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Family Health Outcomes Project
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CalWORKs Home Visiting Program Evaluation Legislative Report

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Appendix G: Challenges Acquiring Secondary Data for Evaluation

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About UCSF

UCSF is part of the 10-campus University of California, the world's premier public research university system, and the only of its campuses dedicated to graduate and professional education. The Family Health Outcomes Project (FHOP) is a cooperative effort of the Department of Family andCommunity Medicine and the Institute for Health Policy Studies (IHPS) at the University of California,San Francisco (UCSF). Our mission is to improve the health of children and their families and communities by supporting development and implementation of comprehensive community assessment and planning, data-driven policies, evidence-based interventions, and effective evaluation strategies. The UCSF School of Nursing's mission is to educate diverse health leaders, conduct research, advance nursing and inter-professional practice, and provide public service with a focus on promoting health quality and equity.

About Resource Development Associates

RDA Consulting is a mission-driven consulting firm based in Oakland, California, that serves government and nonprofit organizations throughout California as well as other states. Our mission is to work toward a just and equitable society by partnering with diverse stakeholders in addressing barriers to individual, organizational, and community well-being. RDA supports its clients through an integrated approach to planning, grant-writing, organizational development, and evaluation.

ACQUIRING SECONDARY DATA FOR EVALUATION

The Evaluation Team encountered many unexpected turns and obstacles in our work to obtain the home visiting case management and related outcome data needed for this evaluation. Because the HVP data landscape is incredibly complex and decentralized, our secondary data analysis team spent the first 1.5 years of this project, from April 2019 to October 2020, conducting factfinding to identify appropriate and available client-level data sources at the national, state, and county level, as well as the consents and processes that needed to be in place to acquire this data. Negotiations for data did not begin in earnest until October 2020, and we received the first HVP case data in the first quarter of 2021. We did not receive final county datasets until November 2021.

When this evaluation began, based on the language in our contract specifying that DSS would provide the home visiting data needed for the evaluation, the Evaluation Team's initial assumption was that client-level CalWORKs HVP case management data was available from state data sources and the four national evidence-based home visiting models. However, during our factfinding, we determined that no state agency collected data that would identify all clients participating in CalWORKs HVP. Further, only one national organization mandates transfer of client-level data collection for select indicators from all affiliates, one organization has a data system that affiliates can use voluntarily, one organization only mandates annual reports of aggregate data, and one did not have any reporting mandate at all for its local affiliates.

For data that the national models did collect, we encountered unexpected processes that included executing non-disclosure agreements between the national organizations, DSS, and UCSF as well as significant unanticipated costs for data queries that were not included in our evaluation budget. This process took place in the Spring and Summer of 2020. By Fall 2020, we learned that even if we purchased data from these organizations and embarked on the long application process to obtain it, we still would not have adequate coverage and representation of the CalWORKs HVP cases because most of the national models did not mandate reporting of client-level data. Cases served by the model with centralized data collection comprised less than 10% of all HVP case in the CalWORKs HVP. The model with the largest HVP client caseload, comprising about 30% of DSS HVP cases, had partially centralized data collection and only 20% of cases were in their centralized database.

At this juncture, we realized that we needed to explore a new strategy to obtain valuable case data that would allow us to identify and describe the client population receiving CalWORKs HVP and compare them to similar families that did not receive HVP. We decided to focus on using data from DSS and its limited data extraction of Consortia databases (i.e., CalOAR) to identify CalWORKs HVP clients. Unfortunately, CalOAR did not initially require counties to use a data field that would allow us to determine which CalWORKs cases were in the HVP. All other HVP-related DSS data sources contained aggregate data, which we could not use for this portion of the evaluation.

Given the fractured nature of current data collection for local home visiting programs, which differ county-by-county with few centralized, standardized repositories, we found that direct request of data from select counties was the most productive route to pursue. We began the first phase of this effort in October 2020, with a focus on making data requests directly to 8

counties with the highest HVP caseload. All of these negotiations ultimately were successful, with DSS mediating communication and county staff working very hard to ensure that needed data fields were in the data transfer.

This phase also included requesting data from a case management database vendor currently operational in nine HVP counties using various HV models. Ultimately, eight of the nine counties granted permission for this vendor to provide relevant data extracts to DSS, who then transferred the data to us in a standardized manner to use in this evaluation. The second phase of this effort included requesting data from an additional three counties that used the centralized database from one of the national model organizations. County staff were asked to export relevant data reports from their database and provide them to DSS for the evaluation.

In the end, we compiled data from 21 different data sources for approximately 5,527 families (representing almost 12,000 family members) who received CalWORKs home visiting, with at least some coverage for all 43 counties participating in CalWORKs HVP. The data sources were: 19 direct county requests (see Table 1), CalOAR (for counties that regularly employed the home visiting variable in Consortia databases), and client interview lists collected by the primary data analysis arm of the evaluation. For the families identified via direct data request from 19 counties, we are able to report about both their HVP experience (e.g., length of enrollment, services received, select legislatively mandated indicators, etc.) and outcomes from other CA administrative data sources. For clients identified via CalOAR (~240 families from 10 counties) and the primary data analysis arm (~400 families from 14 counties), we are able to report outcomes from CA administrative sources only.

Table 1. Direct County Data Request

County	N	%
Fresno	351	7.1%
Humboldt	28	0.6%
Kern	235	4.7%
Kings	141	2.8%
Los Angeles	1141	22.9%
Orange	248	5.0%
Placer	145	2.9%
Riverside	461	9.3%
Sacramento	329	6.6%
San Bernardino	554	11.1%
San Diego	185	3.7%
San Francisco	112	2.3%
San Joaquin	432	8.7%
San Luis Obispo	34	0.7%
Santa Cruz	70	1.4%
Sonoma	75	1.5%
Tulare	132	2.7%
Ventura	257	5.2%
Yuba	42	0.8%
Total Cases	4972	

There are pros and cons to the final data collection strategy that was implemented. Strengths include: 1) being able to build a fairly comprehensive list of CalWORKs clients participating in HVP from inception to June 2021, when no infrastructure existed to collect this information before we embarked on this evaluation project; 2) fairly quick and agreeable responses from county staff and their affiliates, and their understanding that part of the condition of their program funding is to provide such data to DSS for the purpose of program evaluation.

However, we did encounter difficulties with this approach, most having to do with counties not having appropriate client consent for data sharing in place between the local affiliates who implemented the model and the county agency that contracted with them, or appropriate consents between county and DSS for the transfer of identified county-level data. Another difficulty of this piecemeal approach was that data for key indicators (e.g., developmental screening) was collected in many different ways, and we could not easily combine the data for analysis due to differences in how questions were asked or the granularity of the information collected. Additionally, each national model had different foci for interventions, therefore information recorded electronically by each county differed depending on the home visiting model. As a result, substantial programmer time was spent to standardize data across these 21 data sources, and for some measures, summaries could only be reported at the lowest level of granularity.

Other Federal and State data sources

In partnership with CDSS, we attempted to negotiate with the WIC program at the California Department of Public Health (CDPH) for access to their data. However, their client consent did not allow sharing identifiers and so we could not include WIC data in the evaluation. While we were not able to receive WIC data from CDPH, CDSS was able to execute an agreement with CDPH to receive data about clients who received home visiting from MIECHV funding so that we could exclude such clients from our comparison families.