Findings from the MCAH Action Home Visiting Priority Workgroup Survey "Home Visiting for Pregnant Women, Newborn Infants, and/or High-Risk Families"

July, 2006

The Survey was developed by the MCAH Action Home Visiting Priority Workgroup with technical assistance by the Family Health Outcomes Project

The survey results were compiled and this report prepared by the
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Executive Summary

The Home Visiting Priority Workgroup of California's MCAH Action (the statewide organization of Maternal, Child and Adolescent Health Directors for the 61 local public health jurisdictions in California), with the assistance of the Family Health Outcomes Project (FHOP), University of California, San Francisco, developed and disseminated a self-administered questionnaire to the 61 local MCAH directors/coordinators to collect data on local health department home visiting programs that serve pregnant women, newborn infants and/or high risk families. The organization monitors, develops, advocates for and recommends public policy related to maternal, child and adolescent health. It provides expertise and counsel to the State, the legislature and other policy-making bodies in the areas of maternal, child, and adolescent health.

The objectives of this survey were: 1) To develop a profile of the number and types of public health department home visiting programs serving this population; 2) To provide information to promote networking and collaboration among counties with home visiting programs; and 3) To provide data to inform potential health care legislation that would include home visiting services as a covered benefit.

The survey was originally sent via electronic mail in March 2005 to all 61 local MCAH Directors. In September 2005, for the purpose of increasing the number of respondents, FHOP developed a web-based survey. As of December 1st, 2005, completed surveys were received from 34 jurisdictions. FHOP compiled the data using EXCEL, read the data into SAS software version 8.2 and calculated frequencies. A preliminary report was reviewed by the MCAH Action Executive Committee and the MCAH Action Home Visiting Priority Workgroup and input was incorporated into the final version.

Summary Findings

Over one-half (34) of the 61 LHJs responded to the survey

- The 34 jurisdictions responding were: Alameda, Calaveras, Fresno, Humboldt, Kern, Kings, Long Beach, Los Angeles, Madera, Marin, Mendocino, Modoc, Mono, Monterey, Napa, Placer, Plumas, Sacramento, San Benito, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Sonoma, Stanislaus, Sutter, Tulare, Ventura, and Yolo. One jurisdiction (Marin) reported that its Public Health Department did not have a home visiting program serving this population.
- 25 of the 34 jurisdictions indicated that agencies other than their public health department operated programs (1 to 15) serving the population. 7 did not know of other programs and one jurisdiction did not respond to the question.
- A total of 66 home visiting programs from 33 jurisdictions were described.

The responses received from the 66 local home visiting programs completing the survey indicated that home visiting programs serving pregnant women, newborn infants, children and high risk families vary greatly in program design and implementation. Most of these programs provide assessment, education, counseling and information and referral. Additional analysis of the survey findings shows*:

* There were 66 completed surveys, however, there is missing data for individual questions. For each individual question, the denominator is based on the number of respondents that answered a particular question. In some cases percentages may add up to less or more than 100% due to rounding.

- Over one-half (39 of 66) of those programs completing the survey report that they used a pre-existing model when developing their home visiting programs. Slightly over one-half of these (18/39) reported the model used is the Nurse-Family Partnership (NFP) or some variation of the NFP/OLDS[+] model). **NOTE:** However, of these, only 5 of the programs that responded officially participate in the National NFP program (Fresno; Los Angeles; Long Beach, which participates as part of the Los Angeles NFP; Sacramento and Kern). The other programs report that they adapt parts of the model or the general philosophy and approach of the model.

- 67% (40 of 60) of programs have been operating for 10 or more years. Only 3% (2) for less than 2 years.

- 26% (17 of 65) of programs indicate they visit all pregnant women/all newborns.

- 89% (59 of 66) of programs have Public Health Nurses (PHNs) on staff. Of these, 59% (35 of 59) also employ Community Health Workers (CHWs) and 9% (6) employ Family Advocates.

- The average caseload of PHNs ranges from less than 10 to more than 40 cases, with 58% (30 of 52) in the range of 21-40 as an average caseload. For CHWs, 46% (12 of 26) reported a range of 21-40 average caseload.

- Programs generally use more than one client assessment tool. The tools most frequently used are the Denver - 68% (44 of 65), Ages and Stages – 46% (30) and NCAST – 45% (29).

- 81% (52 of 64) of programs have training on the use of their assessment tools provided in-house. 38% (24 of 63) have a certified assessment tool trainer on staff.

- 48% (31 of 64) said staff attends training provided by the model used in the development of their program and 22% (14 of 64) said their program had no formal training for staff.

- 46% (30 of 64) said their staff training curriculum was developed by staff, 8% (5 of 65) replicated training from another program.

- 33% (21 of 64) report a patient curriculum developed by staff, 14% (9 of 64) replicate from another program, 19% (12 of 64) use the curriculum from the home visiting model they use and 39% (25 of 64) have no formal curriculum.

- 44% (27 of 61) of programs provide a monthly home visit (many increase the frequency of visits, if needed), 28% (17 of 61) of programs establish a visit schedule based on client needs, and 16% (10 of 61) have a graduated schedule. 64% (41/64) stop services at a specified age or number of visits.

- 76% (50 of 64) of programs have a case management database. Of these 58% (24) use software programs developed in-house.

[+] The official NFP programs are under contract with the National NFP to implement the NFP program with fidelity to the Olds model of nurse home visitation. Other programs indicating use of the NFP model use the "philosophy" or some element(s) of the NFP program and are not official NFP programs.

- Only 50% (32 of 64) of programs conduct a formal evaluation of their program.

- 85% (51 of 60) of programs have targeted outcomes. These outcomes are primarily related to assessment, birth, health behavior, positive parenting, access to health care/other services, education/counseling/support, child development, and maternal education and support.

- 79% (52 of 66) of programs report having some evaluation measures for monitoring their programs—those most frequently listed are related to birth, behavior change, health service access, and pregnant teen education outcomes. Some programs only report client demographic, service utilization and referral statistics.

- Of the 18 programs that responded to this question, the program cost per client ranged from $190 to $266 a month and $1,812 to $3,485 a year. Methods of determining cost varied.

- The most frequently listed source of funding was targeted case management (20 programs), followed by First Five (16), MCAH (14) and general funds (14). Programs generally used multiple sources of funding. 63% (35 of 56) of programs use matching funds or in-kind resources.

- 81% (48 of 59) of programs said they rely on collaborations/partnerships with other agencies. A broad range of collaborators and partners were listed. 29% (17 of 58) reported subcontractual relationships (some subcontract to other agencies and some are contract employees).

Findings from the MCAH Action Home Visiting Workgroup Survey "Home Visiting for Pregnant Women, Newborn Infants, and/or High-Risk Families"

In March 2005, Maternal, Child and Adolescent Health (MCAH) Directors were asked to complete and/or send to home visiting program staff in their health departments to complete, the MCAH Action Home Visiting Workgroup Questionnaire, "Home Visiting for Pregnant Women, Newborn Infants, and/or High-Risk Families."

There are many home visiting programs operating in California counties, some developed and managed by local health departments and some by community-based organizations and others. California's MCAH Action Home Visiting Priority Workgroup, with the assistance of the Family Health Outcomes Project (FHOP), University of California, San Francisco, developed a survey instrument to collect data on local health department home visiting programs that serve pregnant women, newborn infants and/or high-risk families. The members of California's MCAH ACTION, the statewide organization, are the Maternal, Child, Adolescent Health (MCAH) Directors and Coordinators of California's 61 local health jurisdictions (LHJs). The organization monitors, develops, advocates for and recommends public policy related to maternal, child and adolescent health. It provides expertise and counsel to the State, the legislature and other policy-making bodies in the areas of maternal, child, and adolescent health.

The objectives of this survey were: 1) To develop a profile of the number and types of public health department home visiting programs serving this population; 2) To provide information to promote networking and collaboration among counties with home visiting programs; and 3) To provide data to inform potential health care legislation that would include home visiting services as a covered benefit.

A definition of a home visiting program was not included with the questionnaire, as it was intended that the individual jurisdictions determine the definition themselves. The MCAH Program Directors/Coordinators were asked to indicate if their public health department had one or more home visiting programs that provide services to pregnant woman, newborns and/or high-risk families. If so, they were asked to forward the survey to the home visiting programs within their health department. They were also asked to indicate if any other agencies in their jurisdiction provided home visits to this population. These programs were noted, but not surveyed.

The survey was originally sent via electronic mail in March 2005 to all 61 LHJs MCAH Directors. In September 2005, for the purpose of increasing the number of respondents, FHOP developed a web-based survey. As of December 1st, 2005, completed surveys were received from 34 jurisdictions. FHOP compiled the data using EXCEL, read the data into SAS software version 8.2 and calculated frequencies. The MCAH Action Executive Committee and the MCAH Action Home Visiting Priority Workgroup reviewed a draft of this report and input was incorporated into the final version.

The LHJs that responded as of December 1st, 2005 were: Alameda, Calaveras, Fresno, Humboldt, Kern, Kings, Long Beach, Los Angeles, Madera, Marin, Mendocino, Modoc, Mono, Monterey, Napa, Placer, Plumas, Sacramento, San Benito, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Sonoma, Stanislaus, Sutter, Tulare, Ventura, and Yolo. The LHJs that had not responded by this date were: Alpine, Amador, Berkeley, Butte, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Imperial, Inyo, Lake, Lassen, Mariposa, Merced, Nevada, Orange, Pasadena, Riverside, San Diego, San Luis Obispo, Santa Barbara, Solano, Tehama, Trinity, Tuolumne, and Yuba.

SUMMARY FINDINGS

Of the 34 respondent LHJs, only one reported it did not have a home visiting program serving pregnant women, newborn infants and/or high-risk families within its public health department. The 33 other LHJs reported at least one public health department operated home visiting program. The total number of reported home visiting programs within health departments was 93 (ranged from 1 to 9 reported programs in a jurisdiction, more than 2/3 of jurisdictions had 1 to 4 programs within their department). In some jurisdictions, a questionnaire was not filled out for all of the programs that were reported.

Twenty five (25) of the 34 LHJs (includes Marin) indicated that agencies other than their public health department also operated home visiting programs serving pregnant women, newborn infants and/or high-risk families. Those replying reported 1 to 15 programs operating independent of the local public health department. Seven did not know of other programs and 1 did not reply to the question. These programs were not surveyed.

The following findings are compiled from the 66 questionnaires completed by local public health department operated home visiting programs[*].

Length of Program Operation

Question: How long has your program been operating?

- 60 programs responded to this question (N=60); 6 did not.
- Of the 60 programs, 28% (17) indicated that their program has been operating for 20 or more years; 38% (23) reported from 10-19 years; 30% (18) from 2 to 9 years; 3% (2) less than 2 years.

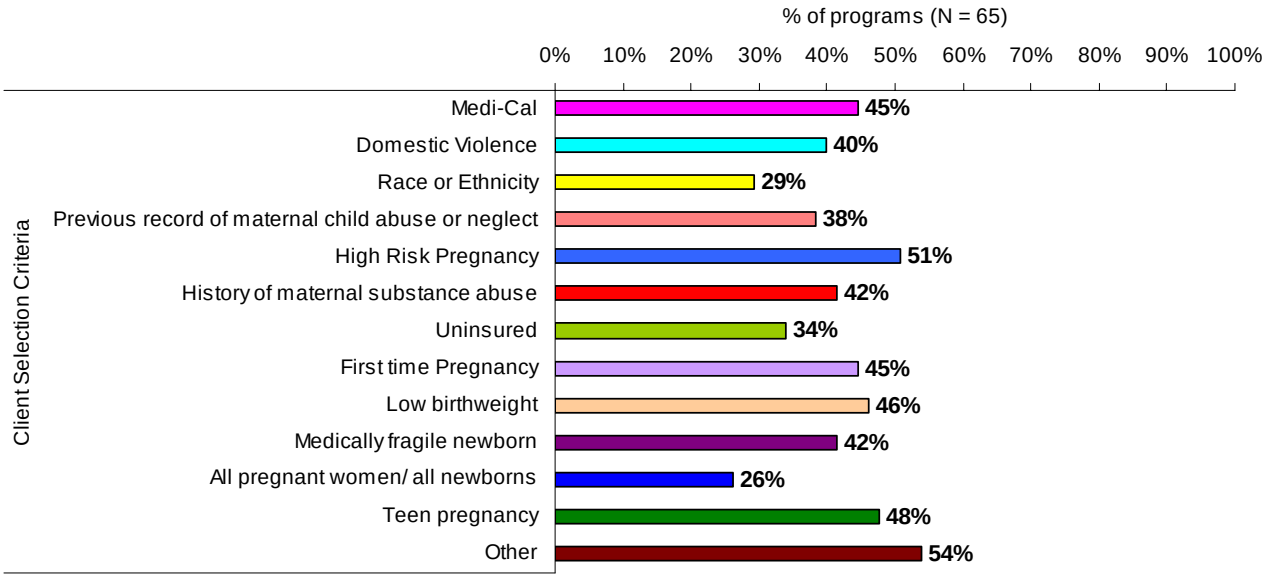
[*] There were 66 completed surveys; however, there is missing data for individual questions. For each individual question, the denominator is based on the number of respondents that answered a particular question. In some cases percentages may add up to less or more than 100% due to rounding.

Client Selection Criteria

Question: Check **all** criteria for entry into your home visiting program that apply. A list of 12 criteria and "other" followed the question.

- 65 programs responded to this question (N=65); one program did not.
- Of the 65 programs, about 1/2 use 5 or more of the listed client selection criteria.
- 51% of programs (33) reported high-risk pregnancy as a criterion for program entry.
- Between 1/3 and 1/2 of programs reported using one or more of the following criteria: 48% (31) of programs used the criterion teen pregnancy, 42% (27) medically fragile newborn, 46% (30) low birth weight, 45% (29) first time pregnancy, 34% (22) uninsured, 42% (27) history of maternal substance abuse, 38% (25) previous record of maternal child abuse or neglect, 40% (26) domestic violence and 45% (29) Medi-Cal insured.
- 26 % (17) of programs indicate they visit all pregnant women/all newborns.

Chart 1. Percent of Programs using Various Client Selection Criteria

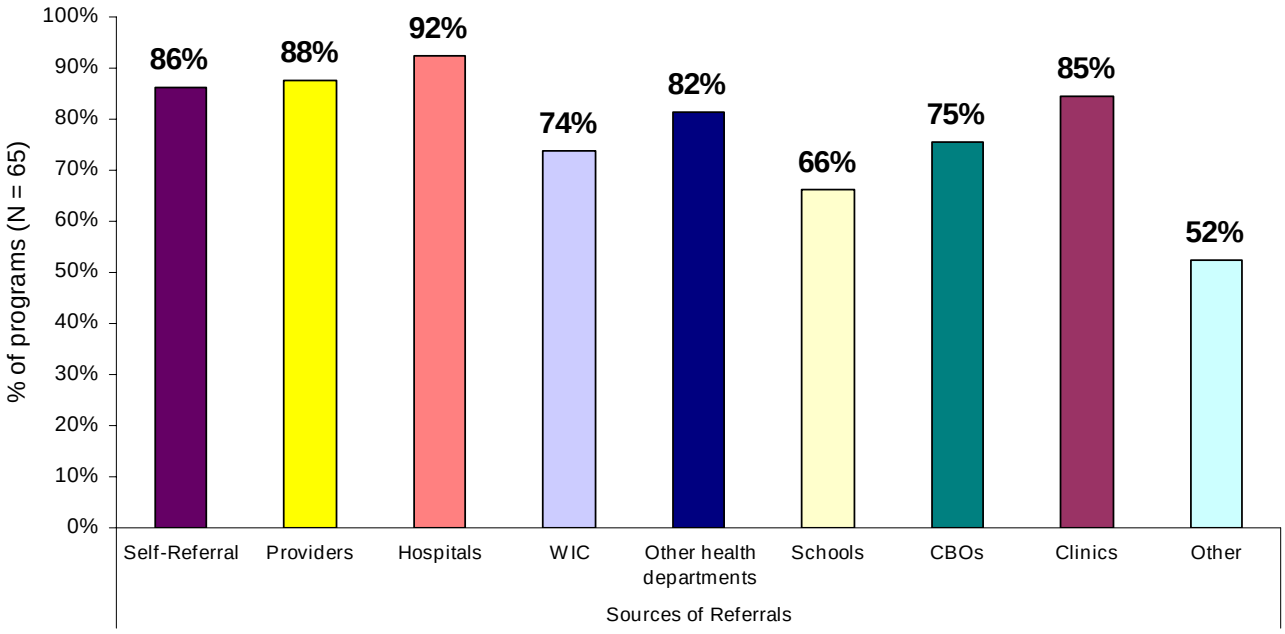


Client Referrals

Question: What are the sources of client referrals? Check **all** that apply. A list of 12 criteria and "other" followed the question.

- 65 programs responded to this question (N=65); one program did not.
- Most programs receive referrals from multiple sources.
- As shown in Chart 2 over 4/5 of programs report receiving client referrals from the following: 92% (60) from hospitals, 88% (57) from providers, 86% (56) from self-referral, 85% (55) from clinics and 82% (53) from other health department programs.
- "Other" sources of referral include alcohol and drug programs, family resource center, newborn house calls, door to door outreach in high-risk area, Developmental Disability Services (DDS), Comprehensive Perinatal Services (CPS), SCAN (Suspected Child Abuse Network Team), courts and probation, recovery programs, therapeutic child care center, community members, word of mouth, family/friends, Children's Health and Disability Prevention Program (CHDP), California Children's Services (CCS) Stork's Nest, women shelters, coroner, Blue Cross, and churches.

Chart 2. Percent of Programs Receiving Client Referrals by Source of Referral



Program Staffing

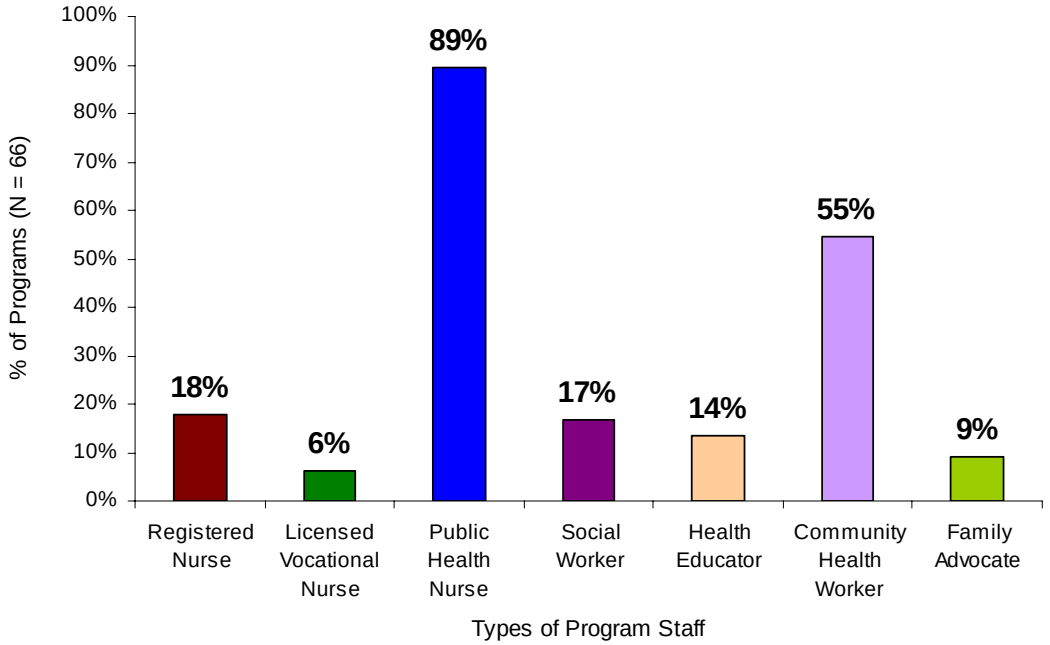
Question: Please 1) indicate with a Y (yes) or N (no) each type of home visiting staff your program uses, 2) enter the number of staff and 3) enter their average caseload. Add any information you think would be useful, e.g., supervisory relationships.

Types of home visiting program staff, as shown in Chart 3 below:

- All 66 programs responded to this question (N=66).
- 89% (59) of programs reported one or more Public Health Nurse (PHN) on staff.

- 55% (36) reported community health worker (CHW) staff and 9% (6) reported family advocate staff.
- 18% (12) reported Registered Nurse (RN) staff, 6% (4) reported Licensed Vocational Nurse (LVN) staff.
- 14% (9) reported Health Educator(s) and 17% (11) reported Social Worker(s) (SW).
- "Other" staff reported included office support, midwives, and mental health therapists.

Chart 3. Percent of Programs using Various Types of Staffing



Number of PHN, RN and CHW Staff Reported

- 57 of the 59 programs reporting PHN staff (N=57) entered the number of PHNs on their staff. The numbers reported ranged from 0.2 full time equivalents (FTE) to 42 FTE. 30% (17) of programs had less than 2 PHN FTE, 40% (23) had 2 to 10 FTE on staff, 23% (13) had 10 to 19 FTE, and 7% (4) had 20 or more FTEs.
- 11 of 12 programs reporting RN staff (N=11) entered the number of RNs. Note: these frequencies reflect RN staff that is not a PHN. The numbers ranged from .15 FTE to 22 FTE's, with 36% (4) reporting less than 1 FTE RNs (all small jurisdictions) and 46% (5) 1 to 3 RNS. One program reports 22 and one 8 RNs. The program not reporting the number of staff noted they hire RNs when they cannot hire PHNs.
- 34 of the 36 programs reporting CHW staff (N=34) entered the number of CHWs. The numbers ranged from .5 to 10 FTE, with 71% (24) of programs reporting 2 to 4 CHWs.

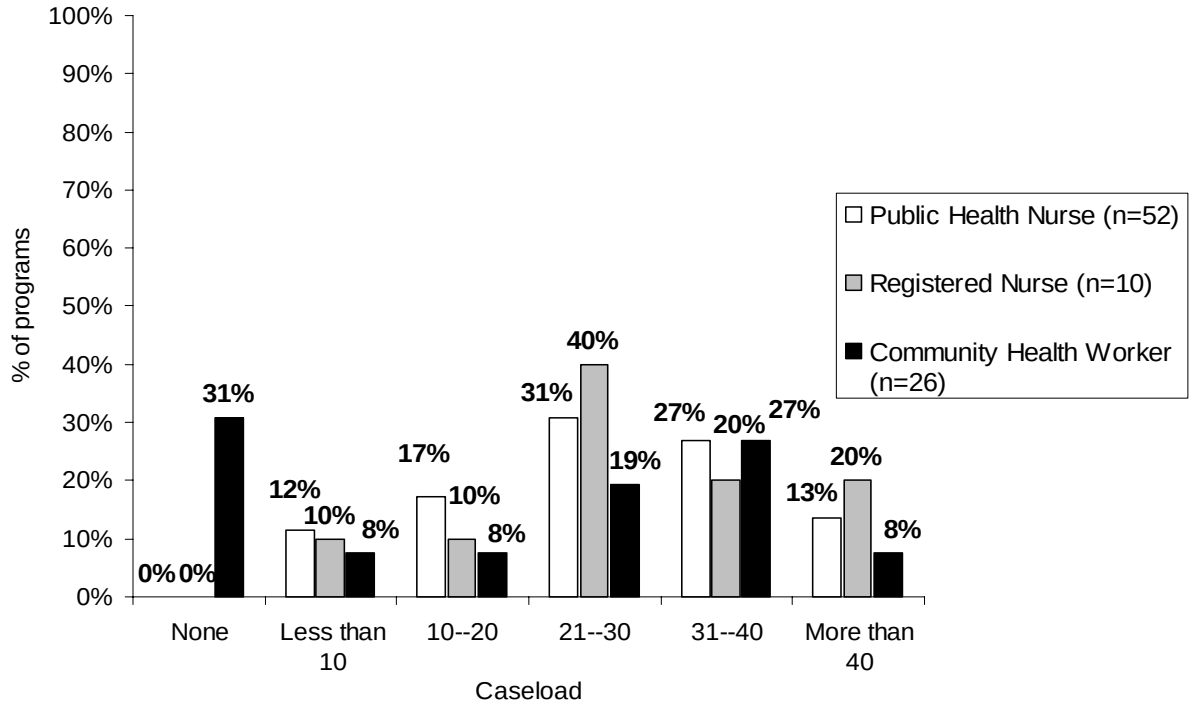
Staffing Patterns

- Of the 59 programs that reported a PHN on staff, 59% (35) of the programs also reported CHWs on staff, 19% (11) also reported RNs, 17% (10) social workers, 15% (9) health educators, 9% (5) family advocates and 5% (3) LVNs.
- Of the 7 programs without a PHN, one program had two LVNs; 4 had RNs (1 program with 60% FTE RN and 1 CHW, 2 programs with 1 RN, and 1 program with 8 RNs and 80 paraprofessionals who provide assessment only); one had thirteen social workers; and one five family advocates who consult with a PHN.

Staff Caseloads, as shown in Chart 4 below:

- Of the 59 programs that reported having PHNs on staff, 52 reported their PHN caseloads (N=52). 12% (6) programs reported PHN caseloads of less than 10; 17% (9) reported caseloads of 10-20; 31% (16) reported caseloads of 21-30; 27% (14) reported caseloads of 31-40; and 13% (7) reported caseloads of more than 40 (one program reported a caseload of 90).
- Of the 12 programs that reported having RNs on staff, 10 reported their RN caseloads (N=10). The caseloads ranged from 8 to 200 with 60% (6) of the programs reporting caseloads ranging from 25 to 35.
- Of the 36 programs that reported CHWs on staff, 26 responded to this question (N=26); 10 programs did not respond to this question. 31% (8) respondents reported that the CHWs did not have a caseload, 8% (2) had a caseload of less than 10; 8% (2) reported a caseload of 10-20; 19% (5) reported a caseload of 21-30; 27% percent (7) reported a caseload of 31-40; and 8% (2) reported a caseload of more than 40, one of which reported a caseload of 80

Chart 4. Homevisiting Caseloads for Programs using PHNs, RNs, and CHW



Program Model

Question: Have you used a pre-existing model when developing your home visiting program (i.e., Olds, Healthy Families America, Parents as Teachers, etc.)? If yes and the model is evidence-based, please provide the **Name of the Model** and, if possible, give the reference.

NOTE: in most instances program responses to this question do not signify strict adherence to the model named or formal designation by the program developer as a replication sites. Based on input to the President of MCAH Action and telephone and e-mail conversations between FHOP and the National Family Nurse Partnership Program staff, language distinguishing between official NFP participating programs and programs inspired by and/or using elements of the NFP was added to this report in the latter part of 2006.

- All 66 programs responded to this question (N=66). See Appendix A – Local Jurisdiction, Program, Model Used/Modified and Assessment Tools Used for specific responses.
- Of the 66 programs, 59% (39) answered that they did use a pre-existing model when developing their home visiting program; 41% (27) did not.
- Of the 39 programs that answered that they did use a pre-existing model, 36 programs provided the name of the model or combination of models they used (N=36); 3 did not. See Chart 5 and Appendix B: Home Visiting Model Used, Whether Evaluated, Targeted Outcomes and Evaluation Measures by Jurisdiction and Program Name. Models named more than once were Nurse Family Partnership (NFP), NFP/OLDS[1], Adolescent Family Life (AFLP), Black Infant Health (BIH), Parents as Teachers (PAT)[2], Stephen J. Bavolek Nurturing Parenting Programs[3], and Touchpoints[4]. Other programs named were Cal-SAHF and Comprehensive Case Management and Care Coordinator Model, Hawaii's Healthy Start Home Visiting Model[5], High Risk Infant Program, Sudden Infant Death Syndrome (SIDS) State Model, Minnesota Program[6], Healthy Families America[7], and the Mandela Model[8]. 6 programs indicated their program was based on a combination of models, and one stated that they reviewed multiple models when developing their program.
- 13% (5) of the programs answering that they used a pre-existing model when developing their program, are official participants in the National Nurse/Family Partnership Program.[+] The official NFP sites are sites that are under contract with the National NFP to implement the NFP program with fidelity to the Olds model of nurse home visitation. The official programs include Fresno, Kern, Los Angeles, and Sacramento. Long Beach is part of the Los Angeles program.

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[1] NFP and NFP/Olds are the same. Olds refers to David Olds the person who developed the NFP model and licenses agencies to use the name. For more information see Olds, D., Hill, P., Mihalic, S., & O'Brien, R. (1998). *Blueprints for Violence Prevention, Book Seven: Prenatal and Infancy Home Visitation by Nurses*. Boulder, CO: Center for the Study and Prevention of Violence or visit http://www.pubinfo.vcu.edu/vabp/program_details.asp?id=121

[2] http://www.parentsasteachers.org/site/pp.asp?c=ekIRLcMZJxE&b=272092

[3] http://www.nurturingparenting.com/about_us.htm

[4] http://www.touchpoints.org/

[5] http://pediatrics.aappublications.org/cgi/content/full/114/3/e317

[6] http://www.duluth-model.org/

[7] http://www.healthyfamiliesamerica.org/about_us/index.shtml

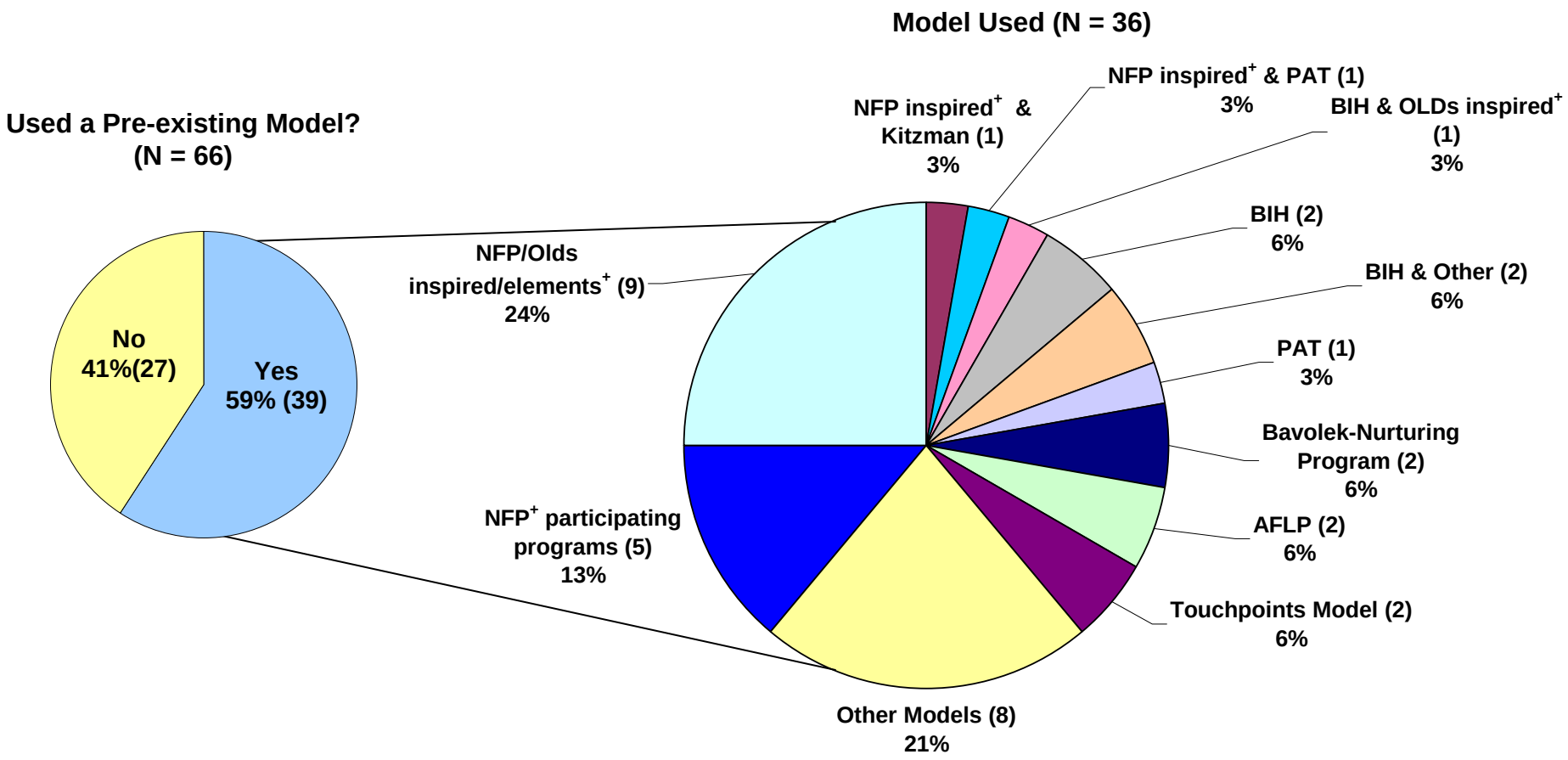
[8] no reference found

[+] The official NFP programs are under contract with the National NFP to implement the NFP program with fidelity to the Olds model of nurse home visitation. Other programs indicating use of the NFP model use the "philosophy" or some element(s) of the NFP program and are not official NFP programs.

- 36% (12) programs reported using some adaptation of the NFP/Olds[+] model, sometimes in combination with elements of another model when developing their home visiting program. On follow-up contact with staff of a few of these programs, staff said their program uses the "philosophy" of the NFP, uses parts of the program or has "modified" the program. They are aware of not implementing the NFP as designed.
- 13% (5) of the programs use Black Infant Health either alone or in combination with another model
- Many other respondents mentioned other programs models or combinations of models for which we have provided references. It is not clear to what extent these programs adhered to the model(s) mentioned since not all of these models have a formal replication and monitoring program like the NFP model. For more information consult the references.

[+] The official NFP programs are under contract with the National NFP to implement the NFP program with fidelity to the Olds model of nurse home visitation. Other programs indicating use of the NFP model use the "philosophy" or some element(s) of the NFP program and are not official NFP programs

Chart 5. Use of Models in the Development of Home Visiting Programs



Key
AFLP = Adolescent Family Life Program
BIH = Black Infant Health
NFP = Nurse Family Partnership
PAT = Parents as Teachers
SIDS = Sudden Infant Death

+ The official NFP programs are under contract with the National NFP to implement the NFP program with fidelity to the Olds model of nurse home visitation. Other programs indicating use of the NFP model use the "philosophy" or some element(s) of the NFP program and are not official NFP programs.

Client Assessment Tools

Question: What client assessment tools do you use? 5 choices were given: NCAST, Denver, P.I.P.E., Bailey, Ages and Stages) and "other".

- 65 programs responded to this question (N=65); one program did not.
- Programs frequently indicated the use of more than one assessment tool.
- 68% (44) of programs used the Denver assessment tool, 46% (30) used Ages and Stages, 45% (29) used NCAST, 14% (9) used P.I.P.E., and 2% used Bailey (1).
- In addition 61% (39) of programs used "other" assessment tools. Examples of "Other" responses included: the Edinburge Post Partum Depression Scale, in-house tools, 4 P's Plus, California's SIDS program tools, Life skills progression, PIER Acuity, SIDS guidelines, and CDC growth charts.

Staff Training on Use of Assessment Tools

Questions: Is there training provided in-house for the tools used? Have one or more of your staff attended a train-the trainer workshop? Do you have a certified trainer on staff for the assessment tool the program uses? Response choices were Yes or No for each question.

- 81% (52) of responding programs provided training in-house for the tools used, 19% (12) did not have training in-house (N=64). 2 programs did not respond to this question.
- 45% (29) of programs indicated that one or more members of the staff attended a train-the-trainer workshop on use of the assessment tools; 55% (35) did not have staff attend (N=64). 2 did not respond.
- 38% (24) of programs have a certified trainer on staff for the assessment tool; 62% (39) did not have a certified trainer (N=63). 3 programs did not respond.

Staff Training

Question: Does your program include formal training for staff? Choice of answers (please check all that apply): 1) Yes, the curriculum was developed by our staff, 2) Yes, we replicated the training from another program, 3) Yes, staff attends training provided by the model used, and 4) No

- 65 programs responded to this question (N = 65); 1 program did not respond.
- 23% (15) of programs indicated that they had no formal training for staff and the remaining 78% (50) of programs have some kind of training. Of the 50 programs, 12 selected more than one answer, e.g., curriculum was developed by staff and staff attends training provided by the model used.
- Of the 50 programs that have some formal training, 60% (30) indicated that their training curriculum was developed by staff, 12% (6) that they replicated the training from another program, and 62% (31) that staff attends formal training by the developers of the model used. Trainings were based on NFP, Touchpoints, and state approved models (e.g. Black Infant Health (BIH) and Adolescent Family Life Program (AFLP).

Visit Schedule

Question: Describe the program's interval schedule for visits, i.e., what gestational age of mother, what age for infant, time interval, etc.

- The responses to this question were narrative (N=61); 5 programs did not respond to this question. Based on grouping of responses:
- 28% (17) of the programs establish a visit schedule based on client needs. For example, one respondent stated, "We do not have assigned visit frequency. The PHN Case Manager makes the visit frequency decision after the initial assessment and grading the acuity tool. The acuity tool numerically measures a family's risk and the visit frequency correlates to the acuity score (low risk - 1 visit per month, medium risk - 2-3 visits per month, high acuity- 3-5 visits per month or more)."
- 16% (10) of the programs have a graduated schedule, in which clients are initially visited frequently and later are visited on a monthly or quarterly schedule
- 44% (27) of the programs schedule a monthly visit. Most of these indicate that they increase the frequency of visits if needed.
- 12% (7) gave responses that did not fit into these categories.

Duration of Intervention

Question: Does your program have a cutoff for age or number of visits after which you terminate the client? Yes or No. If yes, what is it?

- 64 programs responded to this question (N=64); 2 did not.
- More than half the respondents, 64% (41) have a cutoff for age or number of visits after which a client is terminated. 37% (23) respondents did not have a cutoff for intervention.
- 41 programs indicated a cutoff: 34% (14) indicated the cutoff was when the child reaches 2 years old, 15% (6) said 6 months/1 year, 12% (5) reported 5 years, 7% (3) when mother reaches 20 years old, 7% (3) when client reaches age 19-20 and 24% (10) gave other responses, such as 1 visits, 3 years, 2 months.

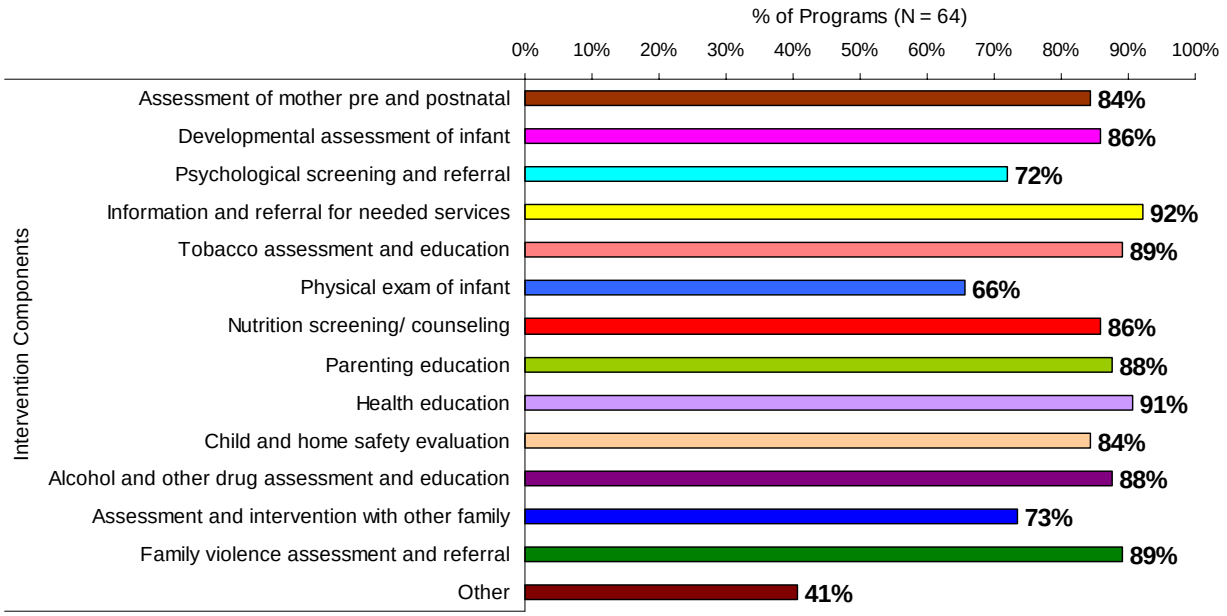
Intervention Components

Question: What are the activities that are included in your program? Please check **all** that apply. 13 activities were listed and an option of "other."

- 64 programs responded to this question. (N=64); 2 did not.
- Chart 6 below shows that programs implement a broad spectrum of assessment and intervention services. Responses indicated that each of the 13 activities listed were included in at least 2/3 of programs. The most frequently checked activities were information and referral, 92% (59); and health education, 91% (58). The least reported activities were: providing a physical exam of infant, 66% (42); psychological screening and referral, 72% (46); and assessment and intervention with other family members, 73% (47).

- Examples of the "other" intervention components included breastfeeding/childbirth education, crisis intervention, assistance with transportation, linkage to high risk infant team, and referrals to housing, substance use, educational and vocational programs.

Chart 6. Percent of Programs Using Various Intervention Components



Patient Education

Question: Does your program have a formal patient education curriculum? Choice of answers: 1) Yes, the curriculum was developed by our staff, 2) Yes, we replicated the patient education from another program, 3) Yes, the patient education curriculum is part of the model used, and 4) No

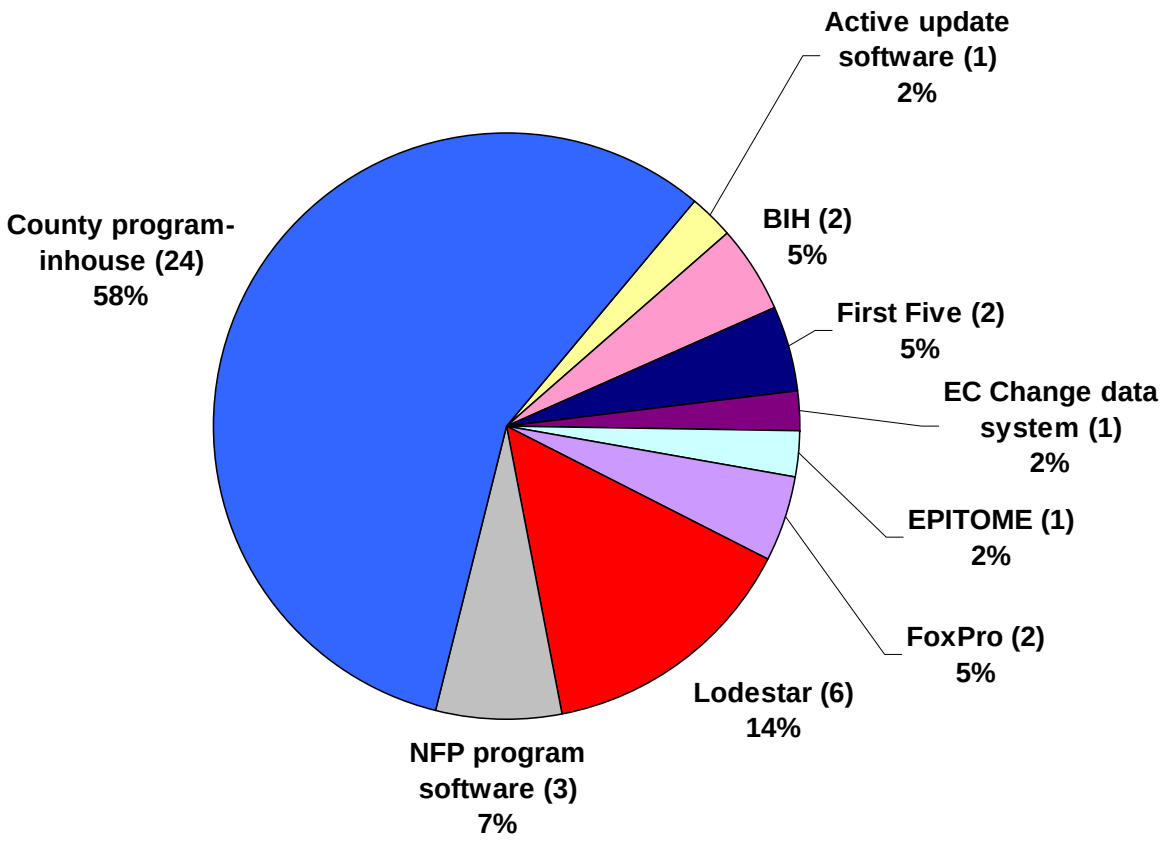
- 64 programs responded to this question. (N=64); 2 programs checked multiple answers; 2 programs did not respond to the question.
- 33% (21) of respondents reported a curriculum developed by staff.
- 14% (9) reported replicating the patient education from another program. Programs include P.I.P.E., Black Infant Health (BIH), Strengthening Multicultural Families, and Touchpoints.
- 19% (12) reported that the patient education curriculum is a part of the home visiting model they are using. These included BIH, Nurse Family Partnership, Parents as Teachers and Touchpoints.
- 39% (25) reported not having a formal education curriculum.

Case Management Database

Questions: Do you have a case management database system? Yes or No. If yes, who inputs the data? What software program is used?

- 64 programs responded to this question (N=64); 2 did not.
- 76% (50) of programs have a case management database system, while 21% (14) do not.
- 40 of the 50 programs that reported having a case management data base indicated who entered their data (N=40), 6 others responded; however, the responses were unclear. Review of these narrative responses showed that almost 2/3 of programs (63%) use clerical or support staff to enter data, PHNs enter the data in 20% of programs. The other 17% of programs report data entry by Case Managers (2 programs), RNs (1), all home visiting staff (1), MCAH Director or Program Manager/Coordinator (3).
- 42 programs wrote in the case management software used (N=42). These responses were reviewed and grouped. Chart 7 shows that of the programs using case management software, 58% (24) use programs developed in-house, 14% (6) use Lodestar, and 7% (3) use NFP program software.

Chart 7. Case Management Software Used by Home Visiting Programs



Key: BIH = Black Infant Health, NFP = Nurse Family Partnership

Program Evaluation

Question: Are you conducting or have you conducted a formal evaluation of your program? If yes, describe or attach description/tools/materials.

- 64 programs responded to this question (N=64); 2 did not.
- See Appendix B: Home Visiting Model Identified, Whether Evaluated, Targeted Outcomes and Evaluation Measures by Jurisdiction and Program Name.
- 50% (32/64) of programs report they have a formal program evaluation component.

Program Outcomes

Question: Do you have targeted outcomes for your program? Yes or No. If Yes, please list.

- 60 programs responded to this question (N=60); 6 did not.
- 85% (51) of respondents reported having targeted outcomes; 15% (9) reported not having targeted outcomes (N=60); 6 programs did not respond.
- See Appendix B: Home Visiting Model Identified, Whether Evaluated, Targeted Outcomes and Evaluation Measures by Jurisdiction and Program Name. Of the 51 programs reporting targeted outcomes, 45 programs provided outcomes, 6 did not. These outcomes are primarily related to assessment, birth, health behavior, positive parenting, access to health/other services, education/counseling/support, child development, and maternal education and support.

Evaluation Measures

Question: What measures are you monitoring to assess the performance of your program (e.g., birth outcome measures, behavioral measures, developmental measures, etc.)?

- 52 programs responded to this question, the responses were narrative; 14 programs did not respond.
- Responses are presented in Appendix B: Home Visiting Model Identified, Whether Evaluated, Targeted Outcomes and Evaluation Measures by Jurisdiction and Program Name.
- The most frequently listed measures are related to birth outcomes (infant mortality, low birth weight); behavior change outcomes (parenting skills, smoking reduction, breast feeding); health service access outcomes (prenatal care visits, link to primary/well baby care); and pregnant teen educational outcomes (high school graduation, GED completion). Some programs only report client demographics, service utilization and referral statistics.

Cost per Client

Questions: What is the cost of your program per client?

How was the cost calculated (e.g., total annual program funding divided by # of clients per year)?

- 42 programs responded to this question (N=42); 24 programs did not.
- Of the 42 programs responding, 55% (23) indicated the cost had not been calculated, didn't have the information/not known, unable to obtain, not sure, not immediately or varies.
- 18 programs reported cost per clients, with some programs providing yearly totals, some providing monthly totals, and some providing totals without indicating if they were per month, per year or how they were calculated. Of the 18 programs reporting cost per client, the cost ranged from $190 to $266 a month and from $1,812 to $3,485 a year.
- Examples of methods used to determine costs are:
  - Approximate home visit, drive and chart time, and case management by nurse, 4 hrs/month times nursing salary approximately $25 times indirect costs =$200 times 12 months = $2,400 for one patient.
  - Annual budget divided by unduplicated clients as measured by First 5 data system.
  - Annual funding ($820,000) + matching funds ($42,000) divided by 1720 clients/yr is $501 per family per year.
  - Total program funding $202,104 divided by 58 clients/year. Calculated per total amount claimed for FY 03/04 divided by number of clients served for that period. ($559,760 / 309 = $1811.52).

Funding Sources

Question: Please list your funding sources.

- 54 programs responded to this question (N=54); 12 did not.
- See Appendix C: Funding Sources and Matching Funds by Jurisdiction and Program.
- Programs listed multiple funding sources.
- Funding sources for home visiting programs include tobacco litigation settlement funds (2), MCAH funding (14), general public health funds (14), AFLP (6), grants (3), First 5 (16), federal funding (14), TCM/targeted case management (20), and BIH (4), among many.

Matching Funds

Question: Do you utilize matching funds? Yes or No. If yes, please list sources below.

- 56 programs responded to this question (N=56); 10 did not respond.
- See Appendix C: Funding Sources and Matching Funds by Jurisdiction and Program
- Of the 56 respondents, 63% (35) use matching funds, 38% (21) do not.
- Some of the sources of matching funds were State General Fund, County General Fund, First Five, Targeted Case Management (TCM)/Title XIX, Blue Cross, Federal Financial Participation (FFP), Realignment, and Tobacco Litigation funds.

Collaborators

Question: Does your program rely on collaborations/partnerships with other agencies? Yes or No. If yes, please list collaborators.

- 59 programs responded to this question (N=59); 7 did not respond.
- 81% (48) of programs rely on collaborations and partnerships with other agencies.
- Examples of the types of partnerships and collaborations were: Partnerships with Child Abuse Prevention Council, local hospitals, First 5, Community Based Organizations (CBOs), Black Infant Health (BIH), Blue Cross of California, Mental Health and Substance Abuse Programs.
- Programs indicated they had partnerships, collaborations, MOUs or subcontractual relationships with collaborators.

Subcontracts

Question: Are any of the home visiting services provided through subcontractual relationships with other agencies or individuals? Yes or No. If yes, describe.

- 58 programs responded to this question (N=58); 8 did not respond.
- 29% (17) of programs responded that they do have a subcontractual relationship with other agencies, 71% (41) reported that they did not.
- Example responses include:
    - Our target population frequently works with a crisis center. We contract to outreach for early entry into prenatal care with two Family Resource Centers.
    - Both our PHN and paraprofessional home visitors are contract employees.
    - All home visits are provided through subcontracts to local agencies.

APPENDIX A: Local Jurisdiction, Program Model Used/ Modified, and Assessment Tools Used

Jurisdication	Program Name	If possible, please provide the name of the model:	Assessment Tools Used
Alameda	Alameda County Public Health Nursing	Family Partnership (David Olds)+ Black Infant Health	Denver, Ages & Stages
Alameda	Special Start at Public Health	Began based on David Olds model+	NCAST, Denver, Ages & Stages
Alameda	Improving Pregnancy Outcomes Project (IPOP)	Black Infant Health - David Olds+	Denver
Alameda	Black Infant Health	David Olds+	Denver
Calaveras	Public Health Nursing		Denver
Fresno	Nurse-Family Partnership+		NCAST, P.I.P.E, Ages & Stages, CLEC
Fresno	Perinatal Outreach and Education		Care coordination is a form of case management done by paraprofessional staff
Fresno	Comprehensive Case Management		NCAST, Denver, 4 P's Plus Edenburg Perinatal Depression Screening
Humboldt	Adolescent Family Life Program		Denver, Ages & Stages, CDC growth charts, newborn assessment sheet, post partum depression assessment
Kern	Perinatal Outreach Program (PCG)		Our own assessment tool used for enrollment to determine risks and needs.
Kern	Black Infant Health	State approved BIH Model	Our own assessment tool used for enrollment to determine risks and needs.
Kern	Nurse Family Partnership+	Olds+	NCAST, Denver, P.I.P.E
Kings	Field Public Health Nursing		NCAST, Denver, Bailey, Ages & Stages
Long Beach	Nurse Family Partnership+	Olds Nurse Family Partnership+	NCAST, Denver
Los Angeles	Nurse Family Partnership+	Nurse Family Partnership (Olds)+	NCAST, P.I.P.E, Ages & Stages
Madera	AFLP	Hawaii HV Model	NCAST, Denver, Life Skills Progression tool
Mendocino	Field Nursing (includes high risk infants, pregnant and parenting and high risk families)		Denver, Ages & Stages, general nursing assessment
Mendocino	Teen Futures (Adolescent Family Life Program)		Ages & Stages, Life Skills Progression tool
Modoc	Perinatal Outreach Education - POE		Developed own assessment tools
Mono	Mono County First 5 Home Visiting Program	Parents as Teachers (began 1981)	Denver, Parents as Teachers materials assess for milestones
Monterey	Public Health Nursing-General Field		
Monterey	Public Health Nursing		NCAST, Denver, P.I.P.E, Ages & Stages
Napa	Welcome Every Baby - Universal Perinatal Home Visiting Program	Touchpoints Model (T. Berry Brazelton)	CLNBAS/NBO
Napa	MCH PHN Home Visitation	Touchpoints Model (T. Berry Brazelton)	NCAST, Ages & Stages, CLNBAS
Placer	MOMS, TAPP, TCM		NCAST, Denver, P.I.P.E, Ages & Stages
Plumas	Plumas County Public Health Agency Home Visiting Program	Nurse Family Partnership+	HIV Charting forms created by staff.

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Jurisdication	Program Name	If possible, please provide the name of the model:	Assessment Tools Used
Plumas	New Born House Calls (funded by First 5)	Olds+ and PAT	Denver, developed in-house
Sacramento	Olds Nurse-Family Partnership+	Olds - Nurse-Family Partnership+	NCAST, Denver, P.I.P.E, key to care-giving
Sacramento	Black Infant Health	Comprehensive Case Management & Care Coordinator Model	
Sacramento	Birth & Beyond	Cal-SAHF	Denver, Ages & Stages, Child Development Mental Health Professionals use IDA
Sacramento	Public Health Nursing Field		NCAST, Denver, P.I.P.E
Sacramento	Perinatal Substance Abuse		Sacramento County Alcohol and Other Drugs Preliminary Assistance
San Benito	Field Nursing(women, Infants & Children) PAC Team- for Pos. tox. SB2669		NCAST, Denver, Ages & Stages
San Benito	High Risk Infants		
San Benito	Public Health Nursing Case Management		NCAST, Denver, Ages & Stages, basic needs
San Bernardino	High Risk Infants		NCAST, Denver
San Francisco	Universal Home Visiting Program	Olds+	PE for mom and baby
San Francisco	MCH Field Nursing		Denver, Ages & Stages
San Joaquin	PHN Home Visiting	Developed with PHNs, but started off using the Minnesota program. Now, we are thinking about using the Los Angeles one	Bailey, NCAST in past
San Mateo	Field Nursing		Denver
San Mateo	Federal Adolescent Family Life Project	We use the Olds-Kitzman Home Visiting Model+	Denver, Ages & Stages, Edinburge Post Partum Depression Scale
San Mateo	Prenatal Advantage/Black Infant Health	We use the models provided by the state since these are the required models	NCAST, Denver, Ages & Stages
San Mateo	State Adolescent Family Life Project	We use the models provided by the state since these are the required models	Denver, Ages & Stages, Edinburge Post Partum Depression Scale
San Mateo	Prenatal to Three Initiative		NCAST, Denver, Ages & Stages, Edinburge Post Partum Depression Scale
Santa Clara	Black Infant Health	State approved Mandela Model	Denver, Ages & Stages, have developed some tools in-house with the help of our data management department, others are provided by the state
Santa Cruz	Public Health Nursing - MCAH	Olds Model and tools+; NCAST; TCM	NCAST, Denver, Ages & Stages
Shasta	Children First Parent Partner Program	Healthy Families America	Children First Parent Partner Program's assessment tool was created specifically by program developers. Program modeled after California Mental Health Advocates for Children and Youth (CMHACY) concepts and programs.
Shasta	Shasta County Women's Shelter PHN Assessments		Denver, P.I.P.E
Shasta	SIDS home visits		California SIDS Program Public Health Services Report Worksheet
Sierra	MOM, Sierra Public Health Dept. Home visiting		NCAST, Denver

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Jurisdication	Program Name	If possible, please provide the name of the model:	Assessment Tools Used
Sierra	MOM Program		Ages & Stages
Siskiyou	Strategies in Parenting		Denver, P.I.P.E, Ages & Stages
Sonoma	Families First Home Visiting	Wide range of programs review to determine best practices	Ages & Stages
Sonoma	Maternal Child Health Field Nursing		Denver, Ages & Stages
Sonoma	Teen Parent Connections	Adolescent Family Life Program (AFLP)	Ages & Stages, Monterey Risk Assessment/ Life Skills Progression
Stanislaus	Cal-LEARN	Bavolek-Nurturing Program	NCAST, Denver, PIER, CLSS Acuity scale
Stanislaus	Adolescent Family Life Program	Bavolek-Nurturing Program	NCAST, Denver, PIER, CLSS Acuity scale
Stanislaus	Adolescent and Sibling Pregnancy Prevention Program		Developed a client risk assessment tool
Stanislaus	Blue Cross Post-Partum visits		Agency developed assessment forms
Stanislaus	High Risk Maternal Child Health	Incorporated the Olds Program when updating	NCAST, Denver, PIER Acuity
Stanislaus	SIDS home visits	State (SIDS)	SIDS guidelines
Stanislaus	High Risk Prenatal	Olds+	NCAST, Denver, Acuity
Stanislaus	Differential Follow-Up		NCAST, Denver, PIER Acuity
Stanislaus	Healthy Birth Outcomes (HBO)	Olds+	NCAST, Denver, Home / CES-D / DLC / CLS
Sutter	Special Babies Program		Denver
Tulare	Medically Vulnerable Infants Program	High Risk Infant Programs- CCS Funded	NCAST, Denver, Ages & Stages
Ventura	All programs - MCAH Field, Rx for Kids and EFC are for high-risk or at-risk women, children adolescents and families.	Olds+	NCAST, Denver, Ages & Stages. PPDS
Yolo	MCAH Outreach Program		NCAST, Denver, Ages & Stages

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APPENDIX B: Home Visiting Model Used/ Modified, Whether Evaluated, Targeted Outcomes and Evaluation Measures by Jurisdiction and Program Name

Jurisdiction	Program Name	If possible, please provide the name of the model:	Formal evaluation of Program? 1=Yes 2=No	Program Outcomes: Do you have targeted outcomes for your programs? If yes, please list:	Evaluation Measures: What measures are you monitoring to assess the performance of your program?
Alameda	Alameda County Public Health Nursing	Family Partnership (David Olds+) Black Infant Health	2		Entered into ECChance, monitored with Case Closure, Chart review, First Five analysis
Alameda	Special Start at Public Health	Began based on David Olds+ model	1	Some of the goals/outcomes of our ECC funded program support programs are: 1A. Enhance parenting and stronger families; 1B. Children are free from abuse and neglect; 2A. Improved child social developmental and emotional wellbeing; 2B. Children have access to high quality and early care and education; 2C.Children enter kindergarten ready for school; 3A. Pregnant women and teens have access to early and comprehensive prenatal care; 3B. Children are healthy, well nourished and receive preventative and ongoing health and dental care from a primary care provider; 3C. Children are in healthy and safe environment; 3D. children are safe from exposure to alcohol, tobacco, and other harmful substances; 4.help a comprehensive system of prevention/early intervention services for families.	Via data entered, via exchange system we can monitor current and up to date immunization status, primary care hook up and if number of well child visits, number of kids at ER visits, percentage of breastfeeding, etc.
Alameda	Improving Pregnancy Outcomes Project (IPOP)	Black Infant Health - David Olds+	1	In no particular order: (1) Reduce infant mortality; (2) [Reduce] Percent of children 0-2 years of age with a medical (can't read); (3) Percent of pregnant participants who have a prenatal visit in the first trimester of pregnancy; (4) Infant mortality rate per 1,000 live births; (5) Percent of very low birth weight infants among all live births; (6) The neonatal mortality rate per 1,000 live births.	IPOP is measured by clients birth outcome
Alameda	Black Infant Health	David Olds+	1	In no particular order: (1) Provide/promote better health care services for at risk African-American women and children; (2) Educate BIH client on who is at risk for poor birth outcomes and importance of early access to prenatal care; (3) Educate on causes of maternal mortality and low birth weight infants; (4) Reduce the use of substance during pregnancy and refer to treatment; (5) Educate clients on SIDS death-risk and prevention; (6) Reduce infant mortality.	The success of the Black Infant Health Program is measured by birth outcomes.

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Jurisdiction	Program Name	If possible, please provide the name of the model:	Formal evaluation of Program? 1=Yes 2=No	Program Outcomes: Do you have targeted outcomes for your programs? If yes, please list:	Evaluation Measures: What measures are you monitoring to assess the performance of your program?
Calaveras	Public Health Nursing		2		
Fresno	Nurse-Family Partnership+	Participate in National Program	1	Healthy baby, decrease child abuse, decrease emergency visits, decrease subsequent pregnancies, decrease smoking and drug use, decrease time on welfare, complete school and obtain a job of the clients choice.	Birth outcome measures, behavioral measures, developmental measures, etc.
Fresno	Perinatal Outreach and Education		1		
Fresno	Comprehensive Case Management		1	Full term infants; Normal birth weight; number of prenatal visits attended; well child visits, iz; interconceptional care.	Birth outcome measures. Behavioral measures
Humboldt	Adolescent Family Life Program		2	Keep pregnant and parenting teens in school as much as possible, completion of high school, prevention of unplanned secondary pregnancies	Birth weight, secondary births, high school graduations, GED completion,
Kern	Perinatal Outreach Program (PCG)		2		Entry to Prenatal Care, Adequacy of Prenatal Care, Birth weight, Mortality Rate for the pregnant women. Immunization Rate and Preventative Health Exam Rates for infants.
Kern	Black Infant Health	State approved BIH Model	1		Birth outcomes, immunizations for infants (see BIH program list)
Kern	Nurse Family Partnership+	Participating in National Program	1	Reduced incidence of Low Birth Weight and Prematurity; reduced maternal smoking; increased immunization rates; increased breastfeeding; increased rate of high school completion; decreased dependence on Welfare System.	Ongoing data input into a central system ran by the National Nurse Family Partnership+ in Denver. Standardized data forms include demographics, family relationships, infant birth data, infant updates (6 mos, 12 mos, 18 mos & 24 mos); encounters, referrals, health habits.
Kings	Field Public Health Nursing		2	Improved bonding between mother and infant by teaching the cues that the baby provides.	At this time we are not engaged in a formal mother/infant program. The PHNs make a plan based on the assessment and evaluates the progress/success of meeting the objectives within the plan.
Long Beach	Nurse Family Partnership+	Participate in National Program, as part of Los			

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Jurisdiction	Program Name	If possible, please provide the name of the model:	Formal evaluation of Program? 1=Yes 2=No	Program Outcomes: Do you have targeted outcomes for your programs? If yes, please list:	Evaluation Measures: What measures are you monitoring to assess the performance of your program?
Los Angeles	Nurse Family Partnership+	Participate in National Program	1	Birth weights, birth conditions, maternal life course, maternal use of welfare funding	Measure % of clients still enrolled at delivery % of clients still enrolled at 12 months after delivery % of normal birth weight births % of minor clients enrolled in school at intake % of minor clients enrolled in school at 6 months Average number of months adult clients in workforce 0-12 months after delivery % of clients delaying subsequent pregnancy at 6 months after delivery % of clients delaying subsequent pregnancy at 12 months after delivery Ratio of expected vs. completed number of visits during pregnancy Ratio of expected vs. completed number of visits during infancy % of clients with > 2 infant ER/UC visits for injury or ingestion of poisons % of nurses reporting awareness of referral for child abuse or neglect % of clients reporting ever breastfeeding % of clients reporting still breastfeeding at 6 months after delivery % of clients reporting smoking cigarettes at 36 weeks of pregnancy % of clients reporting alcohol consumption at 36 weeks of pregnancy
Madera	AFLP	Hawaii HV Model			
Mendocino	Field Nursing (includes high risk infants, pregnant and parenting and high risk families)		2		Number of children referred to Early Start Services; Number of pregnant women assisted to get into care; Number of children referred to CCS; Number of families utilizing Alcohol/other drug services.
Mendocino	Teen Futures (Adolescent Family Life Program)		2		Birth outcome measures such as low birth weight; behavioral measures such as clients use of birth-control when: sexually active (non-pregnant) completion/graduation from high school, repeat pregnancy.
Modoc	Perinatal Outreach Education - POE		2	Outcomes are individual for each client	

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Jurisdiction	Program Name	If possible, please provide the name of the model:	Formal evaluation of Program? 1=Yes 2=No	Program Outcomes: Do you have targeted outcomes for your programs? If yes, please list:	Evaluation Measures: What measures are you monitoring to assess the performance of your program?
Mono	Mono County First 5 Home Visiting Program	Parents as Teachers (began 1981)	1	Appropriate use of parental care-within 1st trimester & throughout pregnancy; improved parenting skills & confidence; increased access to primary health care for clients - health insurance and connected to a primary provider; medical/dental utilizing preventative; well child health care - up to date immunizations & age appropriate health screenings; increased rate & duration of breastfeeding; early identification of delay & referrals for early intervention; increased accurateness of community resources; parents - tobacco, drug issues, domestic violence issues, mental health issues - ensure received treatment.	All numbers and rates related to program outcomes
Monterey	Public Health Nursing-General Field		2	By 07/01/07, the rate of exclusively breastfeeding at 6 months will increase from 29% to 36% among mothers who initiated breastfeeding at birth.	Screen all clients on breastfeeding information, past and present, through the nurse x=case management automation
Monterey	Public Health Nursing				
Napa	Welcome Every Baby - Universal Perinatal Home Visiting Program	Touchpoints Model (T. Berry Brazelton)	1	(1) Increase parental understanding of baby's development, (2) Increase breastfeeding & positive infant feeding behavior, (3) Increase rate of having & visiting "medical home", (4) Increase referral rate to community resources, including referral services for post-partum depression, (5) Increase parental satisfaction with program and providers.	(1) Number of clients in program, (2) Number of well, sick child visits, (3) Number of referrals, including referral services for post-partum depression, (4)Number of weeks breastfeeding, (5)Understanding of baby's development/capacities, (6) Satisfaction with program/providers.
Napa	MCH PHN Home Visitation	Touchpoints Model (T. Berry Brazelton)	1	Following TCM guidelines & outcomes.	TCM service plan- goals met or not met depending on client needs, mostly behavioral changes.
Placer	MOMS, TAPP, TCM		2	Countywide we have outcomes that "All children, adults, and families in Placer County will be self-sufficient in keeping themselves and their families safe, healthy, at home, in school or at work and out of trouble." A standardized screening tool is used to track these outcomes in our programs and in community based programs.	Outcome screening tool.

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Jurisdiction	Program Name	If possible, please provide the name of the model:	Formal evaluation of Program? 1=Yes 2=No	Program Outcomes: Do you have targeted outcomes for your programs? If yes, please list:	Evaluation Measures: What measures are you monitoring to assess the performance of your program?
Plumas	Plumas County Public Health Agency Home Visiting Program	Nurse Family Partnership+	2	We look at indicators that MCAH had identified - access to care for women and children, safe environment, healthy outcomes (birth) - review of birth certificates and analysis to direct [sow] and activities.	As described in program outcomes
Plumas	New Born House Calls (funded by First 5)	Olds+ and PAT	1	Increased awareness of community resources, families accessing appropriate health and safety resources, increase in knowledge of parenting skills and child development, children healthy and ready to learn.	Number of regularly scheduled well child check-ups, regular dental care, appropriate medical/dental coverage, reductions in subsequent pregnancies, baby/child up to date on immunizations, household is environmentally safe (i.e. car seats, smoke detectors, smoking cessation, safe medicine storage).
Sacramento	Olds Nurse-Family Partnership+	Participate in National Program	1	Birth outcomes: Premature and low weight birth rates; Reduction or cessation of smoking; Breast feeding rates; Language development; Reduction or cessation of drug use; Immunization rates; Subsequent pregnancies; Reduction of domestic violence; Work force participation; Reduction in fear of partner or other person; Education; Hospitalizations; Injuries/Illnesses of children; Use of emergency room; Development of children (gross ----, fine ----, mental/cognitive, speech /language.	Birth outcomes: Gestational age at delivery; Weight at delivery; Days in NICU. Developmental: Denver II. Language: Denver II and Mac Arthur CDI short---. Behavioral: NCAST, questionnaire. Immunization rates: Review of immunization records. Smoking, drugs, domestic violence, fear of partner, breastfeeding rates, subsequent pregnancies, injuries/illnesses of children, use of Emergency Room, education, work force participation: questionnaires at specific intervals.
Sacramento	Black Infant Health	Comprehensive Case Management & Care Coordinator Model	2	(1) Reduce African-American infant mortality; (2) Increase the number of African-American women receiving first-trimester care; (3) Reduce the number of African-American infants born low birth (below 2,500 g); (4) Reduce the number of African-American women who smoke, use alcohol, and /or non-prescription drugs during pregnancy; (5) Reduce the number of African-American maternal mortality.	Sacramento BIH monitors all measures listed by data collection in green book including breastfeeding, birth weights, immunizations, and observational issues of behavioral concerns with mothers or infants.
Sacramento	Birth & Beyond	Cal-SAHF	1	Birth & Beyond management	Birth & Beyond management
Sacramento	Public Health Nursing Field		1	(depends on program)	Different measures for different programs. Several utilize measures mentioned above (birth outcome, behavioral, developmental)

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APPENDIX B: Home Visiting Model Used/ Modified, Whether Evaluated, Targeted Outcomes and Evaluation Measures by Jurisdiction and Program Name

Jurisdiction	Program Name	If possible, please provide the name of the model:	Formal evaluation of Program? 1=Yes 2=No	Program Outcomes: Do you have targeted outcomes for your programs? If yes, please list:	Evaluation Measures: What measures are you monitoring to assess the performance of your program?
Sacramento	Perinatal Substance Abuse		2	Ensure universal screening for all pregnant women; Decrease substance abuse used by pregnant women; Decrease number of substance exposed births.	Numbers of OB practices utilizing the screening tool ; Number of pregnant women being screened; Decrease number of positive toxicology at birth; Increase positive indicators at birth (birth weight, length, gestational age)
San Benito	Field Nursing (women, Infants & children) PAC Team- for Pos. tox. SB2669		2	Assessed linked to services WNL on Denver to 2 assessment at 3or 6 months intervals. Referred to another program SARC, Great Beginnings.	TCM Basic Needs, Developmental, Behavioral (parenting), Accessing services
San Benito	High Risk Infants				
San Benito	Public Health Nursing Case Management		2	Basic needs met or family accessing services, developmentally WNL or linked with services; medical home; compliance with DEI multidisciplinary plan; meeting goals established in nurse/patient assessment	Developmental behavioral self-sufficiency linked with services
San Bernardino	High Risk Infants		1		Up to date on IMs, number of CPS referrals while case open, developmental milestones on target
San Francisco	Universal Home Visiting Program	Olds+	1	The targeted outcomes are:1) The mom makes her 6 wk pp check-up, 2) The mom breastfeeds exclusively the first six months, 3) The baby has a healthy home for immunizations, 4) To increase families knowledge of brain development, 5) To provide familieswith information to maintain a tobacco free home	Behavioral
San Francisco	MCH Field Nursing		2		
San Joaquin	PHN Home Visiting	Developed with PHNs, but started off using the Minnesota program. Now, we are thinking about using the the Los Angeles one	2	Improved assess/utilization of medical/health/related programs.	Informal only. First 5 (Children and Families) requires data collection, but does not ask for birth outcomes, etc. Asking for number of visits, etc.
San Mateo	Field Nursing		2		Number of individuals/families serviced and quantity of service.
San Mateo	Federal Adolescent Family Life Project	We use the Olds+-Kitzman Home Visiting Model	1		Birth outcomes, repeat teen pregnancies, behavioral measures, health status measures.
San Mateo	Prenatal Advantage/Black Infant Health	We use the models provided by the state since these are the required models	2		

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San Mateo	State Adolescent Family Life Project	We use the models provided by the state since these are the required models	2		Birth outcomes, repeat teen pregnancies, behavioral measures, health status measures.
San Mateo	Prenatal to Three Initiative		1	Parent child interaction and functioning, breastfeeding, immunizations, early identification and treatment of mental illness, early literacy, child safety (car seats, smoke detectors, poison control number), early identification of developmental delay.	Health, behavioral, environmental, developmental, mental health
Santa Clara	Black Infant Health	State approved Mandela Model	1	Reduce infant mortality and low birth weight rates among African American women	Birth outcomes, behavior, and developmental measures of infants and parents.
Santa Cruz	Public Health Nursing - MCAH	Olds+ Model and tools; NCAST; TCM	1	children have nutrients, sleeping on back, child's activities contribute to social and cognitive growth, immunizations up to date, car seats, social environment for healthy development	children have nutrients, sleeping on back, child's activities contribute to social and cognitive growth, immunizations up to date, car seats, social environment for healthy development
Shasta	Children First Parent Partner Program	Healthy Families America	1	all appropriate clients will be screened and connected to resources, clients will feel mor self-sufficient and connect to support systems, clients will be linked to appropriate services	referral tracking, provider feedback, file review
Shasta	Shasta County Women's Shelter PHN Assessments		2	Entry into medical care services and resources as needed. Improved nutritional status.	24 hours dietary recall, goals evaluated. Care plan developed based on client identified needs. Women do not stay in shelter long enough for outcome measurement.
Shasta	SIDS home visits		2		Report completed and sent to California SIDS program for each SIDS case.
Sierra	MOM, Sierra Public Health Dept. Home visiting		2		Number of women entering prenatal care in the first trimester, breastfeeding initiation rates, birth outcomes
Sierra	MOM Program		2		
Siskiyou	Strategies in Parenting		2	Reduce child abuse	None Formally
Sonoma	Families First Home Visiting	Wide range of programs review to determine best practices	1	Outcome measures include rates of referral and rate of visits accomplished, as well as desired outcome, for example: All will have a medical provider and medical insurance for their baby.	Rates of breastfeeding, smoking, visit acceptance, and many more database fields.

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Sonoma	Maternal Child Health Field Nursing		1	(1.) By date 80% of participants will either verbalize knowledge of attachment behaviors or demonstrate positive attachment behaviors (as documented on the evaluation scale). (2.)By the end of date 80% of participants will appropriately follow through with medical visits/health check-ups for the infant/child (as documented on the evaluation scale). (3.) By the end of date 80% of participants will either demonstrate awareness of domestic violence resources and risks and/or the family will be absent of domestic violence (as documented on the evaluation scale). (4.) By the end of date, 80% of participants will not have a non-voluntary Child Protective Services (CPS) referral (as documented in the client record).	Behavioral measures and knowledge measures Described in program outcomes
Sonoma	Teen Parent Connections	Adolescent Family Life Program (AFLP)	1	Various programs operate with desired percentage outcomes for the measures listed in #16	Birth weight, immunization updates, wellness checks, school enrollment, contraception use, repeat pregnancies.
Stanislaus	Cal-LEARN	Bavolek-Nurturing Program	1	50% of CAL-Learn Participants will graduate or earn their GED, short and intermediate are related to staying in the program and in-home case management	School graduation, case management participation, school attendance
Stanislaus	Adolescent Family Life Program	Bavolek-Nurturing Program	1	Depends on client need - outcomes are evaluated quarterly	Birth outcomes - growth charts; Denver and IV-CAST results; acuity scale; PIER; immunization rate.
Stanislaus	Adolescent and Sibling Pregnancy Prevention Program		1	Depends on client need, but a common outcome goal is 0 teen pregnancy.	Use of abstinence/birth control; school attendance; number of occurring pregnancies per caseload.
Stanislaus	Blue Cross Post-Partum visits		2	Number of breast-feeding Moms-Internal Outcome; Blue Cross Outcomes - Number of mothers who needs HEPIS for post-partum visits, number of infants enrolled in MediCal after birth, number of infants who get to 2 week visit.	
Stanislaus	High Risk Maternal Child Health	Incorporated the Olds+ Program when updating	2	Each case is evaluated regarding the concern / problem - their outcome/goal and service/intervention	Acuity is one.
Stanislaus	SIDS home visits	State (SIDS)	2	Each case is evaluated regarding the concern / problem - their outcome/goal and service/intervention	Acuity is one.

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Stanislaus	High Risk Prenatal	Olds+	2	Each case is evaluated regarding the concern / problem - their outcome/goal and service/intervention	Acuity is one.
Stanislaus	Differential Follow-Up		2	Each case is evaluated regarding the concern / problem - their outcome/goal and service/intervention	Acuity is one.
Stanislaus	Healthy Birth Outcomes (HBO)	Olds+	1	Healthy outcome to high risk pregnancy, i.e. 93% infants will be born weighing 2500 grams or more; 90% infants will be born at 37 weeks gestation or more; 25% of women will breast feed for 6 months; 90% of women entering services w/o prenatal care will initiate prenatal care; 50% of women smokers will report D/C smoking during pregnancy.	Birth outcomes, Behavioral measures
Sutter	Special Babies Program		2		
Tulare	Medically Vulnerable Infants Program	High Risk Infant Programs-CCS Funded	1		
Ventura	All programs - MCAH Field, Rx for Kids and EFC are for high-risk or at-risk women, children adolescents and families.	Olds+	1	Based on Nanda, NIC and NOC using PHN standards of practice. We also use NCAST as an outcome measure as evidenced by increased positive scores on serial NCASTs	Client outcome measures are linked to Nursing Diagnosis and nursing interventions. Positive percentage outcomes are measured by program and/or PHN.
Yolo	MCAH Outreach Program		2		

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APPENDIX C: Funding Sources and Matching Funds By Jurisdiction and Program

Jurisdiction	Program Name	Funding Sources: Please list funding sources below.	Matching Funds: Do you utilize matching funds?	
			If yes, please list program or funding	If yes, please list matching amounts:
Alameda	Alameda County Public Health Nursing	County Funds, TCM, Revenue via a MOU, First Five (Contract)	CHDP, MCAH	
Alameda	Special Start at Public Health	First 5 Alameda/ Every Child Counts (Prop 10 grant) and TCM leveraging are primary sources	TCM	
Alameda	Improving Pregnancy Outcomes Project (IPOP)	Federal Funding		
Alameda	Black Infant Health	State funded - Title V and State General Funds	(1)Title XIX, (2)General Fund	(1)625,242 - 50%; (2)94,126 - 8%
Calaveras	Public Health Nursing	Public Health Dollars - Realignment		
Fresno	Nurse-Family Partnership	FFP and realignment		
Fresno	Perinatal Outreach and Education	General county funds FFP		
Fresno	Comprehensive Case Management	Healthy Start Grant Black Infant Health Realignment funds Federal Financial Participation	FFP	varies
Humboldt	Adolescent Family Life Program	State General Funds, Federal Title V MCH Block Grant Funds and Federal Title XIX	FFP	unknown
Kern	Perinatal Outreach Program (PCG)	Federal, County, State	FFP	varies with activity
Kern	Black Infant Health	Federal, County, State	FFP	varies with activity
Kern	Nurse Family Partnership	First 5 (Prop 10) and targeted case management	First 5 (Kern county)	TCM
Kings	Field Public Health Nursing	TCM General Fund		
Long Beach	Nurse Family Partnership			
Los Angeles	Nurse Family Partnership	MCAH Matching funds. Initially: Department of Public Social Services and First-5 L.A. (Tobacco Tax) Now: UniHealth Foundation and MCAH Matching funds	MCAH State Block Grant	Approx. 47% of total costs
Madera	AFLP			
Mendocino	Field Nursing (includes high risk infants, pregnant and parenting and high risk families)	County funding sources; Target case management.	TCM (title XIX)	unknown
Mendocino	Teen Futures (Adolescent Family Life Program)	State DHS, MCAH Branch; AFLP funding from State general fund, Federal Title V & XIX (matching), as well as local/county public health funds.	State general fund, County (Public Health) Funds	$50,800.00, $52,555.00
Modoc	Perinatal Outreach Education - POE	MCH, Public Health & EHS for childbirth classes		

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Mono	Mono County First 5 Home Visiting Program	Mono County First 5 Commissions. Targeted Case Management (there was some MCH FFD for the first 3 years of the program but not longer). Some Mono county health realignment funds will be directed to the program beginning FY 05-06.	Targeted case management.	We've used this for less than a year so far.
Monterey	Public Health Nursing-General Field			
Monterey	Public Health Nursing			
Napa	Welcome Every Baby - Universal Perinatal Home Visiting Program	First 5 grant for collaborative program.		
Napa	MCH PHN Home Visitation	Targeted case management.		
Placer	MOMS, TAPP, TCM	County, MCAH from state, Federal Financial Participation, TCM, Cal Learn	County General fund	Not calculated by program.
Plumas	Plumas County Public Health Agency Home Visiting Program	MCAH funding, FFP match, County match.	Realignment (county match) & Federal Financing Participation	$66,245. / $208,712.
Plumas	New Born House Calls (funded by First 5)			
Sacramento	Olds Nurse-Family Partnership	Sacramento County Tobacco Litigation Settlement funds; Targeted Case Management; Sacramento City Unified School District.	Tobacco Litigation Settlement, monies are used to draw down TCM monies.	50%-50%
Sacramento	Black Infant Health	California Department of Health Services - Maternal Child Adolescent Health Program.	Antioch Progressive Church	Space use at faculty occasionally (as in-kind contribution)
Sacramento	Birth & Beyond	Birth & Beyond management	Unknown	
Sacramento	Public Health Nursing Field	Targeted case management; County general funds; State funding for federally funded programs; Child Protective Services; Tobacco tax; Maternal Child Health	Maternal Child Health; Childhood lead poisoning prevention	Varies (0-50%); Varies (0-75%)
Sacramento	Perinatal Substance Abuse	Sacramento County CPS, Sacramento County MCAH		
San Benito	Field Nursing(women, Infants & Children/PAC Team- for Pos. tox. SB2669	Public Health Subvention , TCM		

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			If yes, please list program or funding	If yes, please list matching amounts:
San Benito	High Risk Infants			
San Benito	Public Health Nursing Case Management	General public health funds, TCM		
San Bernardino	High Risk Infants		Realignment	50%
San Francisco	Universal Home Visiting Program		(1) MCH Grant; (2) DCYF	(1) 65%; (2) 35%
San Francisco	MCH Field Nursing			
San Joaquin	PHN Home Visiting	MCAH, County and First 5; Small amount from Child Abuse Prevention Council	MCAH, First 5, County	Match with FFP, Title 19
San Mateo	Field Nursing	TMC, General County Funds		
San Mateo	Federal Adolescent Family Life Project	Federal AFL Grant and County General Fund		
San Mateo	Prenatal Advantage/Black Infant Health	(1) State MCAH Branch Title V and State General Fund; (2)First 5 San Mateo County; (3)County General Funds; (4)Federal Title XIX matching funds.	(1) State General Fund, County General Funds, First 5 San Mateo County($317,000); (2) State Title 5 ($208,000)	$340,000
San Mateo	State Adolescent Family Life Project	(1) State MCAH Branch Title V and State General Fund; (2)First 5 San Mateo County; (3)County General Funds; (4)Federal Title XIX matching funds.	(1) State General Fund & County General Funds ($460,000); (2) State Title 5 ($101,000)	$545,000
San Mateo	Prenatal to Three Initiative	(1) First Five San Mateo County; (2) TCM/MAA Revenue (3) Peninsula Community Foundation Grant; (4) BellaVista Foundation Grant	Total revenue 3,052,000	$1,293,000.00
Santa Clara	Black Infant Health	CA DHS-MCAH branch and Santa Clara County Health and Hospital Systems	Federal	
Santa Cruz	Public Health Nursing - MCAH	State General Fund/County General funds; Title V; Title XIX; Medi-Cal TCM		
Shasta	Children First Parent Partner Program	MCAH, First 5 Shasta, Americorp		
Shasta	Shasta County Women's Shelter PHN Assessments	Shasta County Women's Refuge received a grant from First 5 Shasta for PHN assessments, contracts with Shasta County Public Health for PHN assessments.		
Shasta	SIDS home visits	General Funds		

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			If yes, please list program or funding	If yes, please list matching amounts:
Sierra	MOM, Sierra Public Health Dept. Home visiting	PCG program and General public health funding		
Sierra	MOM Program			
Siskiyou	Strategies in Parenting	General public health funds/TCM		
Sonoma	Families First Home Visiting	First 5 Sonoma	FFP MAA Matching funds	$42,000
Sonoma	Maternal Child Health Field Nursing	Targeted Case Management, Human Services Commission: Child Abuse Prevention, Intervention & Treatment funds, County realignment funds, Title XIX funds and Families First funds	Families First, CAPIT, Perinatal Outreach, SIDS & FIMR, Prenatal Care Guidance	(CAPIT) $7,791 (MAA), (Perinatal) $208,462 (federal title XIX), (CARE) $148,031
Sonoma	Teen Parent Connections	Adolescent Family Life, Cal learn, Community Challenge Grant, Minor Parent, Families First, County of Sonoma.	Federal Financial Participation through AFLP Grant	In kind Services only
Stanislaus	Cal-LEARN	County DSS donations from staff for annual graduation parties		
Stanislaus	Adolescent Family Life Program	State, County, Federal match, FFP $.	Federal Financial Participation (through Title XIX)	29%
Stanislaus	Adolescent and Sibling Pregnancy Prevention Program	CA State DHS; Staff/client fund-raisers; Occasional funding from HSA Foundation	Federal Financial Participation (through Title XIX)	22%
Stanislaus	Blue Cross Post-Partum visits	Blue Cross/Targeted Case Management	(1) Targeted Case Management; (2) Blue Cross; (3) Realignment	(1) $90 - federal match; (2) $155;(3) $90
Stanislaus	High Risk Maternal Child Health	Local realignment and medical targeted case management.		
Stanislaus	SIDS home visits	State funds		
Stanislaus	High Risk Prenatal	Local realignment and medical targeted case management.		
Stanislaus	Differential Follow-Up	Contract with community services agency.		
Stanislaus	Healthy Birth Outcomes (HBO)	Family and Children's Commission - Stanislaus County; Prop 10; TCM Matching funds.	Targeted case management.	?
Sutter	Special Babies Program	TCM		

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Tulare	Medically Vulnerable Infants Program			
Ventura	All programs - MCAH Field, Rx for Kids and EFC are for high-risk or at-risk women, children adolescents and families.	MCAH, TCM, First 5, Grants.	First 5, Grants (Private foundations, organizations), Human Service Agency brings down Federal SPMP money, CAPIT money	MCAH, County cost
Yolo	MCAH Outreach Program			