6 per 100,000. Shasta County also has a higher violent crime rate than the state at 695.9 per 100,000 compared to 453.6. Countywide there were 632.4 domestic violence-related calls for assistance per 100,000 population in 2009, compared to 431.9 per 100,000 statewide.

In 2007, 10% of Shasta County households reported that an adult smoked indoors at home, compared to 7% of households statewide. Of women giving birth in 2009 who lived in Shasta County's high risk community, 16% reported smoking at some point during their pregnancy, and 93% of the women who smoked in their first trimester still smoked during the third trimester.

Community Strengths

The strengths of the high risk communities are supported by many resources actually located in the communities, which assists with clients accessing services and receiving needed support.

- Shasta County HHSA has four Regional Offices located in the designated communities where clients can access a number of programs co-located at one site.
- Pregnant women and families in Shasta County access WIC services at a high rate demonstrating the success of WIC staff to make services accessible.
- Breastfeeding Peer Counselors are located at each of the HHSA regional offices and provide support and education to breastfeeding WIC moms and those intending to breastfeed.
- The 4 P's Plus is a partnership between private physicians, the Maternal Child and Adolescent Health program, and treatment agencies in the community that provides assessment, referral and treatment services for pregnant and postpartum women.
- The 211 Shasta is a telephone and internet based single point of contact for more than 2,000 health and human resources in Shasta County. It is a comprehensive

information and referral database with specialized services ranging from food and shelter to job placement and health care programs. It is confidential, free and available 24 hours a day, 7 days and week. Pending Board of Supervisor approval, implementation of the 211 call center and webpage is expected to occur late summer or early fall 2011.

Mechanisms for Screening, Identifying, and Referring Families to Home Visiting Programs

A home visiting program Public Health Nurse (PHN) will be located at each of the four regional offices. Enrollment, eligibility and outreach services for Medi-Cal, CalFresh and other public benefits are also located at the regional offices, and staff working in these programs will be another important referral source to the NFP program. When applications are received for presumptive eligibility or when women apply for Medi-Cal during their pregnancy, eligibility workers can also screen for eligibility into the home visiting program and make the referral when appropriate. Each of these offices also has WIC clinic services that will be a main source of referrals to the home visiting program.

The PHNs will build upon strong relationships already developed with CHDP and Medi-Cal providers, CPSP providers, OB/GYN providers and school nurses to increase referral capacity.

Prior to implementation, planning meetings will be held with stakeholders and other home visitation programs to develop a communication, coordination and collaboration plan. While none of the current home visitation programs use nurses as the primary visitor, they all provide services in the designated community. Plan development will be crucial to the immediate success of the new home visiting program and continued success of the established home visitation programs in Shasta County.

Referral Resources Currently Available to Support Families Residing in the Communities

- **Health:** Women's Health Services; Redding Rancheria Clinic Services (Registered Native Americans); Cottonwood Medical Group; Shasta Community Health Centers; Mountain Valleys Health Centers; Hill Country Community Health and Wellness Center; Pit River Health Services; Shasta Diablo Planned Parenthood; Shingletown Medical Center; Women's Health Specialists; Teenage Pregnancy Prevention Program; Mercy Maternity Clinic; Mercy Family Health Center; Mercy Medical Center; Shasta Regional Medical Center; Mayers Memorial Hospital OGMAR (Generations of Women); CHDP Providers; Anderson Medical Associates; Anderson Walk-in Clinic; Cottonwood Medical Group; Lassen Medical Group; Palo Cedro Family Medical Clinic; Shasta Community Health Center HOPE Van (Health Outreach for People Everywhere); various dentists accepting Medi-Cal as well as adult low-cost/sliding fee payment options; Optometrists
- **Mental Health:** Shasta County Mental Health (severe and persistent mental health conditions); CalWORKs Behavioral Health Team (BHT) (CalWORKs clients only); Shasta Community Health Center; Reflections (sliding scale fee); ACES (sliding

scale fee); Northern Valley Catholic Social Services (NVCSS) (sliding scale fee, Medi-cal accepted for children); Wright Education Services (sliding fee scale); Psychiatric Care Center, Thomas Andrews, MD; Second Home/Community drop in Center

- Early Childhood Development: Far Northern Regional Center; California Children's Services; Center for Autism Support and Treatment; Early Intervention Program (Shasta County Office of Education); Head Start; NVCSS
- Substance Abuse: House of Hope; Right Roads; CalWORKs BHT (CalWORKs clients); Shasta County Alcohol and Drug Treatment; Shasta County Perinatal Treatment Program; Shasta Options; Psychiatric Care Center; Redding Rancheria Substance Abuse Program (Registered Native Americans); 1-800-NO BUTTS; Mercy Quit for Good –tobacco cessation; Empire Recovery; Wright Education; Redeemed Recovery Services; Serenity House; California Access to Recovery Effort (CARE) (helps youth 12-20 years pay for services); Teen Challenge; 4 P's Plus Provider Screening Tool; Narcotics Anonymous; Alcoholics Anonymous
- Domestic Violence Prevention: Wright Education Services; Shasta County Women's Refuge; Shasta County Victim Assistance Center; Shasta Family Justice Center; Mentoring Moms; Family Violence Prevention and Services Program
- Child Maltreatment Prevention: Child Abuse Prevention Coordinating Council of Shasta County; Shasta County Children and Family Services (CFS) ; Parent Partners; SafeCare (Shasta County CFS)
- Child Welfare: Shasta County CFS; Parent Partners
- Education: Mercy Breastfeeding and Childbirth Education Center; Mayers Breastfeeding and Childbirth Education; WIC; Parents in Control; Head Start; Early Head Start; Discipline That Works; Cal Safe; Triple P (provided by many agencies and staff in county); Love and Logic; Local Indians for Education (LIFE); Parent to Parent; TeenAge Parenting Program; Shasta County Office of Education and Early Education
- Other Social and Health Services: Life Light; Care Net; Health and Human Services Agency (Immunization and STD clinics, Child Health and Disability Prevention Program, Maternal Child and Adolescent Health, California Children Services, WIC Breastfeeding Support Services – Peer Counselors); Help Line – crisis number

Referral Resources Needed to Support Families Residing in the Communities

Mental health resources for the uninsured, underinsured and/or Medi-cal recipients is a significant service delivery gap. Coordination with the following resources will ensure that the mental health needs of women are supported:

- The CalWORKs Behavioral Health Team (BHT) services. These services consist of case management and counseling services from social workers as well as short term therapy provided by a mental health clinician, if necessary.

- The 4 P's Plus Substance Use Screening program that is expanding to include mental health screening and referral services. The 4 P's Plus is a referral network for physicians that see pregnant women who are suspected of substance use during their pregnancy. Beginning in 2012, physicians will also be able to make referrals for postpartum women who appear to be suffering from maternal depression and women will be able to access services from a contracted therapist in the community.

Plan for Coordination Among Existing Programs and Integration into an Early Childhood System

Shasta County has systems and frameworks in place to encourage and support collaboration between agencies and organization across programs. The infrastructure of the Shasta County Health and Human Services Agency (HHSA) is one such system along with the ongoing development of its 2020 Strategic Plan. The PREVENT Team (modeled after the Strengthening Families Initiative) is another.

Shasta County HHSA was formed in 2006 by integrating Social Services, Mental Health and Public Health into a single Agency. The main purpose of this integration was to assist HHSA staff to work collaboratively and address the many social, economic, behavioral and health issues that confront populations across program boundaries. Other purposes include improving efficiencies, avoiding unnecessary duplication of efforts, and organizing services to be more responsive to the customer needs. The HHSA transformation has assisted with initiating and enhancing collaborations with programs across HHSA by co-locating services. The home visiting program will benefit from enhanced program collaboration making services more geographically accessible through regional service centers with co-located HHSA services.

Due to the alarmingly high rate of child maltreatment and neglect in Shasta County, the PREVENT Team was established in 2008 with leaders from Shasta County Child Abuse Prevention Coordinating Council, First 5 Shasta, and Shasta County HHSA to address the prevention of child maltreatment in Shasta County. Modeled after the Strengthening Families Initiative, the PREVENT Team encourages and facilitates the use of evidence-based strategies that have been shown to positively impact family function. The purpose of establishing the PREVENT team was to help facilitate the development and implementation of a comprehensive, community-based strategic framework for the primary prevention of child maltreatment. A desired outcome of this effort is to bring coordination to enhance otherwise separate prevention planning and activities within each team member's agency. Continued involvement from the PREVENT Team and inclusion on the home visiting program Advisory Board will be extremely important to the success of the program.

SECTION 2.

HOME VISITING PROGRAM GOALS AND OBJECTIVES



[Type text]

SECTION 2. HOME VISITING PROGRAM GOALS AND OBJECTIVES

1. Mission, Goals and Objectives

CHVP Mission Statement: California Home Visiting Program provides leadership for integrated, collaborative, high-quality maternal and early childhood interventions across multiple systems of health and human services to address the complex needs of diverse families throughout California. California's investment to empower pregnant women and families with children will positively impact maternal health and childhood development, leading to improved health and well-being over the life course and ultimately cultivating resilient communities.

The Goals and Objectives for CHVP are:

1. Goal: Promote maternal health and well-being

- Objectives**
- a. Increase receipt of early and adequate prenatal care
 - b. Increase the proportion of women with health insurance and a medical home just before pregnancy and for 2 years postpartum
 - c. Decrease maternal Emergency Department visits
 - d. Decrease parental use of alcohol, tobacco, illicit drugs
 - e. Decrease the proportion of women with a subsequent birth within 2 years post-partum
 - f. Increase the proportion of women screened and referred for maternal depression
 - g. Increase the proportion of women breastfeeding through 3 months postpartum
 - h. Increase the proportion of women provided domestic violence and reproductive coercion information and resources

2. Goal: Improve infant and child health and development objectives

- Objectives:**
- a. Increase the proportion of children with health insurance and a medical home
 - b. Decrease child Emergency Department visits
 - c. Decrease parental use of alcohol, tobacco, illicit drugs
 - d. Increase breastfeeding
 - e. Increase the proportion of children who complete the schedule of well-child visits
 - f. Decrease incidence of child injuries requiring medical treatment
 - g. Decrease suspected and substantiated child abuse and neglect reports

3. Goal: Strengthen family functioning

- Objectives:**
- a. Increase the number of families receiving information on preventing child injuries and providing a safe home environment
 - b. Decrease parental use of alcohol, tobacco, illicit drugs
 - c. Increase the proportion of families demonstrating high-quality parenting behavior and parent-child relationship in support of children's learning and development
 - d. Increase parental emotional well-being and decrease parental stress
 - e. Increase the number of families that promote positive child development through comprehensive social emotional and developmental screening and referrals for early intervention
 - f. Increase the proportion of families effectively screened and referred for domestic violence including development of a safety plan
 - g. Increase the proportion of parents improving employment status or educational attainment

4. Goal: Cultivate strong communities

- Objectives:**
- a. Increase identification and referral of families in need of services
 - b. Enhance existing, and increase the number of formal agreements with community social service agencies across the home visiting continuum
 - c. Increase maternal and early childhood referral systems and number of completed referrals

5. Goal: Provide leadership for the coordination of maternal and early childhood systems and supports to advance federal, state and local efforts to improve health and well-being for families in California

- Objective:**
- a. Establish a home visiting network continuum of services based upon maternal, family and child needs for children 0-5, reducing duplication of services across home visiting programs

2. Comprehensive, High-Quality Systems in California to Promote Maternal, Infant, and Early Childhood Health

Strengthening Families

CHVP embraces the Strengthening Families framework to guide the development of a comprehensive, high-quality maternal and early childhood system throughout California that promotes maternal, infant, and early childhood health, safety, and development and strong parent-child relationships. This approach is centered on five protective factors for working with children and families in different settings, including the home visiting arena. The five research-based protective factors have been linked to the reduction of child abuse and neglect, and the increase in the optimal development of children. The protective factors are the conditions in families and communities that increase the health and well-being of children and families. A focus on strengths and protective factors is promoted among California MCAH programs as a strategy to address social determinants of health and health inequity, thus promoting health across the life course. Focusing on protective factors helps to develop circumstances that promote health behaviors and decrease the chance children will engage in risky behaviors as they grow up. The five protective factors outlined in the Strengthening Families approach are:

- **Parent resilience:** The ability to constructively cope with and bounce back from all types of challenges. It is about creatively solving problems, building trusting relationships, maintain a positive attitude and seeking help when it is needed
- **Social connections:** Whenever a family is isolated from family or community, the children are at more risk. Many parents may naturally develop friendships with other parents, but others may need help in establishing social connections. Building trusting relationships with all families and helping isolated families connect with other parents strengthens parenting skills and protects the children.
- **Knowledge of parenting and child development:** Parents with knowledge about parenting and their own child's development have more appropriate expectations for their behavior and knowledge of alternate discipline techniques. Early childhood professionals have a wealth of knowledge about child development that they can share with parents, whether through an informal conversation, in a class, or by sharing brochures and other written information.
- **Social and emotional competence:** Children who receive high quality early care get support for healthy social emotional development in many ways. They learn how to identify their feelings, empathize with the feelings of others, share emotions appropriately, and problem solve with peers and adults.
- **Concrete supports in times of need:** When families are in crisis, the children are more protected if the family gets access to the resources they need relatively quickly. Early childhood professionals may not be able to personally provide those resources, but they can provide appropriate referrals and follow-up to families who need immediate support.

Strengthening Families to Promote Collaboration and Systems Development

The protective factors demonstrate the commonality of practice across agencies that work with pregnant women, children and families. They provide an approach for coordination across diverse initiatives, using common language and goals for families at all levels of work. Applying the protective factors at a state level will help to shift policy, resources, cross-system relationships, and support structures that will serve to support local program implementation, leading to the optimal development of all children.

CHVP will use the protective factors approach to serve as an overarching frame for building collaborations across the maternal and early childhood system. CHVP provides a leadership role in cross-systems work at the state level in an effort to promote the health of the maternal, child and adolescent health population. CHVP plans to use the protective factors framework to bring together multiple players around a common set of goals in support of the CHVP mission and vision. Strategies in the protective factors approach will include:

- Engaging multi-disciplinary partners including social services, First 5, mental health, family resource centers, Early Head Start, Head Start, foundations, advocacy groups, education, child abuse and prevention partners, childcare planning groups, the medical community, developmental services, and families
- Linking to cross-system planning efforts by coordinating planning and implementation with other state early childhood initiatives such as the Early Learning Advisory Council (ELAC) and the California Early Childhood Coordinating Systems (ECCS)

See Section 6. Plan for Administration of State Home Visiting Program for further detail

- Promoting the use of the protective factors to define a shared set of outcomes for families across systems and disciplines, a priority for many existing California initiatives
- Partnering with others to identify agencies that fund early childhood initiatives and engage these agencies in planning and implementing family strengthening activities

3. California Strategies for Program Integration

CHVP will utilize strategies for integrating with other programs and systems in California that are related to maternal and child health and early childhood health, development and well-being by integrating home visiting into the ECCS. This involves the key early childhood system components of health care/medical home, early care and education, social and emotional development, family support and parenting education. Specifically, approaches will be developed to:

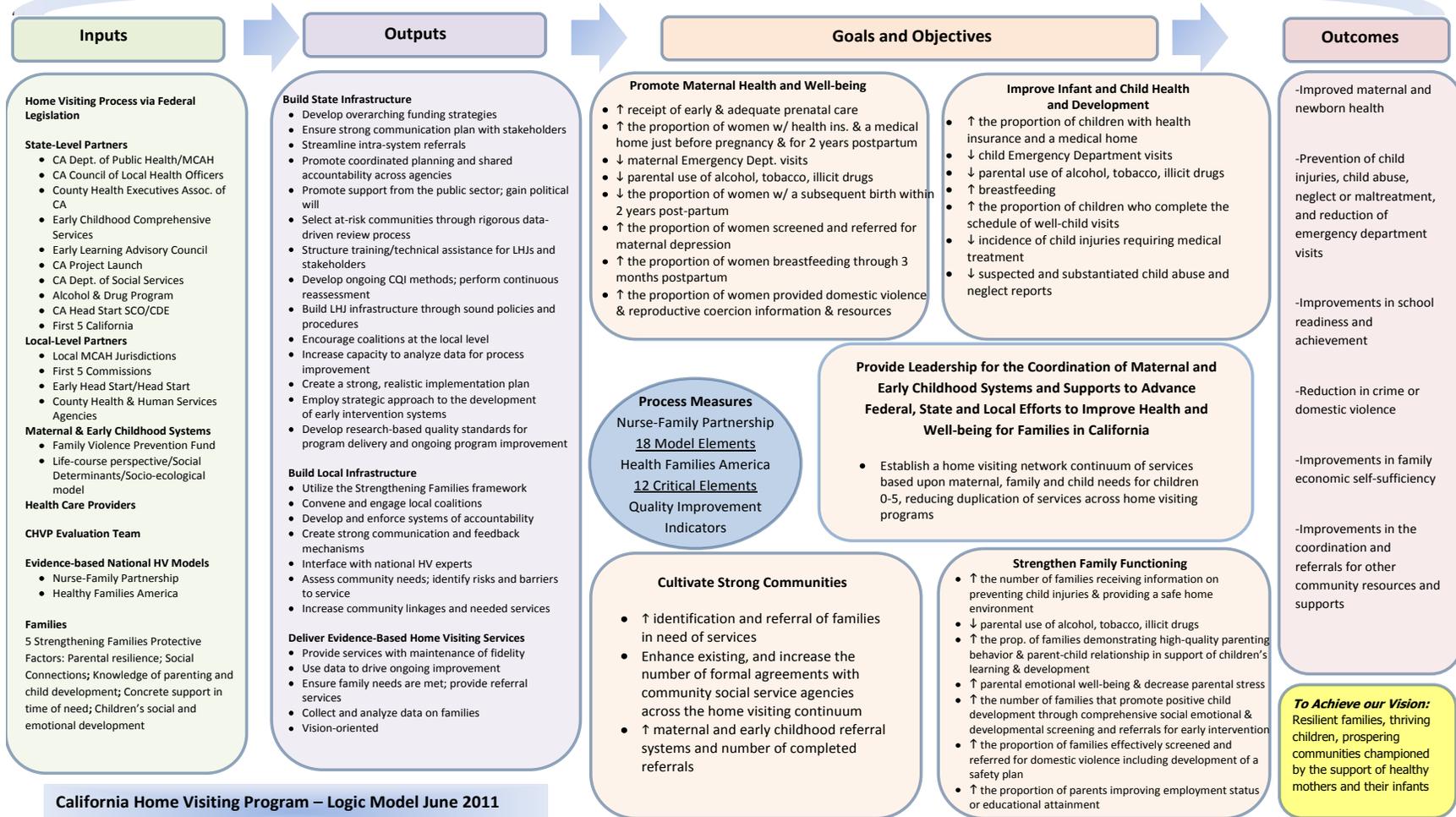
- Establish linkages to existing collaboratives and initiatives to support the integration of program services into wider state system of care

- Integrate home visiting as one component of a continuum of services for children
- Improve and expand timely and early identification of children with developmental delays or at risk of delays and provide early intervention to help children reach full potential
- Develop interagency partnerships to address barriers to services for children who fall through the cracks due to lack of insurance or ineligibility to entitlement services
- Improve effective prevention and early intervention services and provide information, education and training to parents, professionals and decision makers, and others
- Address common barriers that limit a parent's ability to parent and work from a strength-based perspective
- Streamline and improve services through cross-departmental planning and governance that builds on existing initiatives and services
- Work to ensure that services are continuous for children, especially during transition from home visiting to other services, and for those with special needs
- Improve cross-agency coordination between home visiting and early childhood programs to strengthen referral mechanisms to services that are part of the broader linked system or care
- Develop MOUs to promote formalized linkages and coordination among public and private sector partners and to ensure that interagency and cross-systems protocols and practices are effectively implemented and evaluated
- Engage in meaningful interdepartmental collaboration leading to the alignment of policy priorities and objectives, and making targeted improvement to cross-system efforts and interactions.
- Promote better communication and coordination between county and private agencies serving children and their families

4. Logic Model

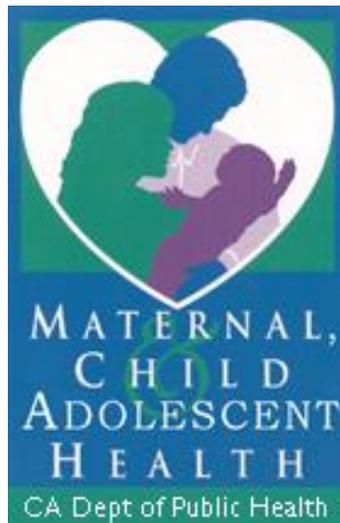
A well-defined Logic Model provides an effective method for charting progress towards meeting outcome objectives, from initial and short-term outcomes towards intermediate and long-term outcomes. The Logic Model focuses program strategies on those activities intentionally designed to impact the desired outcomes. The CHVP Logic Model explicitly captures ACA intent by incorporating benchmarks into the model objectives. Further, the CHVP Logic Model is linked to appropriate tools to measure the outcomes, so that achievements and success can be quantified. Standardized tools are defined to measure benchmarks and to assist with the overall creation of an action plan.

Strengthening Families Framework



SECTION 3.

SELECTION OF PROPOSED HOME VISITING MODELS AND EXPLANATION OF HOW THE MODELS MEET THE NEEDS OF TARGETED COMMUNITIES



SECTION 3. SELECTION OF PROPOSED HOME VISITING MODELS AND EXPLANATION OF HOW THE MODELS MEET THE NEEDS OF TARGETED COMMUNITIES

1. Selection of the California Home Visiting Models

The California Department of Public Health/Maternal, Child and Adolescent Health (CDPH/MCAH) formed an internal workgroup in October 2010 to review the research on primary service strategy home visiting models; a separate workgroup was formed to examine funding feasibility and implementation. The Home Visiting Model Selection Workgroup (HV Workgroup), which consisted of nurse consultants, research scientists and health program specialists, conducted an independent evaluation of eight national models using the following criteria: ability to address the six legislative benchmarks, staff training requirements and competency, adaptability of data management system, evidence-based curriculum design, intensity of services plus local integration of the model. As an internal determination, the HV Workgroup informally identified Nurse-Family Partnership (NFP) and Healthy Families America (HFA) as the top candidates for implementation in California.

After receiving the Supplemental Information Request 2 (SIR-2) in February 2011, the CDPH/MCAH officially selected two evidence-based home visiting models for implementation in California: NFP and HFA. Selection of these two models was based on findings from the Home Visiting Evidence of Effectiveness Review (HomVEE) Study, funded by HRSA, which distinguished NFP and HFA as having the most favorable ratings for primary and secondary outcomes in the benchmark areas.

Nurse-Family Partnership (NFP) Overview

NFP is an evidence-based home visiting model that serves first-time, low-income mothers during pregnancy through two years postpartum. A Client is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of week 28 of pregnancy. NFP provides one-on-one home visits by a trained public health nurse to participating clients. The NFP National Service Office (NSO) supports local agencies and operating agencies and provides training, evaluation services and ongoing consultation for the development of NFP programs.

See **Error! Reference source not found.** for an in-depth description of NFP, including the 18 Model Elements

Healthy Families America (HFA) Overview

HFA is an evidence-based program in which families must be enrolled prenatally or within the first three months after an infant's birth. Once enrolled, services are provided to families until the child enters kindergarten. Individual programs select the specific characteristics of the target population they plan to serve; a program plan is then created based on the needs. HFA is designed for parents facing challenges such as

single parenthood, low incomes, childhood history of abuse, substance abuse, mental health issues, and /or domestic violence.

See **Error! Reference source not found.** for an in-depth description of HFA, including the 12 Critical Elements

2. Description of How Models Meet the Needs of Targeted Communities

After the home visiting models NFP and HFA were identified, CDPH/MCAH needed a method to engage the targeted communities in order to assess the fit of NFP or HFA and the community's readiness for implementation. CDPH/MCAH determined that additional information to further refine the identification of the highest need communities in California where home visiting programs would have the greatest impact would be required to complete the USP. CDPH/MCAH developed a Request for Supplemental Information (CHVP-RSI) to solicit information from each Local Health Jurisdiction (LHJ) to incorporate local expertise in the Community selection process. The CHVP RSI asked LHJs to select either NFP or HFA for each at-risk community they selected and to describe how the selected model would address the following;

- Match the needs in the proposed community;
- Build upon the strengths of the community;
- Utilize other resources available;
- Address any service gaps; and
- Respond to the specific characteristics and needs of families residing in the at-risk community selected

Qualitative information from the CHVP-RSI was combined with quantitative data already available to CDPH/MCAH from California's submitted 2010 Needs Assessment to identify communities in California with a high need for home visiting services and a high likelihood of success in improving the health outcomes of families in those communities. "High-Risk Communities" were selected using a five step process of reviewing and categorizing quantitative and qualitative information obtained from the CHVP-RSI.

Section 1. Identification of the State's Targeted At-Risk Communities provides detailed information on the CHVP-RSI development as well as the five-step process

3. Communities Selected for Funding Beginning in Phase 1

The following 13 LHJ/communities are ranked in the order that they will be funded to implement NFP and HFA in FFY 2010-2011:

- Los Angeles Unified School District (LAUSD) NFP
- Butte (Paradise Ridge/Southern Butte) HFA

- Los Angeles Service Planning Areas or LA-SPA [SPA 2 (San Fernando Valley); SPA 3 (San Gabriel Valley); SPA 7 (East L.A.)] NFP
- Contra Costa (East/West/Central) NFP
- San Diego (North Inland-Coastal Expansion (NICE) - Oceanside/Vista/San Marcos/Escondido/Carlsbad) NFP
- Imperial (El Centro/Imperial/Holtville/Seeley/Heber) HFA
- Kern (Countywide) NFP
- Madera (Western Madera County or WMC) HFA
- Shasta (Shasta Lake/Redding/Anderson/Burney) NFP
- North Coast Tri Consortium (Del Norte/Humboldt/Siskiyou County) NFP
- Alameda (East/West Oakland) NFP
- San Francisco (Bayview Hunter's Point) NFP
- Sacramento (South Sacramento Communities) NFP

4. At-Risk Communities Not Selected for Funding Beginning Phase 1

The following 19 LHJ/communities are ranked in the order that they will be considered for implementation based on future funding availability:

- Merced (Countywide)
- Fresno (Southeastern Fresno)
- Northern Los Angeles SPA 1 (SPA 1- Antelope Valley)
- Sacramento (North Sacramento communities)
- Nevada (Countywide)
- Stanislaus (Countywide)
- San Mateo (North/ Central/ South Counties)
- Solano (Countywide)
- Riverside (Perris/Moreno Valley)
- Tehama (Countywide)
- Yolo (Countywide)
- Sonoma (Sonoma County Hwy 101 Corridor)
- Santa Clara (Countywide)
- Santa Cruz (Countywide)
- Long Beach (The City of Long Beach)

- Marin (San Rafael/ Novato/ Marin City)
- Santa Barbara (North County)
- Northern Tri Consortium (Colusa/Glenn/Tehama County)
- Orange (Countywide)

5. How Models Meet the Needs of Targeted Communities

The information in the following 13 tables is derived from the LHJs in response to the CHVP-RSI. The tables, in alphabetical order, include the 13 counties/communities that will be funded for Phase 1 FFY 2010-2011. They describe how the NFP and HFA models meet the needs of the targeted communities (including one consortium comprised of three distinct counties) in the Phase 1 implementation period. The tables also outline the existing strengths and resources that ensure a good fit with the NFP or HFA home visiting model.

See Section 1. Identification of the State's Targeted At-Risk Communities for further detail

Alameda (East/West Oakland) NFP New	
Targeted high-risk community	East/West Oakland
How the model meets the community needs and service gaps	<ul style="list-style-type: none"> • Based on the significant number of Medi-Cal births to first-time mothers in the target community and the decreasing capacity of home visitors to serve them, there is a significant unmet need. • East/West Oakland has a high rate of low birth rates among the target population which are very difficult to budge and more intensive programming is needed to achieve greater impact. Many of the County home visiting programs are similar to HFA (use paraprofessionals), thus NFP meets a gap in its provision of nurse-based services for those highest-risk first-time moms. • In East/West Oakland almost a third (32%) of first-time mothers are between the ages of 15-19. • Alameda currently does not have enough home visiting services to meet the existing need: most caseloads are full and there is shortage of services for pregnant women as many of our home visiting programs focus more on the post-partum period. • NFP is highly aligned with the service design and has been identified through a county-wide evaluation of home visiting program as a priority model for implementation.
Strengths and Resources	<ul style="list-style-type: none"> • NFP was implemented in the East/West Oakland community in the late 1990's giving the community an understanding of the model and its requirements. The program was discontinued due to misalignment with service design, but was so well received at the time that many NFP components were adopted into existing home visiting programs. • The County has a cadre of culturally representative and responsive public health nurses with decades of experience working with our target populations in East/West Oakland. They are highly familiar with the neighborhoods, the challenges faced by the populations, levels of need and existing services. • Alameda County Public Health Department (ACPHD) is currently active in several initiatives to increase health and wellness in East/West Oakland and helped develop working partnerships with people and organizations with detectible resources directly addressing the social and health inequalities experienced by East/West Oakland target population for NFP program. • ACPHD actively engages residents in East and West Oakland through meetings, youth groups and advisory boards and frequently assesses residents' concerns through focus groups and surveys • Multiple existing programs with home visiting components provide a benefit from regular contact with East/West Oakland community, and a streamlined referral and assessment process for eligible families. • Extensive experience with collaboration through The California Endowment and Building Blocks Collaborative • Connections with school-based health centers, ACPHD currently has 7 schools that it works with and is developing 9 more. • The county does not use a waiting list system per se instead referrals are made based on communication between programs and providers about available space. • Alameda County is the selected local site for Project LAUNCH and is implementing a Strengthening Families initiative • Alameda County Child Care Planning Council (1993) advises and makes recommendations to policy makers to ensure that all children and families have access to quality child care that educates children and enriches their lives.

Source: Alameda County RSI

Butte (Paradise Ridge/Southern Butte) HFA Expansion (Currently called Butte Baby Steps (BBS))

Targeted high-risk community Northern California community of Paradise Ridge (Town of Paradise and Magalia) and parts of Southern Butte County.

How the model meets the community needs and addresses service gaps

- Home visitation identified as a priority by the First 5 Butte County Children and Families Commission in 2008.
- HFA model is already in place in selected communities within the County. BBS, an affiliated HFA program, has been in operation in South Butte County (SBC) since late 2009.
- HFA is proven to be effective in rural communities, where professionally educated personnel can be both difficult to attract and retain and experience challenges connecting with the isolated population.
- Increasing numbers of women traveling to Paradise/Feather River Hospital for their OB care and childbirth.
- BBS currently limits services to mothers who deliver their babies at Oroville Hospital. A significant subgroup of SBC mothers are delivering at Feather River Hospital and may be qualified for BBS home visitation services
- SBC has limited pregnancy, parenting and family support resources available: there only two OB/GYN providers in Oroville and they deliver at Oroville Hospital; and Better Babies provides a limited CPSP program for the Oroville community that doesn't include classes and is not widely utilized by either physicians or eligible mothers.
- Many residents are challenged to access appropriate health care due to transportation issues, lack of culturally appropriate healthcare, challenges obtaining health coverage, and lack of quality healthcare.
- High percentage of children and parents with developmental delays, other mental disease and/or disabilities.
- Paradise Ridge and Oroville include the poorest, most isolated geographic regions in the County. These areas have all the risk factors for child abuse and neglect: limited public transportation, significant substance abuse concerns, and long distances to travel to receive services.
- Substance abuse recovery services are limited, especially for pregnant women. Stepping Stones Perinatal Drug Treatment Program is currently full to capacity.
- In 2009, the Butte Interagency Narcotics Task Force (BINTF) Drug Endangered Children's (DEC) team completed 53 DEC investigations. And as a result, a total of 111 children were provided services by Butte County Children's Services Division (CSD), 78 children were physically detained.

Strengths and Resources

- BBS has developed formal and informal agreements with all relevant service providers within SBC service area
- Early Head Start (EHS), Department of Social Services, Public Health, WIC, Oroville Hospital, Better Babies, Obstetrics/Gynecologist providers, and others benefit from regular contact with BBS staff, and benefit from a streamlined referral and assessment process for eligible families.
- EHS and BBS adhere to a clear MOU that ensures services are not duplicated, expedites the referral process for both programs and ensures that families with the highest needs are identified and prioritized
- Parents As Teachers (PAT) and BBS work together coordinating programs in terms of resources, referrals and trainings on a regular basis and complement each other.
- Families not eligible or interested in BBS services receive a warm handoff to a variety of other services that may appropriately meet their specific needs, as opposed to being put on a waiting list.
- Feather River Hospital in Paradise is home to a wealth of prenatal and pediatric medical programs and services.
- Health Mothers (HM), a CPSP program, successfully enrolls MediCal mothers and provides a case management approach to prenatal services, including many pregnancy and parenting related classes
- Youth For Change offers family reunification services, group home services, Parent Child

Butte (Paradise Ridge/Southern Butte) HFA Expansion (Currently called Butte Baby Steps (BBS))

Interaction Therapy and the Paradise Ridge Family Resource Center (PRFRC).

- The PRFRC offers in-home case management, conducts workshops regarding budgeting, domestic violence restraining orders, and parenting. Other partners that provide services at the Center are: Catalyst Domestic Violence, Planned Parenthood, Paradise Unified School District, and Butte County Behavioral Health.
- Care Net is a non-profit community program that provides support and assistance to young pregnant mothers. Public Health provides the Targeted Case Management program county-wide.
- The Greater Oroville Family Resource Center offers programs, classes and groups for teens and adults, and partners with Oroville Hospital to provide health education.
- Butte County First 5 Commission recently adopted the Strengthening Families (SF) framework. HFA/BBS is funded by the Commission and so will be required to participate in the SF trainings.

Source: Butte County RSI

Contra Costa (East/West/Central) NFP New

Targeted high-risk community

Eight ZIP codes in the County in the cities of Richmond, San Pablo, Concord, Pittsburg, Bay Point, Antioch, Oakley, and Brentwood

How the model meets community needs and service gaps

- Targeted ZIP codes fare much worse with regard to health outcomes, levels of poverty and low educational achievements, including indicators for which the home visiting program is appropriate
- Targeted ZIP codes bear a disproportionate burden of late or no prenatal care, low birth weight, and preterm births compared to the rest of the county
- Services are not adequate to address the substance abuse needs of pregnant and postpartum women, particularly those whose primary language is not English.
- Gaps in services include mental health, substance abuse, transportation, and shelter for women with infants or young children.
- NFP will offer a complementary and distinctly different approach, as the only evidence-based model based on Public Health Nurses as the home visitors, targeting this population.
- Other home visiting programs and case management services offered in the high-risk community are fundamentally different in focus, approach, timing and duration of service from NFP
- The NFP model would add to the existing continuum of services by providing an intensive intervention for higher risk families and much earlier in a woman's pregnancy.
- Little, if any overlap is anticipated due NFP target population, for example, some programs only serve parenting mothers while others only serve the infant for a short time.
- Community need for broad and sustained efforts to create supportive systems that strengthen families.

Strengths and Resources

- Established evaluation unit which specializes in data management and analysis, assessment, planning, and evaluation of public health programs, including the Family, Maternal and Child Health (FMCH) Programs.
- High-risk community has an array of early childhood development collaborations and initiatives, programs, and partnerships
- Contra Costa Health Services integrated health care delivery systems provides full scope of medical and ancillary services
- Uses the New Spectrum of Prevention and the Life Course Perspective to inform FMCH collaborations
- Implements Building Economic Security Today, an asset development pilot project that utilizes innovative strategies to reduce inequities in health outcomes for this and future generations of low-income families by improving their financial security and stability.
- Plan to hire within their system. Has a pool of Public Health Nurses who have an average of 12 years of experience
- Developed a mechanism to identify and provide coordinated treatment options for pregnant women with depression, anxiety, mood disorders, or other mental health conditions
- Utilizes multifaceted quality improvement strategies to ensure quality program processes and outcomes
- First 5 Contra Costa Family Resource Centers are located in five of the hot spot zip codes.
- Families Thrive is a partnership of Contra Costa's Zero Tolerance of Domestic Violence system change initiative.
- Building Blocks for Kids, a partnership for more than 30 agencies works to support healthy development and education of all children and self-sufficiency of all families by engaging the community, block by block

Source: Contra Costa County RSI

Imperial (El Centro/Imperial/Holtville/Seeley/Heber) HFA New

Targeted high-risk community	Central Imperial Valley: includes incorporated cities of El Centro, Imperial and Holtville and the unincorporated cities of Seeley and Heber
How the model meets the community needs and addresses service gaps	<ul style="list-style-type: none">• The location is predominantly in a rural, agricultural community• The most significant risk factors for families are late or no prenatal care, high rates of poverty, unemployment, child maltreatment, substance abuse/binge alcohol use, high birth rate to teens, and domestic violence.• A large portion of non-English speaking families who have limited access to health care.• HFA would serve families not able to link into services through other existing HVP currently operating on a limited basis in Imperial County. HFA would fill a void left by the funding demise of a Perinatal Program that worked to decrease the incidence and prevalence of alcohol, drug, and tobacco use among pregnant and parenting women.• HFA works with the family, at the intensity level needed, for 3-5 years which is significantly longer than any model currently in place. The disruption caused by short-term interventions, that are more of the norm in this community, negatively impacts both retention and long-term outcomes.• HFA would seamlessly link with the structure and frameworks already in place in Imperial County to support collaboration across disciplines and among partners.• HFA will enhance local efforts to improve access and integration of services, reduce red tape and duplication of efforts, and improve efficiency in the provision of social and well-being services countywide.• HFA could collaborate with other family support organizations in the community to effectively utilize scarce resources and provide a comprehensive network of services to families while avoiding duplication of services• HFA would enhance or complement and not overlap EHS's target population.• Imperial Valley Regional Occupational Program's Project Nenes, which uses the HIPPY program model would complement the HFA program but not overlap or duplicate any targeted populations / recipients in that it offers a school readiness program that helps parents prepare their 3- to 5-year-old children for success in school and life.
Strengths and Resources	<ul style="list-style-type: none">• Strong collaboration within the Imperial County public Health Department between Social Services, and Imperial County Office of Education.• Strong collaborative structure in place that provides a solid approach to working with children and families in early education centers, child welfare departments, health-care programs, and other settings.• Strong sense of community and connectedness between families, neighbors, schools and other support systems.• 80% of Imperial County's population are Latinos/Hispanics, which provides a strong cultural identity for communities and families often with multi-generational family ties who support one another when needed.• Despite limited or no prenatal care, women and their babies generally have good birth outcomes, with slightly higher rates of low birth weight babies, and good survival rates, reflected in the very low rate of infant deaths.• Pregnant women care enough about the health of their unborn child that they do not abuse drugs or alcohol despite the higher rates of substance abuse in the overall population.• Lower school drop-out rates are a sign of families' value and commitment to education of their children• The Community has a long history of working with Promotoras community based organizations, have maintained active Promotora cadres that work in a variety of health and community based projects.

Source: Imperial County RSI

Kern County (Countywide) NFP Expansion

Targeted high-risk community

Low Income Pregnant Women and/or Low Income Families with Children Birth to Age 2; Bakersfield, Northwest and Southeast corner of Kern.

How the model meets the community needs and service gaps

- NFP provides limited services to Kern County residents. Although they serve residents in most areas of Kern, due to the large geography and high numbers of referrals, the current program cannot meet all of the community needs.
- Allows the possibility of prospective participants that are currently on the NFP waiting list to be served
- Enables Kern County to build another NFP team which is a great opportunity for staff to be cross-trained.
- Increases the partnership and support of various community agencies such as the Family Resource Centers, and participation with collaborative.
- Builds on outreach efforts to other medical providers such as private offices will be easier to recruit women who are in their first trimester of pregnancy.
- Kern County is below the rest of California and the nation when it comes to wages, employment, and income levels.
- Additional barriers that can compound the situation include the county's size (area of Kern County is 8,141 square miles of valley, mountain, and desert regions)
- Undocumented immigrants experience difficulty in meeting basic needs and accessing services, while facing additional health risks related to low wage jobs that lack protections and benefits.
- Cultural beliefs and practices, and poverty are contributing factors to teen pregnancy.
- Kern County pregnant teens are at increased risk for complications such as premature labor, anemia, high blood pressure and poor socioeconomic consequences.
- Kern County babies born to teenagers are more likely to have lower birth weights, increased infant mortality, an increased risk of hospital admission, less supportive home environments, poorer cognitive development and, if female, a higher risk of becoming pregnant themselves as teenagers.
- Kern County teenaged mothers are often socially isolated, have mental health problems, have fewer educational and employment opportunities and may become financially dependent on her family or on public assistance
- The lack of economic opportunity and resources in the area create a strain on families and can affect children's emotional, social, cognitive, and physical development and thus their readiness for school.

Strengths and Resources

- The Kern County Public Health Services Department (KCPHSD) provides services for a wide variety of health needs including family planning, immunizations, well-child exams, and health education programs.
- Due to economic hardship, living with extended family is a common practice in Kern County is a strength because for those juggling work, children, elderly parents and financial constraints, it provide savings in household costs and family members can share child care responsibilities and assist with transportation.
- The Greater Bakersfield Legal Assistance, Inc. offers free legal services in civil matters to eligible low-income persons residing in Kern County representing residents who are unable or too afraid to speak for themselves either because of racial, economic, social, or legal barriers.
- Community Action Partnership provides comprehensive information and referral services that links Kern County residents to community health and human services and information on services such as food, transportation, rent/financial aid, utility assistance, child care and clothing.
- Search and Serve is a program that provides services from birth until age 21 to a child that has a disability which has the potential to adversely impact the child's ability to learn and works in collaboration with state and local agencies of the Department of Mental Health, Rehabilitation, Health, and Human Services, the County Superintendent of Schools, all public and non-public schools, Kern Regional Center and community agencies that provide

Kern County (Countywide) NFP Expansion

services to children.

- The Alliance Against Family Violence and Sexual Assault (AAFVSA) is a 24-hour hotline nonprofit organization operated by volunteers committed to stopping domestic violence and sexual violence
- Child Death Review Team consists of a competent multi-disciplinary team and provides case review in the investigation and management of individual child deaths.
- The Fetal Infant Mortality Review (FIMR) reviews cases and identifies barriers to care, trends in service delivery, and ideas to improve policies that affect families.
- The Medically Infant Vulnerable Workgroup and Children's Assessment Center identify gaps in services and community agencies by carefully reviewing individual infant cases on medical and social needs.
- MCAH/Public Health Services includes a spectrum of programs available to providers and clients such as the Perinatal Outreach Program (POP) Comprehensive Perinatal Services Program (CPSP), Fetal Infant Mortality Review (FIMR), Black Infant Health (BIH) Program, and Sudden Infant Death Syndrome (SIDS).
- MCAH system including NFP and CIP coordinate the delivery of services to mothers, children and teens in Kern County and may provide bus passes to clients to get to their WIC and medical appointments.
- The MCAH Resource Manual is accessible and available online for Kern residents which provide a list of phone numbers and addresses of various community resources such as Parenting Classes, Dental, Family Planning, and medical providers.

Source: Kern County RSI

Los Angeles Unified School District (LAUSD) NFP Expansion

Targeted high-risk community

Los Angeles Unified School District (LAUSD)

How the model meets the community needs and service gaps

- Expansion of the LA-NFP program is commencing currently within Service Planning Areas (SPAs) 1, 4, 6 & 8, and countywide for the deaf and hard-of-hearing using the "Mental Health Services Act (MHSA)" funding. Hundreds remain under-served by any home visitation or family strengthening program, especially within the geographical area of LAUSD.
- Recently through a partnership with LA County MCAH and assistance of the Nurse Manager of LA-NFP, LAUSD hired one NFP Nurse Home Visitor using a Safe Schools/Healthy Students grant. The time-limited grant restricts the area served to two zip codes resulting in the LAUSD NFP outreach being given to this area only. Referrals outside of this area go to NFP-LA. Expanding LAUSD-NFP as an independent LAUSD program in collaboration with NFP-LA is desirable and the need is great.
- The LAUSD-NFP nurse in the Safe Schools/Healthy Students grant-funded "Washington Investing in Neighborhoods" or "WIN" Project can only receive referrals for clients in two zip codes which limits referral source and caseload. The benefit of the existing partnership with NFP-LA is that referrals may be received district-wide and shared with NFP-LA. This complimentary relationship will allow LAUSD to expand NFP services within the school system.
- Areas targeted to receive NFP services are considered to be high risk as determined by the high numbers of first time mothers who are economically disadvantaged, and received Medi-Cal paid prenatal care. LAUSD pregnant young females/teens are at the highest risk for poor birth outcomes due to their youth and inexperience.
- NFP-LA determined the most serious service gaps for high-risk pregnant youth across the indicated SPAs are: 1) Mental Health support for depression and psychological issues 2) schools or opportunities that will support the pregnant or parenting student to promote high school graduation; and 3) Community centers or "Family Resource Centers" where NFP clients can become more involved within their communities and find local resources and others to help following NFP graduation.
- LAUSD currently has a Ready for School Home Visitation Program in Cudahy serving 25 families and funding ends June 30, 2011. Priority is given to LAUSD teen parents of children 0-2 years and socially isolated families. Having NFP available offers the opportunity to refer pregnant teens with asthma to the LAUSD Asthma Program

Strengths and Resources

- Department of Public Health's NFP program provides services within the LAUSD boundaries for the last 11 years. The program has achieved outstanding outcomes with high risk pregnant youth within the identified LAUSD community
- NFP-LA has a presence in all SPAs with the exception of SPA 5
- The NFP-LA program has been an important referral source for LAUSD, especially with helping pregnant and newly delivered teens to complete high school.
- "Linkages" is a statewide initiative currently sponsored by the Child & Family Policy Institute of California with the goal of effectively integrating CalWORKs and Child Welfare Services.
- LAUSD School Nurses have universal access to students, and every K-12 school has a School Nurse at least once a week. The School Nurse is viewed as a confidant and source of trustworthy information and referral sources.
- LAUSD provides Foster Care counselors offering case management and counseling services to students and their families; and work with children's social workers to ensure school stability.
- There are 15 high school complexes located in SPAs selected based on certain indicators, and all are being developed as Wellness Centers and networks. One LAUSD-NFP school nurse is located in one of these Wellness Centers, working together with LAUSD providers and the soon to be built community clinic staffed by St. John's Well Child and Family Center. Los Angeles County's Prevention Initiative Demonstration Project PIDP builds on existing community capacity developed over the last decade to address the full spectrum of child abuse prevention.

Source: Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health (MCAH) RSI response

Los Angeles Service Planning Areas (SPA) NFP Expansion

Targeted high-risk community	SPA 2 (San Fernando Valley) SPA 3 (San Gabriel Valley) SPA 7 (East L.A.)
How the model meets the community needs and service gaps	<ul style="list-style-type: none"> • NFP is selected for expansion because it is a "strengths-based" model of intervention that was started in L.A. in 1996 and expanded countywide in year 2000 and has shown consistently excellent outcomes. • Selected SPAs for NFP expansion have poverty, fetal deaths and infant/child death indicators with significant need. An increased presence of NFP in the communities at risk has been proven to be a positive influence in addressing these. • High crime areas go hand-in-hand with poverty, and the areas proposed for NFP expansion (SPAs 2, 3 & 7) have pockets of high crime areas where many of pregnant youth are living. • SPA 3: NFP services were greatly reduced in this area following the loss of NFP funding in 2003-4. Currently only 3 NFP nurses serving a maximum of 75 families are assigned to this area previously. • SPA 7: This area has pervasive poverty, high crime rates, numerous gangs and large number of children in foster care; its' resources are very limited. • NFP has been partnering with the L.A. Department of Mental Health, and with the schools, i.e. LAUSD, (promote easy access into school jurisdictions for high school diplomas). NFP administration has also linked with the Los Angeles Trade Tech College and has directly participated in helping to establish family resource centers, such as the Magnolia Place [Family Resource Center] in SPA 4, that serves as a template for building other community responsive centers in other locations.
Strengths and Resources	<ul style="list-style-type: none"> • Often, families are hesitant to seek advice due to their immigration status which is a significant issue in these SPAs. Due to the many legal complications faced by L.A. teen parents, NFP partners with the Children's Law Center Los Angeles, The Alliance for Children's Rights and several other law firms that can and will provide legal support for NFP teens in need. • During the last several years, NFP has developed tight connections with the L.A. Unified (Los Angeles, Service Planning Areas) School District (LAUSD) that has provided invaluable assistance in helping teen parents stay in school. • Because gang involvement impacts all NFP families, NFP-LA has formed a partnership with Homeboy Industries, Inc., a gang-diversion program developed by Father Greg Boyle. Homeboy Industries staff has provided several trainings to the NFP-LA nurses and is a great resource for our enrolled gang youth to become involved in improving their communities. • SPA 2: These families are motivated to learn and are open to positive role modeling and feedback. They are a proud community that in an effort to avoid government aid, have developed several local community centers, some with County-level support and participation. They have resources from L.A. Universal Preschool and Valley College, which has also opened a family resource center and has a variety of programs designed both to build the early care workforce and support families with children under age three. • SPA 3: Presence of Edelman's Children's Court representing the first children's court in the nation designed and dedicated to the health and welfare of abused and neglected children and their families. Los Angeles City's recent "Gang Reduction Program" that brought community resources together to address the large number of gangs that negatively impact their crime rates and City functioning. NFP also works with several community programs, such as the Promotora programs run by the Citrus Valley Health Care Partners, and collaborates with the Pasadena Health Department and their BIH program. • SPA 7: NFP is working closely with many County and private agencies in this SPA, such as St. John's Well Child and Family Center and the County Department of Public Health's newly developing Health Clinic that will serve this area. • Los Angeles has an experienced NFP administrative staff that has been responsible for securing the funding, guiding development, hiring staff and monitoring ongoing operations to ensure fidelity to the NFP model for the last 13 years.

Source: Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health (MCAH) RSI

Targeted high-risk community Western Madera County (WMC)

How the model meets the community needs and service gaps

- Cal-Learn (Cal-Works program for pregnant and parenting teens) will be discontinued 6/30/11. These teens have serious and multiple issues that could effectively be addressed by HFA.
- Other than the 15 families served by the Safe Kids California Project, there currently are no HVP services for children over 12 months of age.
- Resource systems are not transparent or readily accessible. There is no one place to go to find out about resources or to find out changes in resources (see strengths, this has been addressed)
- MC professionals know that there are inadequate number of developmental screens being done for children and too few screeners within the community.
- HFA HVP will provide one more avenue for children residing in WMC to receive developmental assessments and early intervention if developmental delays are detected.
- There are abundant numbers of clients: 2008 zip codes serving WMC show 329 first-time mothers, age 19 and under who received MediCal
- HFA complements and does not duplicate existing HVPs in WMC
- Families identified prenatally with higher risk through HFA would receive weekly visits whereas lower risk families would go into First Parents Program (FPP) and still have visits every 2 weeks.
- FPP does not take mothers under 19 years old. These clients are placed in Madera County Public Health Department (MCPHD) pregnant and parenting adolescent programs. For higher risk teens, the HFA HVP would be preferred allowing for more intensive case management.
- FPP can continue to case manage families living in the central and eastern portions of the county, outside of the WMC higher risk catchment area.
- The opportunity to utilize HFA HVP in WMC to continue case management services for these moderate risk, overburdened families and for families with 1-3 year olds with developmental delays/disabilities will make a significant and positive impact

Strengths and Resources

- Agencies interconnect through a multi-strand network of professionals that participate in and direct a variety of multidisciplinary teams and coalitions; the network is flexible but strong. Agencies are transparent with each other, putting the child/family at the center of the problem solving circle.
- MC professionals share a strong willingness to collaborate.
- MC professionals emphasize a strength –based approach to family problem solving.
- WMC shows a strong sense of community with annual events like Picnic in the Park, A Resource Fair, Family Fun Day: A Day to Celebrate Strength in Families and Child Abuse Prevention.
- Madera Rescue Mission, Doors of Hope, Madera Ministerial Association, churches and a variety of community organizations worked together to provide a network of food clothing and furniture banks to serve those in WMC in poverty.
- WMC is geographically small enough to make personal relationships easier; daily travel by home visitors is efficient.
- WMC is a strength-based, family-centered community with an emphasis placed on parent support, parent-child interaction, infant mental health and secure attachment.
- MCPHD MCAH HVPs provide services predominately to the Hispanic/Latino population which is concentrated in WMC; thus a culturally and linguistically competent staff exists.
- MC’s Children’s Hospital Central California is one of the 10 largest children’s hospitals in the nation. CHCC was the first children’s hospital West of the Rockies to receive Magnate Nursing Designation, the highest nursing benchmark in the world.
- MC’s Vision Madera 2025 Action Plan includes 4 focus areas: A well planned city; a strong community and great schools; good job and economic opportunities; and, a safe and healthy

Madera County Western Madera County (WMC) HFA New

environment.

- Infrastructure for HVP, departmental and community support including referral systems, resources and services for families are in place.
- MCPHD has several experienced staff including Program Managers and Public Health Nurses available for hire or transfer into an HFA HVP.
- WMC is resource rich but there is no organized method within WMC to track resources or navigate through resource systems. Recently Community Action Partners of Madera County purchased subscription to "Self-Sufficiency Calculator" software based regional system.
- MCAH HVP CMs are experts regarding available community resources/services: CM know how to access resources/services; how to navigate the different community systems; the gaps and barriers within resource/service systems; and CM track all changes in resource/service as they are funded, defunded, refunded or shift to another agency.
- A referral network already exist in Madera County (MC) for identifying potential clients for HVP from community partners and has proven to be the best way to identify clients early in pregnancy. Potential clients are also identified through self-referral and from birth certificates.

Source: Madera County RSI

Targeted high-risk community Humboldt, Del Norte and Siskiyou Counties

How the model meets community needs and service gaps

Humboldt:

- Local “skills gap” in employment. Educators, representatives from Department of Health and Human Services , and the business community are working together to promote an initiative to create a “ready and willing, able and capable” workforce
- All three counties were found to have indicators above the 90th percentile in the areas of perinatal substance use, children with special needs, juvenile crime, illicit drug use, prenatal care, foster care, short birth intervals, domestic violence child maltreatment, poverty, premature births, and low birth weight.
- All three counties have waiting lists for their Early Head Start programs. Humboldt County’s adapted Healthy Families America program has a wait list and limited resources to extend fully into Del Norte County.
- Residents face rising housing and transportation costs; unemployment and homelessness; poor or non-existent health care insurance; substance use. The rural, isolated nature of the county magnifies these challenges.
- Many current NFP clients have experienced intergenerational substance abuse, domestic violence and child abuse or neglect
- Distance between the Tri-County consortium is a challenge given the size of the counties, the mountainous terrain and inclement weather but it is not insurmountable
- Without this tri-county consortium, Del Norte and Siskiyou counties would not be able to offer NFP to their high risk communities due to limited funding and infrastructure

Siskiyou

- Extremely frontier county impacts service delivery efficiency and cost
- Current gaps in the ability for the Early Head Start (EHS) home visiting model to effectively address generational dysfunction, addiction issues and complex mental health conditions
- Current home visiting programs do not offer professional home visitors with comprehensive skills and experience in family systems and health assessments
- Current programs have not been able to effectively show measurable outcome improvements
- Current Human Service programs do not target prevention and therefore have been unable to improve outcome data
- Three years ago Siskiyou's Adolescent and Family Life program was defunded. Family Planning Clinics provided in 2 county locations were also discontinued.
- The large volume of Children’s Protective Services emergency response reports prohibit prevention activities
- Three primary challenges that Siskiyou County may encounter across the consortium and at the county level include: 1. Access to timely staff training of the NFP model. 2. Ability to maintain supervisory requirements due to logistical concerns of not having NFP supervisor located in each of the 3 consortium counties. 3. Expedited client enrollment and retention

Del Norte

- Challenges with poverty, child abuse, substance abuse and a large geographical area
- Far exceeds the state rate of reported and substantiated cases of child abuse and neglect. Poverty is the greatest indicator for children requiring out of home placement due to neglect. Drug and alcohol abuse and lack of access of mental health/ family support services are also contributing factors. Entries of children into foster care for the children of Del Norte County are more than twice the rate for the state.
- EHS in the County has a waiting list
- EHS partially meets the community’s home visiting needs, but does not come close to meeting the total need
- Need for increased access to public transportation, safe and affordable housing, improved economy and job market, increased access to family planning services and medical

providers

Strengths and Resources**Humboldt:**

- DHHS is receiving national attention as a model for integrating Public Health, Mental Health and Social Services into one department
- First 5 Humboldt hosts a number of initiatives to improve the health and well-being of children and pregnant women and to strengthen families
- The same remoteness that limits access to these needed services can also create an ideal environment for small close-knit communities that outshine urban and suburban areas in self-sufficiency and inter-family support. Because services are so limited to these remote rural areas the high risk community members are “hungry” for attention and support.
- There are a number of grass-roots programs to support the high risk community
- The rate of enrollment in NFP is also higher than the national rate at 69.6% as compared to 66.2%. Attrition rates are lower in Humboldt when compared to National NFP; 2.7% versus 16% with an objective of 10%.
- Del Norte and Siskiyou staff will utilize internet, telephone and videoconferencing to maintain contact with the Humboldt County NFP supervisor on a weekly basis and schedule face-to-face meetings on a monthly basis.
- Members of the NFP Community Coalition and First 5 Humboldt supported the proposal for expansion.
- Additional benefits of the proposed expansion include: clients traveling between county lines could remain in the NFP program; more clients in Eastern and Southern Humboldt County could be enrolled with additional PHN staffing; Del Norte and Siskiyou counties could benefit from the resources and success of Humboldt County.
- Del Norte County has very limited staff and infrastructure to provide NFP. Humboldt County will recruit and hire a Public Health Nurse (PHN) who lives in Del Norte and is familiar with local programs. Humboldt County will be responsible for fully funding and training this PHN.
- Siskiyou County has already identified a PHN candidate for NFP and will transfer her into that position as soon as notice of funding is received
- The Del Norte County PHN will need to be recruited; there are 2 known PHN’s in consideration
- Humboldt County and Del Norte County are currently in partnership through the Humboldt Del-Norte Medical Society, sharing of Women, Infants, and Children (WIC) services, and oversight by the Humboldt County MCAH Program Director of the CPSP clinic in Del Norte
- Historically, Humboldt and Del Norte maintained a joint Public Health Department
- Both Siskiyou and Del Norte counties join Humboldt in the MCAH Northern Association of Perinatal Advocates, in the First 5 northern region, and as part of the California Center for Rural Policy focus area.

Siskiyou:

- Has had multiple early childhood collaborations over the last two decades
- First 5 has developed a network of family resource centers in 10 communities throughout the county providing family centered services including: school readiness programs, Medi-Cal and Healthy Families application assistance, parent education classes, and support groups
- There is an effort to decentralize behavioral health and substance abuse treatment services and utilize the Federally Qualified Health Clinics and Family Resource Centers to improve access to services
- The tri-county consortium has contiguous borders
- These tri-counties have limited access to convenient proximate partners with huge areas of national forest, a coastal mountain range, the Pacific Ocean and/or the Oregon border framing populated areas.
- Nurturing Parenting classes are offered throughout the county. Each community has developed a service menu that meets the needs of their community culture.
- MCAH coordinator is a certified PIPE Regional Trainer
- The Siskiyou Substance Abuse Coalition has been revitalized in the last 2 years and is

North Coast Tri Consortium NFP New/Expansion

- implementing a county wide substance abuse prevention grant for Siskiyou youth
- Perinatal Drug and Alcohol program offers an outpatient drug and alcohol program, parenting classes, on-site child care, and transportation.
- NFP will complement and enhance existing intervention programs by reducing need for more intense services in the future.
- Humboldt County will serve as the fiscal agent for the consortium. Del Norte and Siskiyou Counties will subcontract with Humboldt County to provide NFP services in their respective counties.
- Supervision for the program will be coordinated among the three consortium counties
- Siskiyou County has an ongoing 5 year relationship with Del Norte County through our Red Cross collaboration. Siskiyou County is a service delivery under Del Norte's Red Cross charter and has a strong working collaborative relationship.
- Siskiyou County has an established collaborative relationship with two medical clinics located in Humboldt County that are on the western border of Siskiyou & Humboldt Counties located in Orleans and Hoopa.
- Siskiyou County is assisting Del Norte County with implementing an Auxiliary Communication for Emergency Services (ACES) amateur radio networking system and providing ACES training opportunities for Humboldt County

Del Norte:

- Strengthening Families is offered at First 5
- The Perinatal Drug and Alcohol program is offered for pregnant and parenting women which includes an outpatient drug and alcohol program, parenting classes and on-site child care
- Will be able to refer families who move to Humboldt or Siskiyou
- Lack of home visiting programs in the County; will be able to begin receiving referrals as soon as staff are hired, within three months of the program funding start.
- Currently in a partnership with Humboldt County through the Humboldt Del-Norte Medical Society, sharing of WIC services, and oversight by the Humboldt County MCAH Program Director of the CPSP clinic in Del Norte. Both Siskiyou and Humboldt counties join Del Norte in the MCAH Northern Association of Perinatal Advocates, in the First 5 northern region, and as part of the California Center for Rural Policy focus area. Siskiyou County has an ongoing 5 year relationship with our county through our Red Cross collaboration.

Source: Humboldt County RSI, Siskiyou County RSI, Del Norte County RSI

Sacramento (South Sacramento Communities) NFP Expansion

Targeted high-risk community Sacramento (communities of Florin, Fruitridge, Oak Park, Parkway and South Sacramento)

How the model meets the community needs and service gaps

- Several risk factors place this community at risk for suboptimal health and developmental outcomes including: low-income first time mothers, teenage mothers, at risk for premature or low-birth weights, or infant mortality; high rates of prenatal substance abuse; high crime rates, particularly homicides; and lower school performance and higher school dropout rates.
- Program data indicates that Sacramento NFP is successfully reaching and serving at-risk first-time mothers. The overall low birth weight (LBW) rate of births to women enrolled in Sacramento NFP is 6.6% which is lower than the National NFP rate of 9.4%. Additionally, LBW rates for teen mothers in Sacramento NFP are lower than National NFP rates
- Women using marijuana or alcohol when they enrolled in Sacramento NFP, showed a 53% decrease in frequency of use of marijuana and an 18% decrease in frequency of use of alcohol at 36 weeks of pregnancy.
- Women 18 years and older, served by NFP, who had a high school diploma or GED at intake, 31% enrolled in higher education/vocational schools
- The Sacramento NFP has a well-established and extensive referral network of service providers that enhance the program's success by providing complementary and support services (health care providers, schools, community-based agencies and family resource centers).
- NFP Sacramento, in its operational history, has never targeted this specific high needs Medical Service Study Area (MSSA) and this target population.

Strengths and Resources

- Consists of communities that are well established in Sacramento County. This diversity is reflected in the rich small business community in this MSSA area.
- Presence of well-established organizations which are located in the community to provide multi-cultural services to the diverse population.
- Presence of a number of associations/ organizations ensuring that the community's infrastructure and business needs are being met at all levels of government.
- The University of Davis Medical School operates a student run clinic in the Oak Park Community Center (Imani) which provides free medical services to the community.
- In 2009, South Sacramento was selected by the California Endowment to be part of a 10 year project to make South Sacramento a healthier place to live. The Sacramento Building Healthy Communities (BHC) is designed to improve health systems and the physical, social, economic, and service structures that support healthy living in California. This is a community driven process which includes the numerous partner agencies.
- Presence of 3 Family Resource centers providing free services to the community including: parenting classes, anger management classes, bilingual classes and services, one stop employment services, exercise classes, baby bonding classes, support groups and youth activities. Some sites also provide clinic services through UCD Medical Center.
- The Oak Park Community Center and Effort Oak Park Community Health Center providing health, primary care and behavioral health care services for women and children. They recently expanded their services to include children's dental services. The Women's, Infant and Children's (WIC) program also provides services at this location. There is a Head Start program at this one location.
- Presence of Sacramento Food Bank Services main office and warehouse providing free adult educational and literacy programs; providing "Havens Transitional Housing" program for homeless families with minor children and operating a "Mother Baby Program" that provides baby supplies and classes for pregnant and parenting women.
- Lutheran Social Services provides services to help families/individuals achieve levels of self-reliance.
- Department of Human Assistance provides Medi-Cal services to low income pregnant and parenting women; and Cal Work services to assist women financially with entering the job market.

Sacramento (South Sacramento Communities) NFP Expansion

- Women Escaping a Violent Environment (WEAVE) and My Sister's House provide domestic violence counseling and support to women who are in or have been in abusive relationships.
- County of Sacramento Department of Health and Human Services Alcohol and Other Drugs (AOD) program provides assessment and resources for families dealing with AOD issues.
- Variety of resources and referral sources are readily available to help the client within Sacramento County. These resources include 13 detoxification centers, 16 residential treatment centers, 23 outpatient and counseling treatment centers, and 14 prevention /early intervention organizations.
- Strong partnership with the County of Sacramento's Alcohol and Drug Unit, Sacramento County Office of Education programs, the Maternal Child Health Advisory Board and the Public Health Advisory Board.
- Supplemental information sites are readily available for nurses' practice from reputable sources such as March of Dimes, and the Center for Disease Control
- Professional development training is available at UC Davis via the Child Abuse Prevention conferences; while WIC Breastfeeding trainings and "Zero to Three" are other organizations whose literature, trainings, and educational resources are available.

Source: Sacramento MSSA 139f RSI and Maternal Outcomes Report, Sacramento NFP 09/30/2010

San Diego (North Inland-Coastal Expansion (NICE)) NFP Expansion

Targeted high-risk community	<ul style="list-style-type: none"> • The North Inland-Coastal Expansion (NICE). Medical Service Study Areas 156d and 156e. NICE overlaps parts of five cities (Oceanside, Vista, San Marcos, Escondido and Carlsbad (a sliver) and the County’s unincorporated area
How the model meets community needs and service gaps	<ul style="list-style-type: none"> • Residents are socially and economically disadvantaged and culturally and linguistically isolated. • Housing costs are higher than many areas of the State • Widespread poverty, violence disparities, high rate of teen births, low educational levels, and limited access to healthcare • There is waiting list and a list of mothers who are enrolled but have not yet been served • Violence is another risk factor that appears to be a problem in some parts of the NICE community • Transportation continues to be a barrier for many families which presents obstacles for families accessing health care and social services (e.g., medical, dental, behavioral, etc.) • In the NICE community the needs of families greatly outnumber the available resources. Having multiple agencies that provide complementary services and share common mission and goals is an immense benefit to the community. • Only 34% of U.S. born Latinas in San Diego County were exclusively breastfeeding their infants at two months of age • Half of the population is Hispanic. More than a quarter are at least 5 years of age and older, speak English less than “very well”. These high risk families have difficulty accessing available services due to language, financial and cultural barriers.
Strengths and Resources	<ul style="list-style-type: none"> • Solid infrastructure and a wealth of experience in implementing NFP for over 10 years • The South Region has successfully implemented an NFP referral pathway and will lend their expertise to convene a planning group to develop a coordinated NICE referral pathway system to assure that there are no overlaps in recruiting and referring eligible families; no service duplication. • Community-based approach of service delivery using public-private partnerships • Diverse representation from public and private alliances (government, education, health care, faith-based, grass-root, councils, schools, and other associations) • Integrated health care system comprised of two community clinics, two hospitals, and other private providers • Strong sense of community and resident groups that build on the strengths of the diverse population. Residents are engaged and committed to solving problems, share risk, and work together. • NICE community is comprised of multi-generational families with rich cultural traditions, beliefs and strong support systems. • Pool of current Public Health Nurses to draw from to staff NICE • Collaborative partners are in conversation to explore Strengthening Families (SF) as a platform to strengthen cross-collaborations. San Diego NFP currently addresses the five SF Protective Factors

Source: San Diego County RSI

San Francisco (Bayview Hunter's Point) NFP New

Targeted high-risk community

San Francisco

How the model meets the community needs and service gaps

- Despite the abundance of governmental and non-profit social service agencies, San Francisco lacks focus on, and coordination of, promoting healthy pregnancies and infants and lacks an evidence-based nurse home visiting arm among its programs directed at families with children
- The poverty, psychosocial disruptions, housing instability, and behavioral health conditions faced by substantial proportions of the San Francisco population are threats to maternal and child wellbeing.
- 53% of the 8437 births in San Francisco were to first time moms
- 22% of those were Medi-Cal
- 2010 yielded 55 births to women 15-17 years of age and 168 to 18-19 years of age
- There were 564 cases of felony child abuse
- NFP targets populations like San Francisco with mothers who are living in poverty, have high rates of DV, child abuse and neglect, are non-English speaking, have histories of substance abuse, and live in unstable environments.
- San Francisco has identified a potential 983 low income, first time mothers that meet criteria for inclusion in the NFP program.
- The NFP model also provides San Francisco the opportunity to engage community partners and stakeholders in ways that strengthen the safety net for services to some of the most vulnerable individuals and families, while contributing to more focus and coordination among service providers. The NFP program, with a community and multi-stakeholder advisory board, closes this gap and helps build an integrated system of care on behalf of the client.

Strengths and Resources

- San Francisco has experience with the home visiting program EHS
- San Francisco's unique culture is a distinct strength: *Living in a progressive, urban environment like San Francisco cultivates unique strengths in women and mothers. Within the diversity of ethnicities, nationalities, and socioeconomic circumstances, there is a commonality of progressiveness, open-mindedness, and hope that permeates the neighborhoods*
- Many low income, first time mothers have already been connected to some type of social service prior to their pregnancy. This builds a high level of familiarity, comfort, and trust with social service and health agencies.
- The City and County of San Francisco provides a wide array of well-resourced, nationally-regarded governmental programs, particularly through the Human Service Agency, Community Behavioral Health Services, the Department of Public Health, Department of Children, Youth and Families, and a network of primary health clinics.
- There are many innovative community-based non-profit organizations that provide highly effective programs. Many programs receive national, state and regional funding and some serve as national models.
- Governmental and non-profit organizations can be valuable partners in referring women during early pregnancy to NFP. The Home Visiting Partnership can communicate, train, and collaborate with community-based programs to provide holistic, wrap-around services for the entire family.
- San Francisco is the home of outstanding research and teaching universities and a powerful financial and high technology economy. These resources are valuable partners in evaluating, supporting, and expanding innovative public health programs.
- The Strengthening Families approach and language has been incorporated into San Francisco's Preschool for All (PFA) Program guidelines, which serves as the overarching vision for high quality early childhood programs.

Source: San Francisco County RSI

Shasta (Shasta Lake/Redding/Anderson/Burney) NFP New

Targeted high-risk community

Shasta County Regional Population Centers. The four communities include Cities of Anderson, Redding, Shasta Lake, and Burney.

How the model meets the community needs and service gaps

- Participants from a Shasta County Health and Human Services Agency (SCHHSA) Stakeholder Group Meeting (2010) identified the need for Perinatal Home Visitation Services and case management and that more of an emphasis on self-sufficiency and getting people off HHS services should be a focus of the Agency.
- SCHHSA Children and Families Services offers the home visiting program SafeCare to families who already have risk factors of child abuse and maltreatment but does not currently offer a home visiting program to prevent the neglect and abuse from occurring. NFP will help fill this gap.
- Tobacco use among pregnant women is especially worrisome in SC. In 2009, 20% of women giving birth who lived in Shasta County's high risk community reported they smoked during the three months before they knew they were pregnant. The NFP program's success around improvements in pregnancy outcomes will be of great benefit, specifically around the decreases in prenatal cigarette smoking.
- SCHHSA has not offered nurse home visiting of any kind to pregnant women or families with young children since 2004. Also, the local hospital stopped offering one-time, nurse home visits to families after the birth of the child in 2008. The major gap that would be filled by the NFP program is the availability of a nurse home visiting program

Strengths and Resources

- SCHHSA has the infrastructure and foundation in place to meet NFP program's six to nine month timeframe from start up to implementation of the program including: organizational structure current staffing/personnel, materials and equipment needs
- Shasta County Regional Services Branch currently has most of the infrastructure needs such as office space, equipment, and vehicles in place to immediately implement the NFP program.
- Shasta County already has a full time supervisor (Clinical Program Coordinator) investing .50 FTE in supervision of the regional PHNs, time that would be available to dedicate to the NFP program.
- WIC programs located at the regional offices will be a major referral source for the NFP program. The relationship and rapport between the NFP nurse and WIC program staff will assist in those referrals being made.
- Referral sources are available, such as Breastfeeding Peer Counselors, Medi-Cal and Cal Fresh application assistants, and immunization nurses are located within the same regional office for streamlined referrals and easier access for NFP participants.
- Shasta County has two skilled, culturally competent and experienced public health nurses (PHNs) that will be assigned to work specifically in the NFP program.
- The existing relationships the PHNs have developed with medical providers and community agencies within their regions will provide easier referrals to the NFP program.
- Shasta County PREVENT Team was formed and is dedicated to addressing prevention of child maltreatment in Shasta County and modeled after the Strengthening Families Initiative of preventing child maltreatments.
- Shasta County has a large number of resources and services available for pregnant women and families with young children, especially in the area of substance abuse.
- The expansion of the 4 P's Plus Substance Use Screening program to include mental health screening and referral services for physicians that see pregnant women who are suspected of substance use during their pregnancy.
- First Five Shasta expanded funding; beginning in 2012, physicians will also be able to make referrals for postpartum women who appear to be suffering from maternal depression. And women will be able to access services from a contracted therapist in the community.
- Currently under development, 211 Shasta is a telephone and internet based single point of contact for more than 2,000 health and human resources in Shasta County supported by public and private agencies will have a huge impact on the coordination of community resources in SC.
- SC has strong retention rates with Public Health Nurses, with an average length of employment being 8-10 years
- Stakeholders' involvements are evident by their advocacy and support for the NFP programs.

Source: Shasta County RSI

6. California's Current or Prior Experience with Implementing the Selected Models and Current Capacity to Support the Model

MCAH/CDPH does not currently oversee an existing statewide, evidence-based early childhood home visitation program where home visiting is a primary intervention strategy for providing services to pregnant women and/or children birth-to-kindergarten entry; however MCAH/CDPH does have experience developing and implementing programs with a home visiting and/or case management component. Several other California state agencies provide management and oversight for health and social service programs that serve as a conduit for federal funding. Although some of these health and social service programs include a home visiting component, home visiting is not the primary service delivery strategy.

While there is no statewide home visiting program, there are multiple national, and some locally developed, home visiting models operating in California. The two selected models, NFP and HFA programs, as well as the other HomVEE-recognized home visiting programs have been implemented and well-established in California. Information obtained through a survey to all 58 counties in August, 2010 and reported in the California Statewide Home Visiting Needs Assessment gives the following quantitative data regarding existing infrastructure for NFP and HFA:

Nurse-Family Partnership: In California, a total of fourteen counties report using NFP and serve approximately 3,096 families annually. Thirteen counties have a current Agency Funding Agreement (AFA) in place with the NFP National Service office and serve approximately 2,458 families annually. These include: Fresno, Humboldt, Kern, Los Angeles, Orange, Riverside, Sacramento, San Diego, San Luis Obispo, Santa Clara, Solano, Sonoma, and Tulare. One county, Madera, is using NFP without any AFA in place and serve approximately 638 families annually. All fourteen counties using NFP report having a waiting list for services.

Healthy Families America: In California, a total of eleven counties report using HFA. Six counties have a current Agency Funding Agreement (AFA) in place with HFA National Program office. These include: Butte, Los Angeles, Nevada, Riverside, San Diego, and Yolo counties. Five counties that are using HFA without any AFA in place are: Contra Costa, Humboldt, Lassen, Napa, and Santa Barbara. The affiliated HFA programs (AFA) do not use waiting lists. In keeping with the model fidelity, the affiliated HFA programs do not use waiting lists; however, they find other resources and referrals for families in a timely fashion.

For additional detail on these and other home visiting programs in place throughout California, see the California Statewide Home Visiting Needs Assessment www.cdph.ca.gov/programs/mcah/Documents/MO-HVP-FinalCaliforniaStatewide-HV-NA.pdf.

Current Capacity to Support the Model in California

CHVP has the capacity to develop, implement and administer a comprehensive statewide home visiting program in conjunction with the NFP and the HFA evidenced-based models. A comprehensive plan to ensure adequate state-level staffing with expertise specific to program development, oversight of contractual and fiscal agreements, information technology, including data system development, policy and strategic planning has been developed. CDPH/MCAH provides the necessary infrastructure to provide administration to coordinate with NFP and HFA. Partner agencies are actively engaged in the implementation of the overall program and understand the value of working with the evidence-based models. CHVP is committed to a coordinated system of intervention models that seek to be cost effective and result in improved health and well-being over the life-course.

MCAH/CDPH has experience developing and implementing programs with a home visiting and/or case management component. For example, MCAH/CDPH funds and administers three programs containing a home visiting component:

- Adolescent Family Life Program (AFLP): Case management services are provided using home visits; however, the venue for case management varies by local program as does the capacity to conduct home visits. When home visits are performed they are on a case-by-case basis; client-specific goals and objectives are developed as part of an Individual Service Plan. Home visiting is a component, but not a primary service delivery strategy of AFLP programs.
- Black Infant Health (BIH) Program: Utilizes a group-based intervention as program delivery strategy; a home visit is considered on a case-by-case basis.
- MCAH Local Health Jurisdictions (LHJs): LHJs may provide one-time, episodic or field Public Health Nursing home visiting services to high risk individuals. They may develop or integrate home visiting services in other programs in order to address community-specific needs. Some MCAH LHJs have implemented nationally recognized home visiting programs or have made local adaptations of these home visiting models.

CDPH/MCAH also administers many early childhood programs and initiatives including the following:

- California's Early Childhood Comprehensive Systems (ECCS): A statewide effort toward comprehensive strategic planning in the areas of early childhood/school readiness
- California Statewide Screening Collaborative (CSSC): Under the umbrella of the ECCS grant; serves as the ECCS and California Project Launch (CPL) Steering Committee
- CA Project LAUNCH (CPL): A \$4.2 million Substance Abuse and Mental health Administration (SAMHSA) grant awarded over five years to MCAH in 2009

- CDPH/MCAH participates in other early childhood efforts:
- State Interagency Team (SIT): provides leadership and guidance to facilitate systems improvements that benefit communities and children 0-5 years and their families. SIT members are generally at the “Deputy” level and have decision-making authority
- Help Me Grow (HMG): a comprehensive and integrated statewide system designed to address the need for early identification and linkage to developmental and behavioral services and supports for children and their families
- Early Childhood Education and Care (ELAC): The California State Advisory Council on Early Childhood Education and Care will build on the work of the California Early Learning Quality Improvement System Advisory Committee (CAEL QIS) in helping define the future policy direction for early learning in California. ELAC is essentially the strategic plan for building a comprehensive early care and education system. CDPH/MCAH will consult with ELAC members to ensure that CHVP is coordinated with the goals of ELAC.

Other California Partners with a Home Visiting Aspect:

- California Department of Social Services (CDSS): (a) Community-Based Child Abuse Prevention Programs fund county child welfare agencies for a home visitation component that ranges from intensive, frequent visits to periodic or one-time in-home evaluations; (b) Promoting Safe and Stable Families Program funds are used to support parenting and healthy marriage classes that increase relationship skills within the family, home-visiting services for young parents with first babies and other family-based services, respite care for caregivers of children with special needs, and numerous other unique and innovative programs and services that local communities rely on for at-risk families; and (c) the Chadwick Center, in cooperation with the Child and Adolescent Services Research Center, the National SafeCare Training and Research Center, and CDSS’ Office of Child Abuse Prevention are disseminating the SafeCare model for home visitation to multiple California counties for young children at-risk for child neglect and/or abuse.
- California Department of Education (CDE): (a) some California Child Care and Resource Network programs include home visitation services; (b) Head Start/Early Head Start programs deliver education services through weekly, parent-focused home visits in the Home-Based Model.

Additionally, the following California Departments partner with CDPH/MCAH to provide feedback and collaboration in the planning, development, and implementation of California’s first state-based home visiting program.

- California Department of Health Care Services (DHCS): provides administration and oversight of local programs that have home visiting as a service strategy, such as the American Indian Infant Health Initiative (AIIHI). The AIIHI provides extensive home visiting and case management services to high-risk Indian families in the five

counties in California that experience the most severe Indian MCH disparities (Humboldt, Sacramento, San Bernardino, Riverside, and San Diego counties).

- California Department of Developmental Services (CDDS): provides intervention services for infants or toddlers who are at risk of or have developmental delay or disabilities. CDDS offers the Early Start program that provides home visiting, not as the primary service strategy for infants and toddlers, but as a service that is integrated into CDDS programs.
- California Department of Social Services (CDSS): provides oversight and administration for programs in which home visiting is a service strategy; however the Office of Child Abuse Prevention (OCAP) does not capture the specific type of service delivery strategy during the annual reporting process. Forty-one of the 58 counties reported using one or more prevention funding sources to fund some kind of home visiting program during FY 2008-09. CDSS also administers the Title IV Temporary Assistance to Needy Families (TANF) program, which in California is called California Work Opportunity and Responsibility to Kids (CalWORKS). The CalWORKS program performs limited home visiting, on a case-by-case basis.
- California Department of Education (CDE): funds a number of infant and toddler services, but does not specifically require that any of these services be home-based.

See Section 6. Plan for Administration of State Home Visiting Program for details on all partners and collaborations

California Home Visiting State Partners Collaborative

The goal of developing a comprehensive, evidence-based service delivery system in California requires a well-coordinated partnership among state agencies and with local programs and partners. In February 2010, CDPH/MCAH officially formed the California Home Visiting State Partners Collaborative (Collaborative) in anticipation of the Patient and Protection and Affordable Care Act of 2010.

Formal in-person meetings of the Collaborative began on December, 2010; subsequent meetings are held on the third Thursday of each month. Membership includes representatives from First 5 California, Alcohol and Drug Program (ADP), California Department of Education (CDE), California Department of Social Services (CDSS), and California Department of Developmental Services (CDDS) and California Department of Mental Health (CDMH). Members of the Collaborative are tasked with the provision of ongoing recommendations to CDPH/MCAH for the role of home visiting in improving health and well-being for California families; the Collaborative will also provide oversight, explore opportunities to increase efficiency and effectiveness, recommend coordination with other agencies on service delivery, and share pertinent research, information and resources. In addition, First 5 California, the First 5 Association of California and local MCAH Directors are designated to represent and act as a conduit of information for MCAH Action (the professional organization for MCAH Directors of LHJS in California). The Collaborative addresses concerns and recommendations from local

stakeholders and partners, and serves as an invaluable resource for collaboration and strategic planning for the CHVP.

7. Implementation of Quality and Program Assurance to Maintain Model Fidelity

As a mechanism for overseeing home visiting quality assurance, CHVP is in the process of developing workgroups to promote interagency coordination, shared accountability and to support model fidelity. Workgroup membership will include CHVP staff, national NFP and HFA representatives, and experienced local MCAH Directors who will provide experience and expertise in collaboration with other programs within their LHJ/communities. The consistency of model fidelity rests with the NFP model elements and HFA critical elements combined with best practices for effective, quality program implementation as described below. Quality Improvement teams will be established at the state and LHJ/community level. Mechanisms for feedback and information exchange will be created and maintained.

See Section 4. Implementation Plan for Proposed State Home Visiting Program for further details on workgroups

The State's Overall Approach to Home Visiting Quality Assurance

CHVP's approach to home visiting quality assurance, program assessment and support of model fidelity is to oversee a system that ensures the primary components of evidence-based home visiting program quality are in place and continuously monitored. Scopes of Work (SOW) and policies and procedures will be developed. These will include clear protocols for monitoring staff development, training, program implementation, evaluation and reporting requirements, data collection, analysis and continuous quality improvement (CQI). The primary structural components of program effectiveness and quality include:

- 1) Clear Specific Goals and Objectives
- 2) Content and Focus of Visits: Curriculum and Activities
- 3) Training, Supervision and Administrative Support
- 4) Family Engagement
- 5) Cultural Consonance
- 6) Program's Ability to Deliver Appropriate Services to High-risk Families
- 7) Linkage to Quality and Diverse Services
- 8) Evaluation Component ^{10, 11}

¹⁰ D. Gomby. (2005) *Home Visitation in 2005: Outcomes for Children and Parents*. Washington D.C.: Committee for Economic Development, Invest in Kids.

¹¹ W. Brunner and C. Pies. (2001) *Intensive Home Visiting Programs: Implications for California Counties*. Contra Costa Public Health Division, California

Clear Specific Goals and Objectives:

To promote an effective program, CHVP goals align with the program's content and follow the ACA guidance. CHVP objectives are measurable, achievable, and realistic; they correlate with the actual child, family and community outcomes desired from the home visiting intervention.

See Section 2. Home Visiting Program Goals and Objectives for further details on goals, objectives and the logic model

Content and Focus of Visits: Curriculum and Activities:

CHVP supports the evidence that the more child-focused the home visits are in content, the higher the levels of children's cognitive and language development, the greater the parents support for language and literacy, and the greater the overall quality of the home environment. Specific activities and evidence-based curriculum shall meet the program goals and objectives. Programs will employ curriculum that is intended by the program designers and clearly addresses the behaviors associated with a poor outcome.

CHVP will utilize the NFP prescribed curriculum, Partners In Parenting Educations (PIPE). HFA has flexibility on which curriculum is selected as long as it meets the requirements of Critical Element #6. Those communities implementing HFA programs in California will negotiate with CHVP to select the evidence-based curricula from a list of recommended options that best meets the needs of their communities.

Training, Supervision and Administrative Support:

Home visitors must have personal skills to establish rapport with the families, the organizational skills to deliver the curriculum to the family, the ability to respond to family crises whenever they arise, the problem-solving skills to address issues in the moment and the cognitive skills to do the paperwork that is required. Home visiting staff will be carefully selected, extensively trained and adequately supervised according to model guidelines and state requirements.

State and local program administrators will provide consistent support and empower their staff to administer the program as designed using techniques such as one-to-one supervision, reflective practices and administrative team meetings. Program administrators are cognizant that workforce development of nurses and paraprofessionals is crucial to increasing proficiency and performance and will create new opportunities for staff to learn and grow on an ongoing basis. Retaining well trained staff will be a critical quality assurance factor.

Family Engagement:

In order to retain families in a home visiting program, families must be invested in the home visiting experience. The primary elements of family engagement are to enroll families voluntarily; deliver services at the right level of intensity; retain families in the

program; and maintain enthusiastic and active family involvement during the home visit process.

To address this issue, HFA has well defined criteria for increasing or decreasing the home visits. HFA offers services at least weekly for the first 6 months. The NFP Program offers highly qualified and credentialed public health nurses (PHN) to deliver their home visiting services. Nurse home visitors and their clients make a two and a half year commitment to each other. Clients are provided health and development education aimed at increasing awareness of specific child development milestones and behaviors and uses a client-centered approach. Both programs offer flexible scheduling time and location.

Cultural Consonance and Competence:

Parenting practices are strongly rooted in culture. The same parenting practices can yield different results for children from different cultures. Home visitors need to provide services that are culturally competent and responsive to the needs of a wide range of families. Ethnic, racial, language, demographic, and other cultural characteristics identified are taken into account in overseeing staff-family interactions. Advice offered by home visitors must be consonant with the family's beliefs about parenting, in order to reduce the risk of being less effective.

Both NFP and HFA models recognize that families have unique histories, perspectives and values that are intrinsically linked to their culture, ethnicity, language communities, geographical identities and historical experiences. The NFP NSO provides cultural competency training which entails cultural and ethnic awareness, encouraging nurses to be fluent in the languages spoken by the families they serve, and making sure that materials are culturally and socially relevant to the families served. HFA's Critical Element # 5 requires that services offered are culturally competent such that staff understands, acknowledges, and respects cultural differences among participants; staff and materials used should reflect the cultural, linguistic, geographic, racial and ethnic diversity of the population served.

CHVP and local home visiting leadership will promote a client-centered approach to each program participant that maximizes service and referral opportunities. In order to recruit, retain, and effectively serve ethnically diverse families, attention to cultural competency should be reflected in both staff training and intervention design¹².

Program's Ability to Deliver Appropriate Services to High-Risk Families:

Quality home visiting programs provide services that require having appropriate curricula and competent staff in place to serve a high- risk population. HFA uses a screening tool to select higher need families; NFP only enrolls low-income, first-time

¹² K. Johnson. (2009) State-based Home Visiting: Strengthening Programs through State Leadership. Columbia University: National Center for Children in Poverty, Mailman School of Public Health.

pregnant women. For long term success, CHVP will address three issues that create especially high risk environments for children: (1) domestic violence; (2) maternal mental health problems, particularly depression; and (3) parental substance abuse. These issues, along with contraception, are often the most difficult for home visitors to recognize, discuss comfortably and address effectively with families, but are more likely to limit or halt progress for parents and harm children. Home visiting services must be modified to respond to domestic violence and these other issues that can have substantial impact on children over the long term.

Linkages to Quality and Diverse Services:

One strategy to improve the effectiveness and cost-effectiveness of home-based services is to improve the linkages and aim for a seamless continuum of services.¹³ Home visiting programs must be linked to an array of effective services and community programs, including medical services and early care and education. The development of effective referral pathways and service coordination, whether linking mothers to prenatal care or transitioning families to center-based services, is the role of CHVP cross-agency planning efforts. To achieve broad child and family health improvements, home visiting programs must work in collaboration with other health, social services, family services, and community-based health efforts.¹⁴

To work towards the goal of a seamless continuum of services, CHVP will strive to develop an inter-program, interagency approach for linking home visiting programs. This may include task forces or planning groups such as the recently established Collaborative, which can make recommendations to improve services and better coordinate resources. As previously mentioned in this section, CDPH/MCAH also administers many early childhood programs and initiatives such as the ECCS, a statewide effort toward comprehensive strategic planning in the areas of early childhood.

In addition, as an overarching supportive mechanism to reinforce home visiting services, CHVP will utilize the Strengthening Families framework which provides:

- A strong platform for required interagency collaboration
- Common language and tools to support the integration of funded home-visiting programs into a system of support at the community level
- A frame for aligning practice across home-visiting models
- A concrete and actionable framework for applying life course theory on the ground

¹³ K. Johnson. (2009) *State-based Home Visiting: Strengthening Programs through State Leadership*. Columbia University: National Center for Children in Poverty, Mailman School of Public Health.

¹⁴ W. Brunner and C. Pies. (2001) *Intensive Home Visiting Programs: Implications for California Counties*. Contra Costa Public Health Division, California

Evaluation component:

An evaluation component which supports research and ongoing data systems is essential to expanding the knowledge and effectiveness of home visiting programs and service gaps. Research has shown that commitment to quality is critical. Well-trained staff and appropriate service intensity increase the likelihood of success; however, these elements require ongoing attention.

CHVP's plan for quality assurance, model fidelity and ongoing evaluation is detailed in *Section 7. Continuous Quality Improvement*. The CQI process provides a systematic approach to achieving effective outcomes, assuring program quality standards are met and identifying any adjustments to the model's protocols in order to accommodate the community needs or to identify opportunities to improve program delivery.

See Section 5. Plan for Meeting Legislatively-Mandated Benchmarks for description of the collection, analysis and reporting of the legislatively mandated benchmark data and plans for evaluating program impact

CHVP will partner with NFP and HFA to monitor program fidelity via the CQI process. The primary aim of quality assurance is to demonstrate that the home visiting services fulfill standards or best practices. Both NFP and HFA support these program quality components through the best practices that are inherently embedded in these home visiting models. For NFP these are the 18 Model Elements and for HFA, the 12 Critical Elements. As NFP and HFA are replicated in new communities, continuous quality improvement, due to the emerging challenges that community implementation inevitably generates, will be addressed in cost-effective, clinically and scientifically rigorous ways.

State Level Leadership:

CHVP will work closely with local home visiting program leaders to improve the quality of home visiting services, more effectively replicate model programs, and link home visiting programs to other efforts focused on promoting optimal early childhood health and development by:

- Implementing deliberate strategies, policies and program designs to achieve quality and improved child and family outcomes from their investments in home visiting;
- Strengthening mechanisms for interagency and cross-program coordination;
- Helping communities and programs align the home visiting intervention with family needs;
- Supporting a continuum of early childhood systems of care and services that can address a wide range of family needs and achieve results in a cost-effective manner;
- Refining, and continually evaluating program objectives and outcome measures;
- Promoting continuous quality assurance, quality improvement, and staff development, training and supervision;

- Analyzing current spending on home visiting programs to blend and leverage funding where appropriate; and
- Supporting research and data systems that expand knowledge of programs and gaps.

8. Anticipated Challenges and Risks to Maintaining Quality and Fidelity and Proposed Response to Issues Identified

To comply with model fidelity, CHVP will monitor and track how services are delivered based on The Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment Initiative (EBHV Initiative), a cross-site evaluation that resulted in a framework for assessing fidelity across five EBHV models including NFP and HFA (detailed in *Section 7. Continuous Quality Improvement*). Although NFP and HFA differ in content and structure, they share certain core fidelity principles as do other evidence-based home visiting programs. The common indicators of high-quality implementation include:

- A belief that low caseloads for each home visitor will improve outcomes
- Strong supervision of staff
- An ability enroll a high proportion of families referred for service
- An ability to consistently deliver home visits to enrolled families
- Low staff turnover among home visitor and supervisors
- Expectations for sufficient service dosage

In order to initiate and sustain high quality implementation to ensure model fidelity, CHVP anticipates common challenges related to program design, caseload, staff and client retention, and relationships with other agencies/partners. One of the major risks of maintaining program fidelity is the potential problem of “drift,” which is defined as *the changes to an evidence-based model that alters the core elements related to program outcomes and may undermine the program’s effectiveness*. During implementation of NFP and HFA, CHVP using internal workgroups and the CQI Teams will assist LHJs/communities in maintaining quality and fidelity. Table 2 identifies how CHVP will anticipate challenges and oversee this task:

Table 2. CHVP Plans for Maintaining Quality and Fidelity

Area	Challenges/Risks to Fidelity	Response/Plan
Program Design	<ul style="list-style-type: none"> • Inflexible and traditional work schedules for staff may have a negative effect on client enrollment and retention 	<ul style="list-style-type: none"> • Use a ‘flexible framework’ allowing staff to plan their own work schedules to include weekend, evening and early morning hours. This enhances client enrollment/retention and better meets the needs of the families.

Area	Challenges/Risks to Fidelity	Response/Plan
Caseload	<ul style="list-style-type: none"> • Caseload “creep”: the temptation to increase caseloads beyond the recommended levels in order to serve more families. 	<ul style="list-style-type: none"> • Work with counties/communities to maintain their commitment to limiting caseloads as a quality assurance practice.
Staff	<ul style="list-style-type: none"> • Turnover due to securing other employment or feeling overwhelmed with the job • Burnout: due to the nature of the work • Indifference: not feel vested in the program’s principles • Uninformed or misinformed about program components • Consortia and/or rural areas: • Supervisory logistics (i.e., one supervisor covering large geographical areas Access to timely training • (It is critical to have long term staff who can build relationships with families. Staff turnover is costly, time consuming and impacts quality services to families and their children) 	<ul style="list-style-type: none"> • Routinely review/revise training calendar. • Cross train staff to lessen impacts to families in the event of a turnover. • Ensure all staff have the opportunity to give feedback in order to maximize job satisfaction • Ensure staff participates in weekly quality individual and group reflective supervision • Comprehensive and methodical recruitment of staff in order to align potential staff members beliefs/strengths • Ensure that qualified, congenial staff are hired and provide regular opportunities for skill building; training, and professional growth • Offer fair wages/benefits • Involve staff in CQI efforts to maximize participation in program planning <p>Consortia and/or rural areas:</p> <ul style="list-style-type: none"> • Supervisory logistics should be considered as participants are enrolled • Inclusion of Consortia/rural areas in scheduling training
Clients	<ul style="list-style-type: none"> • Motivated by “incentives” only, and not interested in receiving services • Forced to be in program • Work schedules make it impossible to be available for home visits during regular 8:00 a.m. – 5:00 p.m. work hours • Non-English-speaking or English as a second language 	<ul style="list-style-type: none"> • Staff will be trained to help actively engage clients in the program. Expeditious follow-up, especially early in recruitment process • Families should be reassured that the program is strictly voluntary. • Staff will be encouraged to have flexibility in work hours in order to conduct home visits that are convenient to the clients • Bi-lingual staff will be hired to meet the needs of targeted clients

Area	Challenges/Risks to Fidelity	Response/Plan
Attrition	<ul style="list-style-type: none"> For a variety of reasons a family may hesitate to follow through with services even though they want and need the support. A family has moved without leaving a forwarding address or contact information 	<ul style="list-style-type: none"> Retention and home visitation completion rates are critical to model fidelity. CHVP supports creative, persistent outreach, such as allowing a “holding” period (i.e., get in touch with HV within 3 months) when families are having difficulty keeping HV appointments. Utilize a signed release of information with community partners to track down lost clients
Local and State Agencies/Community Partners	<ul style="list-style-type: none"> Lack of commitment and/or interest in supporting services Staff turnover: whether frontline staff that recruit/enroll clients for the program or management level Community agencies and other county programs may not feel a sense of buy-in towards the programs Community partners refer families for services who are outside the target population area 	<ul style="list-style-type: none"> Securing buy-in with partners by having them sign a Letter of Commitment/MOU. Provide refresher presentations to keep engaging and motivating partners Ensure that participating staff in (community partners/agencies) are trained quickly and thoroughly as possible. Establish and maintain an advisory group that gives representation to other agencies/programs. CHVP will help educate community and state partners regarding the program parameters. Referred families will be offered referrals to partner programs

9. Anticipated Challenges/Risks of Selected Program Models with Proposed Responses and Anticipated Technical Assistance Needs

During NFP and HFA implementation, CHVP anticipates certain challenges and risks specific to the models selected which will further inform preliminary planning and strategizing for successful implementation. Many of the “anticipated challenges and risks for maintaining quality and fidelity” in Table 3 are the same or similar to the “anticipated challenges and risks of selected program models” in Table 2.

CHVP anticipates HRSA’s provision of technical assistance (TA) for initial and ongoing implementation and assistance in integrating home visiting services into a comprehensive system of support of early childhood care. In addition, CHVP anticipates receiving “program-model-specific” technical assistance from the national and regional offices and the State Leads of NFP and HFA programs. Conversely, CHVP will develop workgroups with internal members, external partners and/or both, as troubleshooting bodies to provide technical assistance.

Table 3 presents some of the issues that are specific to the NFP and HFA models and provides CHVP's responses on addressing the concerns.

Table 3. CHVP Plans for Addressing Challenges of NFP and HFA

Issue	Challenges/Risks Model-Specific	Response
Cost of Program and Staff Retention	<p>NFP is an expensive model. The education and experience level of the PHNs increase the salaries</p> <p>HFA may have retention issues due to lower wages and intensity of job.</p>	<p>CHVP recognizes the value of NFP and HFA as a cost-effective investment in improving the lives of children, families and communities in California. An internal implementation workgroup will explore ways to identify, assess and sustain funding sources and advocate at the state level.</p>
Recruitment of Competent Staff in view of time constraints	<p>NFP PHN shortages presents challenges in hiring NFP staff, especially in rural areas.</p> <p>HFA HV FSWs are selected on personal characteristics (open-mindedness, compassion, maturity), rather than formal education. Because curriculum is flexible, extremely well trained FSWs are needed.</p>	<p>NFP CHVP will support nursing recruitment by coordinating with baccalaureate nursing programs in California and the PHNO of CA, and will endure that LHJs adopt competitive salary ranges for staff.</p> <p>HFA Staff recruitment should be comprehensive, to ensure the correct candidates are recruited. FSWs should not be hired in haste due to external or internal pressures.</p>
Client participation and attrition	<p>NFP/HFA</p> <p>Engagement and retention of families, especially those at-risk</p>	<p>CHVP plans to use existing NFP and HFA program's effective strategies for minimizing attrition rates.</p> <p>Troubleshoot with counties /communities to help identify problems and solutions specific to their program</p>
Model Design	<p>PIPE curriculum has not yet been purchased from NFP</p> <p>HFA has no requirements or protocol for using a specific curriculum, which has raised concern about consistency in data collection statewide and possible difficulty interpreting results.</p>	<p>HFA CHVP recognizes the varying needs of LHJs/communities and the importance of addressing these through the appropriate resources and curricula. CHVP will work with HFA sites to help them determine the most fitting curriculum for their program that meets the CHVP standards</p> <p>CHVP will authorize curriculums purchase as appropriate</p>

Issue	Challenges/Risks Model-Specific	Response
Program Evaluation and Benchmark Reporting	NFP has allowed limited access to measurement tools	CHVP has submitted a Proprietary Property letter to NFP NSO.

Technical Assistance Teams

CHVP has established Technical Assistance (TA) Teams to provide technical assistance to the communities implementing NFP and HFA. The TA Teams will receive training from NFP and HFA to understand the complexities of the programs at the program and community level.

See Section 6. Plan for Administration of State Home Visiting Program for more detail on the TA Teams

CHVP is developing partnerships with NFP and HFA. As these partnerships develop, additional detailed information on technical assistance, capacity, and infrastructure support will be available to local programs during program implementation. CDPH/MCAH will disseminate this information as it is finalized.

SECTION 4.

IMPLEMENTATION PLAN FOR PROPOSED STATE HOME VISITING PROGRAM



SECTION 4. IMPLEMENTATION PLAN FOR PROPOSED STATE HOME VISITING PROGRAM

The California Department of Public Health/Maternal, Child and Adolescent Health (CDPH/MCAH) has the capacity to develop and implement a strong implementation plan within the at-risk communities throughout the state. CHVP will work closely with the leadership in selected communities to build local infrastructure and to support the adoption, implementation, and long-term sustainability of the home visiting programs. An Implementation Team within CHVP will focus on organizational readiness, creating communication and feedback loops, and defining roles and responsibilities.

1. Process for Engaging the At-Risk Communities

CDPH/MCAH's engagement of LHJs as collaborators in administering programs under the Title V MCH Service Block Grant has been a proven roadmap to successfully meeting the needs of at-risk communities in California. In keeping with this philosophy of partnership and collaboration, CDPH/MCAH developed a plan to engage LHJs around California's proposed Updated State Plan for a home visiting program. CDPH/MCAH released the California Home Visiting Program-Request for Supplemental Information (CHVP-RSI) to 61 Local Health Jurisdictions (LHJ) on March 14, 2011. Through the CHVP-RSI, local MCAH Directors provided additional information about the at-risk communities in their counties that builds upon the information submitted to CDPH/MCAH through the 2010 California Capacity Assessment Survey. The CHVP-RSI questions were formulated to ensure that local MCAH Directors were provided with the opportunity to:

- Identify key local stakeholders who provide services and resources within their LHJs/community
- Identify local health priority needs by engaging local public agencies, service providers, non-profit organizations, and families or clients
- Work closely with identified local partners to formulate responses pertaining to the at-risk LHJs/communities
- Correspond with CDPH/MCAH staff for clarification on any questions within the CHVP-RSI

CHVP-RSI responses from local MCAH Directors on behalf of their identified at-risk LHJ/community are woven throughout CDPH/MCAH's proposed Implementation plan for CHVP.

2. Methods to Identify the State's Targeted At-Risk Communities

CDPH/MCAH developed a multi-pronged approach including both quantitative and qualitative data collection and analysis to make the final designation of at-risk communities. The CHVP-RSI collected qualitative information from the LHJs about the communities and populations that local officials know have the highest need, and to

identify the evidence-based home visiting model that would best meet the identified needs. A detailed description of how the quantitative data were combined with the qualitative information submitted from LHJs to identify the overall highest need communities where the CHVP would have the greatest impact is described in Section 1. Identification of the State's Targeted At-Risk Communities.

See Section 1. Identification of the State's Targeted At-Risk Communities for in-depth detail on the identification process

3. Identifying Organizations, Institutions, and Other Groups Consulted

In February, 2010, CDPH/MCAH identified organizations, institutions, and individuals to begin discussions on the implementation of a California Home Visiting Program (CHVP). The process included consultation and collaboration with stakeholders, local MCAH Directors, CDPH partner programs such as California Department of Education (CDE), California Department of Social Services (CDSS), the California Department of Health Care Services (CDHCS), Alcohol and Drug Programs (ADP), California Department of Mental Health (CDMH), as well as public health educators and organizations concerned with the well-being of California's at-risk communities. At this time, CDPH/MCAH officially formed the California Home Visiting State Partners Collaborative (Collaborative) in anticipation of the Patient and Protection and Affordable Care Act of 2010. Formal in-person meetings of the Collaborative began in December, 2010; subsequent meetings are to be held on the third Thursday of each month. Membership includes representatives from First 5 California, ADP, CDE, CDSS, CDMH and CDDS. Members of the Collaborative are tasked with the provision of ongoing recommendations to CDPH/MCAH for the role of home visiting in improving health and well-being for California families; the Collaborative will also provide oversight, explore opportunities to increase efficiency and effectiveness, recommend coordination with other agencies on service delivery, and share pertinent research, information and resources. Additional partner organizations involved in the planning and implementation process included:

California Council on Local Health Officers (CCLHO): The membership of CCLHO includes the 61 legally appointed physician Health Officers in California, one from each of the 58 counties and the three cities of Berkeley, Long Beach and Pasadena. CCLHO provides a state/local forum for the discussion of significant health issues in order to develop recommendations for appropriate health policy, including legislative and regulatory review. CCLHO meets semiannually and its Board of Directors meets monthly. Its various program committees consider technical and policy issues in communicable disease control and prevention; health promotion and chronic disease prevention; environmental health; emergency preparedness and response; and health surveillance and data.

County Health Executives Association of California (CHEAC): CHEAC is a statewide organization of county and city Health Department and Agency Directors, who are responsible for the administration, oversight, and delivery of a broad range of local public health and indigent health care services. Members represent a variety of

administrative and health professional disciplines. CHEAC is dedicated to the promotion, protection, and improvement of the health of California's population. The organization's objective is to maximize local health departments' financial, organizational, and programmatic capacity to deliver local health services. CHEAC promotes effective public policy through legislative, state budget, and administrative advocacy; evaluates program structures, including administrative and fiscal elements, and educates policy makers on strategies to successfully deliver local health services. CHEAC also collaborates with key health and professional organizations to further common health improvement goals.

Early Childhood Comprehensive Systems (ECCS): CDPH/MCAH has authority over HRSA-funded California ECCS, a statewide effort toward comprehensive strategic planning in the areas of early childhood/school readiness. ECCS members include Medi-Cal Managed Care, American Academy of Pediatrics (AAP), Children Medical Services (Early Periodic Screening, Diagnosis, and Treatment), the Departments of Alcohol and Drugs, Developmental Services, Education, Managed Health Care Services, Mental Health, Social Services, and First 5 California. Non-state partners include FIRST 5 County Commissions, California Association of Health Plans, Lucile Packard Children's Hospital, University of California, Davis and University of California, Los Angeles, Kaiser Permanente, WestEd Center for Prevention and Early Intervention. Much of this broad planning in ECCS has been accomplished through collaborative work between CDPH/MCAH and First 5 California. The California Statewide Screening Collaborative, which serves as the ECCS and Project LAUNCH Council, is one of the results of this collaboration.

California Project LAUNCH (CPL): A \$4.2 million Substance Abuse and Mental Health Administration (SAMHSA) grant awarded over five years to MCAH in 2009 provides the opportunity for the California Department of Public Health, Maternal, Child and Adolescent Health Division (State MCAH) and the County of Alameda Maternal, Child and Adolescent Health Program (Local MCAH) to leverage the broader work of the Alameda County Behavioral Health Care Services and the Alameda County Health Care Services Agency to create a continuum of age-appropriate developmental services for children from birth through 8 years of age. Through CPL, the State MCAH and the Local MCAH partners with First 5 Alameda County to demonstrate the feasibility and impact of recommended state policy changes. These policies will support counties in establishing and sustaining comprehensive developmental care continuums that enable children 0-8 years to be healthy and ready to learn.

Section 6. Plan for Administration of State Home Visiting Program describes all partners in detail.

4. CDPH/MCAH Approach to Policy and Standards

The overarching framework for setting standards and policy development at CDPH is a three-faceted Public Health Decision Framework (Framework), which is currently undergoing departmental review and refinement. The Framework consists of action items surrounding Determinants of Health, Healthy People 2020 Advisory Committee

Criteria, and the Core Public Health Functions and Ten Essential Public Health Services. This Framework focuses CDPH efforts on core public health functions and provides guidelines for all CDPH programs; it ensures unified messaging throughout the Department which enables CDPH to promptly address the shifting population burden for public health and proactively responds to budget concerns and programmatic changes.

Through this Framework, CDPH will respond to the changing public health concerns of the 21st century, while maintaining the gains and achievements made in public health during the past century. The Framework also supports the CDPH mission to optimize the health and well-being of the people in California and will help CDPH move closer to its vision of healthy individuals and families in healthful communities.

Determinants of Health: “Determinants of Health” include social factors such as socio-economic status, race/ethnicity and immigration status; institutional factors, such as policies adopted by the private or public sector (e.g., farm subsidies for specific crops), and factors in the physical environment that influence health, such as exposure to toxins or infectious agents, the availability of open space and healthy foods, and land use patterns. The Determinants of Health policy approach considers how these factors contribute to unhealthy outcomes, and how addressing them might improve health. Addressing Determinants of Health requires the inclusion of other policy sectors such as education and housing in health policy decisions.

Healthy People 2020 Advisory Committee Criteria: The Framework uses four Healthy People 2020 Advisory Committee Criteria to help prioritize programs and policies:

- The overall burden of disease, including the overall number of persons affected or potentially affected,
- The potential of an intervention to reduce health inequities, due to race, ethnicity, socio-economic status,
- The degree to which the burden is preventable or reducible, and
- The cost effectiveness of an intervention.

Core Public Health Functions and Ten Essential Public Health Services: The Core Public Health Functions identified in the Institute of Medicines 1998 document, “The Future of Public Health (Assessment, Policy Development and Assurance),” are operationalized through the Ten Essential Services of Public Health.. The Core Public Health Functions and Ten Essential Public Health Services focus attention on the core businesses of CDPH, and provide a common Public Health reference point for all CDPH employees and activities.

Table 4. Core Public Health Functions and Ten Essential Public Health Services

Core Public Health Functions	Ten Essential Public Health Services
Assessment	<ol style="list-style-type: none"> 1. Monitor 2. Detect and Investigate
Policy Development	<ol style="list-style-type: none"> 3. Inform, Educate and Empower 4. Partner 5. Interventions
Assurance	<ol style="list-style-type: none"> 6. Enforce 7. Link 8. Workforce 9. Evaluate 10. Research

5. CHVP Approach to Policy and Standards

CDPH/MCAH is the lead entity for management of the Title V Block Grant and is housed under the Center for Family Health, which oversees provision of supplemental food to women, infants and children, family planning services, prenatal and newborn screening and programs directed at addressing teen pregnancy, maternal and child health and genetic disease detection. CDPH/MCAH has experience in setting policy and standards for the multiple programs it oversees; this expertise will be utilized in setting the policies and standards for the newly formed CHVP. CHVP will define state-level leadership through the development and enforcement of standards, policies and program design, which will ensure high-quality child and family outcomes, and foster support for a continuum of early childhood services.

Policy Development

By integrating the home visiting program into existing comprehensive early childhood systems in California, CHVP has the opportunity to use resources efficiently, and to shape policies that will bring a cohesive approach to the use of data systems and coordinated administration and planning throughout various state agencies. Key policy objectives will provide:

1. Alignment of outcome objectives with actual intervention strategies, clarified through a strong and consistent Logic Model.
2. Coordination of a network of early childhood services to address the various needs of at-risk families and to provide linkages to service strategies.

3. Reduction in duplication of services by ensuring coordination and collaboration with partner agencies at the national, state and local levels. Establishment of mechanisms for interagency coordination.
4. Promotion of quality and adherence to fidelity for the national model developers. Rigorous Continuous Quality Improvement (CQI) efforts, which includes staff training, utilization of standards and protocols, monitoring of results.
5. Development of research-based quality standards to support ongoing improvement.

To provide a strong infrastructure to support collaborative home visiting programs, CHVP will develop policy and a common set of program standards to ensure fidelity and a high-quality system of services for young children and their families, including:

- A system to track standards which monitor program fidelity in each county program(s)
- Creation of a common set of standards to assist LHJs that integrate multiple models of home visiting programs. Standards will address key program implementation areas of professional development and technical assistance, supervision and cultural relevance.
- Professional development and technical assistance
- Development of core competencies for home visiting providers across multiple models
- Assurance of training systems to meet home visiting model requirements and that also allow for appropriate training across models
- Adequate resources and support to LHJ/community home visiting supervisors
- Incentives to link professional development with course credit or higher compensation
- Identification and mechanisms to address technical assistance needs of individual program sites

6. Plan for Working with National Model Developers: Description of Technical Assistance and Support

CDPH/MCAH is in the beginning stage of contracting with NFP and HFA national model developers to develop a comprehensive plan that will include technical assistance and support for CHVP LHJ/communities in California. General components of a future plan for both models are below.

Nurse-Family Partnership

- NFP developers will assist CHVP and LHJ/community staff through assessment and planning to build support for the program, prepare for implementation, and plan for sustainability of CHVP programs.

- NFP instructors will prepare all CHVP LHJ/community PHNS, nurse supervisors, nurse consultants, and administrators to deliver the program using a competency based model of instruction that builds on their education and experience. In addition, they will assist with content expertise for development of organizational educational sessions and materials. NFP NSO Nurse Consultants will work with CHVP and LHJ/community staff to provide consultation on NFP operations, nursing practice, sharing successful practices, addressing implementation challenges and offering support, resources and ongoing professional development educational opportunities for quality implementation of the NFP model of nurse home visiting.
- NFP NSO will assist CHVP LHJ/communities to measure and monitor the quality of implementation of the NFP model. NFP NFO will provide operational guidance and infrastructure design and build to improve current systems and processes CHVP field adoption.

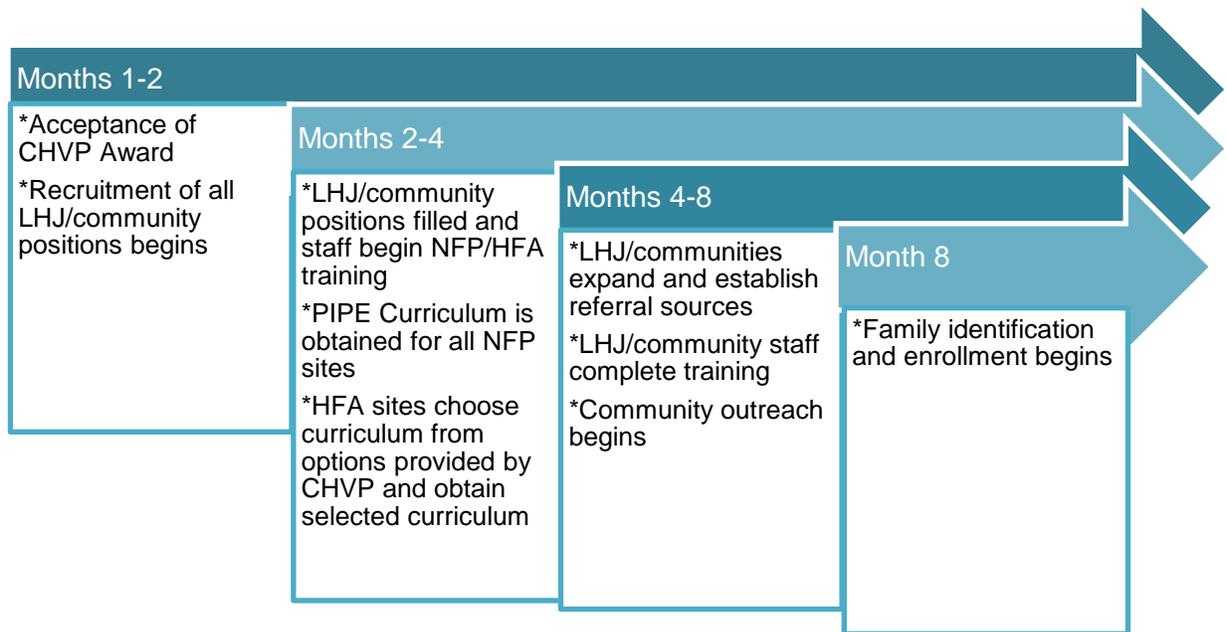
Healthy Families America

- HFA will provide training, technical assistance and quality assurance support to CHVP and LHJ/community staff. This includes instructing CHVP on how to assist all counties/communities in building infrastructure with advocacy, funding, training, quality assurance, and evaluation. HFA will help implement standards of best practice for all CHVP counties/communities to assist in ensuring the highest level of central administrative functioning at the state level.
- Intensive training will be provided to CHVP LHJ/community staff that will administer the assessment tool and provide supervisory support. Training will focus on building skills to engage parents in the assessment process, learn how to gather comprehensive information from parents in regard to their strengths and needs using a conversational style, and obtaining guided practice from a certified user to ensure the tool is administered in a standardized and reliable manner.
- Integrated Strategies for Home Visitor Trainings will be provided to CHVP LHJ/community staff. This includes Home Visitors Core Training, an in-depth, formalized training intended primarily for FSW and Supervisors. The training outlines the specific duties of the FSW in their role within HFA. Topics will include, but are not limited to: communication skills, assessing, addressing, and promoting positive parent-child relationships, creating a trusting alliance with families, goal setting, and strategies to enhance family functioning, address difficult situations, and ensure healthy childhood development.
- Distance Learning Modules will be provided to CHVP LHJ/community staff. This training will cover multiple topics (including infant care, maternal health, child health and development, promoting positive parent child relationships, recognizing and supporting families with issues of mental illness, substance use and partner violence and many other specialized topics). All training will meet the accreditation requirements for wrap-around training.

7. Timeline for Obtaining Curricula or Other Materials

CHVP anticipates obtaining model curriculum for NFP and HFA programs based on the funding and implementation timeline, which is currently to be determined. All curriculum materials will be received prior to staff training, counties/communities referral expansion and establishment, and outreach to targeted communities.

Curriculum Timeline



Nurse-Family Partnership:

CHVP will utilize Partners in Parenting Education (PIPE). PIPE is a preventive intervention curriculum based on social emotional development theory. This curriculum teaches skills of emotional communication, emotion regulation and relationship building. PIPE lessons use experiential learning strategies to teach topics such as temperament and emotional refueling. This curriculum addresses children ages 0-3, is available in English/Spanish, and is currently in use for existing EBHV programs in the following counties/communities:

- Kern
- Los Angeles
- Madera
- Orange
- Sacramento
- San Diego

- Santa Clara
- Solano
- Sonoma

Healthy Families America:

CHVP recognizes the diversity and varying needs of California’s LHJ/communities; addressing these needs through curriculum that matches the needs of the families being served is of high importance to the success of the overall program. Table 5 defines the EBHV curricula designated by CHVP that LHJ/communities may select to fulfill Critical Element #6 which serves to focus on supporting the parent(s) as well as supporting parent-child interaction and child development.

Table 5. EBHV HFA Curriculum

Healthy Families America Curricula	Age of Targeted Population	Considerations
Parents As Teachers (PAT)	Prenatal-5 years	<ul style="list-style-type: none"> • Aligns with Strengthening Families Framework • Reasonable cost • Evidence-based
Partners For a Healthy Baby	<ul style="list-style-type: none"> • Prenatal-3 years • Additional curriculum available for 3-5 years 	<ul style="list-style-type: none"> • Reasonable cost • Currently used by Butte (Paradise Ridge Expansion) • Evidence-based
Growing Great Kids	Prenatal-5 years	<ul style="list-style-type: none"> • High initial cost investment but no recertification, ongoing, or annual fees • Evidence-based
PIPE (Parents in Parenting Education)	Prenatal-3 years	<ul style="list-style-type: none"> • Modified for NFP usage • High cost for materials, additional fees for training • Evidence-based
Home Instruction for Parents of Preschool Youngsters (HIPPY)	3-5 years	<ul style="list-style-type: none"> • Reasonable cost • Available in Spanish • Used in Imperial County for other EBHV programs • Evidence-based

8. Initial and Ongoing Training and Professional Development Activities

CHVP will require formal mechanisms to ensure trainings for staff are appropriate to the NFP and HFA models, and service delivery philosophy and staff training needs are sufficiently met. CHVP will require that each LHJ/community provide a professional growth plan for staff with individually tailored opportunities for additional training. Identification of training needs and opportunities will be ongoing through regular supervision sessions and through an annual employee evaluation process.

CHVP will create a detailed training calendar during the implementation process which will outline ongoing monthly, semi-annual, and annual training and professional development activities to be provided for the funded home visiting programs. State-level trainings will include such topics as progress reporting, understanding data system usage, scope of work creation, and fiscal accountability. The trainings will be delivered via webinar, teleconference, and in-person as needed and appropriate. As described below, CHVP will work in conjunction with the national models to ensure that all Technical Assistance and Training (TAT) opportunities are fully explored and delivered on a timely basis. CHVP will also provide mechanisms, via internal workgroups, to ensure that coordination and collaboration occur among the funded home visiting programs throughout California; this will ensure the use of best practices, reflective practices, and will be an integral part of the overall CQI lifecycle that CHVP embraces and utilizes.

Nurse-Family Partnership:

Model Element #9 of NFP states that nurse home visitors (NHVs) and nurse supervisors complete core educational sessions required by the NFP NSO and deliver the intervention with fidelity to the NFP model. To fulfill this element, NFP nurse home visitors and supervisors attend mandatory one week training. Prior to this training, NFP staff must complete self-study materials. Currently, CHVP is unable to access more detailed information concerning NFP training in lieu of a signed contract between NFP NSO and CDPH/MCAH. CHVP is confident that NFP trainings are comprehensive and will provide ongoing professional development for CHVP counties/communities implementing NFP.

Healthy Families America:

Comprehensive and on-going staff training and professional development is a key component to any HFA program. Critical Element #10 in the HFA Self-Assessment Tool provides extensive detail regarding required training topics and timeline from date of hire. CHVP will require that structure be in place for all HFA home visiting programs to meet the training requirements as a component of the accreditation process (*See **Error! eference source not found.** for details on accreditation*). Completion of rigorous two week training will be required of all staff prior to contact with families:

- Orientation

- Home visitation history, implementation plan, policies and procedures
- Child Abuse and Neglect indicators and mandated reporting requirements
- Asset mapping
- Strength based communication, confidentiality, safety and boundaries
- Curriculum training
- Paperwork and data collection training
- ASQ and ASQ:SE training
- Job shadowing
- Case assignment, assessment and file review

Within six months of program initiation, and prior to providing services to families, all direct service staff and their supervisors/program managers will participate in a four day Core training facilitated by a certified HFA trainer. Core training provides the basic history, philosophy and intent of the HFA program model.

Assessment Core Training: an in-depth, formalized training designed for staff whose primary role is to conduct initial assessments. It is also ideal for home visitors seeking to advance their communication skills to more confidently address difficult situations with families. Four full days for the family assessment worker, plus an additional fifth day for supervisors and program managers include topics such as, but not limited to: identifying overburdened families, interviewing skills, conducting risk assessments, completing necessary paperwork and documentation, family-centered support services, communication skills.

Home Visitor Core Training: Home Visitors Core training is an in-depth, formalized training intended for HFA home visitors. Four full days for the home visitor, plus an additional fifth day for supervisors and program managers, the training outlines the specific duties of the home visitor in their role within HFA. Topics include, but are not limited to: establishing and maintaining trust with families, goal setting, completing necessary paperwork/documentation, the role of the home visitor, communication skills, and intervention strategies.

Additional trainings must be completed within the first year of hire in adherence with Critical Element #10. An example of topics includes:

- Infant Care
- Child Health and Safety
- Maternal and Family Health
- Infant and Child Development
- Culture in Parenting
- Etiology of Child Abuse and Neglect

- Stress and Time Management
- Domestic Violence
- Life Skills and Stressors
- Mental Health
- Substance Abuse

9. A Plan for Recruiting, Hiring, and Retaining Appropriate Staff for all Positions

CHVP will monitor the recruitment, hiring and retention of staff through consistent and systematic feedback with NFP and HFA national model developers, as well as the LHJ/community-level management structure.

County infrastructure: All LHJ/communities identified by CHVP for implementation of a home visiting program have a strong infrastructure in place at the county level for the recruitment and hiring of both professional and paraprofessional staff. Each local MCAH Director can access their county Human Resources Department to recruit and hire NFP and HFA staff from an actively maintained list of qualified applicants within the county. These applicants have been pre-screened and their credentials and experience have been verified.

Targeted outreach: County Human Resources Departments post open positions via a large distribution network, including advertisement in professional journals, through the Internet, and through university nursing programs. Many LHJ/communities implementing NFP programs have access to a clinical nurse recruiter who conducts a targeted outreach for PHNs, depending on the types of skills and specialties that are needed.

Utilization of existing staff: Some LHJ/communities have a plan to shift current county staff to new NFP or HFA programs. In these instances, staff are working in programs that will no longer exist due to the current fiscal crisis California counties are experiencing. CHVP sees the benefit in approving this as a recruitment strategy for program implementation as it will allow for a reduced start-up time and provides new NFP or HFA programs with experienced staff that are familiar with their LHJ/communities resources and networks.

Reflective supervision as a retention tool: In adherence to NFP and HFA model fidelity and as a staff retention tool, high quality clinical supervision and reflective practice will be used by all CHVP programs. This concept is proved to be effective in cultivating an environment that promotes learning and growth by addressing any areas of concern from staff so that issues can be resolved immediately, and staff can receive immediate training and support in areas where they may be struggling. This helps to alleviate the effects of staff burn-out that come from working with over-burdened families who have multiple issues and areas of need.

Competitive salary ranges: CHVP will ensure that all LHJ/communities competitive salary ranges for staff.

Professional Development: Regular training schedules will be available for all LHJ/community staff.

CHVP-sponsored training and technical assistance: Regional NFP and HFA calls will be facilitated by CHVP to address any recruitment and retention issues and to encourage LHJ/communities to discuss best practices for obtaining and retaining staff.

10. Subcontracts

CHVP will not directly subcontract but instead provide funding through established funding provisions. CHVP will utilize an existing allocation process as the basis for disseminating funds. Once the plan receives approval, the selected LHJs will be awarded their CHVP allocation. Some LHJs may enter into subcontract agreements with Community Based Organizations (CBO) or other local agencies.

11. Assurance of High Quality Clinical Supervision and Reflective Practice

CHVP recognizes high quality clinical supervision and reflective practice are mission-critical for successful home visiting programs. Both NFP and HFA national models adhere to high quality supervision and reflective practices and this will be reflected in the implementation and ongoing operation of all CHVP LHJ/communities.

Nurse-Family Partnership Clinical Supervision and Reflective Practices

In keeping with NFP standards for ensuring high quality clinical supervision and reflective practice, CHVP Nurse Supervisors will monitor and ensure that appropriate methodologies, standards, procedures and guidelines are being followed by all staff. Quality control and quality assurance will continually be addressed in LHJ/communities as it is a critical component for the NFP program:

- Reflective supervision as a key component to all CHVP NFP programs: Reflective supervision is critical for better relationships between nurse supervisors, PHNs, and the families being served. Programs will utilize this concept to strengthen staff skill building, facilitate quality assurance, and improve service delivery. All supervisors will receive continuous training in reflective supervision through regional NFP training, which will be provided by NFP NSO.
- Continual communication between Nurse Supervisors and staff at all levels in the NFP process: Emphasis will be placed on regular chart reviews by Nurse Supervisors and discussions during staff meetings or one-on-one encounters to ensure adherence to program standards. Nurse Supervisors will consistently monitor the activities of PHNs to promptly address any areas of concern so that questions and issues are resolved.

- Nurse Supervisors will incorporate discussions on how to be reflective during weekly staff meetings: Case consultations, learning and implementing PIPE, team education.
- Use of available technology to support NFP clinical practice and program management: Some LHJ/communities are establishing an electronic health record that streamlines reporting and charting across all the required data collection systems including NFP, with the end result of a better functioning system and a reduced administrative workload (charting) for all PHNs.
- Quarterly regional meetings facilitated through CHVP for all LHJ/community NFP programs where reflective supervision will be practiced among colleagues in a supportive environment: This meeting will provide a forum for sharing successes, learning from one another and gathering ideas for overcoming challenges related to reflective supervision and any other NFP-related challenges.

Healthy Families America Clinical Supervision and Reflective Practices

Reflective practice is woven throughout the HFA Critical Elements and is a crucial component to the success of HFA with high needs families. Thus, high quality clinical supervision and reflective practice will continually be addressed in all of CHVP LHJ/community HFA programs. High quality clinical supervision and reflective practice for all FSWs, FAW, and Supervisors will take place as part of a formalized and structured plan:

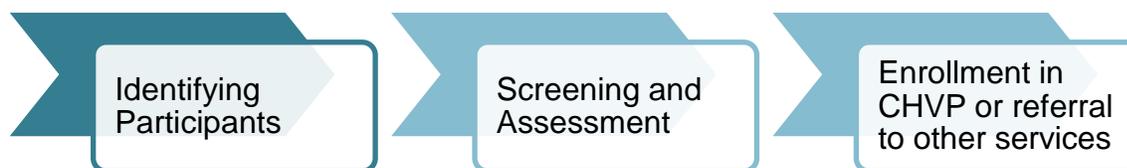
- All staff will receive weekly individual supervision for 1-2 hours per week: Reflective group supervision will also be scheduled on a regular basis and aligned with the HFA Self-Assessment tool.
- Supervisors will accompany FSWS on home visits at least twice in the first year of employment and once annually thereafter: This provides supervisors with a solid understanding of FSWs techniques in working with families and possible opportunities for FSWs to receive additional training and support in needed areas.
- Supervisors will model boundaries and appropriate communication techniques: This will be directly reflected in the interactions that FSWs and FAWs engage in with their assigned families.
- Quarterly regional meetings facilitated through CHVP for all programs where reflective supervision will be practiced among colleagues in a supportive environment; this meeting will provide a forum for sharing successes, learning from one another and gathering ideas for overcoming challenges related to reflective supervision and any other HFA-related challenges.

12. Estimated Number of Families Served

All funded CHVP LHJs/communities will enroll a minimum of 100 families to be served by the proposed home visiting program. This specification is applicable to expansions of existing home visiting programs and new home visiting programs in LHJs/communities.

13. Identifying and Recruiting Participants

As part of the CHVP-RSI process (*explained in Section 1. Identification of the State's Targeted At-Risk Communities*), CHVP requested that LHJs identify, prioritize and describe high need populations they intend to serve with a home visiting program. In reviewing CHVP-RSI LHJ/community identification and recruitment plans for participants, CHVP recognizes that “best practices” exist in some LHJ/community home visiting program expansion sites. These best practices will be replicated at all expansion and new home visiting sites in California. As part of the adoption of best practices, CHVP will work in partnership with state and local stakeholders to develop procedures and protocols to address the potential for the duplication of home visiting services by multiple visitors from different agencies. In addition, CHVP will adhere to national NFP and HFA standards for identifying and recruiting participants for all funded home visiting programs.



Identifying Participants

Local Home Visiting Advisory Committee: The establishment of a Local Home Visiting Advisory Committee is the first step for beginning the identification of NFP and HFA clients. It is critical that all counties/communities bring together a cross-section of community members that will provide the service supports for clients with young children to be enrolled in CHVP. The Local Home Visiting Advisory Committee may be a new group or an existing community collaborative capable and interested in the commitment. A functioning Local Home Visiting Advisory committee will signal that the LHJ/community is ready to look at the service delivery system from a new angle and consider opportunities for improving and expanding this system.

Members of local home visiting advisory committees should include stakeholders from the LHJ/community being served by NFP and HFA programs. Example memberships include the following:

- Business leaders
- Child protective services representatives
- Community library system
- Cooperative extension services
- Domestic violence victim advocates
- Evaluation expertise

- Funders/foundation representatives
- NFP and HFA state leader (particularly if this individual lives within the LHJ/community)
- Head Start/Early Head Start
- Home visiting program representatives
- Local/county government
- Local hospitals
- Local departments of public health and MCAH programs
- Media representatives
- Members of faith communities
- County mental health agencies and mental health providers
- Early intervention
- Early care and education providers, including family home providers
- Child care and resources and referral agencies
- Infant toddler specialist networks
- Family resource centers
- Regional centers
- Other community-based organizations, such as United Way or the League of Women Voters
- Parents/new parents
- Prevent Child Abuse America Chapter representatives
- Public assistance representatives
- Representatives of cultural/ethnic groups, such as La Raza or National Black Child Development Institute
- Representatives of early intervention programs
- Representatives of other home visiting programs
- Substance abuse counseling/treatment providers

Additional Strategies for the identification of participants:

- Utilizing existing relationships: Local MCAH Directors have existing relationships with healthcare and family services providers. These existing relationships with healthcare providers and other community partners are a valuable “in” for accessing and engaging families living in the CHVP LHJ/communities. Another valuable resource is other PHNs and local Public Health Department staff familiar with the

targeted community who have strong relationships with referral sources, and methods for engaging families into public health and PHN services.

- Existing networks: Tapping into networks with access to several Healthcare Advisory Councils Advisory Councils organized by public district hospitals in the targeted community is a “best practice” for identifying clients for recruitment into CHVPs. Local MCAH Directors have existing, long-standing relationships with these networks and councils.
- Development or expansion of existing referral agreements: NFP and HFA expansion sites report that they receive referrals from other community agencies such as Adolescent Pregnancy and Parenting Programs, local WIC programs, First 5, Black Infant Health Programs, Early Head Start Programs, and many more. New NFP and HFA sites may not have existing referral agreements for home visiting programs but referral agreements may exist for other local Public Health Department programs and these could be expanded to include CHVP LHJ/communities.
- Adapt lessons learned from existing NFP or HFA program recruitment strategies: For example, waiting longer for responses to letters sent to pregnant potential clients, since referrals are often made early in the woman’s pregnancy when they are still attempting to figure out what it all means. Allowing a lengthier response time provides the opportunity for the potential client to be more receptive to hearing about NFP or HFA and making the decision to participate.

Screening and Assessment

NFP and HFA screening and assessment is a documented process that takes place once a client has been referred through community outreach networks described above. Clients may also self-refer based on public awareness of the home visiting program and educational campaigns that have informed them of the CHVP’s existence.

Although NFP and HFA CVHPs will utilize different screening and assessment tools, the purpose is the same: to systematically identify clients who are most in need of services and assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes. Once screening and assessment are completed, clients will be enrolled in CHVP LHJ/community home visiting programs. If clients are not a fit, they will be referred to other supportive and appropriate community services and resources.

Nurse Family Partnership: Although CHVP does not currently have access to specific screening and assessment information for NFP until a signed contract is in place between NFP NSO and CDPH/MCAH, there are several guidelines that are critical to maintaining NFP model fidelity within the screening and assessment process:

- NFP clients must be first-time, low-income, prenatal mothers, enrolled in the program no later than 28th week of pregnancy
- First contact with potential clients should be at the earliest possible point in pregnancy

- NFP staff will meet potential clients on referral site, especially medical clinics
- Enrollment in NFP must be voluntary
- All tools and messages will be culturally and linguistically sensitive to potential clients, including special populations
- If ineligible for NFP, clients will be referred to other services and programs. If the client is not interested in NFP, other community-based modalities will be offered to the client

Healthy Families America: Screening and assessment is an integral and highly valued component of an HFA program and is embedded in Critical Elements #1 and #2. The HFA standard is to identify a minimum of 75% of the target population while implementing continuous quality improvement standards to reach 95-100% of the target population.

The identification of potential clients through referral and screening takes place prior to the assessment process. Referrals for screenings may come from many sources such as community partners, pediatricians' offices, postnatal providers, and other family services providers. The standardized screening form is ideally completed by the HFA FAW with a presence in the hospital or clinic within the LHJ/community where the client is giving birth. FAWs are able to make the screening of potential clients a higher priority than hospital/clinic staff. This is vital because the window of opportunity to connect with the client is short and once a client leaves the hospital/clinic, they can be difficult to locate. Based on the results of the screener, clients will be contacted for an assessment or referrals will be made, based on the needs of the client.

A comprehensive and effective assessment process is one of the unique elements of a successful HFA program. The assessment is viewed as an essential part of the service delivery process, and provides a foundation for successes with the family. Information obtained through the assessment process will guide the service delivery plan and Family Success Plan. One of the assessment models being considered by CHVP for HFA programs is the Kempe Family Stress Checklist. This is used in accredited HFA programs throughout the country. The use of this tool is so widespread because it enables the FAW to guide the family in a discussion of histories, beliefs and concerns that results in a comprehensive and concise snapshot of the family's current state.

Two main guides for successful assessment, regardless of the tool used are:

- Assessment should take place in an environment comfortable to the family, preferably in the family's home or another location of their choosing
- Assessment should occur at a time that is convenient to the family

After the assessment conversation has been completed, additional steps will be followed to complete the process:

- The FAW will create a categorical summary and assign a subsequent score

- Category scores will be combined to generate an overall family score
- Each primary caregiver present for the assessment will receive his/her own score

Enrollment

NFP and HFA families who have completed the screening and assessment process, and have voluntarily accepted services, will be contacted by their PHN or FSW, who will initiate the enrollment process. The first home visit for NFP and HFA programs vary but generally include the following components:

- Enrollment paperwork
- Description of program and services
- Safety review
- Information regarding “tips for infant care”
- Scheduling of additional home visits

14. Minimizing Attrition Rates for Participants Enrolled in the Program

CHVP will adhere to NFP and HFA standards for minimizing attrition rates for participants enrolled in home visiting programs. CHVP recognizes that some existing NFP and HFA home visiting programs have effective plans in place for minimizing attrition rates. Best practices from these highly effective attrition plans will be replicated at all expansion and new home visiting sites in California. In addition, this is an area where CQI will be utilized.

Nurse-Family Partnership:

The quality of the nurse/client therapeutic relationship is the key of NFP home visiting programs' success. This relationship is monitored, guided and enhanced through reflective supervision (Elements #13 and #14). NFP Nurse Supervisors conduct joint field visits with their PHNs. Although incentives can help offset and reduce attrition in some cases, the primary strategies for keeping clients and reducing attrition rates include PHNs becoming experts in the following activities:

- Actively listening to what the client is communicating and assisting them in what they want to achieve with as much enthusiasm as possible and scaffolding them for success in goal attainment
- Understanding the client's perspective versus through that of a healthcare provider
- Identifying the client's needs, as opposed to projecting and speculation about what those needs are through the eyes of a healthcare provider
- Ensuring that clients are aware of all of the resources that are available to them and assisting them in the exploration and evaluation of their personal resources as well as their community resources

- Co-planning with the client to set up home visiting appointments; setting small, achievable steps to assist clients in meeting their goals; utilizing the Nurse: Client Visit form effectively for follow-up and follow-through on all commitments made
- Identifying and building on family strengths within the family system
- Establishing positive relationships with family members and friends who are an important part of the client's life
- Considering the client's developmental level in order to speak at a rate and manner appropriate when delivering educational messages
- Possessing self-awareness of non-verbal cues and behaviors which may impede a relationship with a client. Use of non-verbal cues to convey non-judgmental acceptance of the client to establish a relationship based on mutual respect and trust
- Assuring the client that although the PHN is a mandated reporter, her purpose is to provide strengths-based support to the client for meeting the goals of the program: a healthy birth outcome, helping to optimize the growth and development of the child, and assist the client to self-identify goals, providing supportive assistance as needed, which allows the family to navigate towards a positive life course trajectory
- With client's approval, requesting family members to join visits, when possible
- Establishing a complimentary relationship of equality versus a hierarchal relationship between the PHN and the client
- Building "sharing positive emotions" into the PHN-client interactions whenever possible, using creativity while giving consideration into the client's individuality
- Being flexible when scheduling appointments and locations to meet the needs of the client
- "Selling" the NFP program with a team approach (i.e., mentioning to clients that PHNs in the NFP program all deliver the same model with the same standard and approach to providing care)
- Upon initial intake with the client, making an assessment for an understanding to what the client's perceptions are about program participation, using diplomacy to correct any misconceptions (i.e., PHNs are the "baby police")
- Using personal notes/cards to assist in bridging any difficult periods in the PHN-client relationship
- Gaining trust and a sense of the client's needs prior to making referrals, and carefully timing the referrals to the client's needs (i.e., avoid making a mental health referral on the intake visit when no acute needs have been identified)
- Becoming effective with using the NFP tools available to facilitate problem solving; this allows clients to be guided in working through challenges identified with solutions of their own
- Accepting clients as they are and where they are, without making judgments regarding their living conditions or socio-economic status

- Making clients aware during intake of program incentives provided throughout the program at different milestones and the graduation event at program completion
- Utilization of “Incentive Items Schedule” for giving out incentives geared to the developmental milestones of the baby and/or the client which contribute to a more positive client retention rate

Healthy Families America:

HFA stresses the importance of family retention in Critical Element #3. All affiliated HFA sites must measure and review retention rates to identify trends and issues that may be impacting a program’s ability to retain families and minimize attrition. Monthly, the supervisor of each HFA site will utilize the Program Management Information System (PIMS) data system to generate reports, review retention rates and identify patterns in the following areas:

- FSWs and their home visiting completion rates
- Schedules and appointment times of the FSWs and with families
- Families moving or in crisis
- Births for the month
- Age and ethnicity of family
- FSWs triggers with transference or counter-transference issues

The HFA Supervisor will report program retention data to the HFA Program Manager monthly. In addition, FSWs will be engaged in the discussion through group and individual supervision sessions. This process assists FSWs in becoming better informed regarding nuances of family dynamics that may prevent families from being engaged. For instance, a family may not engage with the FSW because of a challenging topic brought up by the FSW, such as domestic violence or substance abuse.

Some families may experience challenges with participation. For a variety of reasons, a family may be hesitant to follow through with services, even though they desire and need the supports being offered. HFA allows for a 3-month period of “Creative Outreach” where the assigned FSW attempts to engage the family. “Creative Outreach” is a time of gentle and persistent encouragement, with the ultimate goal being re-engagement in services. All HFA staff will be trained on creative outreach techniques and concepts including but not limited to:

- Making appropriate and non-threatening phone calls and text messages
- Mailing hand-written note cards and attempted home visits
- Drop-by visits without intruding upon the family
- Inviting families back into the program by offering socialization invitations
- Attempting to engage families at other potential points of contact

All engagement attempts will be documented and discussed with the Supervisor. The Supervisor and the FSW strategize on different techniques to use with families based upon the individual characteristics of the family. It is recommended that HFA staff place more emphasis on the celebration of successes for families for reaching personal goals and program graduation ceremonies.

15. Estimated Timeline to Reach Maximum Caseload

The CHVP-RSI specified that LHJs/communities ensure a minimum of 100 families will be served by the proposed home visiting program for each LHJ/community. This specification is applicable to both expansions of existing home visiting programs, as well as new NFP or HFA programs. There are several factors that impact the timeline for counties/communities to reach the minimum caseload of 100. Timelines are dependent on the following factors:

- Which home visiting program will be implemented (NFP or HFA)
- Whether it is an expansion of an existing NFP or HFA home visiting program or a newly formed program
- If the LHJ/community has prior experience with providing home visiting services with high-risk, low-income families
- The ability of the LHJ/community to hire qualified staff
- Experience in managing data collection
- The level of LHJ/community support for maximizing outreach and improving the network of referral linkages

Time	NFP	HFA	Responsible Party
Month 1	<ul style="list-style-type: none"> • Notification of Award • Acceptance of Award 	<ul style="list-style-type: none"> • Notification of Award • Acceptance of Award 	CHVP Manager, Director of Local MCAH
Months 1 - 4	<ul style="list-style-type: none"> • Nurse Manager assumes position and begins program expansion process. For new sites, Nurse Manager must be recruited and hired. • Secure office space in community • Recruitment notices distributed for all Nurse Manager, PHNs, and Administrative Support • Interviews conducted and positions filled 	<ul style="list-style-type: none"> • Program Manager assumes position and begins program expansion process. For new sites, Program Manager must be recruited and hired. • Secure office space in community • Recruitment notices distributed for Program Manager, Supervisor, FSWs, FAW, and Administrative Support • Interviews conducted and positions filled 	NFP Nurse Manager/HFA Program Manager

Time	NFP	HFA	Responsible Party
Months 4-8	<ul style="list-style-type: none"> Expand and establish referral sources; outreach to agencies Complete NFP educational modules 1, 2 Staff National Orientation Begin community outreach 	<ul style="list-style-type: none"> Expand or establish referral sources; outreach to agencies Staff Completion of rigorous two-week training Begin community outreach 	NFP Nurse Manager/NFP PHNs, HFA Program Manager, Supervisor, FSWS, FAWs
Months 8-11	<ul style="list-style-type: none"> Client identification and enrollment Continue community outreach 	<ul style="list-style-type: none"> Client identification and enrollment Continue community outreach Staff participation in 4-day core training 	PHNs/FSWs
Months 11-13	<ul style="list-style-type: none"> Continue participant enrollment 100 family caseload reached by some counties 	<ul style="list-style-type: none"> Continue participant enrollment Staff completion of additional training All sites reach 70 family caseload 	PHNs/FSWs
Months 13-18	<ul style="list-style-type: none"> 100 family caseload reached by all sites by month 15 	<ul style="list-style-type: none"> 100 family caseload reached by all sites by month 18 in compliance with HFA leveling system 	PHNs/FSWs
Ongoing (Frequency TBD)	<ul style="list-style-type: none"> Collect and analyze client data 	<ul style="list-style-type: none"> Collect and analyze client data 	PHNs/FSWs/Data, Evaluation Support

The timeline for NFP LHJs/communities home visiting program expansions and new programs to reach maximum caseloads of 100 families is approximately 9-15 months. Both expansion and new sites demonstrate the ability to hire qualified staff, as needed.

HFA LHJs/communities home visiting programs expansions and new programs will reach maximum caseloads of 100 families within 18 months. HFA LHJs/communities take longer to reach the maximum caseload requirement of 100 families due to HFA accreditation guidelines and Critical Element #8 of the HFA model, which clearly defines the leveling system, and determines the intensity of services that families will receive. The leveling system ensures the quality of services provided to families is not compromised and FSWs do not become burned out from having entire caseloads of families all needing intensive services at once.

LHJs/communities expanding either NFP or HFA programs have current recruitment strategies in place, job descriptions developed and, in some cases, established relationships with area university nursing programs that allow for seamless recruitment for PHNs. Expansion and new sites have access and support from the LHJ Public Health Human Resources Department. LHJ Public Health Human Resources Departments are adept in screening qualified applicants and providing targeted recruitment outreach to recruit staff for NFP and HFA programs.

Expansion sites exhibit an existing widespread support of home visiting programs and a demonstration of successes in public-private partnerships. Partner referral agreements have been established with agencies and existing staff are experienced in the development of referral pathways for the existing home visiting programs to improve coordination efforts, cross referring of clients, and ensuring services are not duplicated.

New sites demonstrate strong collaborative public-private partnerships across the LHJ/community. Although partner referral agreements are not yet established with agencies regarding a new home visiting program, local MCAH Directors are experienced in working within their LHJ/communities on behalf of high risk populations and families, in particular. Additionally, local MCAH Directors have been meeting formally to discuss the possibilities of implementing a home visiting program with these collaborative partners since the release of California’s Needs Assessment submission in September 2010. Although new staff will be hired for home visiting programs, local MCAH Directors will be instrumental throughout the establishment of local programs.

Table 6 lists LHJs/communities currently ready for implementation as well as those to be considered for implementation if additional funds become available. The table also indicates whether LHJs/communities are expansions or new NFP or HFA programs; also provided are the actual responses from LHJs/communities on their estimated timeline to reach the maximum caseload of 100 families. CHVP notes that some of the LHJs/communities have challenging, short timelines to reach maximum caseloads.

Table 6. Phase 1-Initial CHVP Implementation

Phase 1-Initial CHVP Implementation		
Communities	Model	100 Family Caseload
Los Angeles Unified	NFP/Expansion	Within 12 months
Butte (Paradise Ridge/ Southern Butte)	HFA /Expansion	Within 18 months
Los Angeles Service Districts	NFP/Expansion	Within 15 months
Contra Costa (East/ West/ Central)	NFP/New	Within 10 months
San Diego	NFP/ Expansion	Within 15 months
Imperial	HFA/ New	Within 12 months
Kern	NFP/Expansion	Within 12 months
Madera	HFA/New	Within 9 months
Shasta	NFP/ New	Within 9 months
North Coast Tri-Consortium	NFP/Expansion and New	Within 12 months
Alameda (East/ West Oakland)	NFP/New	Within 9 months
San Francisco (Bayview Hunter's Point)	NFP/New	Within 12 months
Sacramento 139F	NFP/ Expansion	Within 12 months

Phase 1-Initial CHVP Implementation		
Implementation if Additional Funds Are Available		
Merced Countywide	NFP/New	Within 12 months
Fresno (Southeastern Fresno)	NFP/Expansion	Within 12 months
Northern Los Angeles SPA 1 (SPA 1-Antelope Valley)	HFA/New	Within 6 months
Sacramento (North Sacramento Communities)	NFP/Expansion	Within 12 months
Nevada Countywide	HFA/Expansion	Within 6 months
Stanislaus (Countywide)	NFP/New	Within 7 months
San Mateo (North/ Central/ South Counties)	NFP/New	Within 9 months
Solano (Countywide)	NFP/Expansion	Within 9 months
Riverside (Perris/Moreno Valley)	NFP/Expansion	Within 6 months
Tehama (Countywide)	HFA/New	Within 12 months
Yolo (Countywide)	NFP/New	Within 12 months
Sonoma (Sonoma County Hwy 101 Corridor)	NFP/Expansion	Within 8 months
Santa Clara Countywide	NFP/Expansion	Within 9 months
Santa Cruz Countywide	NFP/New	Within 12 months
Long Beach (The City of Long Beach)	NFP/New	Within 12 months
Marin (San Rafael/ Novato/ Marin City)	HFA/New	Within 6 months
Santa Barbara (North County)	HFA/New	Within 4 months
Northern Tri Consortium (Colusa/Glenn/Tehama County)	NFP/New	Within 15 months
Orange (Countywide)	HFA/New	Within 8 month

16. Coordination Between the Proposed Home Visiting Programs and Other Existing Programs and Resources in Those Communities

CHVP will utilize the umbrella of the Strengthening Families framework for the coordination of home visiting programs with other existing resources within each community; this will ensure a common set of outcomes and contribute to strategic planning efforts at the state level. The use of Strengthening Families for programmatic practice will allow LHJs/communities to share a unifying language, via the Five Protective Factors, and will promote cross-sector collaboration and leadership that includes both traditional and non-traditional partners in mental health, early childhood development, substance abuse, domestic violence prevention, child abuse and neglect prevention, education and other relevant social and health services. Strengthening Families will also provide organized opportunities for peer learning and exchange as well as a common approach for service delivery within the home visiting communities.

This framework will provide resources for shared collaboration, service linkages, referrals, and a sense of accountability across programs.

California LHJs/communities where the Strengthening Families framework is already adopted for local level child and family serving programs are as follows:

- Alameda (East/West Oakland)
- Butte (Paradise Ridge/Southern Butte)
- Contra Costa (East/West/Central)
- Imperial (El Centro/Imperial/Holtville/Seeley/Heber)
- Los Angeles Service Planning Areas or LA-SPA [SPA 2 (San Fernando Valley); SPA 3 (San Gabriel Valley); SPA 7 (East L.A.)]
- Los Angeles Unified School District (LAUSD)
- Orange (Countywide)
- San Diego (North Inland-Coastal Expansion (NICE) - Oceanside/Vista/San Marcos/Escondido/Carlsbad)
- San Francisco (Bayview Hunter's Point)
- Santa Barbara (North County)
- Solano (Countywide)
- Sonoma (Sonoma County Hwy 101 Corridor)
- Northern Los Angeles SPA 1 (SPA 1- Antelope Valley)

To further influence coordination between the home visiting programs and other existing resources within each community, CHVP is in the process of developing workgroups to promote interagency coordination and shared accountability. Workgroup membership will include CHVP staff, national NFP and HFA representatives, and experienced local MCAH Directors who will provide experience and expertise in collaboration with other programs within their communities. Additional workgroup members at the state level will include representation from health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other applicable social and health services found within CHVP communities. CHVP will also include non-traditional partners in the workgroups as appropriate. Example workgroups and descriptions are as follows:

Continuum of Care Workgroup:

- Develop best practices for counties/communities to coordinate resources among existing programs
- Provide a forum for counties/communities to troubleshoot linkages and referrals within problem areas

- Conduct periodic technical assistance calls with LHJs/communities to facilitate the adoption of best practices for coordinating home visiting program resources
- When appropriate, reach out to local community organizations who are resistant to LHJ/community collaborative efforts

Public Awareness and Advocacy Workgroup:

- Create a plan to generate public awareness and support for counties/communities
- Provide ongoing guidance in the messaging and marketing of home visiting programs at the LHJ/community level
- Conduct periodic technical assistance calls with counties/communities to facilitate the adoption of best practices for messaging and marketing of home visiting programs
- Identify “champions” and spokesperson for advocacy issues

Program Performance Workgroup:

- Develop processes for best practices for progress reporting, standardizing forms to be used, common language when reporting program status
- Reinforce CQI processes for data collection and ongoing CHVP evaluation
- Provide training and guidance to counties/communities for challenges associated with maintaining quality and fidelity to models
- Assist with LHJs/communities efforts and progress towards improving performance
- Provide counties/communities with effective recruiting and hiring practices
- Develop strategies to enhance staff retention for counties/communities
- Coordinate with, or serve as, the state level CHVP QI Team

17. Obtaining or Modifying Data Systems for Ongoing Continuous Quality Improvement (CQI)

By incorporating home visiting program data into a larger, coordinated data system, better use can be made of the data to measure progress, make decisions and track outcomes. CHVP will identify a new data system, or modify an existing data system, to support CQI efforts in the implementation process and beyond. The data system will provide the following functionalities:

- Data entry and validation for variables/data fields collected on program paper forms
- Flexible modification to the data system based on revision of existing forms or addition of new forms as necessary
- Standard reports for documented benchmark constructs

- Ad hoc query capability for special analyses including CQI
- Standard reports for CQI and fidelity monitoring
- Data quality reports tracking percentage of form completion, field completion, and process timeliness. Data quality reports will be available at multiple levels: the statewide program, program site, program manager, program staff person, and family or individual client.
- Membership services: secure login by user ID and password
- Vertical and horizontal control of membership permissions to enter, modify, or query data
- Secure storage and transmission of electronic data

18. CHVP Approach to Monitoring, Assessing, and Supporting Implementation with Fidelity to the Chosen Models and Maintaining Quality Assurance

CHVP will establish procedures and protocols for monitoring the overall implementation structure with regard to model fidelity through implementation of the State's Continuous Quality Improvement (CQI) plan. CHVP will require adherence to research-based quality standards of practice such as staffing requirements, ongoing training and professional development and stringent reporting requirements and continuous improvement at the program level. This will be achieved through strong data collection systems that will track outcomes and help to better target deficiencies in service. As noted in the CQI plan, fidelity and quality assurance measures at the program level will be monitored in three areas: program characteristics, including home visitor/supervisor characteristics; participant characteristics; and participant experiences or service delivery.

The CHVP Quality Improvement (QI) Team will monitor the following in order to inform local technical assistance, policy change and federal reporting requirements:

- Monitor all QI indicators in order to track quality and fidelity of implementation. Includes contextual factors.
- Identify QI indicators that do not meet the performance standard set by NFP, HFA or CHVP.
- Monitor Local and Community/County level CQI efforts and progress toward improving performance.
- Track and respond to training and technical assistance needs.
- Document challenges to maintaining quality and fidelity and strategies to address these challenges.
- Respond to requests for model adaptations, coordinate response with NFP/HFA and model developers, and track adaptations closely.

CHVP will work closely with NFP and HFA to ensure that national and state quality improvement activities are complementary. To ensure that these efforts are coordinated, CHVP will consult with NFP and HFA to ensure ongoing dialogue and planning activities at the state level.

Nurse-Family Partnership:

NFP has several departments to directly support states and local NFP programs:

- **Program Development:** Program Developers help local, regional, and state leaders through assessment and planning to build support for the program, prepare for implementation, and plan for sustainability of local programs
- **Nursing:** NFP Instructors prepare registered nurses, supervisors, state nurse consultants, and administrators to deliver the program using a competency based model of instruction and building on their professional education and experience. In addition they provide content expertise to the development of organizational educational sessions and materials. NSO Nurse Consultants work with local, regional, or state Nurse-Family Partnership implementing agencies to provide consultation on NFP operations, nursing practice, sharing successful practices, addressing implementation challenges and offering support, resources and educational opportunities for quality implementation of the NFP model of nurse home visiting. The nurse consultant collaborates with NFP implementing agencies, state nurse consultants and program quality coordinators
- **Program Quality Support:** This Department is responsible for ensuring and enhancing the capacity of the National Service Office to measure and monitor the quality of implementation of the NFP model. Through these efforts, this team also provides operational guidance and infrastructure design and build to improve current systems and processes for both internal (NSO) and external (field) adoption. The department achieves this with members experienced in consultation and coaching, research design, evidence-based practice, data management and analytics, and continuous quality improvement.

Healthy Families America:

HFA provides training, technical assistance and quality assurance support to states and local HFA programs.

- **Assessment:** Intensive training is provided to all program staff that will administer the assessment tool and provide supervisory support. The training focuses on building skills to engage parents in the assessment process, learning how to gather comprehensive information from parents in regard to their strengths and needs using a conversational style, and obtaining guided practice from a certified user to ensure the tool is administered in a standardized and reliable manner.
- **Integrated Strategies for Home Visitors:** Home Visitors Core Training is an in-depth, formalized training intended for home visitors of a HFA program. Four full days for

the home visitor, plus an additional fifth day for supervisors and program managers, the training outlines the specific duties of the home visitor in their role within HFA. Topics include, but are not limited to: communication skills, assessing, addressing, and promoting positive parent-child relationships, creating a trusting alliance with families, goal setting, and strategies to enhance family functioning, address difficult situations, and ensure healthy childhood development

- Distance Learning Modules: Affiliated programs have access to distance learning modules through HFAs web-based training system. This training covers multiple topics (including infant care, maternal health, child health and development, promoting positive parent child relationships, recognizing and supporting families with issues of mental illness, substance use and partner violence and many other specialized topics) and meets the accreditation requirements for wrap-around training.

19. Anticipated Challenges to Maintaining Quality and Fidelity, and the Proposed Response to the Issues

CHVP recognizes the challenge of maintaining model fidelity while implementing NFP and HFA within each of the identified LHJs/communities. To address this challenge, CHVP will follow national NFP and HFA guidelines in monitoring, assessing, and supporting implementation for each LHJ/community, which ensures fidelity to the models.

See Section 3. Selection of Proposed Home Visiting Models and Explanation of How the Models Meet the Needs of Targeted Communities for further details on anticipated challenges to maintaining quality and fidelity, and the proposed response to the issues identified

20. Collaborative Public and Private Partners

California Department of Health Care Services (DHCS): provides administration and oversight of local programs that have home visiting as a service strategy, such as the American Indian Infant Health Initiative (AIIHI) The AIIHI provides extensive home visiting and case management services to high-risk Indian families in the five counties in California that experience the most severe Indian MCH disparities (Humboldt, Sacramento, San Bernardino, Riverside, and San Diego counties).

California Department of Developmental Services (CDDS): provides intervention services for infants or toddlers who are at risk of or have developmental delay or disabilities. CDDS offers the Early Start program that provides home visiting, not as the primary service strategy for infants and toddlers, but as a service that is integrated into CDDS programs.

California Department of Mental Health (CDMH): California Department of Mental Health (CDMH): The Early Mental Health Initiative (EMHI) matches grants to Local Education Agencies (LEAs) to implement early intervention programs to promote mental

health. The target population of EMHI funded programs is students in kindergarten through third grades who have been identified as experiencing mild to moderate school adjustment difficulties. Likewise under CDMH, the Children's System of Care (CSOC)/Interagency Enrollee-Based Program (IEBP) is currently funded in seven counties receiving supplemental allocations of federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant dollars to supports services to seriously emotionally disturbed children (Humboldt, Los Angeles, Merced, Monterey, Placer, San Luis Obispo, and Stanislaus).

California Department of Social Services (CDSS): provides oversight and administration for programs in which home visiting is a service strategy; however the Office of Child Abuse Prevention (OCAP) does not capture the specific type of service delivery strategy during the annual reporting process. Forty-one of the 58 counties reported using one or more prevention funding sources to fund some kind of home visiting program during FY 2008-09. CDSS also administers the Title IV Temporary Assistance to Needy Families (TANF) program, which in California is called California Work Opportunity and Responsibility to Kids (CalWORKS). The CalWORKS program performs limited home visiting, on a case-by-case basis.

California Department of Education (CDE): funds a number of infant and toddler services, but does not specifically require that any of these services be home-based.

California's Early Childhood Comprehensive Systems (ECCS): a statewide effort toward comprehensive strategic planning in the areas of early childhood/school readiness

California Statewide Screening Collaborative (CSSC): under the umbrella of the ECCS grant; serves as the ECCS and California Project Launch (CPL) Steering Committee

CA Project LAUNCH (CPL): a \$4.2 million Substance Abuse and Mental health Administration (SAMHSA) grant awarded over five years to MCAH in 2009

State Interagency Team (SIT): provides leadership and guidance to facilitate systems improvements that benefit communities and children 0-5 years and their families. SIT members are generally at the "Deputy" level and have decision-making authority

Help Me Grow (HMG): a comprehensive and integrated statewide system designed to address the need for early identification and linkage to developmental and behavioral services and supports for children and their families

See Section 6. Plan for Administration of State Home Visiting Program for a detailed explanation of all public and private partners

21. Assurance that the California Home Visiting Program is Designed to Result in Participant Outcomes as Noted in the Legislation

The CHVP Updated State Plan provides details on data collection, analysis and evaluation which assures that the home visiting program will be designed and

implemented to result in participant outcomes as noted in the legislation by working closely with HRSA as well as the National Model Developers.

22. Assurance that Individualized Assessments will be Conducted of Participant Families and that Services will be Provided in Accordance with those Individual Assessments

With adherence to the CHVP mission, goals and objectives, as well as the individualized assessment procedures and standards established by NFP and HFA, all California-funded home visiting programs will be required to conduct individualized assessments of participant families. Home Visiting Services provided to participating families will be in accordance with the individual assessments and quality standards, which will be monitored and reviewed by CHVP on an ongoing basis.

23. Assurance that Services will be Provided on a Voluntary Basis

CHVP will adhere to NFP and HFA National Home Visiting Model standards by providing services to families on a voluntary basis; through continuous monitoring, feedback and communication CHVP will ensure that all funded home visiting programs adhere to standards regarding the provision of home visiting services on a voluntary basis.

24. Assurance that California will comply with the Maintenance of Effort Requirement

CHVP provides assurance that the home visiting program will be designed and implemented to comply with the Maintenance of Effort Requirement as specified in the ACA language (Sec. 2951)

25. Assurances that Priority will be given to Eligible Participants

CHVP assures that through continuous monitoring and adherence to model fidelity, priority will be given to those eligible participants who:

- Have low incomes
- Are pregnant women who have not attained age 21
- Have a history of child abuse or neglect or have had interactions with child welfare services
- Have a history of substance abuse or need substance abuse treatment
- Are users of tobacco products in the home
- Have, or have children with, low student achievement
- Have children with developmental delays or disabilities

- Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States

SECTION 5.

PLAN FOR MEETING LEGISLATIVELY-MANDATED BENCHMARKS



[Type text]

SECTION 5. PLAN FOR MEETING LEGISLATIVELY-MANDATED BENCHMARKS

Each grantee must collect data for 35 federally mandated individual constructs across six benchmark areas. This section describes the process for developing the construct measures under each benchmark area and the operational details of the construct, including: reliability and validity of the measure, definition of improvement, data source, timing of data collection, target population, appropriateness of the measure for the target population, type of outcome or process measure it represents and barriers to data collection. The six benchmark areas include:

- Maternal and Newborn Health;
- Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits;
- School Readiness and Achievement;
- Crime or Domestic Violence;
- Family Economic Self-Sufficiency; and
- Coordination and Referrals for Other Community Resources and Supports.

1. Process for Developing Proposed Benchmark Construct Measures

Development of individual construct measures was an iterative process based upon review of information published by HRSA/ACF and its contractors regarding screening tools and constructs; review of published peer reviewed studies of screening tools; review of home visiting program evaluation reports conducted by other states and also published in the peer reviewed literature; and review of technical documentation from the model developers regarding the structure and processes of their models and data collection tools.

Input and technical assistance was also obtained from a variety of stakeholders and subject matter experts. Consultation was obtained on screening tools, referral processes, timing of data collection instruments and how to define “measures of improvement” for individual constructs. Input was received from the following stakeholders:

- **HRSA/ACF Staff.** MCAH staff participated in all HRSA/ACF sponsored technical assistance conference calls and webinars. Additional consultation was obtained directly through emails and phone calls with multiple HRSA/ACF staff as staff from the Design Options for Home Visiting Evaluation team.
- **Model Developers.** MCAH staff consulted with state and national officers from the Nurse Family Partnership. We also consulted with a local HFA program provider, the national HFA office, and HFA officials from other states.

- **MCAH Program Staff.** MCAH staff with expertise in specific subject areas, such as domestic violence and prenatal substance use, were consulted throughout the process.
- **Other Stakeholders.** Epidemiologists in other states responsible for development of HV benchmarks were consulted.
- **Data Systems.** MCAH staff participated in webinars and conference calls regarding various data systems in order to better understand the implications for benchmark reporting of various approaches to data collection and reporting systems.

2. Coordination with Other Relevant State or Local Data Collection Efforts

CHVP selected individual construct measures that were consistent or similar to other data collection efforts currently underway in communities or in other programs whenever possible. For example, data collection processes used by other MCAH programs, such as the Adolescent Family Life Program and the Black Infant Health program, informed the selection of measures and data collection processes for constructs related to program referrals. The use of the 4Ps and 5Ps prenatal substance use screening tools in many local health jurisdictions contributed to the selection of the 5Ps tool for the CHVP. Lastly, questions or reporting timeframes consistent with population-based surveillance systems, such as the Maternal and Infant Health Assessment survey, American Community Survey and the California Birth Statistical Master File were considered. While population-based data from these surveillance systems will not be used as part of federally mandated benchmark construct measures, those data will provide contextual information to better understand the targeting, trends and outcomes of the home visiting program.

3. Defining Measures of Improvement

When possible CHVP selected *outcome* measures to assess program impact, such as health behavior change or access to services. However, many constructs were more appropriately assessed using *process* measures or were required by the federal guidelines to report a process measure (e.g., referrals to domestic violence services).

Two types of comparisons will be used in defining improvement in CHVP construct measures. For certain measures, improvement will be based on *individual* comparisons or a comparison of the measure at two time points for the same individual. For example, use of substances by pregnant women at intake and shortly before they give birth. Other measures will define improvement based on *cohort* comparisons, or a comparison of all program participants in one program year to all program participants in a subsequent program year. Those construct measures of improvement that will be based upon comparison of cohorts of individuals will assess differences between all families in a given program year to another program year. In general, the assumption for most of the cohort comparisons is that the performance of the home visitors and the program itself will improve over time. This type of comparison will be used mostly for process measures and outcome measures that remain constant for individuals. For example, a comparison in the completion of maternal depression screening rates during

their first year in the program among Year 1 enrollees as compared to the completion of maternal depression screening rates during the first year in the program among Year 2 enrollees.

CHVP attempted to provide this level of detail for all constructs; however, not all could be established before the submission of the Updated State Plan. For example, we could not establish whether child maltreatment rates should be measured by individual or cohort comparison due to concern about the possible effects that developmental changes in the child, or the surveillance effect of the improvement in home visitor assessments of signs relating to maltreatment, may have on reporting results. It is our hope that further focused discussion with HRSA and other states participating in the MIECHV program after the submission and analysis of state plans will assist in making this measurement decision. Additionally, more background information from model developers about past experience with these measurements, brainstorming with local grantees and collection of baseline data will help us to refine our analysis plan.

4. Identification and Measurement of Constructs

The following section presents information on the instruments and data sources used to measure each of the 35 federally mandated constructs across the six Benchmark areas. Information is presented separately for each Benchmark area and their corresponding constructs. Each Benchmark area includes a narrative description of the tools used for data collection, including their reliability and validity. As appropriate, additional information is also presented in the narrative, including:

- Barriers to data collection;
- Appropriateness of the measure for the target population; and
- Data collection burden.

Each Benchmark narrative section is followed by a table that provides detailed measurement information for each individual construct for that domain:

- Name of the federally mandated construct;
- Description of the measure (including target population);
- Definition of improvement;
- Source of the measure;
- Timing of data collection;
- Measurement metric; and
- Outcome type (process vs. outcome; individual vs. cohort).

5. Benchmarks

Benchmark I – Improving Maternal & Newborn Health

Benchmark Constructs

1. Prenatal care
2. Parental use of alcohol, tobacco, or illicit drugs
3. Preconception care
4. Inter-birth intervals
5. Screening for maternal depressive symptoms
6. Breastfeeding
7. Well-child visits
8. Maternal and child health insurance status

CHVP will utilize a combination of participant interviews and validated screening tools to collect data on the improved maternal and newborn health benchmark area. Both the NFP and HFA programs will use the same screening tool described below for depression. When possible, data on the other measures will be collected by NFP and HFA in such a way that they can be combined and the models can be compared.

Prenatal care, preconception care, inter-birth interval, breastfeeding, well-child visits, and maternal and child health insurance status. CHVP will ask mothers to self-report to the home visitor on a series of questions related to prenatal care, pre- and inter-conception health care, subsequent births, infant feeding practices, child's health care, and health insurance status. When possible, questions will be taken from existing surveys. These surveys include California's Maternal and Infant Health Assessment (MIHA) Survey, CDC's Pregnancy Risk Assessment System (PRAMS) and Behavioral Risk Factor Surveillance System (BRFSS), and the National Survey of Children's Health (NSCH). These surveys ask women to report on a variety of topics captured by CHVP, which will be assessed at different time periods, ranging from before pregnancy, to during pregnancy, to post-partum. Therefore, CHVP data may be subject to recall bias. However, existing surveys have proven a valid and reliable measure of health status and behaviors over time. For example, a systematic review of maternal recall of breastfeeding practices suggests that maternal recall is a valid and reliable estimate of breastfeeding initiation and duration, especially when the duration of breastfeeding is recalled after a short period (within three years).¹⁵ Therefore, CHVP will interview mothers during regularly scheduled home visits approximately 1-2 months apart in order to limit recall bias. To account for California's large Hispanic maternal population, questions will be available in both English and Spanish.

¹⁵ Li R, Scanlon KS, Serdula MK. The validity and reliability of maternal recall of breastfeeding practice. *Nutr Rev.* 2005 Apr;63(4):103-10.

Parental use of alcohol, tobacco, or illicit drugs. CHVP will use the 5P's Screening Tool to assess and report on parental use of alcohol, tobacco or illicit drugs. The 5P's is a six-question tool that takes approximately 2 to 3 minutes to administer and is non-threatening.² The 5P's focus on pregnant women and women of childbearing age and its non-threatening approach makes it an appropriate method of measurement for this population, which may otherwise underreport use of alcohol, tobacco or illicit drugs.¹⁶ Although the 5P's tool itself has not been validated, four questions in it are based on documented risk for alcohol use in women that comprise the 4P's Plus screening tool, which has been validated across a variety of diverse populations and is available in both English and Spanish.^{17,18,19,20,21} In one data set of 1,884 Medi-Cal eligible pregnant African-American women, the instrument showed 83% sensitivity and 80% specificity. The positive predictive value (PPV) was 50% and negative predictive value (NPV) was 95%.²² In another population of Hispanic and African-American pregnant women in Illinois, the PPV was 36% and the NPV was 97%.²³

Screening for maternal depressive symptoms. CHVP will use the Edinburgh postnatal depression scale (EPDS) to assess postpartum women for depressive symptoms. The EPDS is appropriate because it was developed specifically for use with women 6-8 weeks postpartum. The EPDS can be self-administered and completed in approximately five minutes. The internal consistency reliability is .87 with a sensitivity of 95% and a specificity of 93%.²⁴ Several studies provide a foundation for the psychometric properties of the EPDS. For instance, among antepartum women in the third trimester of pregnancy, the EPDS has a test-retest reliability of .81, a sensitivity of 80%, and a specificity of 93%.²⁵ Among adolescent mothers in one urban area in the United States, the EPDS has an internal consistency reliability of .88.²⁶ The EPDS is also available in both English and Spanish.

¹⁶ Institute for Health and Recovery. Integrated Screening Tool, 2005.

¹⁷ Data collected and analyzed by Janet Brown, epidemiologist, Alameda County Dept. of Public Health.

¹⁸ Chasnoff IJ, Weels AM, McGourty RF, Bailey L. Validation of the 4P's Plus screen for substance use in pregnancy. *Journal of Perinatology* 2007;27:744-748.

¹⁹ Kennedy C, Finkelstein N, Hutchins E, Mahoney J. Improving screening for alcohol use during pregnancy: The Massachusetts ASAP program. *Maternal and Child Health Journal* 2004;8(3):137-147.

²⁰ Chasnoff IJ, McGourty RF, Bailey GF, et al. The 4P's Plus screen for substance use in pregnancy: Clinical application and outcomes. *Journal of Perinatology* 2005;25:368-374.

²¹ Perl HI. Numerous studies demonstrate effectiveness of brief interventions. *Frontlines*, November NIAAA, 2000.

²² Data collected and analyzed by Janet Brown, epidemiologist, Alameda County Dept. of Public Health.

²³ Chasnoff IJ, McGourty RF, Bailey GF, et al. The 4P's Plus screen for substance use in pregnancy: Clinical application and outcomes. *Journal of Perinatology* 2005;25:368-374.

²⁴ Matthey S, Elliott CH, Barnett B. (2006). Variability in use of cut-off scores and formats on the Edinburgh postnatal depression scale – implications for clinical and research practice. *Archives of Women's Mental Health*, 9, 309-315.

²⁵ Cox J, Holden J. (2003). *Perinatal Mental Health: A Guide to the Edinburgh Postnatal Depression Scale*. Royal College of Psychiatrists: London.

²⁶ Bunevicius A, Kusminskas L, Pop VJ, Pederen CA, Bunevicius R. (2009). Screening for antenatal depression with the Edinburgh depression scale. *Journal of Psychometric Obstetrics & Gynecology*,30, 238-243.

Gathering data on sensitive topics, such as use of alcohol and drugs, or depression, pose a significant challenge for the CHVP. Home visitors will be encouraged to engage in one home visit to establish rapport before administering evaluation tools with sensitive topics.

BENCHMARK AREA I. IMPROVED MATERNAL AND NEWBORN HEALTH						
Construct	Description of Measure	Definition of Improvement	Measure Source	Data Collection Schedule	Measurement Metric	Outcome Type
Prenatal Care	Proportion of women receiving prenatal care.	Increase in the proportion of women receiving prenatal care in a given trimester.	Client self-report from assessment forms	During the 1 st , 2 nd , and 3 rd trimester	Numerator: number of women who received prenatal care Denominator: number of women enrolled during pregnancy.	individual or cohort outcome
Parental Use of Alcohol, Tobacco, or Illicit Drugs	Proportion of women who drank alcohol, used drugs, or smoked during pregnancy.	Decrease in the proportion of women who drank alcohol, used drugs or smoked from in-take to the 3 rd trimester of pregnancy.	Client self-report using NFP-developed questions or the 5 P's Plus in HFA	At in-take and during the 3 rd trimester of pregnancy	Numerator: number of women who drank alcohol, used drugs, or smoked during pregnancy. Denominator: number of women enrolled during pregnancy.	individual outcome
Preconception Care	Proportion of women with a medical home.	Increase in the proportion of women with a medical home from just before pregnancy to one year post-partum	Client self-report from assessment forms	At in-take and one year post-partum	Numerator: number of women with a medical home. Denominator: number of women enrolled in the program.	individual outcome
Inter-Birth Intervals	Proportion of women with a subsequent birth within two years post-partum.	Decrease in the proportion of women that report a subsequent birth within two years post-partum.	Client self-report from assessment forms	Date of subsequent birth	Numerator: number of women having a subsequent birth within two years post-partum. Denominator: number of women enrolled in the program at two years post-partum.	cohort outcome

BENCHMARK AREA I. IMPROVED MATERNAL AND NEWBORN HEALTH						
Screening for Maternal Depressive Symptoms	Proportion of women screened for the presence of depressive symptoms.	Increase in the proportion of women who are screened for the presence of depressive symptoms.	Client screened using EPDS	Six to eight weeks postpartum	Numerator: number of women screened for depressive symptoms Denominator: number of women enrolled in the program.	cohort outcome
Breastfeeding	Proportion of women who exclusively breastfeed their infants through 3 months postpartum.	Increase in the proportion of women that exclusively breastfeed their infants through 3 months postpartum.	Client self-report from assessment forms	At regular home visits through 3 months postpartum	Numerator: number of postpartum women with infants aged 3 months or older who were breastfed exclusively through 3 months of age. Denominator: number of postpartum women with infants aged 3 months or older.	cohort outcome
Well-Child Visits	Proportion of children who receive the recommended schedule of well-child visits.	Increase in the proportion of children who receive the recommended schedule of well-child visits (within 1 month postpartum, every other month during months 2, 4 and 6, and every third month between months 9 and 12).	Client self-report from assessment forms	At initial home visit and then at regular home visits coinciding with the recommended schedule of well-child visits	Numerator: number of infants that received all recommended well-child visits for their age. Denominator: number of infants enrolled in the program.	cohort outcome

BENCHMARK AREA I. IMPROVED MATERNAL AND NEWBORN HEALTH

<p>Maternal and Child Health Insurance Status</p>	<p>Proportion of women with health insurance coverage.</p>	<p>Increase in the proportion of women with health insurance coverage from just before pregnancy to one year post-partum.</p>	<p>Client self-report from assessment forms</p>	<p>At in-take (about coverage during the time just before pregnancy) and at one year post-partum</p>	<p>Numerator: number of women reporting having any type of health insurance. Denominator: number of women enrolled in the program.</p>	<p>individual outcome</p>
--	--	---	---	--	---	---------------------------

Benchmark II – Child Abuse, Neglect or Maltreatment and Reductions of Emergency Department Visits

Benchmark Constructs

1. Visits for children to the emergency department from all causes
2. Visits of mothers to the emergency department from all causes
3. Information provided or training of participants on prevention of child injuries including topics such as safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety (i.e. drowning), and playground safety
4. Incidence of child injuries requiring medical treatment.
5. Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated)
6. Reported substantiated maltreatment (substantiated/indicated/alternative response victim) for children in the program
7. First-time victims of maltreatment for children in the program

CHVP will utilize a combination of participant assessments, interviews, and home visitor report to collect data on the prevalence of emergency room visits, the distribution of child injury prevention information, and child abuse and maltreatment.

Visits for children to the emergency department from all causes, visits of mothers to the emergency department from all causes and incidence of child injuries requiring medical treatment. Data for visits to emergency room for mothers and children and medical treatment for child injuries will be collected using questions included on assessment forms administered to parents participating in CHVP on an ongoing basis. According to documentation from the NFP, the questions asked of clients to gather this data have been tested formatively to assure clarity of interpretation by the client and nurse home visitor, and connection to the constructs being assessed. Additional reliability and validity testing of particular data elements is ongoing and targeted to those items for which the risk is greatest for interpretive problems. There are other methods for collecting this data; however, these methods have limitations. Collecting data to assess emergency room visits via patient records could skew accuracy depending on what hospital the family visits. Additionally, requiring matching between the hospital dataset and the home visiting participants, either of which could have missing or incorrect identifying information, could result in inaccurate matches. Moreover, the process of collecting and coding of data from hospital records would create a lag in reporting decreasing the timeliness of the data. Therefore, CHVP will collect self-report data on participants' visits to the emergency room on a regular basis. Asking questions regarding emergency rooms visits and the reason for visits too long after the event could increase recall bias. To reduce this potential source of bias we will ask these questions of families at least every three months. To account for California's large Hispanic maternal population, assessment questions will be made available in both English and Spanish.

Information provided or training of participants on prevention of child injuries.

Information provided to families regarding child injury will be assessed by collecting data on curriculum topics covered by the home visitor over the course of the family's participation in the CHVP. The home visitor will track if and when this information is provided to the family. The curriculum implementation process data collection will be based on field-tested procedures used previously by NFP and HFA home visiting program models and adapted to CHVP. The CHVP data collection and case management system will be utilized to assess the provision of these services to families. Home visiting staff will be responsible for entering data using the case management system regarding multiple aspects of the home visit including completed screenings, referrals, and curriculum topics covered during the home visit.

Reported suspected maltreatment for children in the program, reported substantiated maltreatment for children in the program, first-time victims of maltreatment for children in the program.

The most common way to collect data for suspected, substantiated and first time child maltreatment is to use official child abuse reports. Currently, we do not have a data sharing agreement in place with CDSS to obtain this data. Until this type of agreement is in place, we will collect child maltreatment data using client interviews administered by the home visitor to parents participating in CHVP. There are limitations to collecting data using either method. Previously published journal articles and home visiting evaluations have reported on the shortcomings of the use of official child abuse report data to assess effectiveness of home visiting programs.²⁷ First, some incidents are undetected or may not meet definitional standards which could skew the accuracy of the count. Second, matching between the data provided by CDSS and the home visiting participants may result in inaccurate matches. Limitations of client interviews are that home visitors could become more adept at detecting child maltreatment throughout their tenure as home visitors, causing an increase in rates over program years. Additionally, families may be unwilling to share this type of information with home visitors.

To overcome these limitations, interviewing participants for suspected cases of maltreatment will rely on the strength of the relationship built between the home visitor and the participating mother and training home visitors regarding signs of maltreatment early and often. During the coming year data linkages with the CDSS child maltreatment data system will be explored so that both types of data will be collected.

According to NFP documentation, the questions asked of clients to gather this data have been tested formatively to assure clarity and sensitivity of interpretation by the client and home visitor, and connection to the constructs being assessed. Additional reliability and validity testing of particular data elements is ongoing and targeted to those items for which the risk is greatest for interpretive problems. Currently, local implementations of both NFP and HFA home visiting models utilize these methods to collect data on child maltreatment.

²⁷ LeCroy & Milligan Associates, Inc. (2010). Healthy Families Arizona Annual Evaluation Report 2010. Tucson, AZ: LeCroy & Milligan Associates, Inc.

BENCHMARK AREA II. CHILD ABUSE, NEGLECT, OR MALTREATMENT AND REDUCTION OF EMERGENCY DEPARTMENT						
Construct	Description of Measure	Definition of Improvement	Measure Source	Data Collection Schedule	Measurement Metric	Outcome Type
Visits for Children to Emergency Department from All Causes	Average number of times children visits the emergency room.	Decrease average number of times children visit the emergency room.	Client self-report from assessment forms	At least once quarterly starting postpartum	Average number of emergency room visits for children.	individual or cohort outcome
Visits of Mothers to Emergency Departments from All Causes	Average number of times mother visits the emergency room.	Decrease average number of times mothers visit the emergency room.	Client self-report from assessment forms	At least once quarterly starting postpartum	Average number of emergency room visits for mothers.	individual or cohort outcome
Information Provided Or Training Of Participants On Prevention Of Child Injuries	Proportion of women who are provided information regarding the prevention of child injuries.	Increase in the proportion of women who are provided information regarding the prevention of child injuries.	Home visitor report	Curriculum topics addressed during home visits reported after each visit	Numerator: number of families provided child injury information. Denominator: number of participating families.	cohort process
Incidence of Child Injuries Requiring Medical Treatment	Average number of times children received medical treatment for injuries.	Decrease average number of times children received medical treatment for injuries.	Client self-report from assessment forms	At least once quarterly starting postpartum	Average number of times children received medical treatment for injuries.	individual or cohort outcome
Reported Suspected Maltreatment for children in the program	Proportion of cases of suspected maltreatment of the target child.	Decrease in the proportion of cases of suspected maltreatment of the target child.	Home visit interview & CPS administrative data	At least once a month starting postpartum	Numerator: number of cases of suspected maltreatment. Denominator: number of participating families.	individual or cohort outcome
Reported Substantiated Maltreatment for children in the program	Proportion of cases of substantiated maltreatment of the target child.	Decrease in the proportion of cases of substantiated maltreatment of the target child.	Home visit interview & CPS administrative data	At least once a month starting postpartum	Numerator: number of cases of substantiated maltreatment. Denominator: number of participating families.	individual or cohort outcome
First-Time Victims of Maltreatment for Children in the program	Proportion of target child who were a victim of first time maltreatment.	Decrease in the proportion target children who were a victim of first time maltreatment.	Home visit interview & CPS administrative data	At least once a month starting postpartum	Numerator: number of victims of first time maltreatment. Denominator: number of participating families.	individual or cohort outcome

Benchmark III – Improvements in School Readiness

Benchmark Constructs

1. Parent support for children's learning and development (e.g., having appropriate toys available, talking and reading with their child)
2. Parent knowledge of child development and of their child's developmental progress
3. Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)
4. Parent emotional well-being or parenting stress
5. Child's communication, language and emergent literacy
6. Child's general cognitive skills
7. Child's positive approaches to learning including attention
8. Child's social behavior, emotion regulation, and emotional well-being
9. Child's physical health and development.

CHVP will utilize a combination of participant observations, validated screening tools and process measures to collect data on the improvements in school readiness area.

Parent support for children's learning and development, parent knowledge of child development and of their child's developmental progress, parenting behaviors and parent-child relationship, parent emotional well-being or parenting stress. To assess the constructs related to parent support for children's learning and development, knowledge of child development, emotional well-being and parenting behaviors within the improved school readiness and achievement benchmark area, CHVP will use the Keys to Interactive Parenting Scale (KIPS). KIPS is a structured observational assessment of parenting quality that involves a 20-minute observation of free-play between a parent or caregiver and a child administered either by a professional or paraprofessional provider. The KIPS includes 12 criteria to measure parent-child relationship and adult behaviors related to children's development: sensitivity of responses, response to emotions, physical interaction, involvement in child's activities, open to child's agenda, engagement in language experiences, reasonable expectations, adapts strategies to child, limits and consequences, supportive directions, encouragement, and promotes exploration/curiosity. A KIPS field test showed high internal consistency ($\alpha=0.95$) and high inter-rater reliability (92.4%) on scoring by professionals and paraprofessionals.²⁸

KIPS will be first administered when the infant reaches three months of age and re-administered when the infant is approximately one year old (12- 14 months of age). The KIPS rating scale focuses on the quality of parenting behavior and, through its use of

²⁸ Comfort M, Gordon PR, A, Naples D. (2011). KIPS: an evidence-based tool for assessing parenting strengths and needs in diverse families. *Infants & Young Children*, 24, 56-74.

descriptors, allows for cultural differences in parenting, which is appropriate given California's diverse population. Observing parent-child interaction utilizing KIPS will allow home visitor to tailor services to each parent's strengths and needs.

Child's communication, language and emergent literacy, child's general cognitive skills, child's positive approaches to learning including attention, child's physical health and development. CHVP will use the Ages and Stages Questionnaire-3 (ASQ-3) to assess children's physical and cognitive development. The ASQ-3 is a general developmental screening tool that focuses on asking parents about the child's specific developmental skills rather than their developmental concerns. The ASQ may be completed at home by the parent or during a home visit in approximately 15 minutes.

The internal consistency coefficient alpha for each individual developmental area ranged from .51 in personal-social for the 2-month age-interval group to .87 in gross motor for the 14-month age-interval group.²⁹ Among the subscales with the most internal consistency coefficient alphas were in the areas of personal-social and problem-solving domains.³⁰ The ASQ-3 handout stated that the test-retest reliability over a 2-week period ranged from .75 to .82. The test-retest reliability scores were not delineated by age group or development area. The overall sensitivity was 86.1%; the overall specificity was 85.6%.³¹

Child's social behavior, emotion regulation, and emotional well-being. The ASQ-SE screens infants and young children for possible social-emotional and behavioral concerns that might require further evaluation. The ASQ-SE has seven subscales: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people.³² The overall internal consistency coefficient alpha was .82 with individual alphas ranging from .69 for the 6-month age-interval group to .91 for the 60-month age-interval group.³³ The reliability alphas for those in the 6-month and 12-month age groups did not meet the standard of .70 recommended for tests under development, while the reliability alphas for all other age groups met the standard of .80 or greater for screening tests.^{34,35} The overall positive predictive value was 26.8% with the highest positive predictive values among the 6-month age group (91%), the 12-

²⁹ Squires J, Twombly E, Bricker D, Potter L. (2009). Ages and Stages Questionnaire, Third Edition. Accessed from www.agesandstages.com on May 25, 2011. See pages 1, 3, and 4.

³⁰ Squires J, Twombly E, Bricker D, Potter L. (2009). Ages and Stages Questionnaire, Third Edition. Accessed from www.agesandstages.com on May 25, 2011. See pages 1, 3, and 4.

³¹ Squires J, Twombly E, Bricker D, Potter L. (2009). Ages and Stages Questionnaire, Third Edition. Accessed from www.agesandstages.com on May 25, 2011. See pages 1, 3, and 4.

³² Caselman TD, Self, PA. 2005. Assessment instruments for measuring young children's social-emotional behavior development. *Children & Schools*, 30, 103-115.

³³ Paul H. Brookes Publishing. (Undated) Technical Report on ASQ:SE. Accessed from www.agesandstages.com on May 25, 2011. See pages 8, 15

³⁴ Nunnally JC. 1978. *Psychometric Theory*. McGraw Hill: NY.

³⁵ Paul H. Brookes Publishing. (Undated) Technical Report on ASQ:SE. Accessed from www.agesandstages.com on May 25, 2011. See pages 8, 15

month age group (83%), and the 18-month age group (75%).³⁶ The overall test-retest agreement was 94%.³⁷

BENCHMARK AREA III. IMPROVEMENTS IN SCHOOL READINESS AND ACHIEVEMENTS						
Construct	Description of Measure	Definition of Improvement	Measure Source	Data Collection Schedule	Measurement Metric	Outcome Type
Parent Support for Children's Learning and Development	Proportion families who demonstrate high-quality parenting behavior.	Increase in proportion of parents that demonstrate high-quality parenting behavior.	Home visitor observation using NFP developed interview and observation or KIPS for HFA	Once when child is 3 months and again when child is 12-14 months	Numerator: number of families that demonstrate high-quality parenting behavior. Denominator: number of participating families	individual outcome
Parent Knowledge Of Child Development And Of Their Child's Developmental Progress	Proportion families who demonstrate high-quality parenting behavior.	Increase in proportion of parents that demonstrate high-quality parenting behavior.	Home visitor observation using NFP developed interview and observation or KIPS for HFA	Once when child is 3 months and again when child is 12-14 months	Numerator: number of families that demonstrate high-quality parenting behavior. Denominator: number of participating families	individual outcome
Parenting Behaviors and Parent-Child Relationship	Proportion families who demonstrate high-quality parenting behavior.	Increase in proportion of parents that demonstrate high-quality parenting behavior.	Home visitor observation using NFP developed interview and observation or KIPS for HFA	Once when child is 3 months and again when child is 12-14 months	Numerator: number of families that demonstrate high-quality parenting behavior. Denominator: number of participating families	individual outcome
Parent Emotional Well-Being or Parenting Stress	Proportion families who demonstrate high-quality parenting behavior.	Increase in proportion of parents that demonstrate high-quality parenting behavior.	Home visitor observation using NFP developed interview and observation or KIPS for HFA	Once when child is 3 months and again when child is 12-14 months	Numerator: number of families that demonstrate high-quality parenting behavior. Denominator: number of participating families	individual outcome

³⁶ Paul H. Brookes Publishing. (Undated) Technical Report on ASQ:SE. Accessed from www.agesandstages.com on May 25, 2011. See pages 8, 15

³⁷ Paul H. Brookes Publishing. (Undated) Technical Report on ASQ:SE. Accessed from www.agesandstages.com on May 25, 2011. See pages 8, 15

BENCHMARK AREA III. IMPROVEMENTS IN SCHOOL READINESS AND ACHIEVEMENTS

Child's Communication, Language, and Emergent Literacy	Proportion of families who received scheduled developmental assessments.	Increase the proportion of families who received developmental assessments at least once every 6 months.	Client self report using ASQ3	At least every 6 months starting postpartum	Numerator: number of families that received all scheduled assessments.	cohort process
					Denominator: number of participating families.	
Child's General Cognitive Skills	Proportion of families who received scheduled developmental assessments.	Increase the proportion of families who received developmental assessments at least once every 6 months.	Client self report using ASQ3	At least every 6 months starting postpartum	Numerator: number of families that received all scheduled assessments.	cohort process
					Denominator: number of participating families	
Child's Positive Approaches to Learning Including Attention	Proportion of families who received scheduled developmental assessments.	Increase the proportion of families who received developmental assessments at least once every 6 months.	Client self report using ASQ3	At least every 6 months starting postpartum	Numerator: number of families that received all scheduled assessments	cohort process
					Denominator: number of participating families	
Child's Social Behavior, Emotional Regulation, and Emotional Well-Being	Proportion of families who received scheduled developmental assessments.	Increase the proportion of families who received developmental assessments at least once every 6 months.	Client self report using ASQ-SE	At least every 6 months starting postpartum	Numerator: number of families that received all scheduled assessments	cohort process
					Denominator: number of participating families	
Child's Physical Health and Development	Proportion of families who received scheduled developmental assessments.	Increase the proportion of families who received developmental assessments at least once every 6 months.	Client self report using ASQ3	At least every 6 months starting postpartum	Numerator: number of families that received all scheduled assessments	cohort process
					Denominator: number of participating families	

Benchmark IV - Domestic Violence

Benchmark Constructs

1. Screening for domestic violence
2. Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters, food pantries);
3. Of families identified for the presence of domestic violence, number of families for which a safety plan was completed.

CHVP will utilize a combination of participant assessment tools and home visitor report to collect data on the prevalence of domestic violence (DV) and support for women who experience DV.

Screening for domestic violence. CHVP will ask mothers to self-report on a series of questions related to experiences of domestic violence. Women's Experience with Battering (WEB) Scale³⁸ will be used for the DV screenings, and will be tracked using a CHVP assessment and case management tool. The WEB scale is a ten-item questionnaire that has been validated to assess domestic violence,³⁹ and validated less formally in clinical settings⁴⁰, and in a community population-based study of women of childbearing age (18-45 years old),⁴¹ with high sensitivity (86%) and specificity (91%).⁴²

Collecting data on domestic violence has unique and multiple challenges. Not only is the topic highly personal and private, as with the common DV-induced feeling of low self-worth, but the topic also includes the factors of fear and real danger. Following are some potential barriers to data collection, from the client perspective, and from the home visitor perspective.⁴³ Client barriers may include: (1) lack of privacy; shame, embarrassment, denial; (2) fear of listener's potential lack of understanding and helpfulness; (3) fear of partner; and (4) fear of losing control of decisions about her or her family's future to "the establishment". Home visitor barriers may include: (1) lack of appropriate services or interventions; (2) discomfort with topic, sometimes because of

³⁸ Smith PH, Earp JA, DeVellis R. Measuring battering: development of the Women's Experience with Battering (WEB) Scale. *Women's Health*, winter 1995, 1(4):273-288.

³⁹ Smith PH, Earp JA, DeVellis R. Measuring battering: development of the Women's Experience with Battering (WEB) Scale. *Women's Health*, winter 1995, 1(4):273-288.

⁴⁰ Coker AL, Pope BO, Smith PH, Sanderson M, Hussey JR. Assessment of clinical partner violence screening tools. *J Am Med Womens Assoc.* winter 2001, 56(1), 19-23.

⁴¹ Smith, PH, Thornton GE, DeVellis R, Earp J, Coker AL. A population-based study of the prevalence and distinctiveness of battering, physical assault, and sexual assault in intimate relationships. *Violence Against Women*, October 2002, 8(10), 1208-1232.

⁴² Basile KC, Hertz MF, Back SE. *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1.* Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2007.

⁴³ Anglin D. Diagnosis through disclosure and pattern recognition. In: C. Mitchell and D. Anglin (Eds.), *Intimate Partner Violence: A Health-Based Perspective*, 87-103. Oxford University Press, 2009.

previous personal experience; (3) discomfort regarding client's potential reaction; (4) discomfort regarding mandatory reporting; and (5) fear of having to appear in court. These challenges and barriers can be overcome for the home visitor by education, training, and support, and for the client, by building a relationship of trust with the home visitor, particularly about this topic.

Number of referrals made to relevant domestic violence services (e.g., shelters, food pantries) and number of families for which a safety plan was completed. If a mother screens positive for DV during a home visit, the home visitor's charge will include providing appropriate referral to the mother and working with her to develop or review a safety plan. To assess the completion of these activities a CHVP case management tool will be used to track referrals and the development or review of a safety plan following each positive DV screening. Women are more likely to benefit from a single appropriate referral than from multiple, less appropriate referrals. Since the home visitor is to provide at least one referral and develop or review a safety plan following every positive screen for DV, it is appropriate for the home visitor to record the relevant referral and safety plan activity. The DV referral and safety plan schedule will follow the DV screening schedule, whenever a screen is positive. The CHVP data collection and case management system will be utilized to record the provision of these services to families.

BENCHMARK AREA IV: CRIME OR DOMESTIC VIOLENCE (DOMESTIC VIOLENCE)						
Construct	Description of Measure	Definition of Improvement	Measure Source	Data Collection Schedule	Measurement Metric	Outcome Type
Screening for Domestic Violence	Proportion of women who were screened for domestic violence (DV).	Increase the proportion of women who were screened for DV at recommended intervals.	Client self-report using NFP developed interview or the WEB for HFA	At enrollment, birth, 3 months, 6 months, 12 months, and 24 months	Numerator: number of women who received the screen at all required intervals. Denominator: number of women enrolled in the program.	cohort process
Of Families Identified For The Presence Of Domestic Violence, Number Of Referrals Made To Relevant Domestic Violence Services	Proportion of women receiving at least one referral to a relevant DV service following every positive screen for DV.	Increase in the proportion of screen-positive women who received at least one referral to a relevant DV service at every positive screening.	home visitor report	whenever a screen is positive for DV	Numerator: number of women who received at least one referral to a relevant DV service every time she had a positive screen. Denominator: number of women screened at every required interval, and who had at least one positive screen.	cohort process
Of Families Identified For The Presence Of Domestic Violence, Number Of Families For Which A Safety Plan Was Completed	Proportion of women completing or revisiting a safety plan following every positive screen for DV.	Increase the proportion of women completing or revisiting a safety plan following every positive screen for DV.	Home visitor report	Whenever a screen is positive for DV	Numerator: number of women who completed or revisited a safety plan every time she had a positive screen for DV. Denominator: number of women screened at every required interval, and who had at least one positive screen.	cohort process

Benchmark V– Family Economic Self-Sufficiency

Benchmark Constructs

1. Household income and benefits
2. Employment or Education of adult members of the household
3. Health insurance status

CHVP will utilize a participant assessment tool to collect data on family economic self-sufficiency. CHVP will ask mothers to self-report on a series of questions related to experiences income, benefits, employment and education.

Preliminary definitional guidelines for household, income, employment and educational attainment are:

- Household is defined as all persons living in a home, who stay there at least 4 nights a week on average, and who contribute to the support of the child or pregnant woman in the home visiting program. Tenants or boarders will not be counted as members of the household.
- Income and benefits are defined as earnings from work, plus other sources of cash support. These sources may be private, i.e., rent from tenants/boarders, cash assistance from friends or relatives, or they may be linked to public systems, i.e., child support payments, TANF, Social Security (SSI/SSDI/OAI) and unemployment insurance.
- Employment is paid hours worked plus unpaid hours devoted to the care of an infant.
- Educational attainment is the completion of academic degrees or training certification programs. Information will be collected for these topics by using standard data collection forms for amount and source of income and benefits.

The data collection form will be based on existing questionnaires used by NFP¹, HFA, and the ACS.⁴⁴ As data collection forms are adapted from ACS and other sources, care will be taken that adaptations are appropriate for the low income perinatal population. The data collection form will be available in English and Spanish.

Data for health insurance status is being collected for the maternal and child health insurance status construct under the improving maternal and newborn health benchmark. Therefore, data for will be used to report for both the previously mentioned construct and the health insurance status construct under the family economic self-sufficiency benchmark.

http://www.cdphe.state.co.us/ps/nursehome/CO_10%20Colorado%20NFP.pdf

⁴⁴ United States Census Bureau, American Community Survey, 2011 Questionnaire.
<http://www.census.gov/acs/www/Downloads/questionnaires/2011/Quest11.pdf>

BENCHMARK AREA V: FAMILY ECONOMIC SELF-SUFFICIENCY						
Construct	Description of Measure	Definition of Improvement	Measure Source	Data Collection Schedule	Measurement Metric	Outcome Type
Household Income and Benefits	Income level and public program participation.	Increase in total household income and benefits.	Client self report from assessment forms	At least every 6 months starting at intake	Household income will be reported in dollars. Benefits will be reported in dollars or by category where dollar amount is not applicable.	individual outcome
Employment or Education of Adult Members of the Household	Employment and educational attainment for adults in participating households.	<ul style="list-style-type: none"> • Employment: increase in the number of paid hours worked plus unpaid hours devoted to care of an infant. • Education: increase in the educational attainment (completion of academic degrees or training certification programs). 	Client self report from assessment forms	At least every 6 months starting at intake	<ul style="list-style-type: none"> • For employment, number of adult household members employed during the month, and average hours per month worked by each adult household member. • For education, educational attainment achieved for each adult household member, number of adult household members participating in educational activities since the previous interview, and hours per month spent by each adult household member in educational programs. 	individual outcome
Health Insurance Status	<i>See Benchmark area I, maternal and child health insurance status</i>					

Benchmark VI—and Referrals for Other Community Resources and Support

Benchmark Constructs

1. Number of families identified for necessary services
2. Number of families that required services and received a referral to available community resources
3. MOUs: Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community
4. Information sharing: Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies
5. Number of completed referrals (i.e., the home visiting provider is able to track individual family referrals and assess their completion, e.g., by obtaining a report of the service provided).

CHVP will utilize a combination of participant assessment tools and program report to collect data on the coordination and referrals for community resources and supports.

Number of families identified for necessary services, number of families that required services and received a referral to available community resources and number of completed referrals. CHVP will measure the proportion of families who received intake assessments, referrals and completed referrals to community resources. To track screenings, a CHVP assessment tool will be used to assess family needs and risk factors. To track referrals, the number of families who received an appropriate referral and the completed number of referrals will be tracked with referrals forms. California has experience coordinating and making referrals for our other home visiting or case management programs, such as BIH and AFLP.^{45, 46, 47, 48} Also, both of the EBHV models chosen for CHVP have experience in assessing families' needs and referring to community services. Assessment and referral forms have been developed for and used successfully in low-income, perinatal populations based on previous experience with this population. Assessments will take place at intake for all enrolling families. Referrals tracking will occur at program intake and subsequent follow-ups as necessary.

Potential challenges and barriers for referrals are related to the challenges of the initial intake assessment, and include: 1) lack of services available for referrals, 2) identification of administrative means to ensure follow-up by client and staff on status of

⁴⁵ CDPH Adolescent Family Life Program, Service Matrix Form and Referrals Report.<http://branaghgroup.com/forms/ServMtrxPP.PDF>

⁴⁶ CDPH Black Infant Health Program, Referrals Form and Referrals Report Mockup.

⁴⁷ CDPH, Adolescent Family Health Program, Intake Form: <http://branaghgroup.com/forms/Intake2009.pdf>

⁴⁸ CDPH, Black Infant Health Program: Prenatal Assessment #1 Form

referrals, 3) length of time required for intake assessments across the large number of CHVP program constructs; 4) identification of a suitable place and time for intake assessments (e.g., home or program office) and 5) need for appropriate data collection forms and personnel language skills for non-English speaking clients. To address these challenges, local home visiting programs will focus efforts on flexibility of intake assessment implementation. Home visiting programs will build relationships with as many other community resources as possible.

MOUs and Information Sharing. CHVP will collect data on the number of memoranda of understanding or other formal agreements between each local home visiting program and local social service agencies that can accept referrals from, or refer to, the local home visiting program. Additionally, both selected home visiting models that will be implemented in California require the creation and maintenance of an advisory council to keep other local social services and partners abreast of programmatic implementation, progress towards program goals, challenges, and information sharing. All local programs or county agencies participating in CHVP will be required to list and summarize existing formal agreements and advisory committee participation in a narrative progress report annually. Beyond the initial report, coding of additional MOU status and advisory committee meetings should be possible once the MIS incorporates an established list of social service providers for each local program.

Many local social service agencies may have difficulty establishing formal agreements because of the state budget crisis. Moreover, the economic climate could affect the number of local stakeholders who have available staff time to devote to an advisory committee. Also, local CHVP programs may need assistance from other programs or the state government to identify appropriate partners and means of creating formal agreements. Information sharing may occur at multiple administrative and social levels and in different forms such as meetings of a county board of supervisors, meetings of agency executives, or referral between program staff. Therefore, both qualitative and quantitative methods of data collection may be needed to monitor this construct
<http://branaghgroup.com/forms/ServMtrxPP.PDF>

BENCHMARK AREA VI: COORDINATION AND REFERRALS FOR OTHER COMMUNITY RESOURCES AND SUPPORTS

Construct	Description of Measure	Definition of Improvement	Measure Source	Data Collection Schedule	Measurement Metric	Outcome Type
Number of Families Identified for Necessary Services	Proportion of families receiving intake assessments.	Increase in the proportion of enrolled families receiving intake assessments.	Client self-report from intake assessment form	At participant intake	Numerator: number of families that received an intake assessment. Denominator: number of families enrolling in the California Home Visiting Program.	cohort process
Number of Families that Required Services and Received a Referral to Available Community Services	Number of families identified with a need who receives a referral to available community resources.	Increase in the percentage of families identified with a need who receive an appropriate referral, when those services are available in the community.	Home visitor referral tracking form	Ongoing throughout program starting at intake	Numerator: number of families enrolled in CHVP who received referrals. Denominator: number of families enrolled in the program that needed services.	cohort process
Number of Memoranda of Understanding or Other Formal Agreements with Other Social Service Agencies in the Community	Number of MOUs or other formal agreements between each local program and local social service agencies.	Increase in the number of formal agreements with other social service agencies.	Local program activity/progress report summarizing existing and new formal agreements	At program initiation, annually thereafter	Summary by each local program will be compiled. The measure will be expressed as a count (number).	program process
Information Sharing	Number of agencies with an advisory committee meeting at least quarterly.	Increase in the number of agencies with an advisory committee meeting at least quarterly.	Local program activity/progress report summarizing meeting notes and attending agencies	At program initiation, annually thereafter	Summary by each local program will be compiled. The measure will be expressed as a count (number).	program process
Number of Completed Referrals	Proportion of completed referrals.	Increase in the proportion of referrals completed for which receipt of services can be confirmed.	Home visitor referral tracking form	Ongoing throughout program starting at intake	Numerator: number of referrals completed by CHVP families. Denominator: number of referrals given to CHVP families.	cohort process

6. Data Collection Plan

This section describes the policies and procedures that relate to the collection of benchmark data, including:

- Data Management Infrastructure: data collection, data entry, data management and management information systems (MIS);
- Staff Qualifications and Data Safety Monitoring;
- Data Quality Assurance; and
- Data Analysis, including use of benchmark data for CQI and plan for analyzing data at state and local levels.

7. Data Management Infrastructure

No sampling strategies with independent data gathering efforts are being proposed. Data collection for each construct will be based upon the regular ongoing data collection efforts of the home visitor. Because the proposed constructs are based upon information that would be regularly collected as part of the home visiting intervention, such as standardized screening tools and other assessment information necessary to implement the program, the data collection burden on the client will be minimized and additional costs related to data collection will not be incurred by the program. This data collection approach will also allow for many of the constructs to be effectively used for Continuous Quality Improvement efforts.

Data Management Infrastructure. In collaboration with local and national HFA and NFP providers, CHVP will implement processes and provide the necessary infrastructure to support data collection. Local agencies will be required to provide adequate infrastructure to support program implementation and data collection processes, including desks, computers, office supplies, lockable filing cabinets and other infrastructure components. They will also be required to provide minimum staffing for activities supportive of data entry tasks and other administrative activities.

Data Collection. Data collection for the vast majority of constructs will be based upon the regular ongoing data collection efforts of the home visitor that are necessary to implement the program. Data for these items will be collected initially on the paper client assessment and administrative forms used by the home visitor. Data collection for some constructs will be based upon client self-report to the home visitor, such as substance use during pregnancy, while other items, such as the KIPS, will be based upon home visitor observation of the parent's interaction with the child. A few other constructs, such as the number of MOUs, will be based on the local agency summarizing and reporting their administrative data. All these data will be collected at regular intervals and at least on an annual basis. Minimum data collection timetables for each construct are referenced in the Benchmark tables provided in the prior section.

Data Entry. Depending on local agency preferences, caseload, and capacity, sites may elect to hire a program technician to enter data or use their home visiting staff or

supervisory staff to enter data. For example, one local HFA site has reported that their program supervisor enters the data as this allows the supervisor to closely manage the program and be fully aware of what is happening with each family enrolled in the program. They also report it leads to fewer data entry errors by having only one person enter the data. The national NFP program delineates staffing and other structural requirements at local agencies to ensure quality data collection. For example, NFP Model Element 18 states that a 0.5 FTE general administrative staff member is needed per 100 clients to support the home visitors and supervisors to enter data accurately and on a timely basis as well as providing other administrative support. However, local NFP agencies can also elect to have the nurses enter the data. Final approval for data entry processes implemented at the local agency level will be made in consultation with CHVP.

8. Data Management and MIS

Data for the mandated constructs will be entered into a computerized management and information system (MIS) at the local agency level. The NFP data collection MIS is based on the Efforts to Outcomes (ETO) software developed by Social Solutions. This is a web-based program that allows for local data entry, automatic data transmission via secure Internet to a central server, and the generation of standardized (“canned”) and query-based reports. We are investigating the use of other MIS solutions already in use at CDPH/MCAH, and other commercial off the shelf (COTS) data systems for possible use with the HFA program. Among the COTS software we are investigating is a web-based system complementary to the ETO software used for the NFP data system. A singular statewide CHVP MIS is intended for implementation by CDPH/MCAH in order to centralize the receipt and analysis of CHVP data, and to do so with greatest operational efficiency.

Staff at the state and local level will be trained on use of the MIS software. Protocols related to data entry will be provided. Staff will be trained on the full functionality of the system, including using the MIS for generating program data reports by sub-groups of clients and case workers. The MIS will be provided as part of the contractual arrangements CHVP has with local agencies funded as part of CHVP, and with the national models and/or the software providers themselves.

All local agencies for the respective models will have their data stored in a single database at a central server. Local agencies will have restricted access to data from the centralized server so that they will only be able to access their own local agency data. Pending final selection of software used for HFA and terms of the contractual arrangement for use of ETO for NFP, these data will be available from the central server to the State MCAH program for analysis by scientific staff. To maximize the usefulness of the MIS to our Continuous Quality Improvement activities, ongoing process evaluations, provision of support and Technical Assistance to LHJs/communities, and to ensure data quality and consistency, CHVP intends to serve as Administrator of the MIS over both evidence-based models (NFP and HFA). Serving as Administrator will allow CHVP to implement uniform data standards and quality checks, to implement California specific CQI indicators in a standardized and uniform manner, flexible modification of

the MIS based on revision of existing forms or addition of new forms as necessary, and to implement “canned” data reports that will contribute to managing program Scope of Work and process evaluations. The Administrator role may be shared with national offices for NFP and HFA where Administrative access will be limited to the evidence-based model of the national office and those areas of the MIS that are standardized by the evidence-based model. Data for each construct will be included as data elements in the MIS in a manner reflective of the data collection schedule and measurement metric described in the previous sections.

The MIS will support CQI efforts in the implementation process and beyond by providing the following functionalities:

- Standard reports for CQI and fidelity monitoring
- Ad hoc query capability for special analyses including CQI
- Vertical and horizontal control of membership for permissions to enter, modify, or query data
- Data quality reports tracking percentage of form completion, field completion and process timelines. Data quality reports will be available at multiple levels, including the statewide program, program site, program manager, program staff person and family or individual client

9. Staff Qualifications and Plan for Data Safety and Monitoring

State staff analyzing the statewide data will be Master’s or Doctoral level trained public health scientific staff operating under the supervision of a Doctoral level Research Scientist Supervisor. These staff are all trained in SAS programming and have access to the consultation of other scientific staff within the Epidemiology, Assessment and Program Development (EAPD) Branch. They will all have taken information security training and orientation classes in accordance with information security policies required by the CDPH.

LHJ/community staff who will be using “canned” reports and the query report functionality will have an educational and/or work experience background in applied data analyses. Local programs will be required to demonstrate appropriate knowledge and skill level of analytic staff via information provided in their Annual Report in fulfillment of their Scope of Work. LHJ/community staff will also receive analytic technical assistance from CDPH/MCAH on an as-needed basis. LHJ/community staff will receive training by their respective models on procedures for maintaining client confidentiality.

Statewide home visiting program data, from implementation of both evidence-based models, will be stored on a secure server available for use only by EAPD Branch Staff. Access to these data will be further restricted to only staff directly involved in the analysis of home visiting program data. According to documentation provided by the NFP, MIS data safety standards of the ETO software include:

- NFP utilizes a software platform into which only designated, NFP-approved persons may enter data collected about clients and the Program and obtain reports for managing and evaluating Program implementation and results. The web-based information system is secured against unauthorized use by VeriSign® 128-bit Security Encryption, the industry standard in Internet site protection. Authorized access to the database and website can only be provided by NFP.
- NFP complies with the rules and regulations concerning the privacy and security of protected health information (PHI) under HIPAA and the HiTech Act as if it were a Covered Entity, as defined by those regulations. NFP enters into HIPAA Business Associate Agreements to ensure all its implementing agencies, vendors and agents agree to the same restrictions. NFP protects against non-permitted use or disclosure of PHI using no less than a reasonable amount of care and will promptly report any non-compliance of which we become aware.

Data safety standards of the statewide CHVP MIS will follow these same standards.

10. Data Quality Assurance

Data quality assurance efforts will be implemented at multiple levels, including training of home visiting staff in data collection procedures, establishment of data entry protocols, ensuring functionality of the MIS is supportive of minimizing data errors, implementation of data quality assurance reports, and creation of a data-driven culture at the local and state levels that values in collecting reliable and timely data.

Home visiting staff will be trained in the use and proper administration of the screening tools, referral tracking forms and other data collection processes. The HFA and NFP programs both have their own training and orientation processes for home visitors to ensure data collection quality and operating procedure fidelity related to the implementation of forms, evaluation tools and related activities. Information provided at these trainings will be supplemented by information from CHVP for any additional items related to the reporting of construct data. This information will be documented in policies and procedures manuals provided to local agencies. As discussed earlier, CHVP will ensure adequate infrastructure exists at the local level to facilitate the collection of high quality, timely data. Local agency staff will also be trained on the proper data collection processes and will be given some flexibility to develop data entry processes that are best suited given their size and capacity.

CHVP will require the MIS to have a built-in functionality that identifies out-of-range values for relevant data elements to help prevent data entry errors. The MIS will also allow local agencies to track form and field completeness to ensure data quality and to

generate missing data reports. Data quality assurance reports will be developed at the state level to assess local agency performance in data quality. These quality assurance reports will be stratified across multiple levels, including case worker and agency, to target quality improvement efforts. These reports will also be shared with local agencies so they can see how their data quality compares to other agencies and statewide data quality benchmarks for the program as a whole. CHVP staff will review data collection protocols during site visits to local programs and provide technical assistance on data quality improvement efforts to local agencies.

LHJs/communities will be expected to review information from MIS reports on a regular basis in order to identify areas to improve program operations. Staff and supervisors will be expected to review data together to help guide actions they can undertake to improve service delivery and data reporting. It is expected that ongoing use and application of data to program administration and quality improvement activities will create a data-driven culture at the state and local levels that recognizes the importance of collecting complete and high quality data.

11. Plan for Analyzing Data at the Local and State Level

Data will be analyzed at both the state and local levels. Programs at the local level will be able to use the MIS software to produce quality improvement and other reports on the clients enrolled in the program. Steps will be taken to ensure that local agencies also have the ability to stratify their local data by various subgroups to better understand their service delivery processes and outcomes. This will be accomplished by ensuring the MIS has a functionality that allows for the stratification of data by sub-groups (e.g., client demographics, case worker, etc.) or the provision of these types of reports on a regular basis by the software contractor or CHVP.

State staff within the MCAH program will have access to the statewide client level data in order to conduct in-depth analyses of home visiting program data. Analyses will be conducted on an ongoing basis to monitor program implementation, quality improvement activities, and program outcomes, including progress toward improving Benchmarks. Data will be analyzed at the state and local level and stratified by model type (HFA vs. NFP). Analyses will be conducted to assess: client characteristics, client risk profiles, service utilization and outcomes. Data will be stratified by client socio-demographic characteristics, referral source and other variables of interest to understand the impact the home visiting program is having on different types of clients.

A number of program client characteristics and service use data will be collected in order to support program implementation, monitor progress of key subgroups and assist in the evaluation of program activities. Selected examples include:

- ***Client socio-demographic characteristics:*** age, education, income, marital status, race/ethnicity, employment status, living arrangement, number of persons in household, primary language, among others.

- **Service use:** number of visits, length of visits, content of visits, referrals made, referrals completed, time enrolled in program, among others.

While Benchmark specific reports will be generated by many of the above stratifying data, focused attention will also be placed on program level data and client risk profiles thought to influence the ability to achieve certain benchmarks, such as service duration and intensity variables. Benchmark results showing progress toward achieving goals at both the local and state level will be generated and shared with CHVP and LHJ/community level program staff for review, interpretation and application to program operations.

12. Benchmarks and Continuous Quality Improvement

The CHVP Continuous Quality Improvement plan will incorporate the federally required benchmark data, as well as the NFP and HFA specifically mandated data and additional data elements. The individual constructs used to measure the federal benchmarks represent both process and outcome data. Process data such as percent of women screened for depression, children screened for developmental delay and families educated on injury prevention will be used both as benchmark measures and for CQI. The same is true for many outcome measures such as percent of infants who are breastfed at three months of age and percent of children who receive all recommended well child visits. Virtually all of the benchmark measures lend themselves well to use in CQI activities. Consequently most, if not all, will be for both purposes.

The CHVP CQI plan will be implemented and monitored at the state and LHJ/community level. LHJ/communities will use CQI data to monitor maternal and early childhood systems for quality improvement priorities and opportunities and will provide leadership in rectifying local level gaps in services and linkages. For CQI purposes, demographic data will be used to determine if the CVHP target population is being reached, assure cultural consonance with the home visitor, and to stratify other data elements in order to analyze differences in attrition rate, missed visits, etc. Programmatic data such as caseloads, staff stability, quality of supervision, participant engagement, frequency and duration of services provided, and participant provider relationships will be used for CQI and to ensure model fidelity for both CHVP models.

LHJ/communities will have access to all of their own data for CQI purposes. In addition, LHJ/communities will be provided CQI reports to compare their data with other home visiting programs in the county, region or the state. Technical assistance will be provided to enable local program staff to identify areas for improvement and to design an improvement plan.

13. Barriers and Challenges to Benchmark Reporting

Despite the extensive process undertaken to develop measures for the federally mandated constructs, these measures should be considered “proposed” and subject to revision pending the following issues:

- Additional input from the national models, local HFA and NFP providers, and other subject matter experts. Although we discussed with national NFP and HFA leaders a variety of measurement issues related to the federally mandated benchmark reporting requirements, the model developers themselves are still trying to fully understand the impact of these requirements on their data collection tools and related processes. Further consultation with local home visiting programs during the implementation phase of the program may also result in recommendations to revise the proposed measures.
- The NFP policies prohibit the sharing of their actual screening and assessment tools used by their program until a contractual arrangement is formally established. Information presented regarding specific constructs could only have a limited amount of specificity that could be obtained from publicly released documents from NFP and telephone conference calls and emails with the NFP national office. Therefore, providing information about measures that rely upon program assessment and data reporting forms was made more difficult.
- Selection or revision of data systems for HFA and NFP are not yet determined and may impact the ability to report benchmark indicator data.
- Further technical assistance and guidance from HRSA/ACF may also influence operationalization of the proposed measures. For example, the format of the federally mandated benchmark reporting templates may impact the proposed measures and definitions of improvement.
- Collection of baseline data from local home visiting programs may indicate some of the proposed measures are not feasible to implement. For example, some of the process measures that measure completion rates for screening instruments may result in a “ceiling effect” whereby 100% of screens for a given condition (e.g., maternal depression) are being conducted at baseline and therefore there is no opportunity for improvement.

Barriers and challenges related to program implementation that may also affect benchmark reporting include:

- There is currently a freeze on state hiring. The CHVP will therefore have to rely on existing limited staff resources to implement the program and report benchmark results.
- State of California Department of Public Health rules governing the implementation of MIS projects are complex and may delay implementation of the MIS. Discussions are currently underway with control agencies regarding the procurement of MIS software for the CHVP.
- Contract negotiations with NFP are not finalized. At this time we do not know the extent to which their data collection system and data collection forms can be revised to meet the proposed benchmark, CQI and data collection plans.

SECTION 6.

PLAN FOR ADMINISTRATION OF STATE HOME VISITING PROGRAM



SECTION 6. PLAN FOR ADMINISTRATION OF STATE HOME VISITING PROGRAM

The lead agency for the State Home Visiting Program is The California Department of Public Health, Maternal, Child and Adolescent Health Program (CDPH/MCAH). CDPH/MCAH was designated by former Governor Arnold Schwarzenegger as the single State entity authorized to apply for and administer Health Resources and Services Administration (HRSA) and Administration for Children and Families (ACF) home visiting program funds on behalf of California. The CDPH/MCAH administrative structure has the internal capabilities in place to support the California Home Visiting Program (CHVP) by providing an overarching statewide strategy to ensure and promote the effectiveness of an evidence-based home visiting program, and to provide accountability for public funds.

1. Public and Private Partners

CHVP will collaborate and coordinate with the following partners in the private and public sector to develop cohesive strategies to promote program quality and effectiveness:

California Department of Mental Health (CDMH): The Early Mental Health Initiative (EMHI) matches grants to Local Education Agencies (LEAs) to implement early intervention programs to promote mental health. The target population of EMHI funded programs is students in kindergarten through third grades who have been identified as experiencing mild to moderate school adjustment difficulties. Likewise under DMH, the Children's System of Care (CSOC)/Interagency Enrollee-Based Program (IEBP) is currently funded in seven counties receiving supplemental allocations of federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant dollars to support services to seriously emotionally disturbed children (Humboldt, Los Angeles, Merced, Monterey, Placer, San Luis Obispo, and Stanislaus).

Medi-Cal Services for Children and Young People program is for children and young people, under 21 years of age, who have full-scope Medi-Cal; and is also for the families, caregivers or guardians of those children and young people. A Medi-Cal mental health service called Therapeutic Behavioral Services (TBS) is available from county mental health departments helping those with severe emotional problems; live in a mental health placement or are at risk of placement; or have been hospitalized recently for mental health problems or are at risk for psychiatric hospitalization. DMH also works on the federal Individuals with Disabilities Education Act (IDEA) to ensure that children with disabilities are entitled to a free, appropriate public education in the least restrictive environment. Special education pupils may require mental health services in any of the 13 disability categories.

California Department of Social Services (CDSS): The California Department of Social Services/Children and Family Services Division (CDSS/CFSD), is the state agency designated by statute to promulgate regulations, policies, and procedures necessary to

oversee the State's Child Welfare Services system and to ensure safety, permanency, and well-being for California's children. California's child welfare system is administered at the local level by 58 counties, each governed by a County Board of Supervisors. Federal and state funding requirements mandate spending for the prevention of child abuse and neglect, and for early intervention programs. The counties receive the majority of funds allocated directly, and determine how the funds are spent by a local needs assessment process.

The Welfare and Institutions Code, Sections 18952-18958, gives statutory authority to the CDSS Office of Child Abuse Prevention to administer state and federal funds for child abuse prevention. CDSS administers federal funding of the Child Abuse Prevention and Treatment Act (CAPTA). Title II of the Federal CAPTA Amendments of 1996 (most recently reauthorized in June of 2003, P.L. 108-36) established the Community-Based Child Abuse Program (CBCAP) Program. The majority of the CAPTA/CBCAP funds are allocated directly to counties in California. The counties decide how to spend the allocations in accordance with local needs assessments and funding stream priority guidelines.

CBCAP was established to:

- Support community-based efforts aimed at the prevention of child abuse and neglect,
- Support networks of coordinated resources and activities to strengthen and support families to reduce the incidence of child abuse and neglect, and
- Foster an understanding, appreciation, and knowledge of diverse populations in order to be effective in preventing and treating child abuse and neglect.

CBCAP federal funding is distributed to states and territories under a formula grant. Each state must provide a 100% cash match in non-federal funding of the total allotment. The match funds come from State or private funding; CBCAP funds may be expended for primary and secondary prevention activities. The Office of Child Abuse Prevention (OCAP) oversees grants, contracts, and projects supported by the state-funded Child Abuse Prevention, Intervention and Treatment (CAPIT) and the State Children's Trust Fund.

CAPIT is the State General Fund funding stream that acts as the cash match for the federal CBCAP that is allocated 90% to the counties for child abuse prevention and treatment efforts; the targeted priority is for high risk families being served by county child welfare departments or other children referred by other sources as high risk. Service priority is for prevention programs that identify and provide services to isolated families, particularly those with children five years of age or younger. CAPIT is one funding stream that is braided with CBCAP on the local level. Fifty-seven counties participate in the CBCAP allocation process in California. Individual counties provide additional CAPIT-funded services, including workshops, hospital outreach, individual and group therapy, mentoring, and crisis hotlines.

California Department of Developmental Services (CDDS): Families whose infants or toddlers have developmental delay or disabilities, or are at-risk for developmental delay or disabilities may qualify for developmental monitoring or early intervention services through the *Birth to 36 Month* program at CDDS. Regional centers operated by CDDS offer programs for families with infants and young children who qualify for prevention services, based on risk factors. For those infants and toddlers with identified developmental disorders, CDDS offers the *Early Start* program that provides appropriate early intervention and family support services. Through a regional center program, an Infant Service Coordinator performs a home visit for each *Early Start* enrolled child every six months to review progress, goals, and services. Home visiting is not the primary service strategy for infants and toddlers, but is a service that is integrated into CDDS programs.

California Department of Alcohol and Drug Programs (ADP): The mission of ADP is to lead efforts to reduce alcoholism, drug addiction, and problem gambling in California by developing, administering, and supporting prevention, treatment and recovery programs. ADP was established upon enactment of the Health and Safety Code, Division 10.5, Sections 11750, et seq., (Stats. 1979, Ch. 679). It is designated as the Single State Agency responsible for administering and coordinating the State's efforts in alcohol and drug abuse prevention, treatment, and recovery services. ADP is also the primary state agency responsible for interagency coordination of these services.

In partnership with California's 58 county alcohol and drug program administrators and in cooperation with numerous private and public agencies, organizations and individuals, ADP provides leadership and coordination in the planning, development, implementation and evaluation of a comprehensive statewide alcohol and drug use prevention, intervention, detoxification and treatment and recovery system. The Department utilizes each of the 58 county alcohol and drug programs as the broker of service. The counties in turn are able to provide services to clients either directly or by contracting with local service providers. California enjoys a statewide treatment, recovery and prevention network consisting of over 850 public and private community-based service providers which serve approximately 300,000 clients annually.

California Head Start State Collaboration Office (CHSSCO) of the California Department of Education (CDE): CDE oversees the state's diverse and dynamic public school system which is responsible for the education of more than six million children and young adults in more than 10,000 schools. The CDE, run by the State Superintendent of Public Instruction, is responsible for enforcing education law and regulations and for continuing to reform and improve public elementary school programs, secondary school programs, adult education, some preschool programs, and child care programs. Collaboration Office grants were developed to create a visible presence for Head Start at the state level and to assist in the development of multi-agency and public-private partnerships among Head Start and other interested stakeholders. Head Start is a direct federal-to-local program administered by over 1,600 locally based public or private organizations, called "grantees," across the country.

Head Start is a national program administered by the Office of Head Start within the Administration on Children, Youth and Families, Administration for Children and Families (ACF), Department of Health and Human Services. Head Start programs provide comprehensive developmental services for low-income children from birth to entry into elementary school. Head Start is currently funded at over \$6.8 billion and serves more than 909,000 low-income children and families nationwide. The program is child-centered, family-focused, comprehensive, and community-based. Head Start services are designed to address developmental goals for children, employment and self-sufficiency goals for adults, and support for parents in their work and child-caring roles.

MCAH Local Health Jurisdictions (LHJs): LHJs collaborate with various coalitions and partnerships, community groups, faith-based organizations, schools, medical communities, and policy makers. Collaboration efforts serve as a venue to coordinate with other agencies and increase capacity on issues related to women, infants, children and adolescents and their families, such as perinatal substance use, adolescent substance use, teen pregnancy, Sudden Infant Death Syndrome (SIDS), breastfeeding, nutrition, physical activities, child safety and injury prevention, early access to prenatal care and oral health. LHJs participate in various outreach activities to recruit and refer pregnant women and their families to public insurance and health services. MCAH LHJs may provide service delivery as one-time or episodic home visiting services to high risk individuals, such as an in-home postpartum visit requested by a local hospital or community health care provider. Further, MCAH LHJs may develop or integrate home visiting services in order to address community-specific needs. As reflected in the statewide needs assessment, some MCAH LHJs have implemented nationally recognized home visiting programs, or have made local adaptations of these home visiting models. The state's role is to monitor and encourage local MCAH efforts, and provide technical assistance through a number of health advisors. The state also maintains a comprehensive public website with information and contacts for all its programs. Most MCAH LHJs maintain their own public websites containing specific local program information.

First 5 California: Services and support are designed to ensure that more children are born healthy and reach their full potential; First 5 California works to improve the lives of California's youngest children and their families through an effective, coordinated, and inclusive implementation of the California Children and Families Act at the local and state levels. The Act, also known as Proposition 10, was passed by the voters of California in 1998 to create a comprehensive and integrated system of information and services promoting early childhood development from prenatal to age 5, as well as to support the needs of parents of young children. The ultimate goal of Proposition 10 is to enhance the health and early growth experiences of children, enabling them to be more successful in school and to give them a better opportunity to succeed in life.

California Department of Health Care Services (DHCS): The mission of the California Department of Health Care Services is to preserve and improve the health status of all Californians by working closely with health care professionals, county governments, and health plans to provide a health care safety net for low-income individuals and persons

with disabilities. DHCS finances and administers a number of individual health care service delivery programs, including the California Medical Assistance Program (Medi-Cal), California Children's Services program, the Child Health and Disability Prevention program, and Genetically Handicapped Persons Program.

DCHS also funds a number of health initiatives designed to deliver health care services to low income individuals and families who meet eligibility requirements. The health initiatives help with access to comprehensive health services and ensure appropriate and effective expenditure of public resources to serve those with the greatest health care needs. DCCHS provides administration and oversight of local programs that have home visiting as a service strategy, such as the American Indian Infant Health Initiative. The American Indian Infant Health Initiative (AIIHI) is funded by Federal Title V Maternal and Child Health (MCH) funds through the Indian Health Program, and serves over 200 families. The program receives \$424,000 annually to provide extensive home visiting and case management services to high-risk Indian families in the five counties in California that experience the most severe Indian MCH disparities (Humboldt, Sacramento, San Bernardino, Riverside, and San Diego counties).

DHCS also administers the Children's Medical Services program, which consists of the California Children's Services (CCS), Child Health and Disability Prevention (CHDP), Health Care Program for Children in Foster Care, Hearing Conservation Program, High Risk Infant Follow Up, Newborn Hearing Screening Program, and Pediatric Palliative Care programs.

The CCS program is administered as a partnership between county health departments and DHCS. Currently, approximately 70% of CCS eligible children are also Medi-Cal eligible; the Medi-Cal program reimburses their care. The cost of care for the other 30% of children is split equally between CCS Only and CCS Healthy Families programs. The cost of care for CCS Only is funded equally between the State and counties. The cost of care for CCS Healthy Families is funded 65% by Federal Title XXI, 17.5% by the State, and 17.5% by county funds. Health and Safety Code, Section 123800 et seq. provides statutory authority for the CCS program.¹⁴⁰ The explicit legislative intent of the CCS program is to provide necessary medical services for children with CCS medically eligible conditions whose parents are unable to pay for these services, wholly or in part. The statute also requires the DHCS and the county CCS program to seek eligible children by cooperating with local public or private agencies and providers of medical care to bring potentially eligible children to sources of expert diagnosis and treatment.

The CCS program is mandated by the Welfare and Institutions Code and the California Code of Regulations (Title 22, Section 51013) to act as an "agent of Medi-Cal" for Medi-Cal beneficiaries with CCS medically eligible conditions. Medi-Cal is required to refer all CCS-eligible clients to CCS for case management services and authorization for treatment. The statute also requires all CCS applicants who may be eligible for the Medi-Cal program to apply for Medi-Cal. In counties with populations greater than 200,000, county staff perform all case management activities for eligible children residing within the county. For counties with populations under 200,000, the Children's

Medical Services (CMS) Branch provides medical case management and eligibility and benefits determination through its regional offices located in Sacramento, San Francisco, and Los Angeles.

Futures Without Violence (FWV) (formerly known as Family Violence Prevention Fund):

The mission of Futures without Violence is to prevent violence within the home, and in the community, to help those whose lives are devastated by violence because everyone has the right to live free of violence. For over three decades, the FWV has worked to end violence against women and children around the world. Instrumental in developing the landmark Violence Against Women Act passed by Congress in 1994, the FWV continues to break new ground by reaching audiences including men and youth, promoting leadership within communities to ensure that violence prevention efforts become self-sustaining, and transforming the way health care providers, police, judges, employers and others address violence.

California Council of Local Health Officers (CCLHO): The membership of CCLHO includes the 61 legally appointed physician Health Officers in California, one from each of the LHJs. CCLHO provides a state/local forum for the discussion of significant health issues in order to develop recommendations for appropriate health policy, including legislative and regulatory review. CCLHO meets semiannually and its Board of Directors meets monthly. Its various program committees consider technical and policy issues in communicable disease control and prevention; health promotion and chronic disease prevention; environmental health; emergency preparedness and response; and health surveillance and data.

County Health Executives Association of California (CHEAC): CHEAC is a statewide organization of county and city Health Department and Agency Directors, who are responsible for the administration, oversight, and delivery of a broad range of local public health and indigent health care services. Members represent a variety of administrative and health professional disciplines. CHEAC is dedicated to the promotion, protection, and improvement of the health of California's population. The organization's objective is to maximize local health departments' financial, organizational, and programmatic capacity to deliver local health services. CHEAC promotes effective public policy through legislative, state budget, and administrative advocacy; evaluates program structures, including administrative and fiscal elements, and educates policy makers on strategies to successfully deliver local health services. CHEAC also collaborates with key health and professional organizations to further common health improvement goals.

Early Childhood Comprehensive Systems (ECCS): CDPH/MCAH has authority over HRSA-funded California's ECCS, a statewide effort toward comprehensive strategic planning in the areas of early childhood/school readiness. ECCS members include Medi-Cal Managed Care, American Academy of Pediatrics (AAP), Children Medical Services (Early Periodic Screening, Diagnosis, and Treatment), the Departments of Alcohol and Drugs, Developmental Services, Education, Managed Health Care Services, Mental Health, Social Services, and First 5 California. Non-state partners include First 5 County Commissions, California Association of Health Plans, Lucile

Packard Children's Hospital, University of California, Davis and University of California, Los Angeles, Kaiser Permanente, WestEd Center for Prevention and Early Intervention. Much of this broad planning in ECCS has been accomplished through collaborative work between CDPH/MCAH and First 5 California. The California Statewide Screening Collaborative, which serves as the ECCS and Project LAUNCH Council, is one of the results of this collaboration.

Early Learning Advisory Council (ELAC): The California State Advisory Council on Early Childhood Education and Care (ELAC) will build on the work of the California Early Learning Quality Improvement System Advisory Committee (CAEL QIS) in helping define the future policy direction for early learning in California. ELAC is co-chaired by a representative from the Secretary of Education, State Superintendent of Public Instruction designee, and a California Children and Families Commission designee. The co-chairs invite stakeholders in early learning and members of the public to participate in the upcoming meetings of ELAC.

California Project LAUNCH (CPL): \$4.2 million Substance Abuse and Mental Health Administration (SAMHSA) grant awarded over five years to MCAH in 2009 provides the opportunity for the California Department of Public Health, Maternal, Child and Adolescent Health Division (State MCAH) and the County of Alameda Maternal, Child and Adolescent Health Program (Local MCAH) to leverage the broader work of the Alameda County Behavioral Health Care Services and the Alameda County Health Care Services Agency to create a continuum of age-appropriate developmental services for children from birth through 8 years of age. Through CPL, the State MCAH and the Local MCAH partners with First 5 Alameda County to demonstrate the feasibility and impact of recommended state policy changes. These policies will support counties in establishing and sustaining comprehensive developmental care continuums that enable children 0-8 years to be healthy and ready to learn.

California Statewide Screening Collaborative (CSSC): Under the umbrella of the ECCS grant, CDPH/MCAH established CSSC, which serves as the ECCS and the CPL Steering Committee. This is a collaborative statewide activity involving multiple partners, including American Academy of Pediatrics and the American Academy of Family Practice, to implement the Assuring Better Child Health and Development (ABCD) Screening Academy's Implementation Matrix. The ABCD Implementation Matrix is an outcome of a MCAH led national health initiative sponsored by the National Academy for State Health Policy (May 2007-June 2008). The ABCD Implementation Matrix is intended to enhance California's capacity to promote and deliver effective and well-coordinated health, developmental and early mental health screenings for young children ages 0-5 years. The CSSC and the ABCD Implementation Matrix are ongoing outcomes under the ECCS grant. Given CSSC's scope, this collaborative also serves as the State Council on Young Child Wellness for Project LAUNCH to maintain alignment between ECCS and CPL goals and synergy between their respective activities.

Preconception Health Council of California (PHCC): CDPH/MCAH has expertise and past experience specific to preconception health. CDPH/MCAH established the

Preconception Health Council of California (PHCC) in collaboration with March of Dimes California Chapter. A community-driven, statewide forum for planning and decision-making for the integration, development and promotion of optimal health before pregnancy, the PHCC is composed of representatives from organizations and programs that are stakeholders in the development of preconception care services in California. MCAH Program representatives participate in the PHCC quarterly meetings and workgroups. The PHCC achieves consensus on goals, objectives, and activities in the development of a statewide strategic plan in accordance with the Centers for Disease Control's (CDC) Select Panel Recommendations on preconception care. Each of the three workgroups—Clinical/Research, Finance/Policy, and Public Health/Consumer—has developed an action plan for its particular area of focus and workgroup members are collaborating with local partners to implement these plans. Implicit in preconception health education is a life course perspective which encourages a holistic approach to women's health that promotes care for women and girls across their lifespan, regardless of the choice to reproduce, and recognizes the impact of social and environmental factors on maternal and infant outcomes.

CDPH/MCAH Perinatal Substance Use Prevention Program: efforts related to perinatal substance use prevention are conducted through partnerships and collaboration. CDPH/MCAH representatives participate in the:

- California Fetal Alcohol Spectrum Disorders (FASD) Task Force, an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives of Californians affected by FASD and eliminating alcohol use during pregnancy. Led by the Arc of California, the goal of the task force is to advance the effective prevention and treatment of FASD.
- State Interagency Team Workgroup on Alcohol and Other Drugs, composed of members from the CDPH MCAH, Social Services, Mental Health, Education, Developmental Services and Alcohol and Drug Programs (lead). The goal of the workgroup is to identify interagency and systems issues that, if addressed, could improve identification and treatment of families and children impacted by alcohol and other drugs.

2. California Home Visiting Program Management Strategy

The overall management plan for the CHVP is comprised of CDPH Executive Management, as well as the CDPH/MCAH management team which includes programmatic, epidemiologic, administrative and fiscal administration. The management plan has been organized with both manager and line staff responsible for ensuring the successful systems implementation, fiscal reporting, adherence to program policies, procedure and fidelity, system integrity, evaluation and reporting for the CHVP. CHVP will address program capabilities by regularly conducting thorough internal assessments of organizational attributes, as well as ensure research-based quality strategies and support to promote program effectiveness to guide future funding decisions.

CHVP Technical Assistance (TA) teams have been designated to provide direct support to LHJs along with coordination with the NFP and HFA home visiting models to ensure that LHJs are on pace to meet required benchmarks, guide responses to time sensitive deadlines and ensure that local level staff are operating in fidelity with the model. CHVP TA teams will be comprised of a Nurse Consultant III, Health Program Specialist II, Health Program Specialist I, and Research Scientist I, plus other supporting staff for fiscal and administrative responsibilities. Each team will serve as the subject matter expert to a specific model, and will be the state-level liaison to the LHJ and the model developer. The CHVP TA teams will be fully immersed in training for each model, and will work with developers to implement and clarify fidelity measurements as well as develop data collection strategies with the programs. Policy and procedure manuals are being created to guide CHVP TA teams; the manuals detail the systems to be utilized when CHVP initiates implementation of services in designated at-risk communities, and will assist in the provision of individualized organizational technical assistance and training.

Error! Reference source not found. provides detailed job duties, responsibilities and activities for critical positions that ensure the successful implementation of the CHVP. The overall CHVP team will convene stakeholder groups, establish benchmarks, allocate funding, provide evaluation and monitoring, and deliver ongoing technical assistance, capacity building and quality assurance measures.

3. Coordination and Referrals Across Models

CHVP selected two home visiting models and each funded LHJ/community will support only one model for implementation. Therefore, a plan for coordinating referrals across models is not necessary.

4. Related Evaluation Efforts of Home Visiting Programs in California

Rady Children's Hospital-San Diego (RCHSD): The Safe Kids California Project (SKCP), under the leadership of the Chadwick Center for Children and Families (CCCF) at Rady Children's Hospital-San Diego (RCHSD), and in cooperation with University of California, San Diego Department of Psychiatry (UCSD), the National SafeCare® Training and Research Center (NSTRC), the California Department of Social Services-Office of Child Abuse Prevention (OCAP), and Child and Adolescent Services Research Center (CASRC), will "cascade" SafeCare®, an evidence-based home visitation (EBHV) model, across multiple California counties. SKCP targets the prevention of child neglect by leveraging existing funding streams to transform local home visitation (HV) services from untested models into culturally robust evidence-based service delivery systems. SKCP allows selected counties in California to work together in virtual "Learning Communities" to redirect existing HV service delivery capacity to the SafeCare® model with strong implementation support and fidelity to the model. The mutual support and accountability associated with "Learning Communities" will help accelerate the pace of implementation, reinforce fidelity to the model, and increase the likelihood that the change will be sustained over time.

SKCP aims to quantitatively determine specific indicators associated with variations in fidelity, drift and adaptation, and to develop a heuristic model. Data gathered from the evaluation efforts are also used to identify obstacles to the implementation process and allow intervention to address such problems.

Data collected from site visits (administrative data, interviews, focus groups, and qualitative observations) are used to determine the degree to which implementation progress is occurring based on the plan and logic model. Qualitative data collection includes participant observation and is used largely to assess the evidence-based program implementation progress and process. The study investigators are well-qualified to carry out mixed-methods research that examines implementation issues at multiple system levels. Other qualitative data includes field notes, observations, schedules, and notations prepared by the ethnographer (Dr. Rachel Askew) each day when in the field and is independently coded by the project investigator to condense the material into analyzable units. The evaluation data and analysis efforts are categorized into three critical outcomes of implementation: reach, progress, and fidelity.

The evaluation component of this project began in the first year by building relationships with relevant stakeholders and collaboratively modifying and elaborating evaluation activities to best meet the needs of the grantee and stakeholders. The SKCP Evaluation Team has the requisite experience and expertise to conduct this evaluation by virtue of their statewide study of implementation in Oklahoma and a countywide implementation in San Diego County, CA. The evaluation continues in years two through five with ongoing assessment of reach, progress, and fidelity. However, the evaluation will also document factors leading to changes in the implementation plan as well as documenting any adaptations to the evidence-based program and resulting impacts on fidelity.

5. Leadership and Organizational Capacity

CDPH/MCAH has defined the leadership framework and designated key personnel to implement and monitor CHVP:

Shabbir Ahmad, DVM, MS, PhD, Title V MCAH Director, Acting Division Chief, MCAH Program

Provides leadership for a team of public health professionals, program specialists, researchers, and analysts who provide the scientific basis for identifying areas of concern in MCAH; this includes developing and targeting interventions and measuring the impact of those interventions. Dr. Ahmad will serve as the Project Director/Principle Investigator of the CHVP.

Les Newman, Assistant Chief, MCAH Program

Responsible for budget administration and has managerial responsibility for the development and implementation of complex Title V programs, policies, and long-term strategies. Mr. Newman holds a BA in Political Science, and has over 30 years of experience in government health programs.

Karen Ramstrom, DO, MSPH, Chief, Program Standards Branch, Public Health Medical Officer

Provides supervision and leadership to CHVP through policy development, analysis and implementation of new and proposed legislation, and regulations relative to CHVP, as well as all policy and program aspects of the local MCAH programs; advises on policy and program implications both within and outside CDPH; responsible for editing and final review of reports, issue memoranda, position papers, press releases, controlled correspondence, bill analyses, presentations, and articles for publication.

Laurel Cima Coates, MSPH, Chief, California Home Visiting Program, Health Program Manager III

Provides leadership and guidance to CHVP staff; ensures that required benchmarks are met, guides responses to meet time sensitive deadlines; addresses high profile programmatic issues as they arise; provides progress updates to executive staff, meets regularly with inter-departmental programs concerning collaboration and coordination; prioritizes staff assignments; direct contact with HRSA Project Manager.

Christopher Krawczyk, PhD, Chief, Epidemiology, Evaluation and Data Operations Section, Research Scientist Supervisor II

Provides overall managerial and administrative leadership for the complex multidisciplinary studies of the EEDO, including the development, conceptualization, implementation, and supervision of population-based epidemiologic research programs, surveillance, and program evaluations.

Mike Curtis, PhD, Chief, Surveillance, Assessment and Program Development Section, Research Scientist Supervisor II

Provide managerial and administrative leadership for the complex multidisciplinary studies of the SAPD Section and the coordination of those studies with state, federal, and academic partners; meeting federally mandated reporting requirements for the Title V MCH Block Grant and Title V Five Year Needs Assessment; and development of plans to meet federal Benchmark reporting requirements for the CHVP.

Fred Chow, Chief, Program Allocations, Integrity and Support, Staff Services Manager II

Oversight of program allocations, integrity and CHVP support activities

Jo Miglas, Chief, Financial Management and Contract Operations, Staff Services Manager II

Oversight of budget, contract development, CHVP administrative functions and activities

See **Error! Reference source not found.** for resumes

In addition to the onsite CHVP management team, CHVP is supported by other Division-level management, the CDPH Director's Office, as well as the California Health and Human Services Agency for the State of California. The specific staff roles and responsibilities to support develop, and implement CHVP are listed in the budget narrative, as well as in the organizational chart provided in Appendix 3.

The California Home Visiting Program meets the legislative requirements by employing highly educated, well-trained, competent staff. Professional staff all hold Masters Degrees or above and are well established in the Public Health field. Continuing professional development opportunities are established to maintain a high level of training for all CHVP staff. Staff are encouraged to attend state and National public health conferences and to seek opportunities to present formative research and to create poster presentations. Research and writing of peer-reviewed journal articles on the creation, implementation and management of CHVP will also be highly encouraged. CHVP has access to the Public Health Library at the University of California, Berkeley and regularly utilizes their services for inter-library loan of published journal articles and monographs to conduct formative research. High quality supervision will be provided through a combination of managerial staff experience and education. With over 100 years of combined experience in public health administration, the management team was convened to implement, administer and oversee the CHVP based on their successful performance in other management roles. CDPH provides yearly leadership training for managers, and encourages attendance at additional trainings and conferences to advance professional development. Management regularly interacts with other CDPH and state agency management teams to share best practices and create systems for communication and interaction.

Strong organizational capacity to implement activities is supported by the following interagency CDPH infrastructure: Human Resources Branch, Program Support Branch, Financial Management Branch, Office of Leadership and Workforce Development, Information Security Office, and the Office of Legal Services. At the Division level, MCAH provides Information Technology support, Contracts and Grants Management, Accounting and Business Operations, Epidemiology, Evaluation and Data Operations as well as Surveillance, Assessment and Program Development. MCAH has experience in the management of over 20 distinct statewide programs within California and brings a multitude of experience in designing and managing programs and overseeing administrative issues.

6. Coordination Efforts

CHVP will utilize referral and service networks, such as the Help Me Grow (HMG) program which is administered through the CDPH/MCAH-sponsored California Project LAUNCH, to support the home visiting program and the at-risk families it serves. California was recently awarded a training and technical assistance grant to replicate HMG in counties across the state. HMG is a comprehensive, and integrated statewide system designed to address the need for early identification and linkage to developmental and behavioral services and supports for children and their families; it

will coordinate a learning community for counties interested in implementing this approach. The four core components of a comprehensive HMG system are:

- Centralized telephone access point for connection of children and their families to services and care coordination
- Community outreach to promote the use of HMG and to provide networking opportunities among service providers
- Physician outreach to support early detection and early intervention
- Data collection which includes the identification of gaps and barriers

Members of the learning community will include representatives from state and county MCAH, county information and referral systems and district chapters of the American Academy of Pediatrics (AAP). The learning community will receive technical assistance from the national HMG team, including best practices in development of coordinated systems to address early identification, linkages and supports for children and their families.

7. Monitoring of Fidelity

CDPH/MCAH will monitor the fidelity of program implementation to ensure services are delivered pursuant to each model, NFP and HFA, through Technical Assistance Teams (TA Teams). The TA Teams will be comprised of experts in a specified model, knowing exactly what is required of the model to be successful and ensure services are delivered accurately and in accordance with the legislation and federal requirements.

The TA Teams will also use key fidelity components across program models to monitor fidelity of implementation. These components are built on implementation and sustainability research conducted by Fixsen et al.^{49,50} These implementation components are:

- In-service training – providing information and support to practice new skills
- Consultation and coaching – on-the-job support, encouragement and opportunities to practice new skills
- Program evaluation – assessing the key aspects and overall performance of the program
- Facilitative administrative supports – supports to make use of data and provide organization and focus

⁴⁹ Fixsen, D., Naoom, S.F., Blase, D.A., Friedman, R.M., Wallace, F. (2005) Implementation Research: A Synthesis of the Literature. University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).
<http://nirn.fmhi.usf.edu/resources/publications/Monograph/index.cfm> , 119 pages

⁵⁰ Fixsen, Blasé, Horner & Sugai, 2009

- Systems interventions – strategies to work with system partners to address sustainability issues to support the work of the practitioners

The CHVP Updated State Plan is coordinated with other state early childhood plans including the ELAC Plan and the ECCS Plan. CHVP has developed a partnership with ELAC to coordinate planning efforts.

8. Prerequisites for Implementation

CHVP will comply with HFA implementation requirements as follows:

Staffing Requirements

All California HFA home visiting sites will have three primary staff positions: (1) FSW who conduct home visits with families; (2) FAW who conduct family and child assessments and sometimes screen families for enrollment in the program; and (3) program managers/supervisors who oversee program operations, funding, quality assurance, evaluation, and supervision of staff.

Staff Education and Experience

While HFA does not provide specific educational requirements for direct-service staff, the California HFA program will recommend selecting staff based on their personal characteristics; their willingness to work in, or experience working with, culturally diverse communities; their experience working with families with multiple needs; and their ability to maintain boundaries between personal and professional life. Additionally, CHVP HFA programs will comply with the national HFA mandatory training.

Supervision Requirements

CHVP will comply with the national HFA recommendation of one supervisor for every five staff persons. Regarding supervision, the CHVP HFA programs will recommend program managers/supervisors spend a minimum of 1.5 to 2 hours per employee each week on formal supervision and additional time shadowing the FSWs and FAWs to monitor and assess their performance and provide constructive feedback and development.

Staff Ratio Requirements

CHVP will comply with the national HFA recommendation of one FSW serving up to 15 families. In some instances, the caseload may need to be reduced to accommodate families with multiple needs or to accommodate communities in which there are long distances between home visits.

Data Systems/Technology Requirements

CHVP will incorporate the Program Information Management System (PIMS), into our existing computerized data collection, management, and reporting systems. By incorporating home visiting program data into a larger, coordinated data system, better use can be made of the data to measure progress, make decisions and track outcomes. CHVP will identify a new data system, or modify an existing data system, to support CQI efforts in the implementation process and beyond.

CHVP will comply with NFP implementation requirements as follows:

Staffing Requirements

CHVP will require two primary staff positions which are consistent with the national NFP recommendation: (1) nurse home visitors who conduct home visits with families and (2) nursing supervisors who supervise nurse home visitors. Additionally, an administrative assistant is required to manage data entry and other administrative tasks.

Staff Education and Experience

Consistent with NFP NSO, CHVP will require that nurse home visitors and nursing supervisors are registered professional nurses with a minimum of a Baccalaureate degree in nursing.

Supervision Requirements

Consistent with NFP NSO, CHVP will require that a full-time nursing supervisor provides supervision to no more than eight individual nurse home visitors. CHVP funded nursing supervisors will provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role. Supervisory activities include one-on-one clinical supervision, case conferences, team meetings, and field supervision.

Staff Ratio Requirements

In compliance with NFP NSO, CHVP will require that a full-time nurse home visitor carry a caseload of no more than 25 clients.

9. Strategic Planning Efforts

CHVP will implement strategic planning for making modifications needed to bolster the State administrative structure in order to establish a home visiting program as a successful component of a comprehensive, integrated early childhood system by utilizing the opportunity to integrate home visiting in to the California ECCS Advisory Council by re-organizing the California ECCS Advisory Council into a senior level policy council, and building linkages with ELAC. In consideration of emerging early childhood initiatives, including the home visiting program and California Project LAUNCH, the

California ECCS will coordinate linkages with various child-focused program specific councils. These councils include the Home Visiting Advisory Council, Part C/Early Intervention, Statewide Screening Collaborative, and Project LAUNCH, Incorporating Home Visiting initiatives into the ECCS structure will encourage stronger coordination across health and early care and education services, creating a full continuum of early childhood programs.

Through this coordinated governance, agencies will be better positioned to promote a common set of outcomes for young children, increase program quality, and use existing resources wisely. CHVP will use the five Protective Factors in the Strengthening Families framework to align a broad range of outcomes across multiple systems. The Protective Factors will bring together different stakeholders across multiple agencies, including early childhood, child abuse and neglect prevention, child welfare, mental health, public health, and domestic violence. This approach will enhance CHVP's efforts to track outcomes through improved data linkages.

10. Collaborations with California Early Childhood Initiatives

CDPH/MCAH developed a State Partner Collaborative (Collaborative) in February, 2010 to support the planning and implementation process for the CHVP. The Collaborative includes representatives from CDSS, CDADP, CHSSCO/CDE, First 5 California, CDMH and DDS. These important stakeholders will partner with CHVP and form the Home Visiting Advisory Council which is key to the mission of CHVP which is the provision of leadership for integrated, collaborative, high-quality maternal and early childhood interventions across multiple systems of health and human services to address the complex needs of diverse families throughout California. California's investment to empower pregnant women and families with children will positively impact maternal health and childhood development, which leads to improved health and well-being over the life course, and ultimately cultivates resilient communities.

CHVP will utilize strategies for integrating the home visiting program with other programs and systems in California that are related to maternal and child health and early childhood health, development and well-being by integrating home visiting into the ECCS efforts involving the key early childhood system components of health care/medical home, early care and education, social and emotional development, family support and parenting education. Specifically, approaches will be developed to:

- Establish linkages to existing collaboratives and initiatives to support the integration of program services into wider state system of care
- Integrate home visiting as one component of a continuum of services for children
- Improve and expand timely and early identification of children with developmental delays or at risk of delays and provide early intervention to help children reach full potential
- Develop interagency partnerships to address barriers to services for children who fall through the cracks due to lack of insurance or ineligibility to entitlement services

- Improve effective prevention and early intervention services and provide information, education and training to parents, professionals and decision makers, and others
- Address common barriers that limit parent’s ability to parent and work from a strength-based perspective
- Streamline and improve services through cross-departmental planning and governance that builds on existing initiatives and services
- Ensure that services are continuous for children, especially during transition from home visiting to other services, and for those with special needs
- Improve cross-agency coordination between CHVP and early childhood programs to strengthen referral mechanisms to services that are part of the broader linked system or care
- Develop MOUs to promote formalized linkages and coordination among public and private sector partners and to ensure that interagency and cross-systems protocols and practices are effectively implemented and evaluated
- Engage in meaningful interdepartmental collaboration leading to the alignment of policy priorities and objectives, and making targeted improvement to cross-system efforts and interactions.
- Promote better communication and coordination between county and private agencies serving children and their families

Additionally, a key strategy in CHVP’s California Project LAUNCH initiative is to strengthen the capacity of state child-serving agencies to develop a coordinated system of integrated services. These activities are closely aligned with the CHVP vision for a state home visiting model and will be coordinated with the CHVP Home Visiting Advisory Council.

Figure 6 demonstrates the cross-collaboration of the key state initiatives addressing a comprehensive early childhood system.

Figure 6. Cross-Collaboration of Key State Initiatives

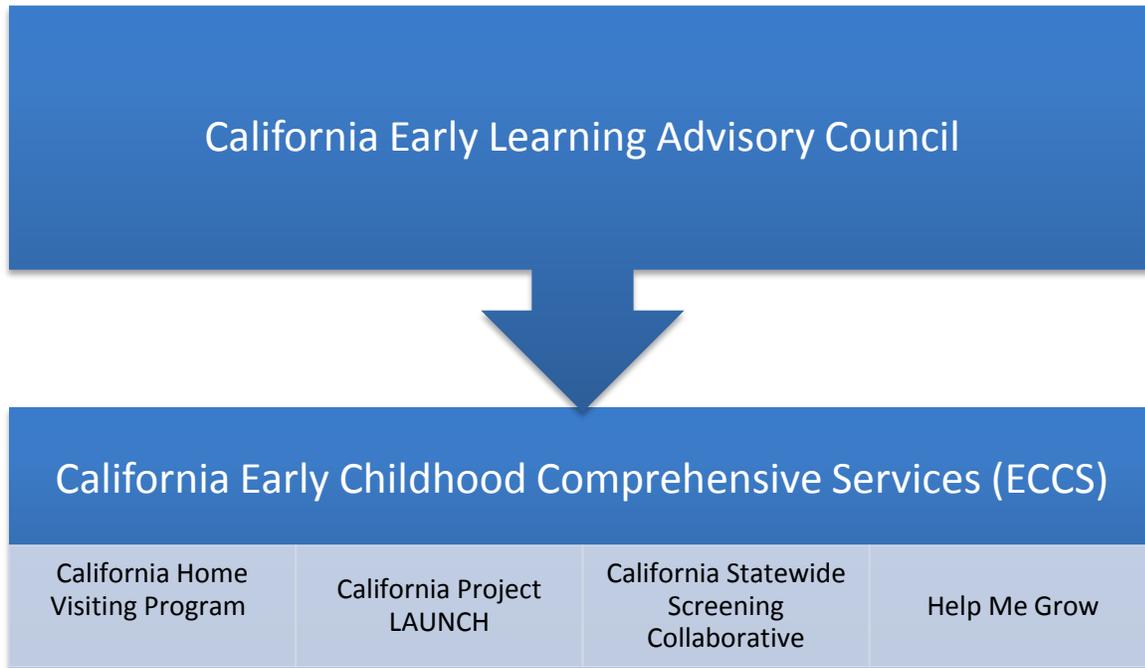


Table 7. Key California Stakeholder Participation in State-level Early Childhood Initiatives

Agency/Entity	Description	Key Role
California Department of Public Health/Maternal, Child and Adolescent Health	Responsible for state MCAH programs	<ul style="list-style-type: none"> • ECCS • Statewide Screening Collaborative • Project LAUNCH • HMG • CHVP
Department of Developmental Services	Lead agency, Part C IDEA	<ul style="list-style-type: none"> • ECCS • Statewide Screening Collaborative • Project LAUNCH • CHVP
Department of Education, Child Development Division	Provides leadership and support to early education programs for children ages birth to 13 years	<ul style="list-style-type: none"> • ELAC • ECCS • Statewide Screening Collaborative • Project LAUNCH • CHVP

Agency/Entity	Description	Key Role
Department of Education, California Head Start Collaboration Office	Oversees administration of Head Start/Early Start programs	<ul style="list-style-type: none"> • ELAC • ECCS • Statewide Screening Collaborative • Project LAUNCH • CHVP
Department of Education, Special Education Division	Partner agency for Part C and lead agency for Part B, of IDEA	<ul style="list-style-type: none"> • ECCS • Statewide Screening Collaborative • Project LAUNCH
Department of Social Services	Provides assistance in adoptions, foster care, children's services and child welfare	<ul style="list-style-type: none"> • CHVP • ECCS • Statewide Screening Collaborative • Project LAUNCH
Department of Mental Health	Provides leadership of the California mental health system	<ul style="list-style-type: none"> • ECCS • Statewide Screening Collaborative • Project LAUNCH
Department of Alcohol, Drug and Substance Abuse	Administers prevention, treatment, and recovery services for alcohol and drug abuse and problem gambling	<ul style="list-style-type: none"> • CHVP • ECCS • Statewide Screening Collaborative • Project LAUNCH
American Academy of Pediatrics, California Chapters	Over 5,000 board-certified pediatrician members of all four California regional Chapters	<ul style="list-style-type: none"> • ECCS • Statewide Screening Collaborative • Project LAUNCH • HMG
California Association of Family Practitioners	A network of more than 7,000 family medicine advocates	<ul style="list-style-type: none"> • ECCS • Statewide Screening Collaborative • Project LAUNCH
Department of Health Care Services /Medi-Cal Division	Covers financing and delivery of individual health care services; finances and administers a number of individual health care service delivery programs, including Medi-Cal	<ul style="list-style-type: none"> • ECCS • Statewide Screening Collaborative • Project LAUNCH

Agency/Entity	Description	Key Role
Office of the Governor	Convenes the newly appointed State Early Childhood Advisory Council	<ul style="list-style-type: none"> • ELAC
First 5 California	Funded through tobacco tax dollars, promotes a comprehensive system of education, health services, childcare, and other crucial programs	<ul style="list-style-type: none"> • ELAC • ECCS • Statewide Screening Collaborative • Project LAUNCH
County First 5 commissions	Funded through tobacco tax dollars, provides services related to health, development and well-being of children birth through five years	<ul style="list-style-type: none"> • ECCS • Statewide Screening Collaborative • Project LAUNCH • HMG
Child advocacy organizations and foundations	A variety of groups including Lucile Packard Children's Foundation, Medical Home Project,	<ul style="list-style-type: none"> • ELAC • ECCS • Statewide Screening Collaborative • Project LAUNCH

SECTION 7.

CONTINUOUS QUALITY IMPROVEMENT



SECTION 7. CONTINUOUS QUALITY IMPROVEMENT

1. The California Home Visiting Program Continuous Quality Improvement Plan

The ACA emphasizes the importance of assessing the fidelity and quality of the evidence-based home visiting models. The concepts of quality improvement and fidelity are related and, therefore, must be considered simultaneously. According to Daro,⁵¹ fidelity includes adherence to a model's staff training, certification, and supervision requirements; delivering family-level services at the specified intensity; and covering the prescribed content. Further, quality refers to how effectively the intervention is delivered to families.

The CHVP CQI plan will ensure fidelity to the NFP and HFA models by applying the Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment Initiative (EBHV Initiative) EBHV Initiative framework. The EBHV Initiative defines fidelity as "the extent to which an intervention is implemented as intended by its designers. It refers not only to whether or not all the intervention components and activities are actually implemented, but also to whether they were implemented properly." This concept requires consideration of two components, namely structural and dynamic aspects of the intervention, as well as the context of implementation. The EBHV Initiative was a cross-site evaluation of five EBHV models, including NFP and HFA that resulted in a framework for assessing fidelity. The framework identified structural and dynamic criteria that define high-quality implementation: consistency in practice, including relatively low caseloads for home visitors; stability of home visitors and supervisors; strong supervision; adequate participant engagement rates among families referred for services; and maintenance of a set standard for home visiting duration and dosage. An additional criterion is the participant-provider interaction, defined by careful family assessment, responsiveness of the home visitor, and respect for the family.⁵²

CHVP will use the process outlined in the Plan-Do-Check-Act cycle (PDCA) to structure its data-driven continuous quality improvement (CQI) plan. Briefly, the four steps of the PDCA cycle include planning what needs to be accomplished, doing a small-scale test of the plan, checking the results, and acting on the results, which may include standardization of the plan or revision and re-testing. More information is available in **Error! Reference source not found..** This simple and systematic approach has been applied across multiple public health agencies and healthcare organizations; therefore, is likely to be familiar to home visiting programs in LHJs. Further, its flexibility allows for coordination with other CQI tools, such as those currently in place at local agencies. Importantly, both the CHVP implementation and CQI plans are anchored to the regular use of data, which supports the early identification of areas in need of improvement. The CHVP CQI plan will be incorporated into the foundation of the implementation

⁵¹ Daro, D. Replicating Evidence-Based Home Visiting Models: A Framework for Assessing Fidelity. Mathematica Policy Research, Inc. Chapin Hall at the University of Chicago. December 2010.

⁵² Daro, D. Replicating Evidence-Based Home Visiting Models: A Framework for Assessing Fidelity. Mathematica Policy Research, Inc. Chapin Hall at the University of Chicago. December 2010.

process. CHVP leadership will establish a culture of learning throughout the program that supports bottom-up and team-based approaches to improving implementation and participant outcomes.⁵³

In order to address the unique cultural and contextual needs of California's diverse communities, some Local HV Programs may identify potential adaptations to national models. CHVP will carefully evaluate requests for adaptations in coordination with NFP or HFA, with attention to maintaining core components of the evidence-based models.

The flexibility of the PDCA cycle allows easy incorporation of elements such as the EBHV Initiative framework criteria and the multiple additional indicators required by the federal guidance, and the national NFP and HFA models. Importantly, CDPH/MCAH has fostered an ongoing dialog with the national offices of NFP and HFA. CHVP will continue to collaborate with the national models in order to meet fidelity criteria and integrate the CQI requirements of each model into the CHVP CQI plan.

See Section 3. Selection of Proposed Home Visiting Models and Explanation of How the Models Meet the Needs of Targeted Communities for details on maintaining model fidelity when challenges arise

2. California's Plan for Fidelity Monitoring and Quality Improvement

The CHVP CQI plan requires three levels of involvement across the public health system: the Program level, including which includes participants and HV staff; the LHJ level, which includes the local system for maternal and early childhood providers; and the State level, which provides overall leadership and coordination across sites. In addition, close collaboration with the national models will be required at each level. Each level is vital to the overall success of the implementation and ongoing process of quality improvement. Both NFP and HFA require local programs to adhere to stringent principals of model fidelity and quality.

CVHP will define fidelity and quality standards and corresponding indicators that will be regularly monitored based on federal guidance, NFP and HFA recommended or required CQI indicators, and input from experts, local programs, and stakeholders. An overview of the CQI processes and indicators for NFP and HFA as they relate to the CHVP CQI plan are described below.

Nurse-Family Partnership: Quality assurance measures are built into NFP; the program focuses on client interactions, program implementation and outcome achievement. CHVP will require all local agencies to follow NFP's 18 Model Elements, undergo any necessary certification processes, and comply with CHVP-specific home visiting program policies and procedures and scopes of work. CHVP will ensure fidelity to the

⁵³ The ABCs of PDCA. Grace Gorenflo and John W. Moran, G Gorenflo, Director, Accreditation Preparation and Quality Improvement, NACCHO and JW Moran, Senior Quality Advisor to the Public Health Foundation and a Senior Fellow at the University of Minnesota School of Public Health, Division of Health Policy and Management. <http://www.naccho.org/topics/infrastructure/accreditation/upload/ABCs-of-PDCA.pdf>.

program model by maintaining national NFP guidelines in monitoring, assessing, and supporting implementation.

NFP guidelines include the following indicators of implementation fidelity:

Client Characteristics/Quality of Care

- Voluntary participation
- First-time mother status
- Low-income criteria
- Percent of referrals enrolled in the program and referral source
- Gestational age at program enrollment
- Client attrition and reason for attrition
- Number of visits completed
- Length of visits
- Content of visits
- Referrals to other services/agencies

Agency Level

- Nurse home visitors and supervisors are registered nurses
- Clinical staff attends Nurse-Family Partnership training
- Clinical staff employs methods promoted by the program
- Clinical staff FTE status; a full-time nurse home visitor carries a caseload of no more than 25 active clients; a full-time nurse supervisor provides supervision to no more than eight individual home visitors
- Caseload size
- Utilization of the data collection and reporting system
- Appropriate supervision provided
- Presence of team meetings for case conference and multidisciplinary input
- Use of an advisory committee
- Presence of sufficient administrative support staff
- Service linkage and referral⁵⁴

⁵⁴ NFP NSO resource, "Guidance for Implementation and Quality of the Nurse-Family Partnership Program" March, 2011, pp.11-13.

Healthy Families America: HFA requires accreditation to ensure participating programs abide by the commitment to deliver the highest quality services possible to families and children. The Self-Assessment Tool (SAT) for programs serves as the program's guide to maintaining quality throughout implementation. The SAT is also used to determine the program's current state of quality. The State will require all local agencies to adhere to HFA's self-assessment and accreditation process. Local programs will be required to follow HFA's 12 Critical Elements and comply with California-specific home visiting program policies and procedures and scopes of work. CHVP will maintain national HFA guidelines in monitoring, assessing, and supporting implementation which ensures fidelity to the program model.

The HFA SAT recommends monitoring and analyzing the following factors to assure adherence to national HFA guidelines:

Programmatic Factors

- Target population
- Referral sources
- Staffing issues (patterns & trends among assessment staff)
- Number of days between referral and assessment
- Assessment timeframe (e.g., prenatal, at birth within two weeks, more than two weeks)
- Enrollment timeframe (e.g. enrolled prenatally, at birth, or at a later period)
- Length of time in program
- Age of target child(ren)
- Approaches to service delivery and evaluation of these approaches (use of curriculum, IFSP development – information may be gathered through the Quality Assurance Plan)
- How policies impact what happens with families and program outcomes
- Relationships with other agencies or community providers
- Training of staff
- Program funding

Demographic Factors

- Gender
- Age
- Race & ethnicity
- Marital status

- Education
- Language
- Employment
- Income level
- City/zip code

Social Factors

- Assessment score
- Working or in school
- Socio-economic status
- Family or friend support
- Teen parent(s) living independently or with parents
- Grandparents raising target child
- Linkages to other community resources
- Religious affiliation
- Domestic/family violence
- Cognitively delayed parents
- Substance abusing parents
- Parents with mental health issues
- Heightened gang or other criminal activity^{55, 56}

3. Role of the Local Program in Fidelity and Quality Improvement

The CHVP CQI approaches will be integrated into all aspects of the LHJs/communities to support fidelity, empower home visitors and supervisors to continually improve practices, and ensure achievement of participant outcomes. Importantly, the LHJs/communities contribute expertise to the overall CHVP CQI effort. Local programs are the best able to identify barriers to implementation, solutions to problems, and strategies to better address the needs of participating families.

Each LHJs/community will be required to establish a CQI Team based on the guidelines provided by the national model and the CHVP scopes of work. The CQI Team will have responsibility for leading local efforts. Inclusion of participating families in the CHVP CQI

⁵⁵ Healthy Families America, "Self Assessment Tool", 2008-2011

⁵⁶ Healthy Families America website:www.healthyfamiliesamerica.org/

process will occur at the LHJs/community level. LHJ/communities will have the following responsibilities:

- Capture and routinely monitor CQI indicators as required by CHVP and HFA or NFP in order to track quality and fidelity of implementation
- Identify and address CQI measures which do not meet the performance standard set by NFP, HFA or CHVP
- Choose at least one quality indicator per quarter to improve upon; document corresponding new knowledge and practices
- Document resulting changes and improvements and report to CHVP
- Report deficiencies in referral networks to the LHJ/community
- Document training and technical assistance needs identified through the CQI process.
- Document challenges to maintaining quality and fidelity and strategies to address these challenges.
- Take advantage of local insights to identify the need for adaptations based on local expertise. Consult with national models NFP/HFA and CHVP on the recommended adaptation prior to implementation. Develop CQI indicators to monitor the adaptation and report changes
- Complete all required State CHVP reporting at specified intervals.

4. Role of the LHJ in Fidelity and Quality Improvement

At the LHJ/community level, the CQI activities will include monitoring of the LHJ/community, with a specific emphasis on supporting a strong maternal and early childhood system of services. LHJ leadership, including the MCAH Director, will be involved in monitoring CQI indicators that inform systems of care, such as completed referrals and access to care. LHJ CQI activities would then address gaps in local services, enhancing collaboration among local agencies, and prevention of duplication of LHJ/community services with other programs. In addition, the LHJ will be involved in identifying contextual factors that inform success or serve as challenges to model implementation. LHJ leadership will be involved in assessing the need for and implementing model adaptations.

5. Role of CHVP in Fidelity and Quality Improvement

CHVP will establish overall leadership for the CQI plan and ensure a coordinated process across Local HV Program, LHJ, and State levels. Guidance to LHJ and Local HV Programs will be provided through scopes of work and program standards documents, training, and ongoing technical assistance. Emphasis will be placed on integrating the CQI process throughout all aspects of program implementation and soliciting input from Local HV Programs and LHJs to ensure the CHVP achieves benchmarks. In addition, CHVP will establish a State-level CQI Team that will be

responsible for developing required CQI measures, standards and reporting timelines; identifying/selecting data sources and measurement tools; providing necessary training, and managing CQI data systems. CVHP will be responsible for ensuring overall focus on model fidelity and quality, in coordination with the national models. CHVP is also responsible for supporting communication across sites, developing statewide training and technical assistance resources, and addressing systems-level factors that impact quality, such as ensuring a strong network of services.

CVHP CQI Team will have the following responsibilities in order to recommend local technical assistance, inform policy change and meet federal reporting requirements:

- Monitor all CQI indicators in order to track quality and fidelity of implementation; including contextual factors
- Work with local programs to identify CQI indicators which do not meet the performance standard set by CHVP
- Monitor LHJ/community CQI efforts and progress toward improving performance
- Track and respond to training and technical assistance needs
- Document challenges to maintaining quality and fidelity and strategies to address these challenges
- Respond to requests for model adaptations, coordinate adaptations with NFP and HFA national offices and closely monitor adaptations

The multi-level investment in CQI principles, use of the simple PDCA approach, and commitment to regular use of data will support achievement of participant outcomes in the CHVP. The lessons learned from CQI processes will be used to develop a body of best practices that can be shared across CHVP sites to respond changing community needs. These lessons will inform the future expansion of CHVP to support efficient implementation at sites with high need but lower capacity.⁵⁷

⁵⁷ Nurse-Family Partnership. "State Management of a Multi-Site Nurse-Family Partnership: Outlines the major functions that state infrastructure must fulfill to assure sustainable high quality local programs." August 2010. http://www.nursefamilypartnership.org/assets/PDF/Policy/HV-Funding-Guidance/State_Manage_Multi-Site_NFP. Accessed online April 2011.

SECTION 8.
TECHNICAL ASSISTANCE



SECTION 8. TECHNICAL ASSISTANCE

CHVP recognizes that over the course of implementing a new home visiting program within California that technical assistance (TA) from HRSA may be needed. CHVP anticipates the following:

1. Needs assessments
 - Provide needs assessments from other states as appropriate
 - Connect appropriate federal partners to assist in ongoing needs assessments as appropriate.
2. Statewide Early Childhood Comprehensive System (ECCS)
 - Provide national examples of ECCS
 - Connect appropriate federal ECCS partners
3. Strategic planning
 - Provide ongoing strategies regarding future planning
 - Assist with development of strategies to support long-term sustainability
4. Collaboration and Integration
 - Provide guidance on how best to collaborate and incorporate ECCS, ELAC and Project LAUNCH
 - Assist in creating effective partnerships with other states as modeled by HRSA and ACF
 - Provide communication systems with other state home visiting programs
 - Guidance to assure integration into a comprehensive statewide system of support for early childhood
 - Coordination with national model developers
5. Communication and Marketing
 - Provide strategies for communication, marketing, and public outreach
6. Budget and fiscal leveraging
 - Provide guidance on fiscal leveraging
 - Provide ongoing Federal Fiscal Year information
7. Implementation of a state-level Home Visiting Program
 - Provide examples of continuous quality improvement/quality assurance, workforce issues, developing training systems, participant recruitment and retention, sustainability, and infrastructure development specifically for rural areas
8. Systems capacity issues

- Provide guidance in accurately analyzing performance in meeting national and state performance measures and goals
 - Provide assistance in the development of systems for identifying, reviewing, and analyzing maternal morbidity and mortality that will serve as a framework for the improved maternal standard of care.
 - Provide tools for conducting cost-effective analysis of home visiting program
 - Provide criteria to measure the effectiveness of evidence-based early childhood home visiting models, guidelines for reporting to fulfill the needs assessment requirements and developing quantifiable measures
9. Benchmark specialty issues (e.g., substance abuse, mental health, domestic violence, rural and frontier issues)
- Provide the federal perspective on issues such as substance abuse, mental health, domestic violence, rural and frontier issues
10. Program evaluation
- Provide examples of program evaluation methods and research designs appropriate to home visiting
 - Connect existing program evaluation systems
11. Compliance with federal legislation
- Provide ongoing technical assistance systems development to ensure the that state is in compliance with the federal legislation
 - Provide reporting requirements.

CHVP anticipates the need for further TA upon implementation of the home visiting program from both models, NFP and HFA in the following areas:

- Implement models with fidelity
- Refinement of constructs
- Workforce issues such as recruitment of PHN staff, provision of professional development opportunities
- Client participation and attrition
- Data
- Training
- Recruitment/retention
- Program evaluation

SECTION 9.
REPORTING REQUIREMENTS



SECTION 9. REPORTING REQUIREMENTS

California Department of Public Health/Maternal, Child and Adolescent Health (CDPH/MCAH) provides assurance that the California Home Visiting Program (CHVP) will comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the program. CHVP will comply with the specific due dates and formatting requirements for submission of all required reports. Based on further guidance, the reports shall address all requested information, such as:

1. CHVP Goals, Objectives and Logic Model

CHVP will provide progress made under each goal and objective, including updating of the Logic Model, during the reporting period, including any barriers to progress that have been encountered and strategies/steps taken to overcome them; updates/revisions to goal(s) and objectives identified in the implementation plan will also be addressed:

- CHVP Health Program Manager III will assign lead staff to oversee reporting requirements and will utilize strategic planning efforts to ensure consistent and effective reporting on goals and objectives. CHVP will develop a template for reporting that includes details of any and all progress made under each goal and objective during the HRSA specified reporting period. The report will contain any barriers to progress that have been encountered and strategies/steps taken to overcome them. Updates/revisions to goal(s) and objectives identified in the Updated State Plan will be identified through strategic planning efforts during the implementation phase. The Health Program Manager III will assure that the revisions are necessary and further the overall programmatic goals of the home visiting program. CHVP will include proposed revisions, based on HRSA guidance, in an annual report to the Secretary.
- CHVP will identify and report any changes made to the Logic Model, and will provide information on continuous efforts to contribute to a comprehensive, collaborative, high-quality early childhood system throughout California. Through strategic planning efforts, analysis of the Logic Model and linkages with partners and stakeholders, systems for the planning and implementation of early childhood systems will be identified. Advances made utilizing the Strengthening Families Framework will also be reported on via the Logic Model.

2. CHVP Promising Program Update

Updates and copies of reports will be provided on evaluation of any implemented promising programs, if applicable at a later date

3. Implementation of Home Visiting Program in Targeted At-Risk Communities

CHVP will provide updates regarding experience in planning and implementing the home visiting programs selected for each community of need; items listed below will be addressed in the reporting format provided by HRSA. CHVP will also provide information on any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges:

- An update on CHVP's progress for engaging the LHJ/communities around the proposed implementation plan;
- Update on work-to-date and a description of the technical assistance and support provided through the national NFP and HFA offices;
- Based on the timeline provided in the implementation plan, an update on securing curriculum and other materials needed for CHVP;
- Update on training and professional development activities obtained from NFP and HFA, or provided by CHVP, or the implementing local agencies;
- Update on staff recruitment, hiring, and retention for all positions including subcontracts; Update on participant recruitment and retention efforts;
- Status of home visiting program caseload within each at-risk community;
- Update on the coordination between home visiting program(s) and other existing programs and resources in those communities (e.g., health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services); and
- A discussion of anticipated challenges to maintaining quality and fidelity of each home visiting program, and the proposed response to the issues identified.

4. Progress Towards Meeting Legislatively Mandated Benchmarks

CHVP will provide updates on data collection efforts for each of the six benchmark areas, including updates on data collected on all constructs within each benchmark area; definitions of what constitutes improvement, sources of data for each measure utilized, barriers/challenges encountered during data collection efforts, and steps taken to overcome them will also be addressed in the reporting format provided by HRSA.

5. CHVP Continuous Quality Improvement Efforts

CHVP will provide updates and reports regarding the planning and implementation of CQI efforts for the home visiting program. Evaluation and reporting will follow the "Plan, Do, Check, Act" (PDCA) (See **Error! Reference source not found.**) model which will begin with identifying and prioritizing CQI opportunities, development of an action plan, implementation, collection and documentation of the data; documentation of the problems, unexpected challenges, lessons learned, and knowledge gained; and finally,

analysis, and decisions on adoption, adaption or abandonment are made; the process then repeats.

6. Administration of State Home Visiting Program

CDPH/MCAH will have ultimate administrative authority over CHVP and will approve internal administrative changes. CHVP will provide the following as requested, and as applicable:

- Updated organization chart
- Updates regarding changes to key personnel (as approved by HRSA), including resumes for new staff, if applicable
- An update on CHVP's efforts to meet the following legislative requirements, including a discussion of any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges:
 - Training efforts to ensure well-trained, competent staff;
 - Changes in key personnel require prior approval by HHS.
 - Steps taken to ensure high quality supervision;
 - Steps taken to ensure referral and services networks to support the home visiting program and the families it serves in at-risk communities; and
 - Updates on new policy(ies) created by CHVP to support LHJ/communities.

7. Technical Assistance Needs

CHVP will provide updates on technical assistance needs for implementing the home visiting program or for developing a statewide early childhood system.

