Newborn Home Visiting Programs: A Scan of Services and Data

A REPORT PREPARED FOR THE SOUTHERN CALIFORNIA ALLIANCE FOR LEARNING AND RESULTS

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Acknowledgements

We would like to thank the First 5 Association and the eight First 5 county commissions in Southern California (Imperial, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura) whose collaboration and support made this project possible. We would also like to acknowledge and thank Kate Anderson, Amber Aviles, and other colleagues at the Los Angeles County Perinatal Home Visitation Consortium who helped identify programs, provided feedback as the survey was developed, and then rallied consortium members in Los Angeles to participate. This report was prepared by the Children's Data Network, a university, agency, and community-based data collaborative funded by First 5 LA with additional support from the Conrad N. Hilton Foundation, housed at the USC School of Social Work, and developed in partnership with the California Child Welfare Indicators Project. The present report was developed based on data collected from the Southern California region, however, the knowledge gained may be applicable statewide. We hope that this report is useful to First 5 County Commissioners both within and outside the Southern California region.

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Summary

The eight First 5 county commissions in Southern California (Imperial, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura) have been jointly investing in evaluation and data collection efforts since 2008. These efforts have included the development of a database for evaluation reports; re-assessments of program investments in oral health, developmental screening, and school readiness; and the creation of a needs index based on population-level indicators. Recently, interest has turned to building regional evaluation capacity around the provision of services to families with newborns, including home visiting, with the goal of tracking infant outcomes across counties and programs.

This focus on services provided to families with newborns is timely and relevant to policy discussions at the state and federal level, particularly as home visitation (HV) is considered with ACA implementation. If the potential of home visitation is to be realized, the availability of data to document which families are served and to examine the impact of this intervention strategy will be critical to sustainability.

As an initial step toward enhanced regional capacity to track the delivery and outcomes of HV services, the Southern California Alliance for Learning and Results (SCALAR), through funding from the First 5 Association, contracted with the Children's Data Network (CDN) at the University of Southern California. The current report summarizes the findings to emerge from this effort, which included a regional "scan" of HV programs. The goal was to better understand what programs were being delivered, what data were being collected, and to examine the potential for linking home visiting data to birth, child protective service (CPS), and other administrative records for the purposes of research and evaluation.

For the purposes of this project, home visiting was defined as "a program that is a voluntary and sustained effort that pairs new and expectant families with trained professionals to provide parenting information, resources and support during pregnancy and throughout their child's early years."

Home visiting can be used as an intervention for a range of purposes and with very different populations of children and families. Although various Southern California Commissions employ home visitation as an intervention strategy for other outcomes such as early literacy, or oral health education and prevention, the focus of the present scan was the identification of programs that employ a newborn assessment strategy and home visitation, as appropriate, to impact health, safety, and family strengthening outcomes. This fairly specific definition excludes many types of home visiting programs, but made sense given the desire to generate information concerning home visiting services most immediately relevant to current local, state, and federal discussions with the implementation of ACA, and to identify home visiting programs that shared enough features (e.g., target population, program goals) that it was credible to consider how they might be included within a broader regional evaluation effort.

Therefore, in conducting the scan and developing this report, we focused our attention on three areas:

1. Gathering information regarding providers in the Southern California Region that deploy home visiting before or shortly after the birth of a child as an early intervention strategy;

2. Reviewing identified home visitation programs to support a further classification of programmatic characteristics (e.g., use of evidence-based curricula, service delivery protocols), including the collection of client-level data that would allow for the linkage of records with other administrative sources (e.g., birth records, child protection records); and

3. Developing recommendations to enhance county and regional capacity for compiling and using home visiting data to advance research and evaluation agendas, including the potential linkage of these data.

To gather information regarding newborn home visiting programs and the data collected by different providers, we held initial informational interviews with First 5 commission staff in each of the 8 Southern California counties, contacted local county departments of public health, called 2-1-1 to develop a home visiting referral list, and conducted web-based searches specific to each county. This allowed us to develop a comprehensive list of HV programs across the region and to develop home visiting profiles for each county. We additionally conducted a review of the home visitation literature and compiled a list of data elements required for collection among some of the most commonly employed home visiting programs. Information from all of these sources was used to develop an electronic survey that was sent to over 180 providers.

We received completed surveys from 126 of the 183 home visiting providers, translating into a 68% response rate.

The survey included general program questions such as the HV program type, funding sources, use of newborn assessment tools, referral sources, the number of clients/families served, and eligibility criteria. The survey also asked questions relating to methods for collecting and managing data, specific client-level data elements that would be required for the linkage of records, and whether data were collected for a range of outcome domains. Finally, the survey was also used as another point of referral to HV providers that were not identified in the initial search, with each respondent queried as to other providers they were aware of. In Los Angeles County, we additionally partnered with the Los Angeles County Perinatal and Early Childhood Home Visitation Consortium to identify HV providers and administer the survey.

The majority of HV providers identified through the methods noted above (i.e., interviews with First 5 commission staff, departments of public health, web searches) received the survey on May 12th, 2014. Several follow-up emails were sent and phone calls were made to maximize the response rate. The survey was officially closed on June 9th, 2014.

Overall, we received responses from 126 of the 183 HV providers that were identified and targeted for the survey (68% response rate). Not surprisingly, the number and nature of providers identified in each county varied widely, as did the context in which services were delivered. Every county in the

region had a home visiting program that was either independently funded by First 5, jointly funded by First 5 and outside funds, or funded by an outside organization known to the commission. Almost all providers reported collecting data electronically, including client-level information that would support linkage to other data sources. Yet, with few exceptions, HV data are not currently being assembled into a single data system within the county, but are captured and managed in different forms and in systems with different functionality. Further, few providers reported having had evaluations of program outcomes in the past 5 years or having data-sharing partnerships.

ORGANIZATION OF REPORT

The remainder of this report is organized into six sections. We begin where this project ended – with a description of the recommendations that arose. Although the current disaggregation of client HV data creates significant hurdles, we outline concrete ways in which the commissions might advance a regional agenda of research and evaluation. Having presented these ideas, we then step back to review the context for these recommendations by providing a brief overview of recent literature related to child maltreatment, home visiting interventions, and policy changes associated with home visiting. Next, a description of the eligibility criteria and program features of those home visiting programs deemed to be evidenced-based by the Federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Department is provided. Although these selected home visiting programs represent only a fraction of all programs, they provide a useful and sample of programs with well-documented criteria for which it is possible to examine program similarities and differences. This is followed by a detailed outline of the report methodology, including the description of the development of the inventory of HV providers, and creation and administration of the survey. Given the uniqueness of each county and relevance of understanding the local home visiting context, survey and other findings are presented individually for each of the 8 Southern California counties. These county profiles include a presentation of the county's birth characteristics, survey response rate, the commission's goals and strategies, a description of HV programs, and a detailed summary of HV data collected. Finally, the Appendix includes a list of survey questions, data measures suggested by Pew Charitable Trusts and collected by Nurse Family Partnership programs, an overview of an electronic data collection program, and a list of the Los Angeles HV providers contacted for this survey (this list was too long to be included in the body of the report).

Recommendations

California relies on a state-supervised, county administered system for child protection. Despite the vastness of the state, the uniqueness of each county and the range of programs delivered, child protection data from all 58 counties are entered into a single case management system. By assembling these client data into a unified system, unique children can be longitudinally followed through the child protection system over time, and standard indicators and outcomes can be tracked.

Of course, CPS data present only a partial picture of the characteristics, service experiences, and outcomes of children reported for abuse or neglect. But the standardized collection of these data into a single system facilitates the extraction of client records for linkage purposes. And by linking these records to information collected through other systems (e.g., education, developmental service, mental health), rich opportunities for research and program evaluation emerge.

There is growing interest and a growing amount of resources being devoted to early intervention services, including the delivery of home visiting. The regional scan that serves as the basis for the present report indicated that there are active home visiting programs in each of the 8 counties in Southern California, that nearly all of these programs collect client-level data in an electronic format – and that a majority of programs are connected by funding through county First 5 commissions. Yet, findings also indicate that very few providers have had formal evaluations conducted within the last 5 years, that there are no established guidelines or uniform definitions for data entry spanning programmatic boundaries, and overwhelmingly, data are collected in discrete, non-standardized systems.

The absence of uniform definitions and standardized data collection protocols makes it challenging to promote accountability and track outcomes.

The First 5 commissions in the Southern California region have already assumed a critical role in the area of home visitation by funding programs and convening providers. Still, many in the growing network of home visiting providers in the region and throughout the state operate without guidelines for the collection of data or a platform for compiling and managing client records for research and evaluation. This not only makes it challenging to promote accountability and track outcomes, but also limits opportunities to leverage data collected through other systems to support studying longer-term outcomes and for cost-effective program evaluation.

Based on the information gathered for this project, we have developed 8 recommendations that we believe will advance the region's capacity to collect and use home visiting data in the short and longer-term. Some counties are currently, or will soon be, in a position to begin regularly harvesting home visiting records that could be linked to other data sources. Others have a much more dispersed network of providers serving a small number of clients, increasing the effort that would be required to assemble and use this information. Given these variations, we have focused our recommendations on those most salient to the region overall.

1. Establish uniform definitions of data elements and standardized data collection strategies for home visiting providers.

   It is a public policy axiom that one must be able to both define and then measure what one ultimately hopes to track, manage and improve. The commissions should establish uniform definitions and standardized approaches to the collection of client-level data among home visiting agencies funded through the First 5's. These definitions could be aligned with those that have emerged from other efforts, such as the Pew Performance Initiative which sought to examine the range of data collected by HV programs and create a consensus about the key measures that ought to be collected. A summary of Pew measures has been included in the Appendix. Additionally, a comprehensive list of data elements collected by all NFP programs has been provided in the Appendix as another example. Ensuring data are collected uniformly across programs is critical to creating a resource of value for research, evaluation, and outcomes/accountability efforts.

2. Promote transparency and generate interest by publishing data (any data!) on a public site.

   As Peter Drucker said (and related to the first recommendation), "What gets measured gets managed". The commission should identify data indicators and outcomes that are currently tracked and available (even if incomplete, imperfect, and available for only for a handful of providers) and should make those data public. Beyond promoting transparency, it will also help jumpstart a dialogue related to meaningful indicators and data quality. For example, home visiting data could be pushed out to www.kidsdata.org to be published by county – and the commissions could direct stakeholders and providers to that site. The hope is that this will create "community demand" for still more information which will help propel efforts forward.

3. Advocate for statutory reporting requirements that would necessitate enhanced data collection, data reporting, and data sharing.

   Policy development and advocacy are core to commission work. Although advocacy related to data collection, data reporting, or data sharing among government departments is probably not at the top of any commission's agenda, our experience suggests that it is incredibly powerful to be able to point to specific statutory requirements when it comes to ensuring there are high quality data. (Keeping in mind that what comes out of an administrative data system is only as good as what gets entered into it.) To return to the example of child protection, state and federal reporting requirements have led to vast improvements in the quality of the data that were being entered, making those data ever more useful for still other research and evaluation efforts. And in the area of data sharing and data linkage, requirements for indicators of cross-system involvement have helped bring varied agency partners to the table. The commission should develop a shared advocacy agenda around required data collection, data reporting, and data sharing as it relates to home visiting programs.

4. Invest in a web-based data collection system for the entry of client-level information for case management and/or research and evaluation purposes.

A key hurdle to county, regional, and state home visiting evaluation efforts is the absence of platform for assembling client records generated by different programs and providers. The aggregation of HV records into a single, standardized data collection system would support a range of commission interests, including the tracking of indicators, increased accountability and a focus on outcomes among providers, and the ability to extract records for linkage with other data sources. In our interviews with commission staff, it became apparent that although many providers are required to enter aggregated caseload statistics into a commission-administered data system, these data systems were not designed to collect the client-level needed for more rigorous evaluation and research activities. Orange and Los Angeles counties provide two examples of how such client-level data platforms or portals might be developed. First 5 LA has invested in two data collection systems related to HV: The Stronger Families Database and the Data Warehouse. Meanwhile, in Orange County, the county commission manages the collection of newborn assessment and home visiting data across the Maternal and Child Health Network through the Bridges Connect Database. County commissions should explore opportunities for leveraging current and future investments in data collection systems (both among commissions and through other agency partners), particularly if uniform definitions of data elements and standardized data collection protocols have been established (see #1 above).

5. Ensure that client consent forms include provisions for the linkage of records for research and evaluation purposes.

The best data and indicators for assessing the impacts of home visiting on children's health, mental health, and education—core components of wellbeing—are collected by the systems that deliver those services. If we want to track home visiting provider success in effectively triaging children and families into the appropriate mental health services that improve child functioning, we should use mental health data, not attempt to messily duplicate its collection in home visiting data systems (which also creates additional data burdens on home visiting staff). Likewise, if we want to track the educational progress of children served by home visiting programs, we should use data already collected by our schools. To ensure that data originating in other systems can be used to support ongoing research and evaluation efforts, the commissions should establish standard language specific to accessing client-level administrative records for inclusion in all HV provider consent forms. Although researchers can make post-hoc requests for waivers of consent, given that a consent procedure is already in place for HV services, it is a missed opportunity when this is not used to obtain explicit consent for data linkage.

6. Leverage administrative data already collected by other systems to support cost-effective program evaluations.

Randomized controlled trials (RCTs) are the "gold-standard" in research and generally considered the only definitive method for confirming program effectiveness (because as long as the sample is large enough, observable and unobservable differences that may exist between individuals and may be related to the outcome being studied should be randomly distributed across the two conditions, leaving these studies uniquely positioned to attribute

any differences in observed outcomes to the intervention itself.) Yet, quasi-experimental methods applied to linked administrative data can produce useful and very cost-effective designs for evaluating programs. For example, birth record data can be used to create synthetic cohorts of children with similar risk profiles for comparison to a subset of children who were born and received a particular program intervention. From a methodological perspective, administrative records offer complete coverage of a given population, avoiding the uncertainty of sampling errors. Administrative records can be configured longitudinally, allowing events such as client service encounters or recidivism to be tracked over time. Additionally, the cost of analyzing administrative data for large populations is relatively small compared with the resources required to collect information through surveys or other methods. This last dynamic is particularly valuable in the context of events with low base rates, such as studies of child abuse or neglect, in which large samples are required to develop adequately powered evaluation studies. The commission should develop a regional HV evaluation agenda that builds upon information already collected in available administrative data systems and should help develop county and regional infrastructure for work with these data.

7. Engage external partners to support research and evaluation activities.

California has a strong tradition of academics from both public and private universities, as well as other research entities, partnering with government agencies and community-based providers. With increasingly limited budgets available for data mining and evaluation activities in many agencies, these partnerships and the software and other statistical resources in universities will become even more valuable. The commissions should seek to strengthen research partnerships throughout the region and leverage those to support HV providers in data and evaluation work. As a prime example of a resource that is uniquely available to researchers, but may be of great value to assembling HV data in smaller counties where the cost of a centralized database cannot be justified, see our overview of the REDCap system in the Appendix. Relatedly, ongoing local, regional, and statewide efforts are increasingly focused on issues related to data sharing and system interoperability. Joining these emerging and existing efforts may move the conversation forward more quickly than if a separate home visiting data linkage movement were to begin.

8. Use birth record data linked to home visiting data to characterize children served by HV programs and document variations in need across communities.

Despite evidence indicating that the greatest costs and benefits of home visiting programs occur for the highest-risk children and families (Kilburn, 2014), relatively little attention has been paid "case finding" approaches that could be employed to ensure children at greatest risk are being identified and triaged into home visiting programs. Given the absence of truly universal home visiting programs in California, knowledge of which children and families are identified as being at risk and then referred to home visiting programs is critical. This information is needed because we have an ethical obligation to ensure that if and when limited service slots are available, children and families with the greatest concentration of risks are appropriately prioritized in our triaging efforts. Similarly, we have a fiscal imperative to ensure that if and when programmatic effects vary across population risk levels, efforts are made to thoughtfully triage clients to maximize benefits relative to costs.

Universally collected birth records provide a valuable source of data for characterizing children served by HV programs, documenting whether the availability of services matches need, and examining whether children with the highest concentration of risk factors are referred to HV services. To test the feasibility of such a project, the CDN collaborated with the Children and Families Commission of Orange County to link archival data from the Bridges for Newborns assessment tool to already linked birth and child protection records for the years 2006 and 2007. The goal was to determine the quality of the information captured in the Bridges for Newborns electronic data system and the feasibility of probabilistically linking these records to birth and child protection records. The match rate from this pilot data linkage project were excellent, with over 90% of assessment records successfully linked to a birth record based on personally identifiable data for mothers and children. The commissions should use birth record data as a simple means of characterizing and tracking newborn populations across the region; counties with access to client-level HV data should explore similar feasibility data linkage projects.

Background

CHILD MALTREATMENT

In the United States in 2012, an estimated 1,700 children known to a child protective services (CPS) agency died as a result of what was deemed an intentional injury; more than three quarters of these children were younger than 4 years old (US Department of Health and Human Services [USDHHS], n.d.). Beyond deaths due to maltreatment, referrals involving approximately 6.3 million children believed to have been harmed or at risk of harm were made to CPS agencies. An estimated 3.4 million of these children were included in an investigation and 686,000 were found to have been maltreated.

The Fourth National Incidence Study (NIS-4), which estimates the number of children abused and neglected in the United States based on both formal reports made to child protective services agencies, as well as knowledge of maltreated children gleaned through other sources, determined that more than 1.2 million (1 in 58) children are demonstrably harmed or injured by child abuse or neglect annually. If a more inclusive "endangerment" standard for defining child maltreatment injuries is applied, the NIS-4 suggests that nearly 3 million (1 in 25) children are endangered by maltreatment each year (Sedlak et al., 2010). A new article published by Wildeman et al. (2014) estimates that 1 in 8 children have been substantiated for abuse or neglect before age 18, much greater than the roughly 1/100 who are substantiated in any given year. Regardless of the definition used, these estimates leave little doubt that the scope of the immediate public health threat posed by child abuse and neglect is likely to be quite underappreciated.

Recent estimates from the United States indicate that 1 in 8 children are substantiated for abuse or neglect before age 18.

Further highlighting the significant public health burden of child maltreatment is a growing body of empirical research indicating that even after maltreatment ends, the consequences of the abuse or neglect are often far reaching (Petersen et. al., 2014). Adverse effects associated with physical, cognitive, social, and emotional development are commonly observed among victims of child maltreatment. Although disheartening, this growing body of scientific evidence has suggested that preventing initial and recurring instances of child maltreatment may be a highly effective strategy for promoting health and reducing disease burdens later in life—objectives of most public health agendas.

There is little doubt that the prevention of maltreatment, rather than its treatment, is critical to reducing the public health burden of injuries from child abuse and neglect. Efforts to prevent maltreatment, however, will only be successful if we: (1) generate research that allows for a better understanding of the dynamic interaction between risk and protective factors that can be targeted by prevention efforts; (2) expand our surveillance techniques to better understand the scope and nature of this health threat at a population level; and (3) develop and validate population-level screening and assessment tools that can be embedded within service systems to more effectively triage children and families into primary prevention programs.

HOME VISITING

Home visiting as a primary prevention tool has been rigorously tested and shown to improve outcomes for children, parents, and family systems. Exposure to prenatal and infant home visiting programs has been shown to improve education, health, and socioeconomic outcomes while decreasing the likelihood and frequency of incarceration among youth throughout childhood and adolescence (Eckenrode et al., 2010). Home visiting services have also been associated with delayed subsequent pregnancy and birth among participating mothers, a factor that has been linked to improved economic self-sufficiency among parents (Rubin et al., 2011; Yun et al., 2014). These programs have also led to increased positive and nonaggressive parenting practices (Dodge, Goodman, Murphy, O'Donnell, & Sato, 2013; Guterman et al., 2013). Participants in a 2-year home visiting intervention required less government spending per year on food stamps, Medicaid, Aid to Families with Dependent Children, and Temporary Assistance for Needy Families than control families at a 12-year follow-up (Olds et al., 2010). A brief nurse home visiting curriculum that was disseminated throughout Durham County, NC, led to improvements in the quality of home environments (Dodge et al., 2013).

Home visiting programs have also been used to reduce the risk of child abuse and neglect, although the corresponding empirical evidence has been less conclusive. In a review of randomized clinical trials, nurse home visiting interventions were identified as efficacious in the prevention of child maltreatment when interventions included the following strategies: targeted provision of services to high-need families; nurse involvement that begins prenatally and is maintained through the child's second birthday; emphasis on health-promoting behavior and qualities during caregiving; and service provision to ameliorate social and environmental stressors that affect family functioning (Olds, 1992). In 2003, the Task Force on Community Preventative Services conducted an extensive review of 22 existing studies that evaluated the effectiveness of home visitation programs in terms of reducing the risk of child abuse and neglect. The task force concluded that home visitation programs are effective interventions for the prevention of child maltreatment, particularly for low-income households, single parents, and infants with low birth weight (Hahn et al., 2003).

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POLICY

Home visiting models are presently defined by the California Department of Public Health (2011) as in-home supportive services that aim to improve parent and child outcomes, particularly among at-risk populations. These programs have been in existence since the 1880s and aim to support the child, family, and home environment and focus on prevention of "low-birth-weight babies, child abuse, reliance on public assistance, learning delays," among other aspects of child wellbeing (Sweet & Appelbaum, 2004, p. 1435). The contemporary concept of home visiting as an intervention delivery strategy was reintroduced in public health and social welfare systems nationwide during the 1970s (Sweet & Appelbaum, 2004). Programs involving home visiting feature common goals of improving pregnancy outcomes, promoting quality parental caregiving, and supporting child health and

developmental outcomes (Olds, Kitzman, Cole, & Robinson, 1997). They also share a family-centered, personalized approach to service delivery (Sweet & Appelbaum, 2004).

In 2008, the Children's Bureau (CB) and the U.S. Department of Health and Human Services (USDHHS, n.d.) collaborated with 17 subcontractors across 15 states to implement evidence-based home visiting programs (EBHV) as a primary tool to prevent child maltreatment. This 5-year initiative is now supported through the Maternal, Infant, and Early Childhood Home Visiting Program under the 2010 Affordable Care Act, which has designated 14 home visiting models as evidence based (Del Grosso et al., 2011) The primary goals of the EBHV strategy are to: (1) improve implementation fidelity of evidence-based home visiting program models, (2) replicate service models in new service areas or among previously untargeted populations, and (3) secure the sustainability of service models beyond the EBHV initiative. Evaluations of the project have suggested home visiting prevention strategies are achieving greater fidelity, consistency, and sustainability through cost-effective implementation, although the achievement of outcomes varies considerably (Boller et al., 2014). As demonstrated by the CB's investments in this large-scale and multisite home visiting evaluation project, there is presently great interest in understanding the adoption and implementation of evidence-based programs in direct practice.

Investigation of these programs is timely because the Affordable Care Act recently amended Title V of the Social Security Act (42 U.S.C. 701 et. seq.) and established a funding stream that allows states to fund and collect data on evidenced based HV programs. The state of California applied for and secured these funds and is in the process of developing and implementing new home visiting programs. In California, the implementation of this new law is administered by the Maternal Child, and Adolescent Health Program of the California Department of Public Health (CDPH, 2011).

Investigation of these programs is timely because the Affordable Care Act recently amended Title V of the Social Security Act (42 U.S.C. 701 et. seq.) and established a funding stream that allows states to fund and collect data on evidenced based HV programs.

After the law was enacted, the Department collaborated with a broad range of state departments and stakeholders to apply for the federal home visiting funds, develop a state needs assessment to assess at-risk communities, and submit a state plan for the implementation of home visiting in California, per federal law (California Department Public Health [CDPH], n.d.).

California submitted the application for federal funding in 2010 and received approval that same year (CDPH, n.d.). To complete a needs assessment, states were required to identify concentrations of at-risk communities and determine the capacity of' existing early home visiting, substance abuse, and counseling programs and services. In effort to identify communities at-risk, the state analyzed indicators aimed at determining the vulnerability of given counties. On each of these indicators, all 58 California counties were ranked to determine if the score for each county fell above or below the median statewide score (CDPH, n.d.). Indicators included poverty, domestic violence, substance abuse, and child maltreatment, among others (CDPH, n.d.). The analysis concluded that all 58 of California's counties are at risk because each of them scored below the state's median on at least two indicators of risk (CDPH, n.d.).

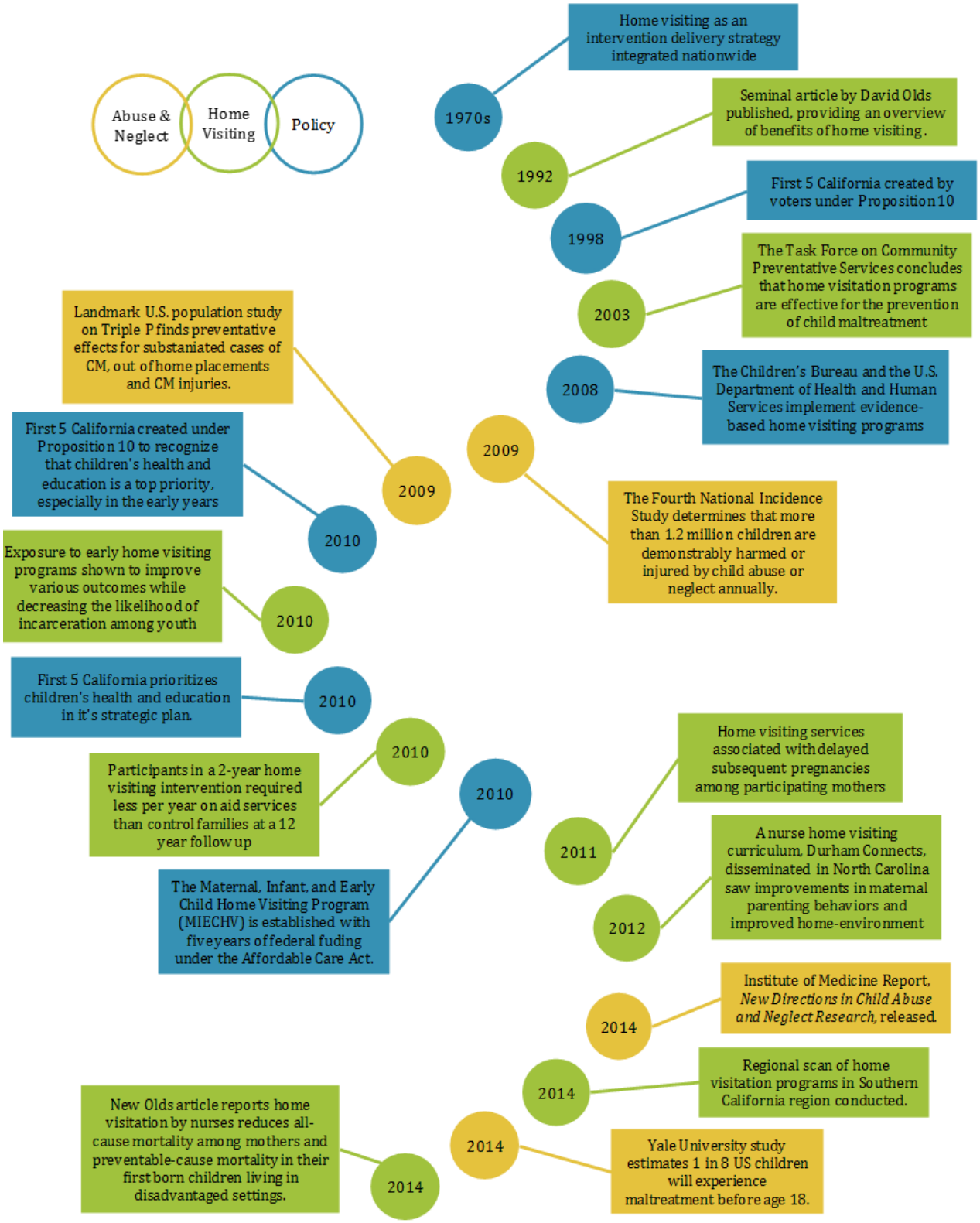
Even before the Affordable Care Act (ACA) was signed, the CDPH established a Home Visiting Collaborative Workgroup consisting of members from local Maternal, Child and Adolescent Health Directors, First 5 Association, California First 5, California Department of Social Services, California Department of Alcohol and Drug Programs, and the California Department of Education Head Start State Collaboration Office (CDPH, n.d.). This group aims to identify existing home visiting programs in the state and assist with decision-making related to home visiting programs and policies (CDPH, n.d.). Before ACA was signed, California did not have "an early childhood home visitation program or initiative," however, some of these programs were operating at a local level (CDPH, n.d.). CDPH developed and uses the Capacity Assessment Home Visiting Survey to gather information about home visiting programs. In an effort to simplify the process, "this survey focused on eight nationally recognized models which, respectively, establish their own standard of program quality" (CDPH, n.d., p.262).

California chose to fund two types of home visiting programs (Healthy Families America and the Nurse Family Partnership) in 13 select regions (CDPH, 2011). The chosen regions are specified below:

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

For the purposes of the present investigation, we examined home visiting programs in Imperial, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura Counties. In Figure 1, below, we attempt to integrate and depict a recent timeline of notable events as they relate to our knowledge of child maltreatment, developments in home visiting, and changes in policy, all of which have shaped the current landscape.

Figure 1. Timeline of recent policy changes and research relevant to home visitation and child maltreatment prevention



Evidence-Based Home Visiting Programs

The Federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Department has identified the following home visiting programs as evidenced-based interventions (CDPH, n.d.):

1. Early Intervention Program for Adolescent Mothers
2. Early Headstart
3. Family Check Up
4. Healthy Families America
5. Healthy Steps for Young Children
6. Home Instruction for Parents of Preschool Youngsters
7. Nurse Family Partnership
8. Parents as Teachers

Programs vary based on the individuals they target (e.g., adolescent mothers, low income families), staff training and background (e.g., nurses, paraprofessionals), length of service delivery, measures used, data collected, and theoretical models, among other factors (USDHHS, n.d.)

Programs vary based on the individuals they target, staff training and background, length of service delivery, measures used, data collected, and theoretical models, among other factors.

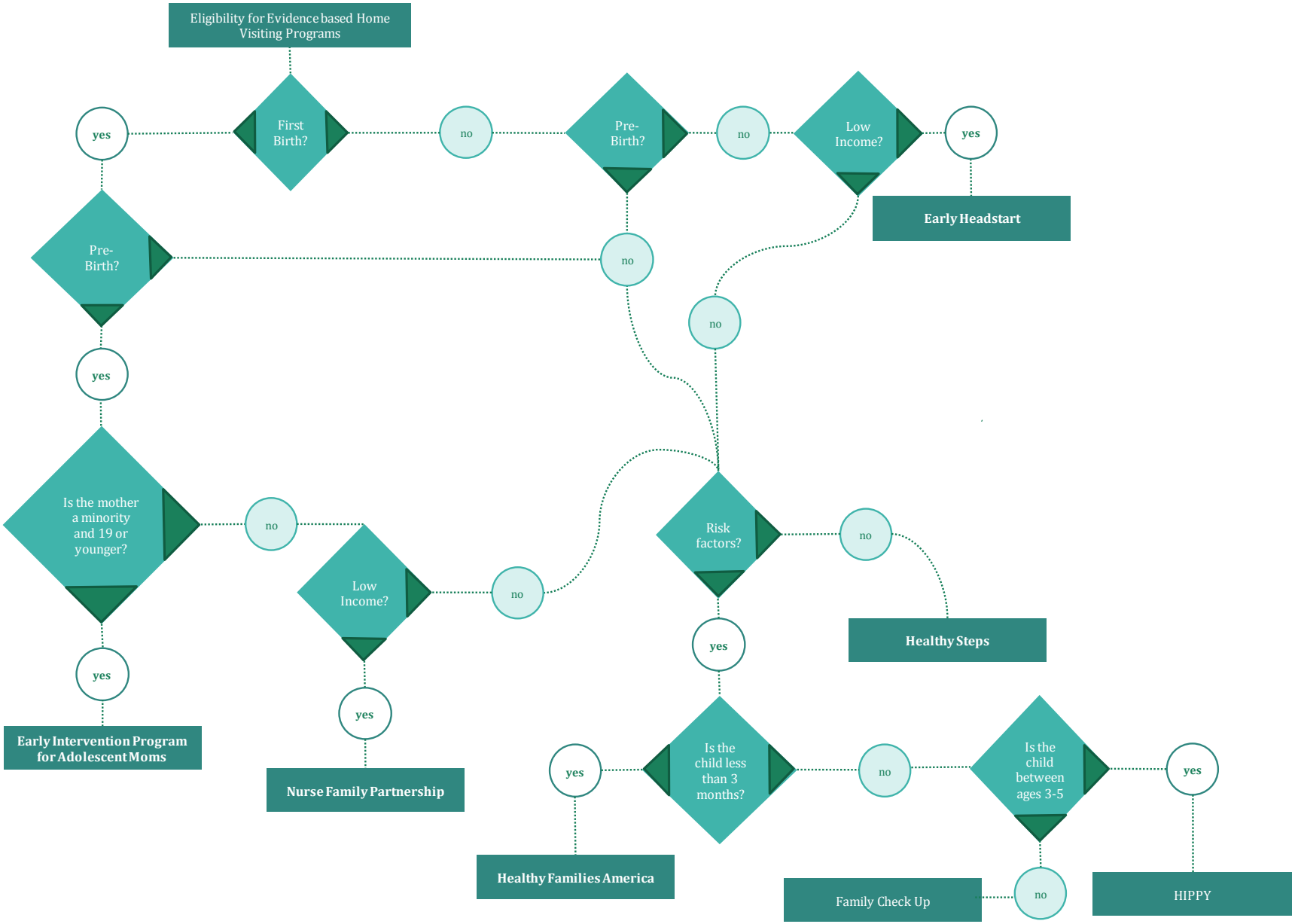
These programs have shown mixed results when it comes to the prevention of child maltreatment, however, statistically significant differences are difficult to demonstrate because there are relatively few cases of child maltreatment and there is increased surveillance of families who participate in the HV programs (Howard & Brooks-Gunn, 2009).

HOME VISITING CRITERIA

The eight programs designated as evidenced-based by MIECHV have complex eligibility criteria leading to the selection of varied populations of families with newborns and young children. To outline these variations and provide a map of client eligibility, these eight programs were selected and depicted as a flowchart.

[Parents as Teachers was excluded because this program specifies that eligibility criteria are determined by local provider affiliates. All of the evidence-based programs depicted apply only to families with children under age five. The flowchart begins at the top diamond with the question "First birth?" To move forward in the flowchart you must follow the triangles which dictate the flow of the diagram.]

Figure 2. Eligibility for Home Visiting Programs identified by MIECHV as evidenced-based



OVERVIEW

The following section provides brief summaries of the eight programs MICHEV has designated as evidenced-based. These programs have been examined by researchers and evidence suggests these programs support positive outcomes in families. The target populations and outcome of interest vary by program.

Early Intervention Program for Adolescent Mothers

This program aims to improve maternal health, birth outcomes, mother-child interactions, educational achievement, and social competence (USDHHS, 2011a). Eligible participants include pregnant women between the ages of 14 and 19 who are racial or ethnic minorities (USDHHS, 2011a). Nurse Home Visitors provide education in the home relating to, "health, sexuality and family planning, maternal role, life skills, and social support" (USDHHS, 2011a). This program was developed by researchers at UCLA and implemented in San Bernardino County (USDHHS, 2011a). Evaluation efforts showed that this program successfully reduced premature births, the incidence of low birth weight babies, and time spent in hospitals (related to birth and other reasons). Moreover, mothers in these programs were less likely to drop out of school (Koniak-Griffin, et al., 2000).

Early Head Start

Early Head Start (EHS) aims to serve low-income children from infancy to age 3 (USDHHS, 2013a) and promote prenatal health, improve child development, and strengthen family functioning (Howard & Brooks-Gunn, 2009). This intervention targets the child's "physical, social, emotional, and intellectual development" (CDPH, n.d., p.262). The long-term goal is to encourage parents to become self-sufficient (CDPH, n.d.). These goals are met by facilitating access to a set of required services such as comprehensive health and mental health services for children, and literacy and job training for adults in the family (CDPH, n.d.).

Not all EHS programs involve home visits. The home based program option includes a maximum of 12 families per week for a minimum of 1.5 hours per visit by an Early Head Start educator (a trained paraprofessional) (CDPH, n.d.). Only 8% of families participate in this option and 2% of families participate in both home visiting and center-based options (CDPH, n.d.). Home visits aim to improve parenting skills and use the home as the "child's primary learning environment" (CDPH, n.d., p.262). The program is funded by the Federal Office of Head Start, Administration for Children and Families, in the U.S. Department of Health and Human Services (CDPH, n.d.). Examinations of EHS programs have demonstrated mixed results of effectiveness. Positive changes include reduced spanking, increased immunizations, and marginal effectiveness at decreasing the use of harsh parenting techniques (Howard & Brooks-Gunn, 2009).

Family Check Up

This intervention targets families with "unskilled family management practices" (Dishion et al., 2008, p.1397) to prevent later behavior problems among children ages 2 to 17 (USDHHS, 2011b). This intervention is based upon the Ecological Approach to Family Intervention and Treatment model and targets both prevention and treatment of child and family behaviors (USDHHS, 2011b; Dishion et al., 2008). Treatment consists of three initial home visits with a trained parent consultant and annual follow-up (USDHHS, 2011b). During the first meeting, parents discuss perceptions of the child's behavior. Next, the home visitor conducts a comprehensive assessment. In the last session, the family is given feedback about strengths and areas for change (Dishion et al., 2008). These interventions strive to be motivational and work to fit the specific needs of each family (Dishion et al., 2008). Child and family risk factors include: low socioeconomic status, conduct problems, academic difficulties, depression, and risk of early drug and alcohol use (USDHHS, 2011b).

Healthy Families America

The primary goal of Healthy Families America (HFA) is to prevent child maltreatment (Howard & Brooks-Gunn, 2009). This program identifies families at risk of maltreatment early and administers services aimed at promoting permanency (CDPH, n.d.), improving parent-child interactions, and promoting the "long-term mental and physical health of parents and their children" (Healthy HFA, 2008). HFA programs target at-risk mothers or pregnant women with newborn to preschool aged children (CDPH, n.d.) and connect families to services (HFA, 2008). Families are identified in hospitals and community organizations and there are no income requirements to participate (Healthy Families America, n.d.). This program serves families with pregnant mothers or children up to age 5 (Howard & Brooks-Gunn, 2009). The program only enrolls families with children who are not in preschool (Howard & Brooks-Gunn, 2009). Additionally, families are screened to assess the level of risk (Howard & Brooks-Gunn, 2009). Agencies develop their own plans and have flexibility with the implementation of the program as long as they include "activities, indicators, and a quality assurance plan" (CDPH, n.d., p.263). Paraprofessionals are trained for approximately 5 days (80 hours) in parent education and the needs of families in the community before conducting home visits. "In California, 10 counties use the model and serve 1,007 families per year, as of 2008" (CDPH, n.d., p. 263).

The HFA program is based on the Hawaii Healthy Start project. Outcome evaluations have occurred in California, Texas, Colorado, Alaska, and New York (Howard & Brooks-Gunn, 2009). The studies conducted in California, Alaska and New York were randomized controlled studies. One study demonstrated a 48% decline in rates of child maltreatment among program participants. However, randomized control studies have not demonstrated a reduction in the rate of substantiated CPS cases. The New York investigation found no significant differences between the control group and the group that participated in HFA in terms of substantiated child maltreatment reports in one year, but did find evidence of reduced harsh parenting techniques among program participants (Howard & Brooks-Gunn, 2009).

Healthy Steps for Young Children

The Healthy Steps for Young Children program aims to facilitate stronger relationships between parents and health care professionals to promote successful child development (USDHHS, 2011c). The program model targets parents with children ages 0 to 3 and requires collaboration with a medical practice; the services are delivered by medical practitioners and a Healthy Steps Specialist (USDHHS, 2011c). The specialist conducts home visits to identify risk factors and relay information, with the goal of addressing behavioral and developmental concerns (USDHHS, 2011c). A broad range of services are offered including well-child visits with a clinician and specialist, health checkups, referrals, books, and educational materials (USDHHS, 2011c).

Home Instruction for Parents of Preschool Youngsters

Home Instruction for Parents of Preschool Youngsters (HIPPY) strives to improve school readiness and early literacy by promoting parent involvement in schools and ameliorating the negative effects of low-educational attainment, poverty, social isolation, etc. (CDPH, n.d.). Home visitors from the community (paraprofessionals) help parents become the child's primary educator and facilitate the parents' involvement with the school to improve early learning experiences for the child (USDHHS, 2013b). It is recommended that programs start with children who are 3 years old (USDHHS, 2013b). The program serves participants for one or two academic years, typically beginning before kindergarten through the end of kindergarten. Visits occur every other week throughout the 30-week school year (Gomby, 2005). Former HIPPY parents are often engaged to participate as home visitors after receiving services. The home visitors receive two days of training, weekly supervision, and ongoing training (Gomby, 2005). Evaluations show mixed results. Participants have shown improvements in school participation and cognitive development (Gomby, 2005), academic achievement, and classroom behavior (Bradley & Gilkey 2002).

Nurse Family Partnership

The Nurse-Family Partnership (NFP) curriculum promotes healthy pregnancies, empowers mothers to become successful caretakers, and encourages economic self-sufficiency (NFP, 2011). The model also aims to improve the maternal life course by increasing the length of time between birth intervals and reducing the number of later births (Howard & Brooks-Gunn, 2009). The delivery is based on a home visiting model in which a registered nurse provides ongoing services in the clients home (CDPH, n.d.). The nurse's role is to engage mothers in prenatal care, breastfeeding, improved diet, and reduce drug and alcohol use. First-time, low income mothers are eligible from pregnancy to2 -years after the birth (CDPH, n.d.). The visits begin weekly and decrease in the frequency over time (Howard & Brooks-Gunn, 2009).

In Howard and Brooks-Gunn's (2009) analysis of home visiting programs they describe the NFP as "the most well developed home visiting program in the United States" (p. 123). The program has been evaluated in different states and on samples that are ethnically diverse and include adolescent mothers (Howard & Brooks-Gunn, 2009). This program has demonstrated reductions in harsh parenting behaviors, injuries and hospital admission, and child mortality (Howard & Brooks-Gunn, 2009).

Parents as Teachers

Parents as Teachers (PAT) aims to "improve parenting skills and child school readiness, provide early detection of developmental delays and health problems, and reduce child abuse" (CDPH, n.d., p.265) through health screenings, group meetings, home visits and the provision of resource networks (CDPH, n.d.). PAT provides a minimum of 12 one-hour-long home visit sessions annually with more available to high-need families. Families are served for at least 2 years between pregnancy and the child's entry into kindergarten (USDHHS, 2013c). PAT is offered throughout 20 counties in California, serving an estimated 11,000 families each year. The program is associated with Even Start, EHS, family literacy, and family resource centers. The National PAT office is responsible for oversight and technical assistance regarding program development (CDPH, n.d.).

Methodology

To conduct a scan of HV programs in the eight Southern California Counties the Children's Data Network developed a work plan for gathering information and contacts for the distribution of the survey. Key steps are outlined below.

HOME VISITING INVENTORY

A complete regional listing of HV programs does not exist in each county for either HV programs funded by First 5 commissions or for programs funded by outside sources. Further, a list has not been developed that describes which programs fall under the definition of "newborn home visiting programs" and which do not meet the criteria.

- The research team met with the eight Southern California First 5 county commissions to provide an overview of proposed project activities and gather contact information.
- Literature regarding California's HV programs was examined and potential programs in each county were identified; First 5 websites were reviewed for information concerning HV investments.
- Informational interviews were conducted with each Executive Director (or other designated commission staff) to discuss the county's strategic plan, engagement in newborn HV, and obtain contacts for HV providers, as well as and contacts within each county's department of public health.
- The research team conducted a guided web search of HV programs and providers based on information gleaned from earlier activities. 2-1-1 websites were searched for programs that could be a potential match and each County's 2-1-1 was contacted by phone for additional information about HV programs where families are referred in the county.
- Identified agencies and county departments in Imperial, San Bernardino, Santa Barbara, Riverside, and Ventura Counties were contacted to develop a comprehensive list of programs with program manager contact information. Already compiled program and contact information existed for Los Angeles, Orange, and San Diego counties.
- As part of an introduction, researchers described the HV inventory being developed, the survey to be administered, and obtained the appropriate individual's contact information within the organization. If given the opportunity, the researcher shared the currently identified programs with the contact and asked if the agency contact was aware of any programs that had not yet been identified in the county. Contacts were attempted three times for each identified agency; one agency refused to participate but contact was made with all other agencies and appropriate contact information was obtained.

SURVEY DEVELOPMENT

After developing a comprehensive list/inventory of HV programs an online survey was developed to gather consistent information about each program using the survey software platform Qualtrics.

- Survey questions were developed based on a review of prior evaluations conducted that related to HV programs. Specifically, questions were based on data collected by the Nurse Family Partnership programs and reports developed by the Pew Project, Alameda County's 2011 investigation of home visiting programs, and the 2012 LA Best Babies Network home visiting survey, and drafted to meet the needs of this project. After drafting the report questions a draft was shared with Los Angeles County Perinatal Home Visitation Consortium. The survey was modified further based on feedback from the consortium.

- Final survey questions included general information such as the program type, funding sources, number of individuals served, and eligibility criteria. The final survey also requested details relating to the data collection and storage process, specific data elements, and measures utilized. (Please see the Appendix for a copy of the survey.)

Survey questions included program type, funding sources, number of clients/families served, eligibility criteria, as well as information about data collected.

SURVEY ADMINISTRATION

- The final survey was designed to cover information regarding one survey per program and could be repeated for multiple programs within an agency. Participants were asked to fill out the survey for each HV program. It was suggested that the agency contact share the survey link with the most appropriate person at the agency to complete the form for each program run within the agency.

- Individuals were contacted and asked to participate in the survey was told they would receive one raffle entry for completing a HV program survey. The prize for the survey was an iPad Air. Two weeks after the survey closed all names of survey participants were entered into a drawing and a winner was chosen. That individual was contacted and confirmed receipt of the iPad Air a week later.

- Survey participants in Riverside, Santa Barbara, Ventura, San Bernardino and Imperial were provided with a list of all identified HV programs in the county and asked to share any other possible HV programs that had not been identified. For example, Imperial County's respondents suggested we connect with two additional HV programs that had not been identified through our additional search. Once these new programs were identified, contact information was acquired through the survey respondent or an online search. After the appropriate contact was obtained, the survey was sent to the newly identified program.

- In Los Angeles County researchers partnered with the Los Angeles County Perinatal and Early Childhood Home Visitation Consortium to identify HV programs, administer the survey, and conduct personal follow-up to ensure a high response rate.

- First 5 Orange County and First 5 San Diego maintain a list of early/newborn home visiting programs. To draw information regarding these programs, an excel version of the survey was developed (with drop-down menus) so information for multiple programs could be entered more quickly by a single individual.

- The majority of survey participants received the survey on May 12th, 2014 and were asked to respond to the survey before the deadline of May 23rd. Survey reminder emails were sent every three days to those who had not yet responded and one reminder phone call was made to all non-respondents during the second week of the survey window.

- Identified contacts in each agency were told their agency would be eligible for entry into a raffle with all other participants and the winner of the raffle would receive an iPad. Each time a survey was completed, the program/participant was entered into the raffle. Thus, those that responded to multiple surveys for multiple programs were given the corresponding number of raffle entries.

- A decision to extend the survey deadline was made as follow-up phone calls revealed that some participants were unable to complete the survey by the May 23rd deadline, but were interested in participating if the timeline was extended. Given the deadline extension, a second phone call was made to all non-respondents after May 23rd to encourage participation. The survey was officially closed June 6th, 2014 and the CDN began to analyze and summarize the data.

SURVEY RESPONSE

A county breakdown of the number of identified providers and the number of surveys received is presented in Table 1. In Tables 2 and 3, we additionally present information examining which counties specifically reference home visiting in their current strategic plan, support home visiting with First 5 or other funds, a (rough) estimate of the number of clients/families served annually (inclusive of clients/families that may have been served by non-First 5 funded agencies), and the percentage of providers that reported receiving funding from each of six different sources.

Table 1: Survey Response Rates by County

	Survey Responses		
	Providers Targeted for Survey	Total Number of Surveys Received	Response Rate
Imperial	4	3	75%
Los Angeles	137	93	68%
Orange	7	7	100%
Riverside	12	6	50%
San Bernardino	7	6	86%
San Diego	12	7	58%
Santa Barbara	4	3	75%
Ventura	1	2	50%
TOTAL	**186**	**126**	**68%**

Note. Table 1 details the number of providers who responded to the survey and the response rate, stratified by county. The response rate was developed by dividing the number of identified providers that responded to the survey by the total number of providers identified and targeted. Agencies delivering more than one type of HV program were asked to complete one survey for each provider. It is unknown how many HV providers were not identified and therefore not surveyed. Likewise, despite attempts to confirm that non-respondents were, in fact, still engaged in the delivery of HV, it is unknown how many may have been inappropriately targeted for this survey.

Table 2: Characteristics of home visiting programs by county

County	Home Visiting Mentioned in current Strategic Plan?	First 5 Commission currently funds HV Programs?	HV Programs Independently or Dually Funded by Other Sources?	Estimated Number of Clients/Families Served Annually
Imperial	Yes	Yes	Yes	180
Los Angeles	Yes	Yes	Yes	25,674
Orange	Yes	Yes	Yes	13,917
Riverside	Yes	Yes	Yes	1,210
San Bernardino	N/A	Yes	Yes	1,648
San Diego	Yes	Yes	Yes	5,885
Santa Barbara	N/A	Yes	Yes	3,105
Ventura	Yes	No	Yes	6,000

Note. Table 2 reports data for the 8 southern California counties. Please note that San Bernardino and Santa Barbara have structured their strategic plans to be outcome based and therefore do not name specific program or intervention types. In Orange County, a structured search for HV providers was not conducted as the list maintained by the Commission was thought to be a complete inventory for the county. The reported count of families/clients served may be an underestimate because not all agencies responded to the survey. It may also be an overestimate because a client/family was served by more than one agency or because some agencies responded by reporting multiple individuals within a family (rather than the family as single client).

Table 3. HV services by funding type (providers were able to select multiple funding sources)

County	First 5 Commission funds?	County funds?	State funds?	Federal funds?	Foundation / Private funds?	Other funds?
Imperial (n=3)	67%	0%	0%	33%	33%	0%
Los Angeles (n=93)	51%	17%	12%	33%	3%	4%
Orange (n=7)	100%	29%	0%	100%	0%	100%
Riverside (n=6)	67%	17%	33%	0%	17%	0%
San Bernardino (n=6)	33%	0%	0%	67%	0%	0%
San Diego (n=7)	50%	38%	25%	25%	0%	13%
Santa Barbara (n=3)	66%	0%	66%	33%	33%	66%
Ventura (n=1)	100%	100%	0%	100%	0%	0%

Note. Table 3 depicts the percentage of HV survey respondents that indicated receiving funding from each of six different sources (First 5 Commission, county, state, foundation, or other). Respondents could report multiple funding sources. The above percentages do not reflect the share each funding source contributed to the total funding received.

DATA ANALYSIS

After the survey deadline passed, all data were downloaded from the online survey software program, Qualtrics, for the purposes of data cleaning, coding, and analysis.

- The data were organized into eight files, or one data set per county. The organization of the survey questions differed slightly for some counties. For example, targeted providers in Los Angeles County was asked questions related to the zip codes because this information was of interest to the Los Angeles Home Visiting Consortium. Also, in counties where a complete list of HV programs was not provided by the commission, the last question of the survey provided a list of all programs identified and requested information about any programs meeting the study's criteria that were not yet included.

- Orange County had a unique survey process since the commission maintained information about all HV programs in the county and one staff person was assigned to fill out the survey for all county programs. In effort to expedite this process an excel document with drop down menus was developed to increase the speed for data entry. Once this information was obtained, CDN researchers transferred the answers to Qualtrics and exported the data.

- All statistical analyses were conducted in Stata version 13. The first step of the data coding process was to de-duplicate surveys in instances where more than one staff person from a single provider completed a survey. De-duplication was required to ensure that each survey represented a unique provider/program.

- Next, the research team contacted survey participants whose responses to open-ended questions with unclear or inconsistent answers. Once the data were cleaned and accuracy was confirmed, the variables were coded and organized. We then created descriptive tabulations for the region as a whole and by county.

Each county was – not surprisingly – quite unique, therefore, findings presented in the next section are organized by county with a description of existing programs and an overview of data collected. Following this section, recommendations are provided that relate to the potential for enhanced regional coordination and evaluation of HV programs, as well as ideas and opportunities for future cost-effective data evaluations based on linked information.

County Home Visiting Profiles

Each county is introduced with a description of the sociodemographic characteristics of children born in each area to provide a sense of the population served by HV programs. We examined state birth characteristics and linked those data to CPS records to better understand the characteristics of high risk children in the Southern California Region.

Prior research suggests that characteristics at birth are strongly correlated with later risk of child maltreatment and CPS child involvement (Putnam-Hornstein & Needell, 2011; Wu et. al., 2004). In most jurisdictions, however, it is unknown whether the newborns with the highest concentration of risk factors are identified, referred, or successfully engaged in home visiting or other early intervention services.

ORGANIZATION OF COUNTY DATA

Each county profile is organized in a consistent fashion and contains information specific to home visiting providers in that county. A brief overview of sections within each county profile is provided below:

- *Overview*

  A recent CDN project (funded by First 5 LA) led to the linkage of birth records for all children born in California in 2006 and 2007 to statewide child protection records through each child's fifth birthday. These linked records were then analyzed by county of birth, allowing the characterization of children at birth and the generation of longitudinal, cumulative estimates of CPS involvement throughout the first 5 years of life. Based on these data, we have presented county profiles of "100 births" as a means of characterizing the population of children born and who might be served by home visiting programs.

- *Response Rate*

  The response rate was calculated by dividing the number of unduplicated providers who responded to the survey by the total number of providers identified and targeted for the survey.

- *Goals and Strategies*

  Summaries of county goals and strategies were based on interviews with executive directors and key commission staff, online searches for information on county commission websites, and a review of the current strategic plan. Strategic plans were also reviewed to examine whether the plan explicitly mentioned home visiting as a strategy.

- *Description of County and Commission Programs*

  Based on informational interviews and a review of other materials, a description of First 5-and non-First 5 funded HV programs was developed. This included information related to data collection.

- *Table of Data Elements*

  Finally, each county profile includes a table depicting the collection of data elements. For each element, we report the number or percentage of providers currently collecting those data in that county. For counties with fewer than 4 HV providers, we list all providers and detail a provider-specific checklist. For counties with 4 or more providers, we instead report the percentage of providers in the county that reported collecting a given data element/domain. Additional information concerning these data elements is provided below. Actual survey questions can be found in the Appendix.

- *Personal Information.* Providers were asked whether they collect individual and family level identifiers and sociodemographic data such as the names, dates of birth, address, social security number, and race/ethnicity.

- *Health.* This section included a series of questions about whether or not specific health-related data were collected. Health data domains included prenatal care, drug/alcohol use, birth intervals, breastfeeding practices, maternal depression, and child immunizations.

- *Child Injury.* Providers were surveyed as to whether they collect data that would assess a range of indicators of child injury and maltreatment, including whether children had emergency room visits, Child Protective Services (CPS) reports, an open CPS case, had been placed in foster care, or whether the parent self-reported maltreating the child.

- *Domestic Violence.* Questions were asked about data collection practices for a variety of ways to assess domestic violence (DV) such as the use of DV screening tools, referrals to DV services, arrests in the family as a result of DV, or any self-reports of DV.

- *Child Development.* This section of the survey asked a range of questions about data collection practices related to the assessment of a child's development. Questions included data elements specific to the level of parental knowledge of children's developmental milestones, enrollment in an early childhood program, and the child's communication, language, cognitive, and social skills.

- *Life Course Measures.* To assess data collection practices related to life course measures, providers were asked whether information regarding parental education, family income, and receipt of public assistance were collected.

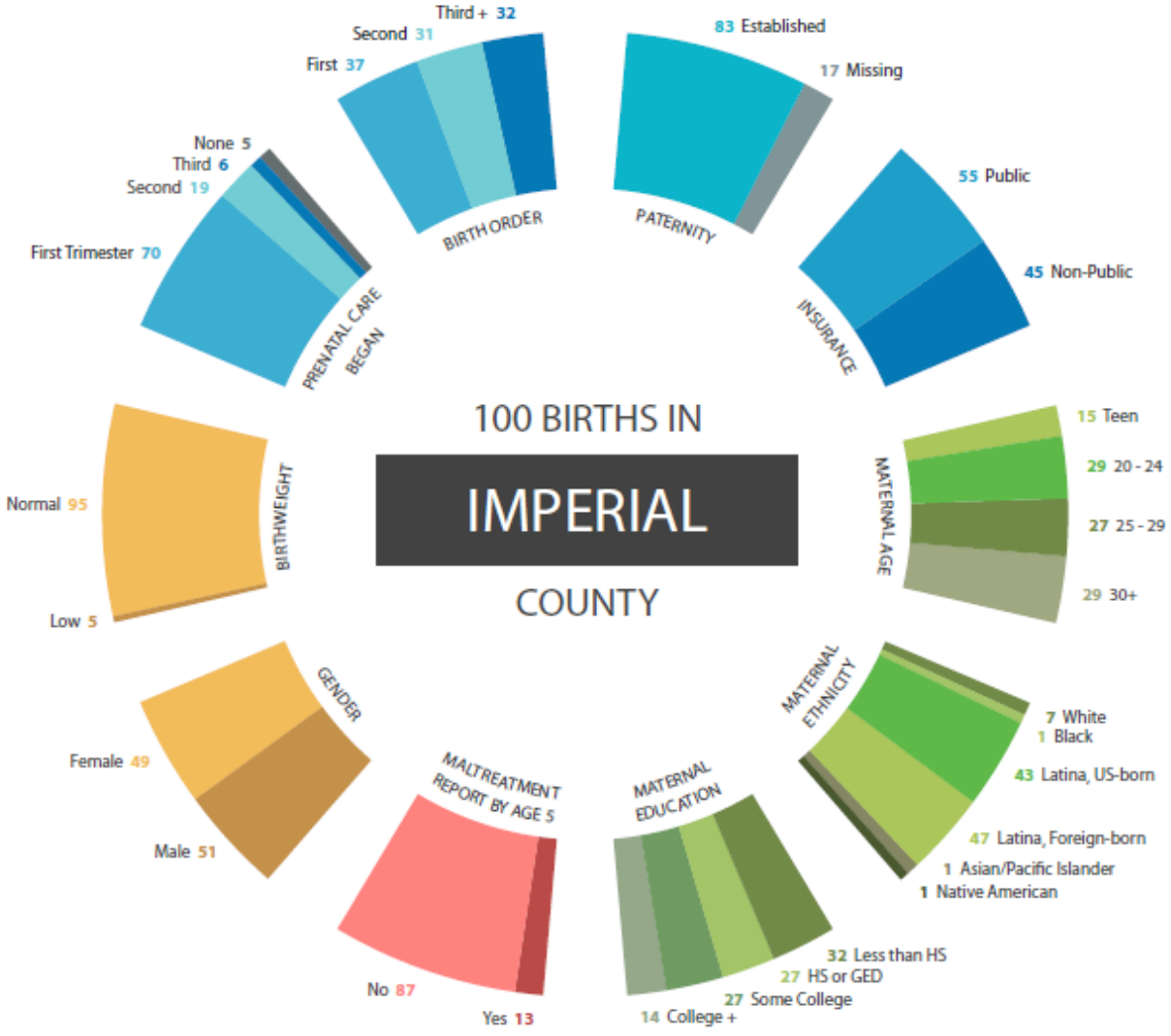
- *Data.* In the portion of the survey related to data collection, questions were asked as to whether or not providers were required submit data funders or umbrella program offices. Additional questions were asked to determine if submitted data were client/case level or aggregated. Other questions included whether there had been recent provider/program evaluations and whether there were any ongoing partnerships for data linkage.

IMPERIAL COUNTY

Overview

In 2006 and 2007, 6,205 children were born in Imperial County. Although prenatal care began during the first trimester for a majority of children, 1,846 children (29.7%) were born to mothers who received prenatal care that started late or not at all. A plurality of children (91.3%) were born to Latina mothers (43.2% - US born / 48.1% - foreign born). A total of 14.7% of children were born to teen mothers. **Among children born in the county, 817 were reported to CPS for alleged child abuse or neglect before the age of 5, representing 13.2% of children in the birth cohort.**

Figure 3. A profile of 100 births in Imperial County, 2006 & 2007



Response Rate

In Imperial County, surveys were sent to:

1. Imperial County Office of Education
2. Imperial County Children and Families First Commission
3. Imperial Valley Regional Occupational Program
4. Imperial County Home Visiting Program

All agencies responded except the County Office of Education, translating into a 75% response rate.

Imperial County's Goals and Strategies

Imperial County First 5 has a strategic plan that is revised annually and was last approved in January 2013. The county's vision is for children to "thrive in supportive, nurturing and loving environments, enter school healthy and ready to learn, and become productive, well-adjusted members of society." The commission has identified three primary goals that are intended to address and support positive child development:

- Promote parenting and caregiver education services to enhance optimal child development and to encourage healthy, stable and economically independent families.
- Improve the development and school readiness of young children from birth through age five.
- Develop multi-disciplinary interventions and treatment services to enhance the medical, emotional, physical and mental well-being of young children.

The strategic plan targets child development, behavioral, and health issues based on the goals listed above. Based on this plan, the commission aims to enhance services that will meet these goals including: parent education, provision of basic family needs, family literacy services, and other family functioning services. The county measures results in priority areas by examining changes in the number of parents involved in family literacy activities, proportion of all pregnant women who receive prenatal care early and breastfeed, the amount of children who are overweight, and proportion of children who are cared for in a culturally appropriate, safe, healthy and nurturing environment, among others.

Home Visitation in Strategic Plan

The county aims to support children in out-of-home care or at-risk of separation from parents by using home visitation strategies. The strategic plan states "support services could include intensive parenting for families, comprehensive home visitation programs, or direct advocacy for the child" (p.10). As noted in the plan, Imperial hopes to develop programs that support home visitation and parent involvement as well as increase the number of home visitations completed by early care and education teachers.

Imperial County Programs

Non-HV Programs Funded by First 5

First 5 funding goes to several child and family programs as described below.

- The Child Asthma Project offers asthma and case management services for children from infancy to age 5 and family support through home visits. The Project also addresses nutrition and physical education as it relates to asthma risk.

- The Child Signature Program assists preschool agencies with the completion of Readiness Assessments trainings for preschool teachers using the Early Education Effectiveness Exchange

- The Family Treehouse aims to increase the number of developmental screenings among children ages younger than age 5 countywide.

- The Healthy Children/Healthy Lives Project offers services promoting healthy eating and healthy lifestyles among children and families to prevent obesity.

- The School Readiness Program coordinates Family Resource Fairs and Summer Kinder Transitional Programs to engage families, community members and educators in preparing children, younger than 5, for kindergarten. Programs within this program includes the following projects and initiatives:

    - Children Ready for Kinder Project, which supports children entering kindergarten, particularly those who have no preschool experience.

    - Family Health and Community Resource Fairs aim to narrow the gap between schools and parents and offers local agencies' resources and information to families.

    - The Home Visitation Project connects parents with a social worker who assists with readiness activities and materials to support the development of children. This program targets school readiness issues, therefore it does not fall within the home visiting definition used for the purpose of the present investigation.

    - Early developmental screening services are conducted by the school readiness social worker.

HV Programs Funded by First 5

First 5 Imperial funds two HV programs, both which are HIPPY programs. These programs also receive additional funding from other sources.

- **The Imperial Valley Regional Occupational Program's HIPPY Program (VROP).** This program serves approximately 90 children between 3 and 4 years of age each year who are not attending preschool. HIPPY paraprofessionals provide home visits to parents who meet income criteria and stay-at-home parent.

    - Data Collection. The VROP HIPPY program submits paper and aggregated electronic data quarterly using First 5's electronic platform. Data submitted include the child and mother's names, dates of birth, addresses, and race/ethnicity. Additional data include child immunizations, comprehensive developmental measures (e.g. the child's cognitive skills, communication, physical health) and life course measures (the parent's education, income, and use of public assistance). Currently, there are no efforts to link these program data to other data sources.

- **Imperial County Children and Families First Commission's HIPPY Program (CFFC).** This program serves 10 families each year via three or four visits lasting two hours. Children must be younger than 5 years old. Services are provided by individuals with Bachelor's in Social Work.

    - Data Collection. Imperial County Children and Families First Commission's HIPPY program collects paper and electronic records of client information and progress including identifying information for the mother and child (e.g., names, dates of birth), measures of prenatal care, and

comprehensive developmental and life course measures. The agency is required to submit aggregated data to First 5. The survey respondent reported that there are current efforts being made to link program data to other information from programs and agencies.

HV Programs Funded by Outside Sources

In addition to HV programs funded by First 5, partners at the Imperial County Public Health Department runs the Imperial County Home Visiting Program.

- **Imperial County Home Visiting Program (HVP).** This program is based on the HFA Model and provides weekly home visits to pregnant mothers, 30 years old or younger, and to families with a first born child who is a newborn (younger than 2 weeks old). Regular home visits are provided by family Support Workers for the first 6 months and ongoing support through age 5. This program is funded with federal dollars and serves 80 families a year. ICHPV utilizes the Kempe assessment for families to determine program service delivery.
  - Data Collection. Data for the ICHVP program are collected via paper case records and entered electronically into the data base, called Efforts to Outcomes, as required by HFA. Data collected include the Infant's, Mother's and Father's names, dates of birth, addresses, and race/ethnicity. Comprehensive maternal newborn and health measures are collected such as prenatal care, use of alcohol/drugs, and child immunizations, among others. To assess child injuries and maltreatment, data are collected regarding emergency room visits and CPS reports. Domestic violence measures include screenings and referrals. Comprehensive developmental measures and life course measures are also gathered. ICHVP is required to submit case-level and aggregated statistics to the funder; however, there are no current efforts to link program data to other agencies or departments.

Table 4. Summary of data elements collected by surveyed HV providers in Imperial County

	CFFC	HVP	VROC
Personal Information			
Child Name	X	X	X
Mother's Name	X	X	X
Father's Name	X	--	X
Child's DOB	X	X	X
Mother's DOB	--	X	X
Father's DOB	X	X	X
Child's SSN	--	--	--
Mother's SSN	--	--	--
Father's SSN	--	--	--
Child's Address	X	X	X
Mother's Address	X	X	X
Father's Address	--	X	--
Child's Race	X	X	X
Mother's Race	X	X	X

	CFFC	HVP	VROC
Father's Race	--	X	--
Health			
Prenatal Care	X	X	--
Parental Drug/Alcohol Use	--	X	--
Birth Intervals	--	X	--
Breastfeeding	--	X	--
Maternal Depression	--	X	--
Maternal and Child Health Insurance	--	X	--
Child Immunizations	--	X	X
Chronic Health Issues	--	X	--
Well Child Visits	--	X	--
Child Injury			
Child Emergency Room Visits	--	X	--
CPS Reports	--	X	--
Open CPS Case	--	--	--
Child Placed in Foster Care	--	--	--
Self-Report of Maltreatment	--	--	--
Domestic Violence			
DV Screening	--	X	--
DV Service Referral	--	X	--
DV Arrest	--	--	--
DV Self-Report	--	--	--
Child Development			
Parental Knowledge	X	X	X
Communication and Language	X	X	X
Cognitive Skills	X	X	X
Social & Emotional Behavior	X	X	X
Physical Health & Development	--	X	X
Enrollment in Early Childhood Program	--	--	X
Life Course Measures			
Basic Life Resource Needs	X	X	--
Parent Education	X	X	X
Family Income	X	X	X
Receipt of Public Assistance	--	X	X

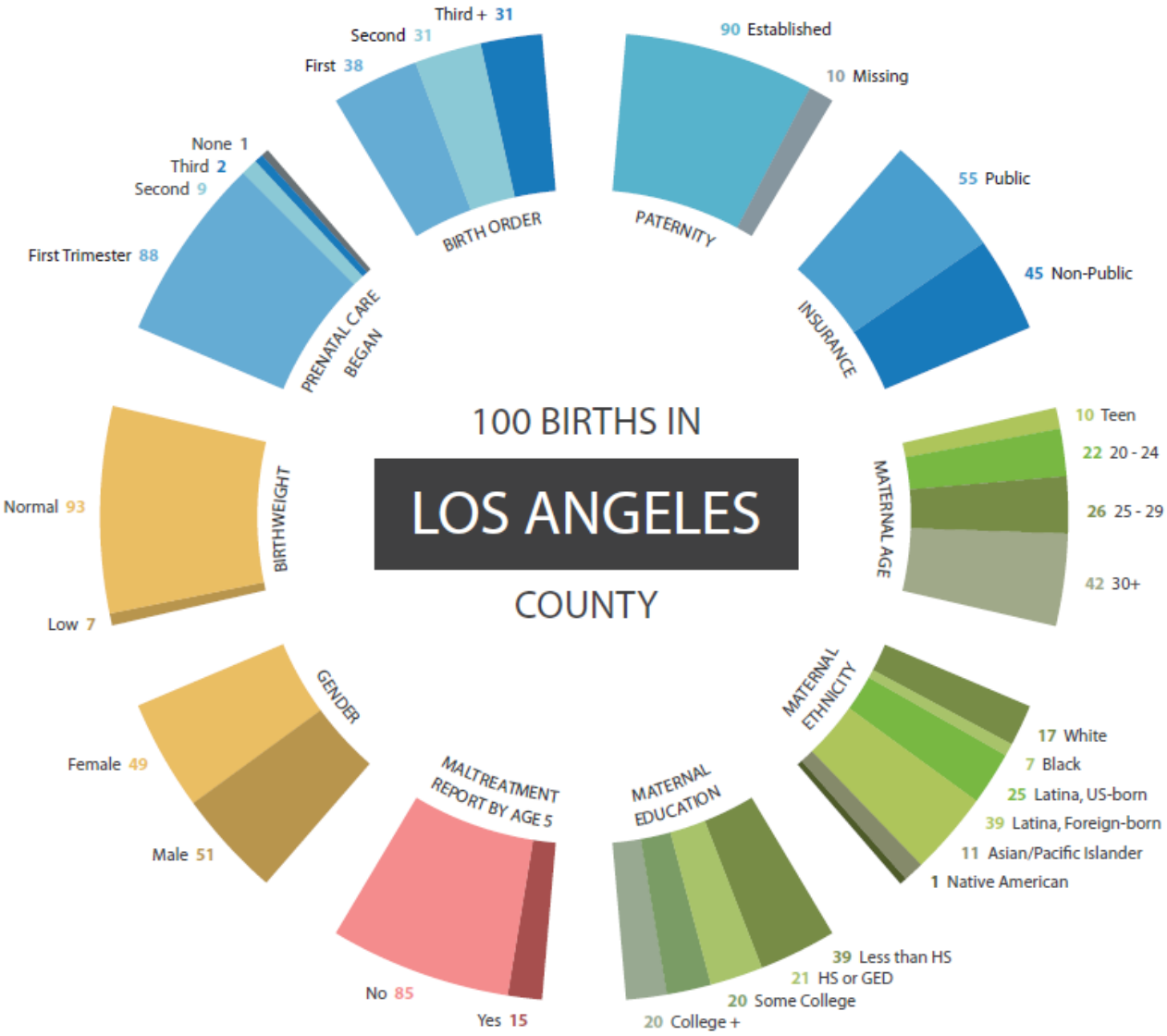
	CFFC	HVP	VROC
Data			
Required to Submit Data to Funder/Program	X	X	X
Case Level (required for submission)	--	X	--
Aggregated (required for submission)	X	X	X
Program Evaluation last 5 yrs	missing data		
Partnerships for Data Linkage	X	--	--

LOS ANGELES COUNTY

Overview

In 2006 and 2007, 310,700 children were born in Los Angeles County. Although prenatal care began during the first trimester for a majority of children, 36,609 children (11.9%) were born to mothers who received prenatal care that started late or not at all. A plurality of children (63.8%) were born to Latina mothers (24.7% - US born / 39.1% – foreign born). A total of 9.9% of children were born to teen mothers. **Among children born in the county, 45,297 children were reported to CPS for alleged child abuse or neglect before the age of 5, representing 14.6% of children in the birth cohort.**

Figure 4. A profile of 100 births in Los Angeles County, 2006 & 2007



Response Rate

The response rate for HV programs in LA County was 68%. Of the 107 programs identified, 93 surveys on programs were completed. The CDN partnered with the Los Angeles County Perinatal and Early Childhood Home Visitation Consortium to develop the survey, identify HV programs, administer the survey, and conduct follow-up. Please see the Appendix for full list of programs.

Los Angeles County's Goals and Strategies

First 5 LA's strategic plan was last approved in June 2009 and will next be revised for approval in November 2014. First 5 LA's vision reflects a commitment "to creating a future throughout Los Angeles' diverse communities where all young children are born healthy and raised in a loving and nurturing environment so that they grow up healthy, are eager to learn and reach their full potential." The mission is to "work to make significant and measurable progress towards this vision by increasing the number of children from prenatal through age five who are physically and emotionally healthy, safe and ready to learn."

This vision is concretized through a focus on four specific goals that are measured to assess need and progress. First, the commission aims to ensure babies are born healthy. Second, First 5 LA seeks to help children maintain a healthy weight. The third goal is to keep children safe from abuse and neglect. Fourth, the commission aims to promote school readiness and ensure children are prepared for kindergarten.

Current strategies aimed at achieving these goals include family strengthening, community capacity building, other direct services, organizational support and systems improvement. A key part of achieving the vision is encouraging all grantees to move toward a program model that can be sustained independent of First 5 LA funding. Sustainment is encouraged by building the capacity of organizations and the community through technical assistance, leadership development, empowerment strategies, and skill development. Encouraging resource mobilization (i.e., improved leveraging of funding and other resources) is another key strategy to advance sustainability.

Home Visitation in Strategic Plan

The First 5 LA Commission describes HV programs as a strategy to strengthen families. Specifically, the strategic plan states that HV as a program model provides a "nationally proven intervention for properly designed home visitation programs to have strong positive impact on many child, health, safety and family functioning outcomes." The commission's support for these programs is evidenced by the large proportion of current HV programs in the county (51%) that receive some funding from First 5 LA.

Los Angeles County's Programs

First 5 LA plays an active role in coordinating the delivery of services to pregnant women and parents with infants and young children. Currently, the Welcome Baby Program provide the foundation for supports and activities delivered prenatally and shortly after birth, including referral to Select Home Visitation, which features intensive home visiting services provided until the child is 5 years old for eligible families.

Welcome Baby (WB)

The WB program offers hospital and home-based services for pregnant women and mothers who have just given birth. The main goal of WB is to work with families to enhance the parent-child relationship and the health, safety and security of the baby, and to make it easier for families to access support services when needed. WB includes up to three prenatal engagement points, a hospital assessment at the time of the child's birth, followed by up to five post-partum engagements. California Hospital Medical Center, in partnership with Maternal Child Health Access, began implementing a pilot of WB (in the Metro LA region) in 2009. First

5 LA has expanded WB to include strategic partnerships with 13 additional birthing hospitals. As of June 2013 all 13 hospitals are in implementation and providing services. All participating hospitals deliver a portion of births for families residing within one of 14 Best Start Communities, a First 5 LA initiative that supports and enhances community-based efforts to support families with children between infancy and age 5 in neighborhoods with a concentration of risk factors. Families identified as being at risk of poorer outcomes and residing within a Best Start Community through a risk assessment are eligible to be referred to higher intensity home visiting services as warranted.

Select Home Visitation (SHV)

The First 5 LA approved the Select Home Visitation programs, which are national evidence-based programs, to provide additional support to families in Best Start Communities that would benefit the most from more frequent home visits and supportive services. Twenty-one grantees, consisting of local community-based agencies, began contracts to implement the following HV programs: Healthy Families America, Parents as Teachers, and Triple P (Positive Parenting Practices). Services to clients began in July 2014.

Los Angeles County's Data Collection

To support the compilation of data across the vast network of home visiting programs in the county, First 5 LA is developing two critical data systems: (1) the Stronger Families Database and (2) the LA County Home Visiting Data Warehouse. The Stronger Families Database provides a platform for collecting data for the Welcome Baby and Select Home Visitation programs and is currently in its first year of implementation. The Data Warehouse will compile data from Welcome Baby and the Select Home Visitation programs funded by First 5 LA, in addition to LA home visiting programs operating via other funding sources. Home visitation providers with existing data collection systems will have the option of either transitioning over to the Data Warehouse system to support their data collection and reporting needs, or they can continue to use their existing data system and have their data imported into the Data Warehouse to support Countywide reporting. (For example, Nurse Family Partnership is required to use the Efforts to Outcomes (ETO) data system, so First 5 LA would establish protocols for the regular transmission of data from ETO into the Data Warehouse.)

Based on data assembled through the SCALAR / LA Home Visitation Consortium survey, 75% of agencies administering home visitation programs in Los Angeles County collect data electronically. Data systems include Child Plus, Efforts to Outcomes (ETO), Stronger Families, and Welligent, among others. Among programs collecting data electronically, more than 90% reported collecting identifying information (which could be used to support data linkages) and a majority of programs collect data related to health, child maltreatment, domestic violence, child development, and life course measures. Survey results further indicate that approximately 82% of responding HV programs are currently required to submit data to their funders. As such, First 5 LA is preparing to implement a platform for systematically standardizing the data that are collected across programs, using that information for tracking countywide service slots relative to need, and ultimately integrating these data with other data sources to better understand the impact of program participation on children's outcomes.

Table 5. Summary of data elements collected by surveyed HV providers in Los Angeles County

	Los Angeles County Providers
Personal Information	(n=93)
Child Name	81%
Mother's Name	83%
Father's Name	75%

	Los Angeles County Providers
Child's DOB	83%
Mother's DOB	71%
Father's DOB	61%
Child's SSN	20%
Mother's SSN	19%
Father's SSN	15%
Child's Address	81%
Mother's Address	84%
Father's Address	71%
Child's Race	79%
Mother's Race	79%
Father's Race	69%
Health	
Prenatal Care	74%
Parental Drug/Alcohol Use	73%
Birth Intervals	53%
Breastfeeding	75%
Maternal Depression	69%
Maternal and Child Health Insurance	69%
Child Immunizations	76%
Chronic Health Issues	67%
Well Child Visits	70%
Child Injury	
Child Emergency Room Visits	52%
CPS Reports	61%
Open CPS Case	56%
Placed in Foster Care	48%
Self-Report of Maltreatment	53%
Domestic Violence	
DV Screening	46%
DV Service Referral	70%
DV Arrest	54%
DV Self-Report	20%
Child Development	

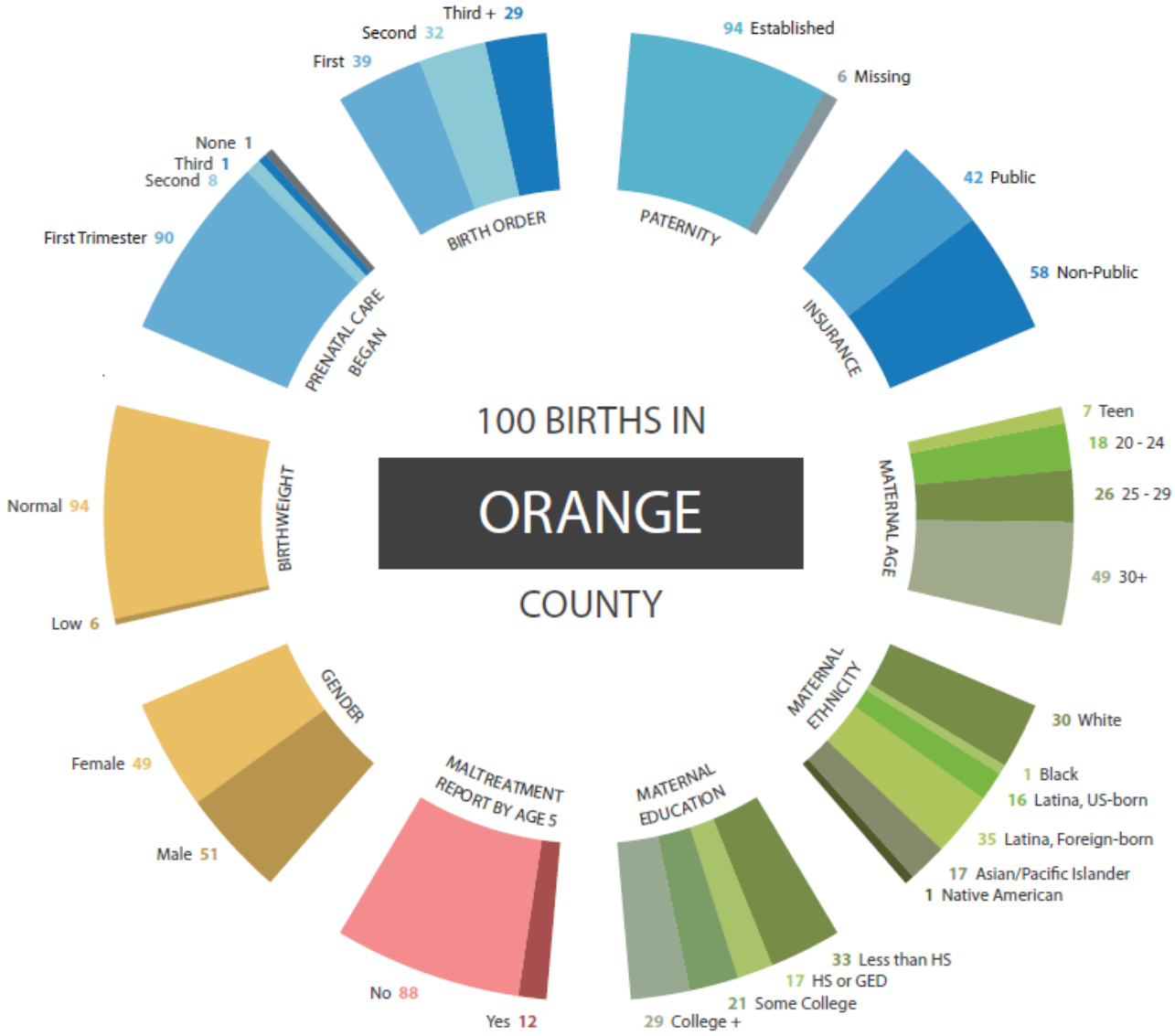
	Los Angeles County Providers
Parental Knowledge	79%
Communication and Language	71%
Cognitive Skills	71%
Social & Emotional Behavior	71%
Physical Health & Development	73%
Enrollment in Early Childhood Program	53%
Life Course Measures	
Basic Life Resource Needs	81%
Parent Education	75%
Family Income	72%
Receipt of Public Assistance	65%
Data	
Required to Submit Data to Funder/Program	82%
Case Level (required for submission)	40%
Aggregated (required for submission)	54%
Data Evaluation Last 5 Years	39%
Partnerships for Data Linkage	37%

ORANGE COUNTY

Overview

In 2006 and 2007, 93,963 children were born in Orange County. Although prenatal care began during the first trimester for a majority of children, 9,656 children (10.2%) were born to mothers who received prenatal care that started late or not at all. A plurality of children (51.6%) were born to mothers of Latina race/ethnicity (15.9% - US born / 35.7% - foreign born). A total of 7.0% of children were born to teen mothers. **Among children born in the county, 10,834 children were reported to CPS for alleged child abuse or neglect before the age of 5, representing 11.5% of children in the birth cohort.**

Figure 5. A profile of 100 births in Orange County, 2006 & 2007



Response Rate

The Children and Families Commission of Orange County (OCCFC) maintains a comprehensive listing of agencies delivering early home visitation programs that it funds. To compile information regarding these programs, an excel document was developed based on data elements included in the survey administered in other counties. This approach provided a means of more efficiently entering information about multiple programs by a single individual. This process also ensured that all programs were identified and included in this project. As a result, 14 agencies were identified and responded, and OCCFC completed surveys for each program, resulting in a 100% response rate.

Orange County's Goals and Strategies

Orange County's current strategic plan was developed in July 2006 and is reviewed annually. The last review was completed in April 2014. OCCFC envisions ensuring that, "All children are healthy and ready to learn"; its mission is to "Provide leadership as a funder, convener, and planner to support healthy development and learning for Orange County's young children." Primary goals related to achieving this vision, and in pursuit of this mission, are to:

1. Promote the overall physical, social, emotional and intellectual health of young children.
2. Provide early learning opportunities for young children to maximize their potential to succeed in school.
3. Support and strengthen families to promote good parenting for the optimal development of young children.
4. Promote an effective and quality delivery system for young children and their families.

Home Visitation in Strategic Plan

A discussion of home visiting programs are included within the Commission's first goal for healthy child outcomes. The County's Bridges Maternal Child Health Network (MCHN) is a comprehensive strategy for coordinating services to promote children's outcomes and conducts screening and referrals for HV programs. The main purpose of the MCHN is to work with families to enhance parent–child relationships and the health, safety, and security of infants, and to make it easier for families to access support services when needed. A unique feature of the MCHN program is a reliance on an automated, universal pre-screening tool that aims to identify newborns at greatest risk of later adversities. Based on this pre-screening, bed-side clinical assessments (based on the Bridges Screening Tool) are conducted with identified families of at-risk newborns so that a more complete understanding of the family strengths and needs can be developed. This assessment is then used to refer families to the appropriate level of voluntary, community-based services, including home visitation. The Bridges Screening Tool has been validated and used by the MCHN for more than a decade.

OCCFC's strategic plan underscores the importance of ongoing evaluations, measurement efforts, and continuous quality improvement, both in the context of home visiting and other programs. The commission measures outcomes using aggregated data capturing the number of individuals served by OCCFC-funded programs, grantee milestones to document accomplishments of individual programs, core data elements to assess client feedback through questionnaires, and project level questions to ensure service are linked to commission goals.

Orange County's Programs

OCCFC supports programs ranging from developmental screenings, to early learning programs, to broad health initiatives, to catalytic programs that address emerging community needs.

Non-HV Programs Funded by First 5

OCCFC funds both school district and countywide early learning programs. School district based Early Learning Specialists aim to facilitate the transition into kindergarten by promoting best practices for early care, training parents to promote school readiness, encouraging collaboration among community residents, and coordinating the distribution of resource information. The Countywide Early Learning Programs aim to improve the school readiness by targeting "early literacy and math, special needs services, speech and language training, and health and safety support to early care providers." Programs that screen young children for developmental and behavioral issues and link them to services are funded to increase early intervention and improve long term child outcomes. Homeless prevention programs provide families most at risk with the support they need in crisis, such as shelter beds for pregnant mothers and young children.

HV Programs Funded by First 5

As described above, OCCFC funds the Bridges MCHN, a program that aims to improve access to medical care, health services, and child development for all prenatal women and their babies. The program links mothers and babies to home visiting and early intervention services, when appropriate. ***Orange County is somewhat unique among Southern California counties in that all of the identified HV programs receive funding from OCCFC.***

This funding connection between HV programs and OCCFC has facilitated not only the uniform utilization of a single screening tools as a means of triaging newborns into home visiting service interventions (the Bridges for Newborns assessment tool), has also supported the standard utilization of a single system for ongoing data collection (the Bridges Connect Database), and has provided a centralized program management to build strategic partnerships to ensure responsive services for families to support strong maternal child health outcomes.

The OCCFC-funded Bridges MCHN includes several core components and home visitation strategies to address the diverse needs of families:

- **Early Outreach and Referral Services**. Ten high birthing hospitals in Orange County "greet" babies when they are born and link children and their families with needed support to ensure optimal, healthy development. Participating hospitals include: (1) Anaheim Regional MC, (2) Coastal Communities Hospital, (3) Fountain Valley Hospital and MC, (4) Garden Grove Hospital and MC, (5) Hoag Presbyterian Intercommunity, (6) Mission Hospital, (7) St. Joseph Hospital, (8) St. Jude Hospital, (9) Western MC Anaheim and (10) Western MC Santa Ana. Funding is also leveraged through donations, in-kind provider support of the program, and participation in Medi-Cal Administrative Activities program. Last year 11,886 families received web-based and bedside screening to assess risk. Referrals are made to community providers for home visitation services, based on the level of family need. Enrollment is available prenatally and for new moms and services are provided by a paraprofessional.

- **Orange County Health Care Agency**. This agency implements four home visitation programs that are funded by the Commission and received Targeted Case Management reimbursements. Public Health Nurses deliver services. The Nurse Family Partnership Program serves first time young pregnant women. 152 families were served in 2013-2014. Families are referred by clinics, schools, and health care agencies. The organization also runs a Perinatal Substance Abuse Services Initiative and Assessment and Coordination Team (ACT) with the same funding. The program served 461 families last year and eligibility was based on the child's age index (less than 12 months), with prenatal enrollment preferred. The Medically High Risk Newborn program provides in-home services to

medically fragile infants. Last year 82 families were served. Referrals are typically made through the NICU and health care providers. Eligibility is restricted to families with infants who meet medical eligibility criteria. The Public Health Nursing Access and Promotion Services project targets special populations of young children and their families including a focus on children living in motels, children in foster care, teen moms, children of mothers in jail, and other special populations. As many as 75 families are served through this program per year.

- **Maternal Outreach and Management Services (MOMS) of Orange County**. This agency runs *Paso a Paso*. This program utilizes OCCFC funding and Medicaid Targeted Case Management reimbursements to serve about 1,000 families a year. This program also targets pregnant women and services are delivered by nurse supervised paraprofessionals.

- **Children's Bureau & Orange County Child Abuse Prevention Center**. These organizations implement two HV programs funded by the OCCFC and Medicaid Targeted Case Management reimbursements, one program is for families with toddlers and one for families with infants. The program for toddlers implements the Triple P program. Last year the infant program served 1,483 families and Triple P served 770 families. Eligibility for both is based on age (infant services up to 18months; toddler services up to 5 years) and services are delivered by a paraprofessional.

Orange County's Data Collection

In Orange County, data from the MCHN are collected through the Bridges Connect Database. This database is a web-based referral and case management system used by the 10 participating hospitals and other network partners. This Database includes patients' prescreen risk scores, Bridges Network hospital screening data, electronic referrals, case management information, reports, and invoicing capability for Medicaid Targeted Case Management. The Bridges Connect Database allows all HV programs in Orange County to collect a wide range of data including the family's identifying information, complete maternal and newborn health measures, child maltreatment, domestic violence, developmental data and life course measures.

- All programs collect client level data.

- Appropriate to their scope and work with clients, Early Outreach and Referral collects fewer maternal and prenatal care measures, only one child maltreatment measure, and developmental data are not collected. Children participate in this component of the program only during the hospital stay when they are born, and receive a Bridges screening tool assessment.

- Other than with the OCCFC's data reporting system that was implemented across all funded programs and integrates data for clients served by those programs, none of the programs are currently linking data to other sources in any systematic fashion. The CDN has conducted a pilot data linkage project and was able to successfully match more than 90% of Bridges Connect newborn screening records to a birth record.

- The Nurse Family Partnership and MOMS have had formal evaluations during the past 5 years. In addition, programs used a validated curriculum, including the Triple P program.

Table 6. Summary of data elements collected by surveyed HV providers in Orange County

	Orange County HV Providers
Personal Information	*(n=14)*
Child Name	100%
Mother's Name	100%
Father's Name	100%
Child's DOB	100%
Mother's DOB	100%
Father's DOB	100%
Child's SSN	0%
Mother's SSN	0%
Father's SSN	0%
Child's Address	100%
Mother's Address	100%
Father's Address	100%
Child's Race	100%
Mother's Race	100%
Father's Race	100%
Health	
Prenatal Care	86%
Parental Drug/Alcohol Use	86%
Birth Intervals	21%
Breastfeeding	93%
Maternal Depression	93%
Child Immunizations	29%
Chronic Health Issues	29%
Well Child Visits	29%
Child Injury	
Child Emergency Room Visits	29%
CPS Reports	100%
Open CPS Case	21%
Child Placed in Foster Care	14%
Self-Report of Maltreatment	29%
Domestic Violence	
DV Screening	100%

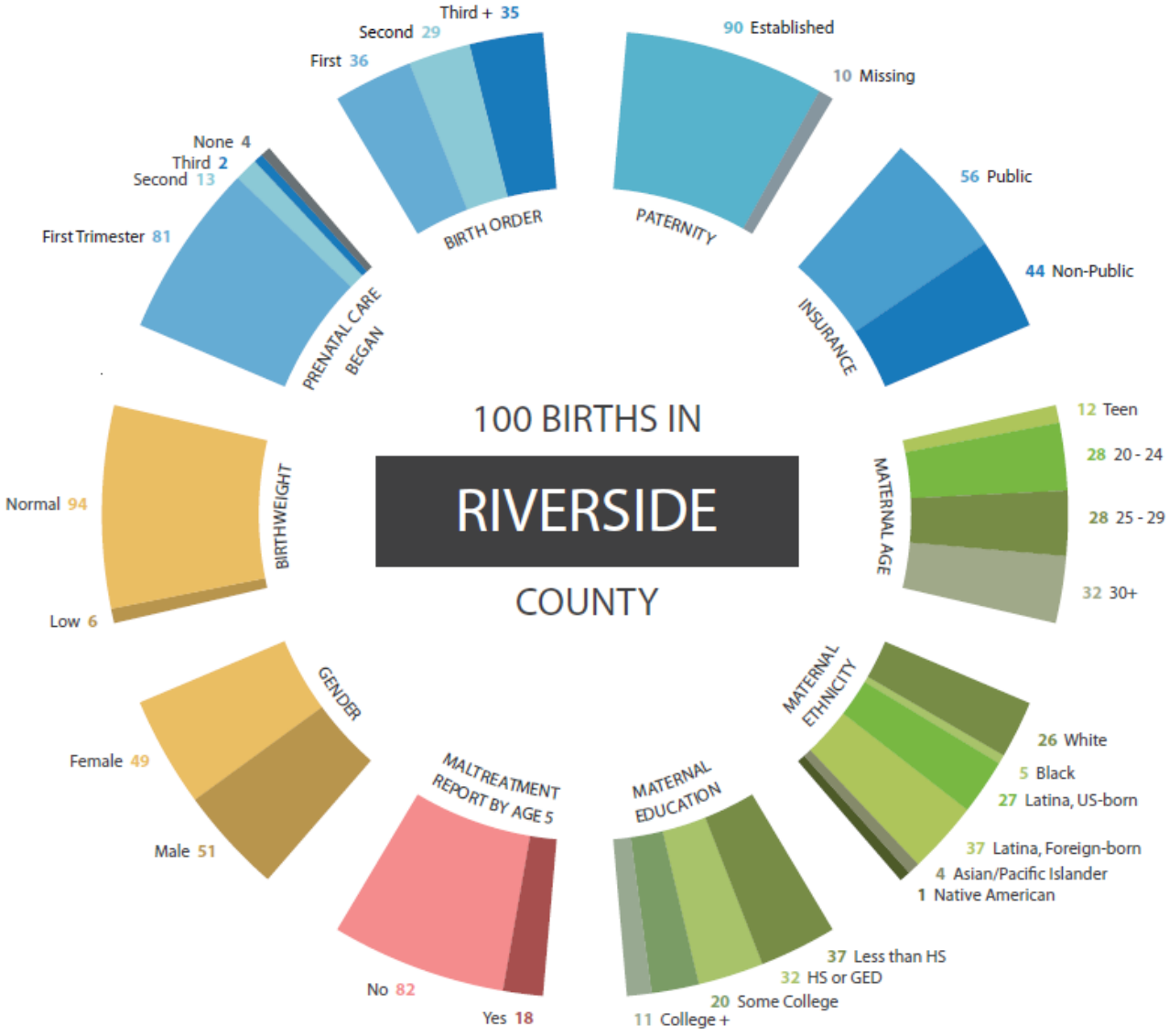
	Orange County HV Providers
DV Service Referral	100%
DV Arrest	0%
DV Self-Report	100%
Child Development	
Parental Knowledge	29%
Communication and Language	29%
Cognitive Skills	29%
Social & Emotional Behavior	29%
Physical Health & Development	29%
Enrollment in Early Childhood Program	14%
Life Course Measures	
Basic Life Resource Needs	100%
Parent Education	100%
Family Income	100%
Receipt of Public Assistance	100%
Data	
Required to Submit Data to Funder/Program	100%
Case Level (required for submission)	100%
Aggregated (required for submission)	100%
Data Evaluation in Last 5 Years	14%
Partnerships for Data Linkage	100%

RIVERSIDE COUNTY

Overview

In 2006 and 2007, 57,031 children were born in Riverside County. Although prenatal care began during the first trimester for a majority of children, 10,828 children (19.0%) were born to mothers who received prenatal care that started late or not at all. A plurality of children (64.1%) were born to Latina mothers (27.5%-US born and 36.6%-foreign born). A total of 12.3% of children were born to teen mothers. Among all children born, 10,459 children were reported to CPS for alleged child abuse or neglect before the age of 5, representing 18.3% of children in the birth cohort.

Figure 6. A profile of 100 births in Riverside County, 2006 & 2007



Response Rate

In Riverside County surveys were sent to:

1. El Sol Neighborhood Education Center
2. Family Services Association
3. JFK Memorial Foundation
4. Riverside Department of Public Health
5. Riverside County Department of Public Social Services Division
6. Riverside County Office of Education, ECE Programs

El Sol Neighborhood Education Center, JFK Memorial Foundation, and the Riverside County Department of Public Social Services Division responded to the survey, resulting in a 50% response rate.

Riverside County's Goals and Strategies

Riverside's current Strategic Plan was adopted in 2011 and is set for renewal and revisions in 2016. The county's three primary focus areas are early care and education, health, and systems change. The goals outlined in this plan include: (1) integration, coordination, and sustainment of services, (2) accountability and evaluation of services, (3) education of public, providers, and parents, (4) early childhood advocacy, (5) promotion of services, and (6) training and technical assistance.

The commission assesses indicators of goal achievement by funded agencies, such as (1) percentage of agencies leveraging public funding, (2) number of agencies with co-located services, (3) amount of agencies with expanded or flexible service hours, (4) number of parents reporting awareness of services, and (5) adoption of policies promoting child health and development.

Home Visitation in Strategic Plan

The commission allocated resources toward the targeted home visitation programs, which aims to promote optimal birth outcomes and maternal/child health. These programs are run by the El Sol Neighborhood Educational Center (El Sol) and the Riverside County Department of Public Social Services (DPSS). The programs focus on "improved pregnancy outcomes, child health and utilization of comprehensive healthcare services and personal and social support systems that promote well-being." Programmatic performance is measured by tracking the percentage of women receiving early prenatal care, babies born with low birth weight, and pre-term births. The number of parents screened for depression, substance abuse, and other risk factors, and who are referred for treatment is also assessed.

Non-HV Programs Funded by First 5

Riverside supports a broad range of programs ranging from child care and education to breastfeeding, health, mental health and oral health services across the county.

HV Programs Funded by First 5

The commission funds two agencies delivering HV programs: El Sol Neighborhood Educational Center and Safe Care. El Sol provides HV services through three separate programs.

- **El Sol Neighborhood Educational Center (El Sol)**
  - **Program #1.** This program provides home visits to families with children through 5 years of age who have risk factors including poverty, isolation, language and literacy barriers. These programs promote positive child development and support families with children in out-of home

placements (such as foster homes) to strengthen parenting skills. Specifically, El Sol runs a *HFA program* that serves 180 families annually. Families are enrolled with children less than 12 months old. Assessments used to determine program eligibility include the ASQ-3, ASQ-SE, AAPI, Edinburg, and a Parent Survey. Promotores deliver home visiting services to families with children under age 5.

  - Data Collection. El Sol's HFA collects data in both paper form and electronically (using a program called Efforts to Outcomes, ETO). Data are collected regarding the names, dates of birth, addresses, and race/ethnicity of children, mothers, and fathers. Extensive information related to maternal and newborn health measures, child maltreatment reports, domestic violence, developmental measures, and life course measures are collected. Case level and aggregated data are collected. Current efforts to link program data are underway, however no formal program evaluations have been conducted in the past five years.

- **Program #2.** El Sol also delivers a HV program using the *Parent-Child Home Program* curriculum that serves 180 families a year. Referral primarily occurs through community-based agencies, faith organizations, schools, and self-referral. Assessments used to determine program eligibility include the ASQ-3, ASQ-SE, AAPI, CBT, PACT, and PSI. To be eligible for this program, children must be under 5 years of age and must not be participating in any school readiness programs. Promotores also deliver services for this program.

  - Data Collection. El Sol's Parent-Child Home Program collects data similar to the *Healthy Families America* program using ETO, however, fewer data are acquired related to maternal and newborn health measures and domestic violence. El Sol is not required to submit these data to First 5.

- **Program #3.** The third HV program run by El Sol is a *HIPPY program*. Annually, this program serves 230 families with children under age 5 who are referred by the same agencies as the Parent-Child Home Program and by the federal Woman, Infants, and Children. The Branken School Readiness Assessment and others similar to the Parent-Child Home Program are used for screening purposes. Again, children must not be participating in any school readiness program to be eligible to participate and Promotores deliver services.

  - Data Collection. The data collection for the HIPPY program is identical to that collected for the HFA Program.

- **Riverside County Department of Public Health**. The Riverside County Department of Public Health has collaborated with First 5 to implement the SafeCare Public Health Nursing In-Home Program in. SafeCare targets families at-risk of maltreatment, as well as those families that have been reported to CPS. According to the Department, the goals are, "to reduce child welfare re-entry, and reduce child maltreatment, among families with a history for maltreatment or with risk factors for maltreatment." The program focuses on improving three primary areas for risk-reduction: health, home safety, and parent-child interactions. The curriculum lasts for 18 to 20 weeks, with one meeting per week. The county's staff members are based in DPSS CPS offices and carry a caseload of 12 to 15 families at a time.

  - Data Collection. The Riverside County Department of Public Health's SafeCare program also collects data electronically, using the Differential Response and Access Database. They collect the same identifying information as most programs, but fewer data related to maternal and newborn health measures and no data related to domestic violence. However, they collect comprehensive

information concerning child maltreatment, developmental measures, and life course measures. Efforts to link program data and program evaluations have recently been conducted.

HV Programs Funded by Outside Sources

- **The JFK Memorial Foundation.** JFK runs a SafeCare program using state funding. This program receives client referrals from CPS and serves about 200 individuals per year.
  - Data Collection. The JFK Memorial Foundation's SafeCare Program collects slightly different data than the other Safe Care program in the county. Identifying information regarding the child's, mother's and father's name, date of birth, and address are collected but not race/ethnicity. Comprehensive information regarding maternal and newborn health, child maltreatment, domestic violence, developmental measures, and life course measures are collected. This program uses state funds and these data must be submitted to the funder as case-level data. There have not been any evaluations and the program officials were unaware of any current data linkage efforts.

Table 7. Summary of data elements collected by surveyed HV providers in Riverside County

	Riverside County HV Providers
Personal Information	(n=6)
Child Name	100%
Mother's Name	100%
Father's Name	100%
Child's DOB	100%
Mother's DOB	83%
Father's DOB	100%
Child's SSN	0%
Mother's SSN	0%
Father's SSN	0%
Child's Address	100%
Mother's Address	100%
Father's Address	100%
Child's Race	83%
Mother's Race	83%
Father's Race	83%
Health	
Prenatal Care	50%
Parental Drug/Alcohol Use	66%
Birth Intervals	50%
Breastfeeding	50%
Maternal Depression	66%

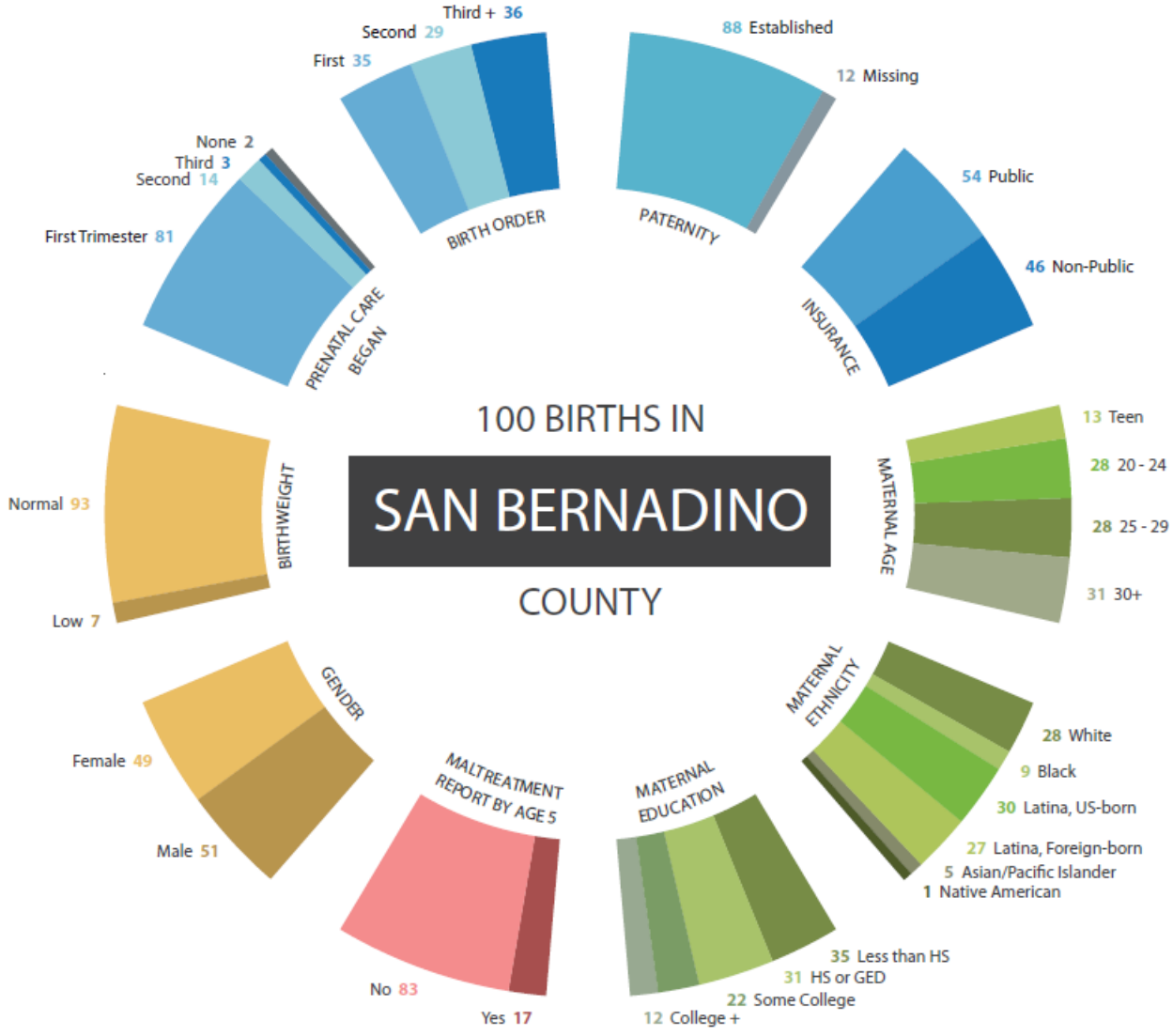
	Riverside County HV Providers
Maternal and Child Health Insurance	83%
Child Immunizations	66%
Chronic Health Issues	50%
Well Child Visits	100%
Child Injury	
Child Emergency Room Visits	83%
CPS Reports	100%
Open CPS Case	83%
Child Placed in Foster Care	100%
Self-Report of Maltreatment	66%
Domestic Violence	
DV Screening	17%
DV Service Referral	83%
DV Arrest	50%
DV Self-Report	33%
Child Development	
Parental Knowledge	100%
Communication and Language	100%
Cognitive Skills	83%
Social & Emotional Behavior	100%
Physical Health & Development	100%
Enrollment in Early Childhood Program	67%
Life Course Measures	
Basic Life Resource Needs	100%
Parent Education	100%
Family Income	83%
Receipt of Public Assistance	100%
Data	
Required to Submit Data to Funder/Program	33%
Case Level (required for submission)	33%
Aggregated (required for submission)	17%
Data Evaluation in Last 5 Years	17%
Partnerships for Data Linkage	33%

SAN BERNARDINO COUNTY

Overview

In 2006 and 2007, 57,807 children were born in San Bernardino County. Although prenatal care began during the first trimester for a majority of children, 10,915 children (18.9%) were born to mothers who received prenatal care that started late or not at all. A total of 13.0% of children were born to teen mothers. Among all children born, 10,030 were reported to CPS for alleged child abuse or neglect before the age of 5, representing 17.4% of children in the birth cohort.

Figure 7. A profile of 100 births in San Bernardino County, 2006 & 2007



Response Rate

In San Bernardino County surveys were sent to:

1. Easter Seals
2. Volunteers of America
3. San Bernardino County Preschool Services Department
4. High Desert New Beginnings
5. Save the Children
6. Department of Public Health
7. RIM Family Services

All agencies responded except High Desert New Beginnings.

San Bernardino's Commission Goals and Strategies

San Bernardino recently submitted a revised strategic plan for the period from 2015 through 2020. San Bernardino's vision is for all children to be "healthy, safe, nurtured, eager to learn, and ready to succeed." The mission of the commission is to "promote, support and enhance the health and early development of children prenatal through age five and their families and communities."

The primary goals of the strategic plan include: funding programs that improve outcomes among children ages zero to five, supporting efforts to leverages resources, targeting the areas of greatest need, facilitating the use of measurements to assess services and outcomes, and incentivizing collaboration at every level. The commission aims to improve outcomes by ensuring young children and their families have access to health and behavioral health services by connecting expectant parents and those with children ages birth – five with services.

The commission has two strategic priority areas: (1) children and families and (2) systems and networks. Young children and families will be supported by providing culturally appropriate resources, information, and opportunities needed for children to achieve success in school and life. Meanwhile, at the system level, efforts will be made to develop and enhance support systems serving children prenatally through age 5, their families, and communities that results in sustainable and collective impact. Specific goals include partnering with community stakeholders to align county resources and supporting ongoing professional development.

Home Visitation in Strategic Plan

Home Visiting programs are not specifically mentioned in First 5 San Bernardino's strategic plan, although it does currently fund home visiting programs as described in the sections that follow.

San Bernardino County's Programs

HV Programs Funded by First 5

First 5 San Bernardino partners with three organizations and funds three HV programs: Early Steps to School Success, Partnerships for Healthy Mothers and Babies, and Rim Family Services Literacy Program.

- **Save the Children.** Save the Children is funded to provide the Early Steps to School Success program in rural and remote areas of the County: an early childhood development home visiting curriculum that helps children from low-income families develop early learning skills. The goals include appropriate social and emotional development, positive brain development and improved success later in life. This program includes home visits from paraprofessionals with children and parents and

structured activities, such as reading hours, to promote early language and literacy skills. The program encourages aims to enhance parent-child bonding, healthy brain development, and early literacy skills by encouraging more reading. Annually, this program serves roughly 70 clients/families in San Bernardino County with children under age 5.

  - Data Collection. The Early Steps to School Success Program collects electronic data which is stored through Save the Children's data system. Identifying information for clients and comprehensive developmental and life course measures are collected. Prenatal care measures are tracked and information regarding child maltreatment and domestic violence are recorded via self-report. The organization is required to submit outcome data and collect client-level data. Although evaluations have been conducted recently, there are not current efforts to link data to other sources.

- **Department of Public Health.** The Department of Public Health partners with First 5 to fund and implement the *Partnerships for Healthy Mothers and Babies*. This program targets pregnant women who have tested positive for alcohol, tobacco and drug use. The goal is to help pregnant women stop use of these substances prior to the third trimester. The program connects pregnant women with nurses who provide and counseling services to expectant mothers. This program serves up to 400 families each year. Families are referred by the Department of Mental Health, CPS, and hospitals. The program uses the 4 P's Plus assessment.

  - Data Collection. Partnerships for Healthy Mothers and Babies collects data electronically using the electronic data collection platform, Persimmony. Identifying information for the mother and child, but not the father, are collected. Comprehensive information regarding prenatal care, child maltreatment, developmental measures, and life course measures is collected. Domestic violence is assessed by reporting any client referrals to domestic violence programs and self-reports of domestic violence. The program is required to submit outcome data for aggregated statistics, but no data linkage efforts are currently underway. Formal program evaluations have not yet been conducted.

- **RIM Family Services**. RIM Family Services is funded by First 5 San Bernardino and receives federal funding to deliver *Parents as Teachers*, a home based parent education program. In this program, certified parent educators conduct home visits once a month and provide developmentally appropriate parent education (specific eligibility criteria for the program were not reported). The goals are parent empowerment. The program provides services for over 160 families.

  - Data Collection. Rim Family Services Literacy program collects electronic data that are stored through the Persimmony data system. Data collected are comprehensive and include personal identifying information (e.g., name and address) and developmental measures (e.g., parent knowledge and child communication). The organization is required to submit outcome data and collect client-level data. Although evaluations have been conducted recently, there are not current efforts to link data to other sources.

HV Programs Funded by Outside Sources

In addition to HV programs funded by First 5, there are three additional home visiting programs operating with funding from other sources.

- **Volunteers of America.** This agency runs an Early Headstart-HV program in San Bernardino. As with all EHS programs, this program is funded with federal dollars and eligibility is based on income.

A family strengths assessment called the Individualized Family Service Plan (IFSP) is conducted. Last year, this program served 244 families. Families were referred to the program by CPS, WIC, and 2-1-1 hotline. There are no standardized assessments required for program entry.

  - Data Collection. Volunteers for America's Early Head Start program collects paper case record only. Data collected are comprehensive and include personal identifying information, maternal newborn and health measures, developmental measures and life course measures. The data collected related to child maltreatment and domestic violence rely on self-report of experiences. The program is required to submit case-level data to the funder. Evaluations have recently been conducted, but efforts to link data have not begun.

- **Easter Seals**. Easter Seals also runs an early Headstart-HV program in the county with federal dollars. This program served 34 individuals last year who were referred by a wide variety of community organizations. This program only enrolls mothers into the program prenatally and for mothers with children who are younger than 2 years old.

  - Data Collection. Easter Seals collects data electronically using the COPA database system. General identifying information are collected and comprehensive information on maternal and newborn health measures, experiences of child maltreatment, developmental measures, and life course measures are obtained. Domestic violence measures are based on referral only. The organization is not required to submit data but is working to link data to other sources.

- **San Bernardino's Preschool Service's Department**. The third Early Headstart-HV program is run by San Bernardino's Preschool Service's Department. This program serves 900 individuals per year and is run by teaching staff.

  - Data Collection. The Preschool Department also maintains records on COPA and collects nearly identical aggregated data as Easter Seals.

Table 8. Summary of data elements collected by surveyed HV providers in San Bernardino County

	San Bernardino HV Providers
Personal Information	(n=6)
Child Name	100%
Mother's Name	100%
Father's Name	83%
Child's DOB	100%
Mother's DOB	83%
Father's DOB	67%
Child's SSN	17%
Mother's SSN	17%
Father's SSN	17%
Child's Address	100%
Mother's Address	100%
Father's Address	83%

	San Bernardino HV Providers
Child's Race	100%
Mother's Race	83%
Father's Race	67%
Health	
Prenatal Care	83%
Parental Drug/Alcohol Use	83%
Birth Intervals	17%
Breastfeeding	67%
Maternal Depression	67%
Maternal and Child Health Insurance	100%
Child Immunizations	83%
Chronic Health Issues	67%
Well Child Visits	83%
Child Injury	
Child Emergency Room Visits	17%
CPS Reports	50%
Open CPS Case	67%
Child Placed in Foster Care	50%
Self-Report of Maltreatment	83%
Domestic Violence	
DV Screening	100%
DV Service Referral	50%
DV Arrest	100%
DV Self-Report	67%
Child Development	
Parental Knowledge	83%
Communication and Language	100%
Cognitive Skills	83%
Social & Emotional Behavior	83%
Physical Health & Development	83%
Enrollment in Early Childhood Program	67%
Life Course Measures	
Basic Life Resource Needs	83%
Parent Education	83%

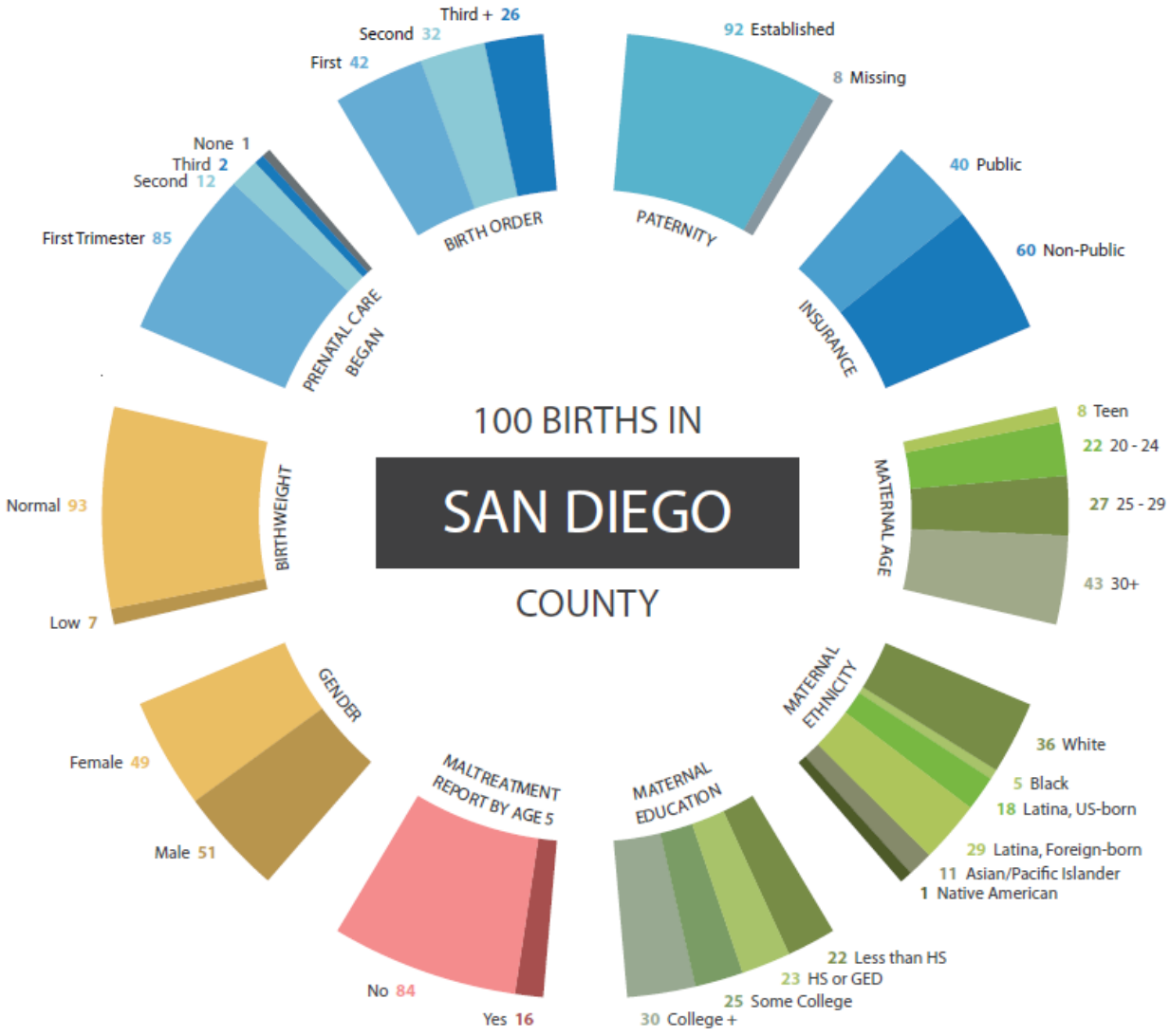
	San Bernardino HV Providers
Family Income	83%
Receipt of Public Assistance	83%
Data	
Required to Submit Data to Funder/Program	83%
Case Level (required for submission)	33%
Aggregated (required for submission)	33%
Data Evaluation in Last 5 Years	67%
Partnerships for Data Linkage	33%

SAN DIEGO COUNTY

Overview

In 2006 and 2007 in San Diego County, 85,349 children were born. Although prenatal care began during the first trimester for a majority of children, 13,108 children (15.4%) were born to mothers who received prenatal care that started late or not at all. A plurality of children (47.5%) were born to mothers of Latina race/ethnicity (18.7% - US born / 28.8% – foreign born). A total of 7.7% of children were born to teen mothers. **Among all children born, 13,602 were reported to CPS for alleged child abuse or neglect before the age of 5, representing 15.9% of children in the birth cohort.**

Figure 8. A profile of 100 births in San Diego County, 2006 & 2007



Response Rate

In San Diego County surveys were sent to:

- First 5 San Diego
- First 5 First Steps
- *Programs within the San Diego County Department of Public Health*
  - Black Infant Health
  - Public Health Nursing, Maternal Child Health
  - Public Health Nursing, Nurse Family Partnership
- *External Programs*
  - Easter Seals
  - MAAC Project Intake
  - New Parent Support
  - Palomar Health Care
  - San Diego Health and Human Services Agency
  - San Diego Adolescent Pregnancy and Parenting Program
  - NCAS, ASQ

We received survey responses from First 5 San Diego, Black Infant Health, Easter Seals, MAAC Project Update, San Diego Health and Human Services Agency, and San Diego Pregnancy and Parenting Program (58% response rate).

San Diego County's Goals and Strategies

The Commission's vision is expressed in their 2010-2015 strategic plan that "all children ages 0 through 5 are healthy, are loved and nurtured, and enter school as active learners." In order to advance this mission, the organization focuses on promoting the importance of the first five years of life. The four core functions are described as:

1. Funding effective and relevant services and activities.
2. Advocating at the state and local level.
3. Leading the coordination and integration of existing services.
4. Building organizational capacity that promotes family support.

The commission has specified that the strategic goal will be oriented around health, learning, family and community issues. The aim is to promote children's social, emotional, and physical health; support children's development and school readiness; encourage safe and nurturing homes; and empower the community to effective support families and children. They have also outlined key objectives including: (1) increasing dental treatment, (2) reducing smoking during pregnancy, (3) increasing developmental screenings, (4) increasing positive parenting practices, and (5) increasing access to necessary services. Strategies to meet these objectives include smoking cessation programs, information and referral efforts, and early identification efforts.

Home Visitation in Strategic Plan

HV programs are specifically mentioned in the strategic plan as a core strategy for supporting the commission's vision and mission. HV programs are described as a way to provide services to pregnant women and families that support healthy child development. The commission plans to target these programs for specific at-risk populations.

San Diego County's Programs

HV Programs Funded by First 5

- **First 5 First Steps.** First 5 San Diego recently launched HFA programs that served approximately 345 families during its first year (began accepting clients October 14, 2013) and is expected to reach 594 families during its second year. Community-based organizations, schools, medical health agencies, WIC, DHS, DMH, and DPH refer clients using standardized referral forms. First Step staff utilize the New Baby Questionnaire and Parent Survey for eligibility and referrals to best fit services. Eligibility is dependent upon the mother's prenatal enrollment and is one of the following target populations: teens, military, immigrant, refugee, or 200% below the Federal Poverty Level/low income. Participants do not need to be first-time mothers. Service providers are selected for their ability to form relationships with families. No specific academic credentials are required.

    - Data Collection. First 5 San Diego Commission's First 5 First Steps program collects paper and electronic records, which are warehoused through the First 5 San Diego–specific Contract Management Evaluation Database. Personal data is collected for children and mothers, but not fathers. First 5 San Diego collects information about maternal and newborn health measures, family resources, and provides screenings for depression and developmental outcomes. The program is required to submit client-level and aggregated statistical data for review. There have been no formal program evaluations or attempts to link administrative data to date.

San Diego County Public Health HV Programs (may have blended funding)

- **The Family Health Centers of San Diego (some funding from F5SD).** These centers receive First 5, county and state funds to provide Black Infant Health services to 180 families. Referrals come from WIC, public insurance agencies, 2-1-1 hotline, healthcare providers, and the County Departments of Health Services and Mental Health. Self-referrals are also accepted. Eligibility is dictated by mother's birth status, race/ethnicity and child's age. Services are reserved for Black/African American families and are offered to pregnant mothers or those with children younger than 12 months. First-born status does not affect eligibility. Case managers conduct all home visits.

    - Data Collection. The Family Health Centers of San Diego's collect paper and electronic records on the Back Infant Health program, which are stored in the Black Infant Health Management Information System. Complied data include: identifying information about mothers, fathers, and children; comprehensive maternal and newborn health factors; self-reports of domestic violence victimization; extensive physical and cognitive developmental measures of children; and family financial and educational resources. Data regarding child maltreatment are not collected. Evaluations have occurred during the past 5 years requiring the submission of aggregated data, but it remains unclear whether these data have been used for record linkage.

- **The Health and Human Services Agency, North Central Region.** This agency runs a Nurse Family Partnership and relies on county funding to provide services to an estimated 150 families. Clients are referred to NFP by CPS, WIC, 2-1-1hotline, health service providers, public insurance providers, community-based agencies, schools, families themselves, and the county Departments of Health Services, Public Health, and Mental Health. Service duration is time limited and dependent upon the child's age.

- Data Collection. Information on data collection and storage was not available for the HHSA, North Central Region NFP program. However, it is reasonable to assume the data collection process aligns with requirements of all NFP programs, which is rigorous and comprehensive.

- **San Diego Pregnancy and Parenting Program (some funding from F5SD).** Program. This program receives county and state funds, as well as financial support from First 5, to operate the San Diego Pregnancy and Parenting Program. The 975 families served each year are referred by the County Department of Public Health, community-based agencies, schools and the families themselves. Eligibility is determined according to a pregnancy and/or parenting age limit. Case managers provide in-home services.

  - Data Collection. The San Diego Pregnancy and Parenting Program compiles paper case records and stores client information in a Lodestar database. Personal information on mothers, fathers and children is collected. Other data include maternal and newborn health measures, developmental evaluations, and family educational and basic needs assessments. Data on child maltreatment or domestic violence histories are not collected. The program is required to provide aggregated statistics to funders and is formally assessed. No efforts have been made to link available data with other administrative records.

Non-First 5 Funded HV Programs

- **Palomar Home Care**. This program is funded by Medi-Cal, private insurance and California Children's Services to provide Well Baby services to approximately 3,500 families annually. Families must have a physician's order to be eligible for services, which are provided by professional nurses.

  - Data Collection. Palomar Home Care collects a combination of paper and electronic data. Case records include identifying information about the child and mother, comprehensive maternal and newborn health measures, extensive child maltreatment information, family financial and life resources, and evidence of domestic violence based on self-reports and service referrals. Data collected regarding children's developmental progress is limited to the mother's knowledge of her child's progress. No information is collected about fathers. Palomar Home Care is not required to submit client outcomes or other data for review, and has not engaged in any data linkage efforts to date.

- **MAAC.** MAAC runs an Early Head Start-HV program using federal funds. The program serves an estimated 450 families each year referred by CPS, WIC, Medicaid/Medi-Cal, 2-1-1 hotline, community members and the county Departments of Health Services, Public Health, and Mental Health. Eligibility is not based on a standardized assessment, but the program restricted to families with first-born children under age 5 that fall within an established income range. Paraprofessional education home visitors deliver services to families.

  - Data Collection. The federally funded Early Head Start-Home Visiting program collects data using ChildPlus, an electronic case management system. The system documents comprehensive developmental indicators, basic identifying information, history of prenatal care, child immunizations, well child visits, evidence of chronic health conditions, open CPS cases, domestic violence service referrals, and the financial security of families. The program is required to submit aggregated statistical data to the government. Formal evaluations have been conducted during the last 5 years, yet no efforts have been made to link data.

- **Easter Seals Southern California**. Easter Seals runs a second federally funded EHS-HV program in San Diego, which serves 36 families per year. Referrals come from CPS, WIC, 2-1-1 hotline, health providers, community-based agencies, schools, clients themselves, and the county Departments of Health Services, Public Health, and Mental Health. Eligibility is determined based on family income and the child's age (under 5 years), but is not limited to first-born children. Home visiting services are provided by paraprofessionals with a background in child development.

  - Data Collection. Easter Seals Southern California's EHS-HV program uses paper case records and then uploads data to a COPA online database. Comprehensive identifying information is collected about the child, mother and father. Maternal and newborn heath, CPS involvement, children's development progress, and family resources are all well documented. Domestic violence referrals are also noted. The agency is required to provide the government with aggregated statistics and is formally evaluated, though evaluation efforts that incorporate linkages to other data sources have not been conducted.

Table 9. Summary of data elements collected by surveyed HV providers in San Diego County

	San Diego HV Providers
Personal Information	(n=8)
Child Name	88%
Mother's Name	88%
Father's Name	62%
Child's DOB	75%
Mother's DOB	88%
Father's DOB	63%
Child's SSN	25%
Mother's SSN	38%
Father's SSN	25%
Child's Address	75%
Mother's Address	88%
Father's Address	63%
Child's Race	75%
Mother's Race	75%
Father's Race	50%
Health	
Prenatal Care	88%
Parental Drug/Alcohol Use	75%
Birth Intervals	50%
Breastfeeding	63%
Maternal Depression	75%
Maternal and Child Health Insurance	75%

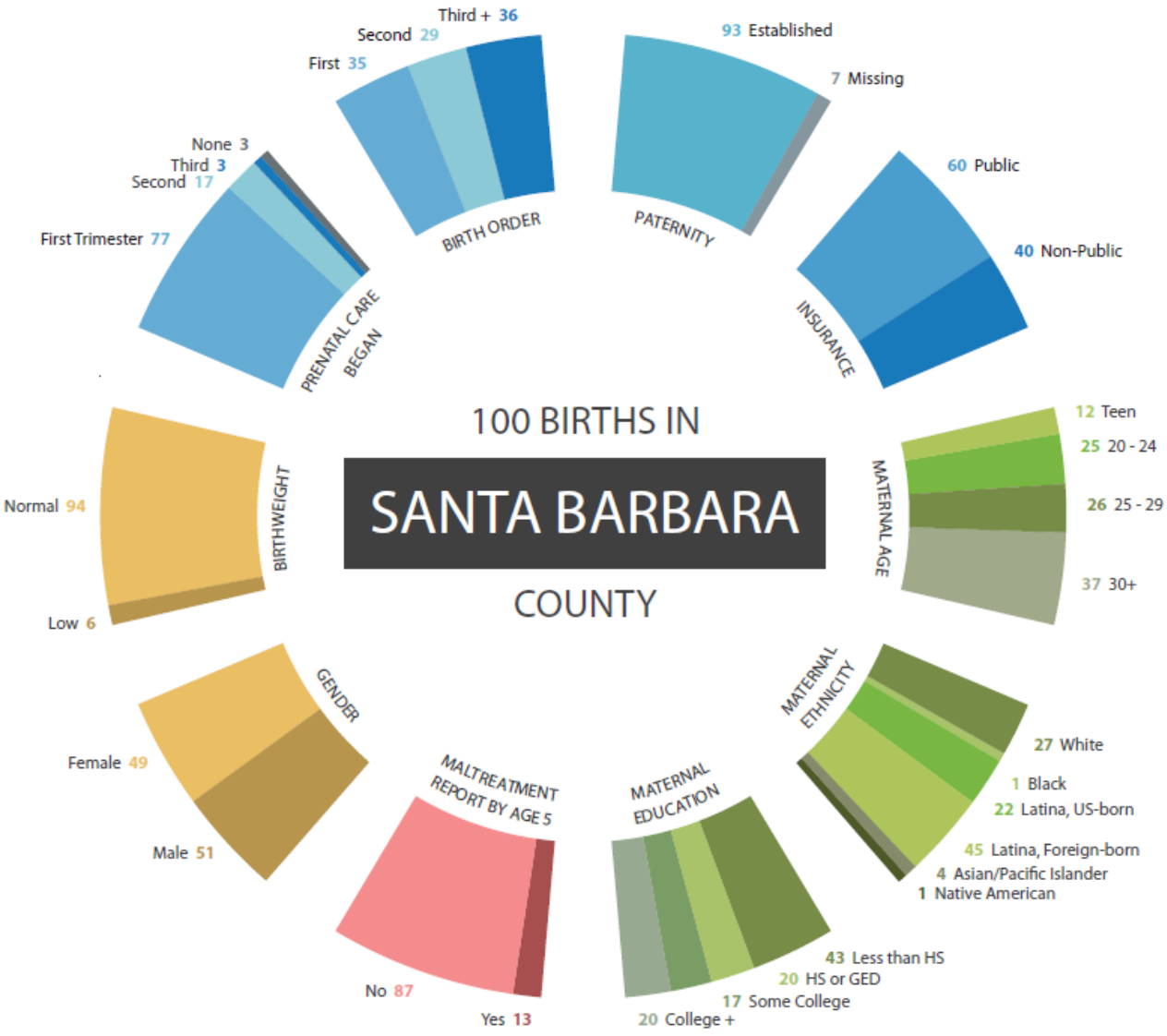
	San Diego HV Providers
Child Immunizations	88%
Chronic Health Issues	63%
Well Child Visits	88%
Child Injury	
Child Emergency Room Visits	25%
CPS Reports	25%
Open CPS Case	63%
Child Placed in Foster Care	50%
Self-Report of Maltreatment	25%
Domestic Violence	
DV Screening	25%
DV Service Referral	63%
DV Arrest	13%
DV Self-Report	50%
Child Development	
Parental Knowledge	88%
Communication and Language	50%
Cognitive Skills	75%
Social & Emotional Behavior	75%
Physical Health & Development	75%
Enrollment in Early Childhood Program	50%
Life Course Measures	
Basic Life Resource Needs	88%
Parent Education	88%
Family Income	63%
Receipt of Public Assistance	63%
Data	
Required to Submit Data to Funder/Program	86%
Case Level (required for submission)	25%
Aggregated (required for submission)	75%
Data Evaluation in Last 5 Years	57%
Partnerships for Data Linkage	14%

SANTA BARBARA COUNTY

Overview

In 2006 and 2007 in Santa Barbara, 11,903 children were born. Although prenatal care began during the first trimester for a majority of children, 2,675 children (22.5%) were born to mothers who received prenatal care that started late or not at all. A plurality of children (67.3%) were born to mothers of Latina race/ethnicity (22.1% - US born / 45.2% - foreign born). A total of 11.7% of children were born to teen mothers. **Among all children born, 1501 were reported to CPS for alleged child abuse or neglect before the age of 5, representing 12.6% of children in the birth cohort.**

Figure 8. A profile of 100 births in Santa Barbara County, 2006 & 2007



Response Rate

In San Barbara County surveys were sent to:

1. Child Abuse Listening Meditation
2. Santa Barbara County Public Health Department
3. Santa Barbara Education Foundation
4. Welcome Every Baby

The Santa Barbara County Public Health Department, Santa Barbara Education Foundation, and Welcome Every baby Program responded to the survey and the response rate was 75%.

Santa Barbara County's Goals and Strategies

Santa Barbara's First 5 commission approved the 2014-2017 Strategic Plan in November 2013. This plan was developed in concert with providers, community members, and parents by hosting focus groups and administering surveys.

First 5 Santa Barbara coordinates its efforts so that "All children are healthy, safe, and ready for kindergarten." In order to achieve this vision, the Commission has adopted the mission "To help all children prepare for kindergarten by supporting families to be healthy and strong and by enhancing the availability of high quality childcare and preschool."

To do this, First 5 is focused on Family Support and Early Care/Education. Secondary areas of focus include: (1) Capacity Building and Systems Change, (2) Communications, and (3) Health Insurance and Access for Children. Five guiding principles underpin all activities:

1. Serving those most at risk.
2. Supporting tiered levels of services to meet the full diversity of needs that all families face.
3. Leveraging both funding and results.
4. Funding direct services through evidence based strategies, while maintaining the flexibility necessary to respond to emerging needs and opportunities.
5. Maintaining clear separations between First 5's role in supporting direct services, and First 5's role in assuring accountability, public review, and reporting on results.

Home Visitation in Strategic Plan

This commission does not list any program types by name in the strategic plan. Santa Barbara's First 5 commission, however, indirectly assesses home visiting by examining increases in the number of families who can identify and access family and child resources, the quality of early care and education experiences, the number of parents who have skills to support children's readiness, access to health services, advocacy within the community, and sustainable funding sources. At the time this information was collected First 5 was going through its new request for proposal process for funding cycle 2014-2017. The grant process has now concluded and Welcome Every Baby (WEB) has been selected as a funded partner to provide nurse home visits. Additionally, First 5 has also selected Family Services Agency and Alpha Resource Center to provide family strengthening activities, including home visits for case-managed families.

Santa Barbara County's Programs

HV Programs Funded by First 5

- **Welcome Every Baby.** Santa Barbara funds a program called Welcome Every Baby, in partnership with Marian Home Care and Public Health and the Santa Barbara County Office of Education. This is a free, county-wide, universal service available to all newborns and their families with the goal of linking families to community resources. The program is funded by First 5 in partnership with state funds and the Cottage Hospital to provide a total of 1,500 home visits per year. Until this year, funding had been universal, however, as a result of a decrease in funding, the program will be targeted based on high risk zip codes, mother's age (teen), a history of post-partum depression, and other high risk factors.

  As part of this program, First 5 has developed a Welcome Every Parent Handbook which was developed for parents in the program and provides developmental, nutrition, and safety information to support parents. First 5 has also developed a new parent kit aimed at increasing reading, health care, and reducing childhood obesity. These resources are available to all on their website. This program serves as the primary platform for the county's early identification of children with special needs and the targeted delivery of preventive interventions and supports. Welcome Every Baby includes a home visiting component in which a child development specialist visits the family soon after the baby is born to provide services. The nurse helps with breastfeeding, newborn care, service referrals, and other questions or concerns the family may have. *Importantly, the Welcome Every Baby program developed in Santa Barbara has served as the basis for the development of similar programs, initiatives, and efforts in other counties*.

  - Data Collection: Data for the Welcome Every Baby are collected via paper records and electronically. The program uses the Mosaic GEMS database to store information. Identifying information is collected for the child, mother, and father. Information regarding maternal and newborn health records, domestic violence, and child development are also collected. The program does not collect data on child maltreatment and collects minimal information on life course measures. The program is required to submit outcome data and formal evaluations are conducted annually by an independent evaluator at UCSB. However, the program's officials were unsure if current efforts are underway to link data to other sources.

HV Programs Funded by Outside Sources

In addition to Welcome Every Baby, at least two HV programs are funded by non-First 5 sources.

- **Santa Barbara HIPPY**. This program is supported through foundation funding and serves 105 families per year. Referrals are generated from community-based agencies, schools, and self-referrals. Families must have a child 3-5 years of age to participate. Services are delivered by paraprofessionals. *Note:* First 5 funded this program in Santa Maria and Guadalupe during the 2011-2013 fiscal years.

  - Data Collection. Data for the HIPPY program are not collected electronically. Paper records include information regarding the name of the child, mother, and father; date of child's birth; address and race/ethnicity. Information regarding maternal and child health insurance status, chronic health conditions, domestic violence referrals and self-report, and a comprehensive assessment of developmental measures are also collected. HIPPY is not required to submit

outcome data but recent program evaluations have been conducted. Data linkages are in process.

- **The Maternal and Child Health Department (MCHD)**. This program provides HV services and is supported by state and federal funds. Specifically, MCHD is funded through the Federal Financial Participation program via MCAH, TCM/MAA, and Perinatal Services Program funding (through PHD FQHC clinics). MCHD serves roughly 1,500 unique families. Clients are referred through a variety of community sources and assessments are standardized and completed in the home. All high-risk, low-income women of child bearing age and their children are eligible to participate. The level of risk is determined by a standardized acuity tool and incudes questions related to the parent's status as a teen parent, need for health insurance, and medical conditions.

  - Data Collection. Nurses conduct home visits on behalf of MCHD and enter the data into an electronic case management system housed at the county's Public Health Department. Identifying information is collected for the child and mother. Comprehensive information regarding the maternal and newborn health records, child maltreatment, domestic violence, and life course measures are also collected. The Department is not required to submit outcome data and formal evaluations have not been conducted recently; however, current efforts are underway to link data to other sources.

Table 10. Summary of data elements collected by surveyed HV providers in Santa Barbara County

	Santa Barbara HV Providers		
Personal Information	HIPPY	MCHD	WEB
Child Name	X	X	X
Mother's Name	X	X	X
Father's Name	--	X	X
Child's DOB	X	X	X
Mother's DOB	--	X	X
Father's DOB	--	--	--
Child's SSN	--	X	--
Mother's SSN	--	X	--
Father's SSN	--	--	--
Child's Address	X	X	X
Mother's Address	X	X	X
Father's Address	--	--	X
Child's Race	X	X	X
Mother's Race	X	X	X
Father's Race	X	--	X
Health			
Prenatal Care	--	X	X
Parental Drug/Alcohol Use	--	X	--

	Santa Barbara HV Providers		
Birth Intervals	--	--	--
Breastfeeding	--	X	X
Maternal Depression	--	X	X
Maternal and Child Health Insurance	X	X	X
Child Immunizations	--	X	--
Chronic Health Issues	X	X	--
Well Child Visits	--	X	X
Child Injury			
Child Emergency Room Visits	--	--	--
CPS Reports	--	X	--
Open CPS Case	--	X	--
Child Placed in Foster Care	--	X	--
Self Report of Maltreatment	--	X	--
Domestic Violence			
DV Screening	--	X	--
DV Service Referral	X	X	X
DV Arrest	X	X	--
DV Self Report	--	--	--
Child Development			
Parental Knowledge	--	X	X
Communication and Language	X	X	X
Cognitive Skills	X	--	X
Social & Emotional Behavior	X	--	X
Physical Health & Development	X	X	--
Enrollment in Early Childhood Program	--	--	--
Life Course Measures			
Basic Life Resource Needs	--	X	X
Parent Education	--	X	--
Family Income	--	X	--
Receipt of Public Assistance	--	X	--
Data			
Required to Submit Data to Funder/Program	--	--	X
Case Level (required for submission)	--	--	X
Aggregated (required for submission)	--	--	--

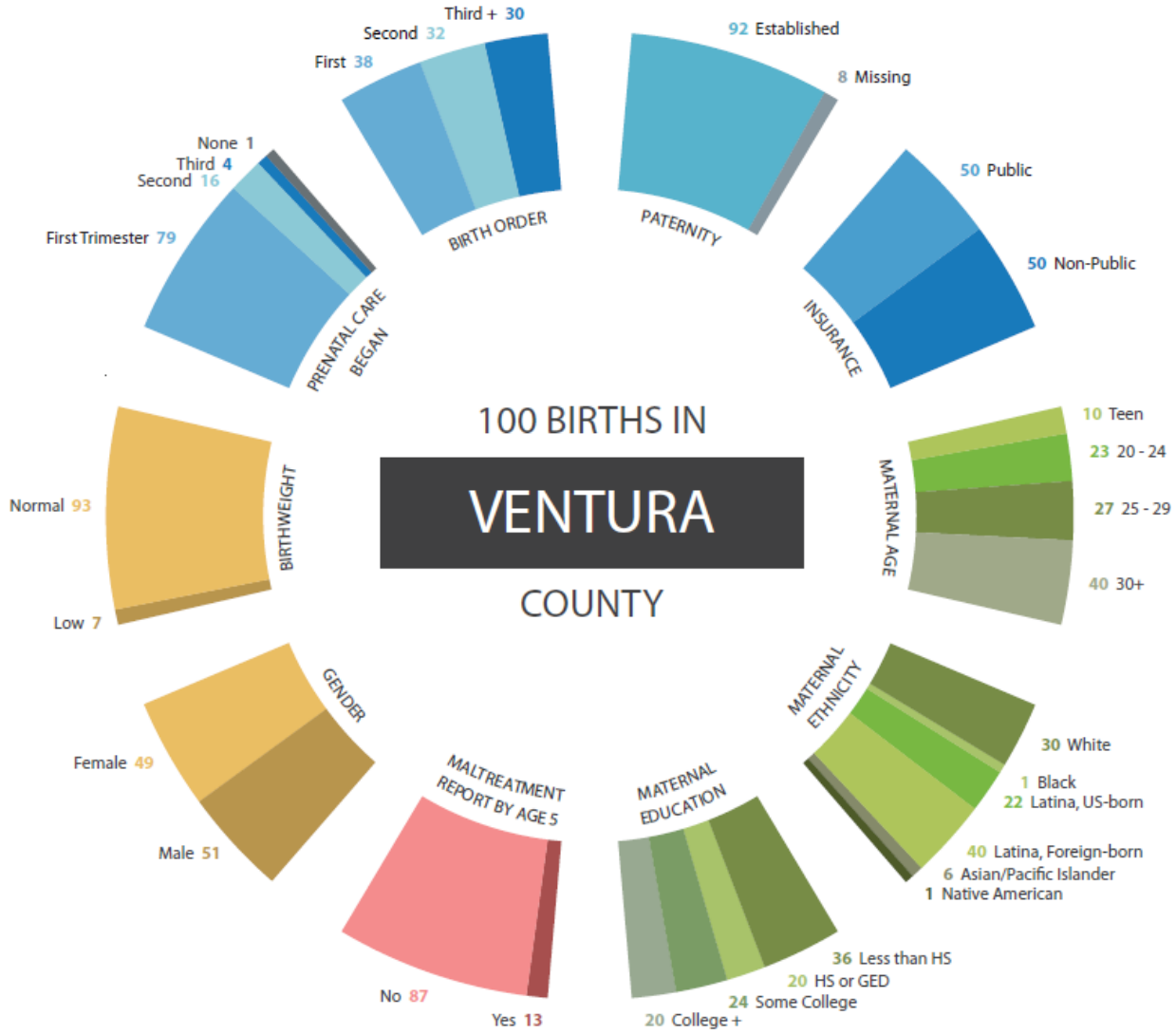
	Santa Barbara HV Providers		
Data Evaluation Last 5 Years	--	X	X
Partnerships for Data Linkage	X	X	unsure

VENTURA COUNTY

Overview

In 2006 and 2007 in Ventura County, 21,713 children were born. Although prenatal care began during the first trimester for a majority of children, 4,489 children (20.7%) were born to mothers who received prenatal care that started late or not at all. A plurality of children (62.1%) were born to mothers of Latina race/ethnicity (22.5% - US born / 39.6% - foreign-born). A total of 9.8% of children were born to teen mothers. **Among all children born, 2,823 were reported to CPS for alleged child abuse or neglect before the age of 5, representing 13.0% of children in the birth cohort.**

Figure 10. A profile of 100 births in Ventura County, 2006 & 2007



Response Rate

In Ventura County surveys were sent to:

1. Child Development Resources
2. Ventura County Department of Public Health

The Ventura County Department of Public Health responded to the survey. We did not receive responses from Child Development Resources.

Ventura County's Goals and Strategies

To develop its strategic plan, Ventura County's First 5 commission conducted an assessment of the county service environment, developed a comprehensive literature review, designed a parent survey and hosted a series of community focus groups. The current First 5 commission's strategic plan was adopted in 2010 and will be revised again in 2015.

The commission's vision is for "a future where all Ventura County children thrive in healthy supported environments with loving and nurturing caregivers in the home and throughout the community. This future embraces the value of active partnerships between families, service providers, civic leaders, local business and the community at-large, honors and respects the diversity of our community and prioritizes the need to ensure optimal health and development for young children and their families."

F5VC programming combines three broad elements:

- An outcome-driven, strategic framework with defined, evidence-based program priorities for the initiative as a whole.
- Within this framework, decentralized local governance, program development, and implementation with strong central office support for local capacity building.
- Additional services, supports, and capacity-building, funded and delivered at the county or regional level. This approach is used when it is deemed to be more effective or cost-effective.

Home Visitation in Strategic Plan

The strategic plans references home visitation as one of the commission's specialized program strategies falling within their Neighborhoods for Learning Initiative, which is at the heart of First 5 Ventura County. There are 11 First 5 NfLs with 25 Family Resource Centers located in communities across Ventura County. This place-based model provides parents with high quality, locally based resources to help them raise children who are healthy, nurtured, and prepared to meet their full potential.

Each First 5 NfL is governed by its community and decides how best to serve the area's health, early learning and family support needs. NfL resources may include preschools or preschool scholarships, family resource centers, and early learning activities for children 0-3. Through partnerships with the Ventura County Health Care Agency and other local organizations, First 5 Ventura County provides community-based access to health services, dental treatment, developmental check-ups, behavioral health counseling and parent education. Parents access these resources through their local Neighborhood for Learning, reducing barriers and increasing access to essential services.

Ventura County's Programs

Non-HV Programs Funded by First 5

Although First 5 Ventura County does not fund a stand-alone home visitation program, many of the services accessed by families through their Neighborhood for Learning program are of similar intensity and share the vision of comprehensively addressing a family's needs and strengths.

- Family literacy and early learning for parents and children together (PACT) programs target children in the earliest stages of development. These programs focus on positive interactions between caregiver and child to promote bonding and attachment, and emphasize the importance of reading early and often. These programs aim to improve service coordination, positive parenting, and parent education as well as early identification of children with special needs. NfLs and countywide implementation partners, including Ventura County Public Health (VCPH) and MICOP, offer service coordination and case management to address identified needs and help families access appropriate services. Home visitation is also employed as best practice intervention when needed. Through NfLs and Ventura County Behavioral Health (VCBH) professionals, First 5 Ventura County implements the Triple P positive parenting program, empowers families through parenting education, and addresses children's social-emotional and behavioral concerns

- F5VC partners with Ventura County Public Health and the Landon Pediatric Foundation to create a comprehensive system to increase the number of children receiving an age appropriate developmental screening. Health educators work with the PACT teachers and FRC staff on providing developmental check-ups to detect possible developmental delays, and refer children and support their access to early intervention services. In addition, Pediatrician and family practice providers receive training and technical assistance to integrate surveillance, screening, assessment, and referrals for developmental problems in young children into routine well-child care.

HV Programs Not funded by First 5

- **The Ventura County Public Health Department.** The county's Public Health Department runs the community health nursing home visitation program. This program is curriculum based and funded through county and federal dollars. The nurses serve 6,000 families a year. This program is voluntary and serves women postnatally whose children have been deemed to be at risk of poor development, health, or safety outcomes.

    - Data Collection. Data are collected for the home nursing program through an electronic data system called the Nursing Referral System, developed by the Public Health Department. Complete identifying information, maternal and newborn health measures, child maltreatment measures, domestic violence measures, developmental measures, and life course measures are collected. The program is required to submit aggregated, outcome data. To date, no efforts have been made to link these data to other sources, but formal evaluations have been conducted.

Table 11. Summary of data elements collected by surveyed HV providers in Ventura County

	Ventura
Personal Information	**DPH**
Child Name	yes
Mother's Name	yes
Father's Name	yes
Child's DOB	yes
Mother's DOB	yes
Father's DOB	yes
Child's SSN	yes
Mother's SSN	yes
Father's SSN	yes
Child's Address	yes
Mother's Address	yes
Father's Address	yes
Child's Race	yes
Mother's Race	yes
Father's Race	yes
Health	
Prenatal Care	yes
Parental Drug/Alcohol Use	yes
Birth Intervals	yes
Breastfeeding	yes
Maternal Depression	yes
Maternal and Child Health Insurance	yes
Child Immunizations	yes
Chronic Health Issues	yes
Well Child Visits	yes
Child Injury	
Child Emergency Room Visits	yes
CPS Reports	yes
Open CPS Case	yes
Child Placed in Foster Care	yes
Self-Report of Maltreatment	yes
Domestic Violence	

	Ventura
DV Screening	yes
DV Self Referral	yes
DV Arrest	yes
DV Self-Report	yes
Child Development	
Parental Knowledge	yes
Communication and Language	yes
Cognitive Skills	yes
Social & Emotional Behavior	yes
Physical Health & Development	yes
Enrollment in Early Childhood Program	yes
Life Course Measures	
Basic Life Resource Needs	yes
Parent Education	yes
Family Income	no
Receipt of Public Assistance	yes
Data	
Required to Submit Data to Funders/Programs	yes
Case Level (required for submission)	no
Aggregated (required for submission)	yes
Data Evaluation in Last 5 Years	yes
Partnerships for Data Linkage	no

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Appendix A: Home Visitation Inventory

Below is the base version of the Home Visitation Inventory. This survey was administered through the web-based software program, Qualtrics. Questions specific to zip code catchment areas were only used for LA County. In counties where a complete list of HV programs was not provided by the commission, the last question of the survey provided a list of all programs identified and requested information about any programs meeting the study's criteria that were not yet included.

Home Visitation Inventory

We are conducting an inventory of perinatal and early childhood home visitation programs in [X] County in partnership with [X]. The goal of this survey is to gain a better understanding of the range of home visiting programs in the Southern California Region to help build a more sustainable, cohesive system of home visiting.

Your program and/or agency has been identified as an entity delivering home visiting services to pregnant and/or parenting families. We would like to include you in our inventory and *it will be extremely helpful if you are able to provide us with information about you program by responding to the following questions. Completion of this survey should take roughly 20 minutes. To thank you for your participation, we will be raffling off an iPad on [X] for [X].*

Home visiting, for the purposes of this inventory, is defined as a program that is a voluntary and sustained effort that pairs new and expectant families with trained professionals to provide parenting information, resources and support during pregnancy and throughout their child's early years. Any public reports produced from this survey will include aggregated information only.

Survey Respondent

1. Name:
2. Role/Title:
3. Agency:
4. Thank you in advance for completing this survey. May we contact you if we have follow-up questions? (y/n)
    - If yes, please provide the best way to reach you below. (open ended)

Section 1: General Program Questions

In this section, we ask questions that will help us better understand the nature of home visiting (HV) services delivered throughout the region – and will help us to develop an inventory of programs to assist with referrals.

1. Please check the HV program that your agency provides. Note: If your agency has more than program please fill out this survey regarding the program you selected. This survey should be completed separately for each additional HV program. (Checklist below. *Note: all **other** checklists should allow participants to check more than one answer.*)
    - Black Infant Health
    - Child FIRST

- Child Parent Enrichment Program
- Early Headstart-Home Visiting
- Even Start Home Visiting
- Early Start
- Healthy Families America
- Healthy Start
- Home Instruction for Parents as Teachers of Preschool Youngsters
- Nurse Family Partnership
- Parent as Teachers (Home Visiting)
- Parent-Child Home Program
- Partnerships for Families
- Safe Care
- Positive Parenting Program (Triple P)
- Welcome Baby
- Well Baby Other Local Programs
    i. Name (open ended)
    ii. Is this a curriculum-based program? (y/n)

2. If your HV program serves a specific geographic area, do you know the zip codes this includes? (y/n)
    - If yes, please enter the zip codes below. (open ended)

3. What is the current funding source for your HV program? (checklist)

    First 5 Commission

    County funds

    State funds

    Federal funds

    Foundation / Private funds

    Other
        i. Please specify (open ended)

4. What is the estimated number of clients/families served by your HV program each year? (open ended)

5. How is duration of service determined for your HV program? (checklist/open ended)
    - Time Limited
    - Index Child Age

    (Specify to answer chosen)

6. What agencies/programs refer clients to your HV program? (checklist/open ended)
    - County Department of Health Services
    - County Department of Public Health
    - County Department of Mental Health
    - Child Protective Services (CPS)
    - Women, Infants, and Children (WIC)
    - Medicaid/Medi-Cal
    - 2-1-1

- Hospitals/Clinics/Health Providers
- Community-based Agencies
- Schools
- Self-Referral
- Other
    i. Please specify (open ended)

7. Is entry into the HV program based on a formal or standardized assessment? (y/n)
    - If Yes: What is the name of the assessment protocol used? (open ended)

8. What criteria are used to determine eligibility for HV program entry? (y/n)
    - Mother's Birth Status
        - Prenatal Enrollment Only
        - Postnatal Enrollment Only
    - Index Child's Age at Program Entry (if yes then drop-down menu of ages)
        - Less than 12 months
        - Less than 24 months
        - Less than 5 years
    - Mother's Age at Birth
        - Teen (Less than 20 years)
        - Other
    - First Birth (y/n)
    - Race/Ethnicity
        - Black/African American
        - Latino/Hispanic
        - Asian/Pacific Islander
        - Native American
        - Other
    - Other Criteria (open ended)

9. What type of staff does your HV program use as primary home visitors? (checklist)
    - Social Worker/Licensed Mental Health Care Clinician
    - Nurse
    - Other (EX: Case worker, Paraprofessional, Promatoros)

<u>Section 2: Specific Data Element Questions</u>

In this section, we ask questions about the collection of client data and other measures.

1. How are data and information collected by your HV program stored? (checklist)
    - Paper case records (y/n) (if yes, please specify)
        - ✓ Is the information also entered into an electronic data system? (y/n)
    - Electronic data/case management system (y/n)
        - ✓ If yes, please specify the name of the database or electronic platform (open ended)
    - If other, please specify (open ended)

2. Is the following personal information collected about clients served by your HV program? (checklist)
    - Index Infant/Child Data (if yes, add the following checklist)
        - First and Last Name (y/n)
        - Date of Birth (y/n)
        - Social Security Number (y/n)
        - Address (y/n)
    - Mother's Data (if yes, add the following checklist)
        - First and Last Name (y/n)
        - Date of Birth (y/n)
        - Social Security Number (y/n)
        - Address (y/n)
        - Race/Ethnicity (y/n)
    - Father's Data (if yes, add the following checklist)
        - First and Last Name (y/n)
        - Date of Birth (y/n)
        - Social Security Number (y/n)
        - Address (y/n)
        - Race/Ethnicity (y/n)

3. Is the following health, safety, and child development information collected about clients served by your HV program? (checklist)
    - Maternal and newborn health measures (if yes, add the following checklist)
        - Prenatal care (before birth) (y/n)
        - Parental use of alcohol/drugs (y/n)
        - Inter-birth intervals (amount of time between births) (y/n)
        - Breastfeeding (y/n)
        - Well-child visits (y/n)
        - Screening for maternal depression (y/n)
        - Maternal and child health insurance status (y/n)
        - Child immunizations (y/n)
        - Chronic Health Conditions (y/n)

    - Child injuries and maltreatment measures (if yes, add the following checklist)
        - Visits for child and/or mother to the emergency department (y/n)
        - Maltreatment reported to child protective services (y/n)
        - Open child protection case (y/n)
        - Child's placement in foster care (y/n)
        - Self-reported maltreatment of child (y/n)

    - Domestic violence measures (if yes, add the following checklist)
        - Screening for domestic violence (y/n)
        - Referrals for domestic violence services for families (y/n)
        - Arrest convictions for domestic violence (y/n)
        - Self-reported domestic violence victimization (y/n)

    - Developmental measures (if yes, add the following checklist)

- Parent knowledge of child development and his/her progress (y/n)
- Child's communication, language, and emergent literacy (y/n)
- Child's general cognitive skills (y/n)
- Child's social behavior, emotion regulation, and emotional well-being (y/n)
- Child's physical health and development (y/n)
- Child's enrollment in a regulated early childhood program (i.e. regulated child care, Head Start or state pre-k) (y/n)

4. Are the following life course measures collected about clients served by your HV program? (checklist)
    - Family's basic life resource needs met or unmet (y/n)
    - Parent's education (y/n)
    - Family income (y/n)
    - Receipt of public assistance (y/n)

5. Are you required to submit client or outcome data to one or more funders? (if yes, add the following checklist)
    - Case-level data
    - Aggregated statistics

6. Are you aware of any efforts to link program data to other information within your agency or from other agencies or departments? (Ex: a data warehouse, links with public assistance data.) (y/n/unsure)

7. Have any impact evaluations of your HV program been completed by external entities in the last 5 years? (y/n/unsure)

8. Do you have an outcome measures document you can share? (y/n)
    - If yes, could you please upload it as an attachment?

Note: Questions were developed based on questions from the Pew Project, Alameda County's 2011 investigation of home visiting programs, the 2012 LA Best Babies Network home visiting survey, and drafted to meet the needs of this project.

Appendix B: Los Angeles County Home Visiting Provider Inventory

[Providers listed in black were contacted and responded to the survey. Those listed in red were contacted multiple times, but did not respond.]

Alma Family Services
Antelope Valley Health Center
Antelope Valley Hospital
Antelope Valley Partners for Health
Baldwin Park Unified School District
Bienvenidos Children's Center
California Hospital Medical Center
CCRC
Centinela Hospital
Child and Family Guidance
Child and Family Guidance Center
Child Care Resource Center
ChildNet Youth and Family Services, Inc.
Children's Bureau
Children's Center of Antelope Valley
Children's Clinic
Children's Hospital Los Angeles
Children's Institute, Inc.
Citrus Valley Health Partners
Citrus Valley Medical Center, Queen of the Valley Campus
Clinica Msr. Oscar A. Romero
Counseling and Research Associates. Inc. (Masada Homes)
Counseling 4Kids
D'Veal Corporation (D'Veal Family and Youth Services)
East Valley Community Health Center
El Centro de Amistad, Inc.
El Nido Family Centers
El Rancho Unified School District
Esperanza Community Housing Corp.
Every Child
Exchange Club Family Support Center
Families in Good Health
Family Focus Resource Center: Santa Clarita Valley
Five Acres
Foothill Family Services
For the Child
Friends of the Family
Gateways Hospital and Mental Health Center
Great Beginnings for Black Babies, Inc.
Helpline Youth Counseling, Inc.
Hillsides
Home Safe
Hope Street Family Center
Human Services Association
Human Services Association
Kedren Community Health Center, Inc.
Korean American Family Service Center, Inc.
Koreatown Youth and Community Center, Inc.
LA County Department of Public Health
Lancaster School District: Early Childhood Education Office
Latino Diabetes Clinic - Family Health Education Center
LAUSD/Lincoln Heights Alliance for Health Families
Los Angeles Child Guidance Clinic
Los Angeles Education Partnership (Urban Education Partnership)
Long Beach Department of Health and Human Services
Long Beach Unified School District
Maternal and Child Health Access
Miller Children's Hospital
Mission City Community Network, Inc.
Northridge Hospital Medical Center
Options-A Child Care and Human Services Agency
PACE
Pacific Asian Counseling Services
Pacific Clinics
Palmdale Unified School District: Early Childhood Education Office
Paramount Unified School District: Early Childhood Education Office
Parents' Place
Partners in Care Foundation
Pasadena Public Health Department

Pediatric Therapy Network
Plaza Community Services
Plaza de la Raza Child Development Services, Inc.
Pomona Unified School District
Project ABC
Prototypes
Providence Holy Cross Medical Center
Providence Little Company of Mary/Torrance Memorial Medical Center
Rainbow Services, Ltd.
Richstone Family Centers
Rosemary Children's Services
Rowland Unified School District, Family Resource Center: Ready, Set, Go
Saint John's Child & Family Development Center
SHIELDS for Families, Inc.
South Central Family Health Center
South LA Biomed
SPIRITT Family Services
St. Anne's Maternity Home
St. Francis Medical Center
St. John's Well Child & Family Center
St. Mary Medical Center - Families in Good Health
The Children's Collective, Inc.
The Clinic
The HELP Group
The Whole Child
TIES for Families
UCLA/Mattel Children's Hospital
UCLA - Nathanson Family Resilience Center
Universal Love Foundation
USC - School for Early Childhood Education
Valley Presbyterian Hospital
Venice Family Clinic - Children First
VIP Community Mental Health Center, Inc.
Vista Del Mar and Family Services
Volunteers of America
Westside Children's Center
White Memorial Medical Center
Wilmington Community Clinic

Appendix C: Pew Home Visiting Data for Performance Initiative

The Pew Charitable Trusts (Pew) launched a Home Visiting Data for Performance Initiative to examine the range of data collected by HV programs and create a consensus about the key measures that ought to be collected. As a result of this initiative, Pew has developed a list of summary of core measures for home visiting programs in effort to encourage uniformity across programs. The data that Pew suggest to collect are listed as follows:

1. Adult participant date of birth
2. First-time parent
3. Target child's date of birth
4. Number of home visits provided to each participant during the observation period
    a. Required data elements: Dates of home visits
5. Mean time between home visits for each participant
    a. Required data elements: Dates of home visits
6. Duration in program
    a. Required data elements: Date of first visit, date of last visit
7. Percent of available caseload slots filled, per case worker
    a. Required data elements: Percent FTE of case worker; number of caseload slots per FTE per report period; number of caseload slots filled per report period
8. Percent of participants successfully completing services
9. Distribution of reasons for incomplete services
    a. Required data elements: Date and reason for service termination
10. Interconception care/ use of postpartum visit
    a. Percent of women who receive a postpartum visit
11. Interpregnancy interval
    a. Percent of women with an interpregnancy interval of less than six months
12. Breastfeeding
    a. Percent of mothers in home visiting programs who are breastfeeding infants at 3 months
13. Tobacco use among mothers
    a. Percent of mothers served in home visiting programs who are previous smokers not currently smoking
14. Maternal depression
    a. Percent of women served in home visiting programs who receive depression screening (within the past year)
    b. Percent of women who have a positive screen for depression and have a completed referral for intervention services
15. Child injury measures
    a. Home safety and hazards

        i. As measured through an observational checklist or similar program measure
    b. Preventable injury-related hospitalizations
    c. Preventable emergency room visits for injury
    d. Child abuse or neglect fatality
16. Child maltreatment measures
    a. Reported maltreatment
    b. Child's placement in foster care
    c. Child maltreatment fatalities
    d. Self-reported maltreatment
        i. As measured through a questionnaire or interview
17. School readiness measures
    a. Child's enrollment in a regulated early childhood program (i.e. regulated child care, Head Start or state pre-k) following participation in the home visiting program
    b. Child's attendance during kindergarten
    c. Progress reports on a few key school readiness indicators specific to the child in the home visiting program, during the time of the child's participation in the program.
18. Life course measures
    a. Family's basic life resource needs met or unmet
        i. As measured through self-report scales (e.g., Family Resources Scale)
    b. Parent's graduation (or progress towards graduation or equivalent)
    c. Family income
    d. Births
    e. Receipt of public assistance
19. Strong coordination with local resources and providers
20. Proactive management of the client population (use of a registry database)
21. Staff/client ratio
22. Culturally appropriate pairing of staff and clients (e.g., language)
23. Continuing staff education, training, and supervision

Appendix D: Nurse Family Partnership, Required Data Elements

The **Nurse Family Partnership** has developed a comprehensive list of data that are collected by all NFP programs. This list includes data domains detailed below:

1. Prenatal Care
    - # of clients who entered prenatal care reported by each trimester
    - # of prenatal visits completed
2. Parental use of alcohol, tobacco or illicit drugs
    - # of clients who indicate alcohol use
    - # of clients who indicate tobacco use
    - # of clients who indicate illicit drug use
3. Preconception Care
    - # of clients pregnant with 2nd child and received post-partum and/or well woman care after child
4. Inter-birth intervals
    - # of clients with a subsequent pregnancy when first child reaches Infancy 6 months
    - # of clients with a subsequent pregnancy when first child reaches Infancy 12 months
    - # of clients with a subsequent pregnancy when first child reaches Toddler 18 months
    - # of clients with a subsequent pregnancy when first child reaches Toddler 24 months
5. Screening for maternal depressive symptoms
    - # of clients screened for depressive symptoms at 36 weeks gestation
    - # of clients screened for depressive symptoms at Infancy 1-8 weeks
    - # of clients screened for depressive symptoms at Infancy 4-6 months
    - # of clients screened for depressive symptoms at Infancy 12 months
6. Breastfeeding
    - # of clients who indicate breastfeeding at infant birth
7. Well-child visits
    - # of well-child visits completed
8. Maternal & child health insurance status
    - # of clients with Use of Government & Community Services forms completed at each interval
    - # of clients with Use of Government & Community Services forms that have a child completed at each interval
9. Visits for children to the Emergency Department from all causes
    - # of children with Emergency Department visits for injury/ingestion at each interval
    - # of children with Emergency Department visits for all other causes at each interval

- # of children with Urgent Care visits for injury/ingestion at each interval
- # of children with Urgent Care visits for all other causes at each interval

10. Visits of mothers to the Emergency Department from all causes
    - # of clients with Emergency Department visits at each interval
    - Total # of client visits to the Emergency Department by phase
    - # of clients with Urgent Care visits at each interval
    - Total # of client visits to the Urgent Care by phase
11. Information provided or training of participants on prevention of child injuries topics such as safe sleeping, shaken baby syndrome, or traumatic brain injury, etc.
    - # of clients receiving information or training on injury prevention during at least one home visit per phase
    - # & % of home visit encounters that indicate receipt of information or training on injury prevention per phase
12. Incidence of child injuries requiring medical treatment
    - # of children with injuries requiring treatment at each interval
13. Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated)
    - # of suspected cases of child maltreatment at each interval
14. Reported substantiated maltreatment (substantiated /indicated /alternative response victim) for children in the program
15. First-time victims of maltreatment for children in the program
16. Parent support for children's learning & development (e.g., appropriate toys available; read & talk with child)
    - Score for “Learning Materials” at Toddler 18 months – Score at Infancy 6 months
    - Score for “Involvement” at Toddler 18 months – Score at Infancy 6 months
17. Parent knowledge of child development & of their child's developmental progress
    - Score at Toddler 18 months – Score at Infancy 6 months
18. Parenting behaviors & parent-child relationships (e.g. discipline strategies, play interactions)
    - Score for “Responsivity” at Toddler 18 months – Score at Infancy 6 months
    - Score for “Acceptance” at Toddler 18 months – Score at Infancy 6 months
19. Parent emotional well-being or parenting stress
    - # of clients screened at 36 weeks
    - # of clients screened at Infancy 1-8 weeks
    - # of clients screened at Infancy 4-6 months
    - # of clients screened at Infancy 12 months
20. Child's communication, language & emergent literacy
    - # of children screened at each interval
21. Child's general cognitive skills
22. Child's positive approaches to learning including attention
23. Child's positive approaches to learning including attention
24. Child’s social behavior, emotion regulation & emotional well-being
25. Child's physical health & development
    - # of children screened for weight at each interval
    - # of children screened for height at each interval

- # of children screened for head circumference at each interval

26. Crime: Arrests Convictions
27. Domestic Violence: Screening for domestic violence
    - # of clients screened for domestic violence at each interval
28. Domestic Violence: Referrals for domestic violence services for families with identified need
    - # of referrals made for domestic violence services
29. Domestic Violence: Safety plan completed for families with identified need
    - # of safety plans, reviewed, discussed or made for clients with identified need
30. Household income & benefits
    - Mid-point of selected income range at Infancy 12 month - mid-point of selected income range at Intake
    - # of in-kind benefits for client and child at Infancy 12 months – # of in-kind benefits at Intake
31. Employment of adult members of the household (NFP defines the household as client and child)
    - Usual # of hours of employment at Infancy 12 months - usual # of hours of employment at Intake (by range)
    - Usual # of hours of employment at Infancy 12 months - usual # of hours of employment at Intake (by range)
    - Usual # of hours of unpaid child care at intake (by range) - usual # of hours of unpaid child care at Infancy 12 months (by range), increase, decrease, the same.
32. Education of adult members of the household
33. Health insurance status
    - # of clients with health insurance at Infancy 12 months - #clients with insurance at Intake
    - # of children with health insurance at Infancy 12 months
34. Number of families identified for necessary services
    - # of families screened for need
35. Number of families that required services & received a referral to available community resources
    - # of families who received referral to available community resources
36. MOUs or other formal agreements with other social service agencies in the community
37. Information sharing
38. Number of completed referrals
    - # of families with identified needs where the receipt of services can be confirmed by category

Appendix E: REDcap (Research Electronic Data Capture)

http://project-redcap.org/

For smaller counties, developing a central repository for compiling and managing data collected by home visiting providers is unlikely to make sense from a cost/benefit perspective. One possible approach to supporting a county-wide or regional evaluation of home visiting services (that would also provide a foundation for assembling client-level data required for linkages to other data sources), would be to engage a university-based research partner in the work and then use REDCap, a HIPAA-compliant, secure web application for building and managing ad hoc electronic databases. We have outlined some core features of REDCap below:

Tool Background

- REDCap is a software available at no cost to REDCap Consortium Partners. There are over 300 institutional partners worldwide, including major universities, research institutions, and hospitals.

[Both the Children's Data Network at USC, and its partner the Child Welfare Indicators Project at UCB, are consortium members. We expect that UCLA, UC Santa Barbara, UC San Diego and other Universities are also members.]

Tool Features

- Users can move from project conception to a production-level database or survey very quickly. Projects can be created using 2 methods (the software is flexible and users can easily move back and forth between the 2 methods):
  - Online designer which serves to create an ad hoc electronic data base with specified data elements (easy drop down menus, etc.)
  - Uploading data dictionaries (excel / csv file manipulation)
- There are 2 main Steps for research projects in REDCap:
  - Development (project / instrument development). The process is very flexible and allows for significant pre-testing of forms/reports in the Development phase.
  - Production (data entry). Additionally, changes to forms/report can be made, approved, and implemented during data entry phases also.
- Variable format are customizable (all types of data can be collected)
  - Hard and soft data validation options are available
  - Branching logic is available for multiple choice questions.
  - Shared library of validated data instruments (questionnaires / behavioral scales, etc.) are available for import.

- The software can be used for multiple research/study designs. 3 primary research designs are supported.
  - *Classic Study*. Data entry format is easily customized. Can be used for ongoing research
  - *Longitudinal Study*. More structured. Includes sophisticated calendaring / scheduling tools for follow-ups
  - *Survey.* Online survey administration. Post survey data manipulation more difficult.

[Based on our review of the 3 methods – the classic design may be best for the home visiting data, because it is more flexible. If multiple versions of the same data entry report are used (monthly or annually, etc.) responses can be linked across reports. Essentially the data can be collected traditionally, but analyzed longitudinally.]

Tool Access and Data Security

- *Web-based and Secure.* Users can design projects / input data over a secure web connection from anywhere.
- The software provides multiple levels of secure data access. Software includes user rights grids so access rights are easy to manage
- The software provides audit trails and access logs so that every change to a research projects is tracked.
- *Multi-site access*. REDCap databases/surveys can be used by researchers from multiple sites and institutions. There is no limit to the number of sites.

[For the home visiting data – a University partner could set this up with the DAG (data access groups) function for various agencies. This would assign and agency level prefix to each record ID.]

Data Analysis for Research, Evaluation, and Quality Assurance

- Exports raw data and syntax files to common data analysis packages such as SAS, Stata, R, and SPSS.
- Exports can be customized and users can export multiple levels of data (based on user's access rights).
- Includes graphical data view and stats modules that can be used within agencies for simple views of the data, data quality monitoring, and data cleaning.
- Has a customizable report builder for queries, allowing reports to be accessed by users at all levels depending on their access rights.

[In the context of home visiting data, agencies could download copies of reports specific to their agency.]