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June 21, 2017

TO: Each Supervisor

FROM: Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

SUBJECT: **MAXIMIZING AND EXPANDING HOME VISITING SERVICES FOR FAMILIES IN LOS ANGELES COUNTY UPDATE**

This is in response to the December 20, 2016 Board motion instructing the Department of Public Health (DPH), in collaboration with First 5 LA, the LA County Perinatal and Early Childhood Home Visitation Consortium, the Office of Child Protection (OCP), the Children's Data Network, and the Departments of Health Services (DHS), Mental Health (DMH), Public Social Services (DPSS), Children and Family Services (DCFS), and the Probation Department (Probation), to develop a plan to coordinate, enhance, expand, and advocate for high quality home visiting programs to serve more expectant and parenting families so that children are healthy, safe and ready to learn. Specifically, your Board directed DPH to:

I. Assess how national models and best practices, including those with a single entry portal, may inform or be adapted to improve outcomes for Los Angeles County.
II. Create a coordinated system for home visitation programs that includes a streamlined referral pathway and outreach plan to ensure maximum program participation, especially in Los Angeles County's highest risk communities. A single responsible department or organization may be identified to maintain the coordinated referral system.
III. Identify gaps in services for high-risk populations based on review of effective national models, existing eligibility requirements, and cultural competencies. The plan should develop strategies to address these gaps.
IV. Increase access to voluntary home visitation for families at high risk of involvement with the child welfare system, consistent with the recommendations of the Los Angeles Blue Ribbon Commission on Child Protection.
V. Collect, share and analyze a standardized and consistent set of outcome data leveraging the Consortium's Los Angeles County Common Indicators pilot project.
VI. Include a framework to maximize resources by leveraging available funding, and, where possible, identify new and existing, but not maximized, revenue streams (through State and federal advocacy, and opportunities for local investments) to support home visiting expansion.

For purposes of this report, home visiting is defined as follows: Perinatal and early childhood home visiting is a multi-disciplinary, family-centered support and prevention strategy with services delivered by trained professionals in the home that: (1) is offered on a voluntary basis to pregnant women and/or families with children through the age of five; (2) provides a comprehensive array of holistic, strength-based services that promote parent and child physical and mental health, bonding and attachment, confidence and self-sufficiency, and optimizes infant/child development by building positive, empathetic, and supportive relationships with families and reinforcing nurturing relationships between parents and children; and (3) is designed to empower parent(s) to achieve specific outcomes which may include: healthy pregnancy, birth and infancy; optimal infant/child development; school readiness; self-sufficiency; and prevention of adverse childhood and life experiences

In preparing this response DPH convened a bi-weekly cross agency research and planning team (Planning Team). The Planning Team completed the requested national and local research, drafted Guiding Principles, a Collective Vision, and Focal Areas for a system of home visiting in Los Angeles County. In addition, the Planning Team engaged the other County departments and organizations listed in the Board motion as well as the business and philanthropic communities, and hosted structured opportunities to gather stakeholder input, identify barriers/opportunities, inform priorities, and build consensus. Below are highlights of specific engagement activities:

Hosted Home Visiting Providers Community Roundtable
The Planning Team hosted a Community Roundtable on March 17, 2017, in order to gather the input and expertise of local home visiting providers regarding community needs and opportunities for system improvement. Over 90 agency representatives participated and helped identify both countywide trends and needs specific to Service Planning Areas (SPAs). Appendix A, "Executive Summary of Home Visiting Roundtable," summarizes the results of the feedback gathered at this event. The most-cited opportunity to improve outcomes for families was the opportunity to better coordinate connections to ancillary services, particularly mental health services. Home visiting agencies expressed that the effectiveness of services could be enhanced by strengthening access to County supports for home visiting clients, especially for pregnant and new mothers suffering from perinatal mood and anxiety disorders. Other key points included: (a) confirmation by community leaders of the need for more flexible funding to make home visiting services available to all families in need, (b) interest in exploring medical billing options, (c) interest in investment in technology (to improve efficiency, outreach/engagement, referrals, billing, and outcome tracking), and (d) desire to strengthen ties with the medical community.

Convened County Leadership
The leadership of all County departments and organizations named in the December 20, 2016 motion convened for a series of four planning sessions (April 11, May 10, May 24, and June 7, 2017) to build a common vision for planning and collaboration, informed by the results of the Planning Team's research and the Community Roundtable. Participants included Directors, Deputy Directors, and other high-level leadership of DCFS, DPSS, DMH, DHS, Probation, OCP, the Children's Data Network, First 5 LA, and the Consortium. Through these convenings, County departments were able to establish a shared commitment to collaborating with provider agencies, community members, and one another in order to achieve an optimal and integrated system of quality home visiting support in Los Angeles County. The agreed upon Guiding Principles,

Collective Vision, and Focal Areas for future collaboration established through this process are outlined in section three of this report.

Engaged Business and Philanthropic Communities
Planning Team members engaged both the business and philanthropic communities, providing education on home visiting and opening up opportunities for both communities to provide supporting roles in upcoming home visiting system investment. DPH, DMH, and First 5 LA representatives presented a panel on home visiting in Los Angeles County and the associated Board motion at the Child Welfare Funders Collaborative meeting on February 15, 2017. A Home Visiting Ad-Hoc Funders Workgroup made up of foundation representatives who have agreed to be ambassadors for efforts in the philanthropic sector was formed to help develop and vet the proposals that come out of the County's planning efforts, such as requests for data infrastructure, capacity building of community-based organizations, support for new billing mechanisms, or outreach/marketing expertise. Planning Team members also met regularly with staff from the Los Angeles County Economic Development Corporation and the Los Angeles Area Chamber of Commerce to develop their support for home visiting initiatives.

This report summarizes progress on the six key elements outlined in the Board motion and proposes next steps for DPH, other County departments, the business and philanthropic communities, and other key stakeholders to advance a coordinated system of home visiting programs in Los Angeles County.

I. National Models and Best Practices

Analysis of national models and best practices, including interviews with leading researchers from Chapin Hall and University of Southern California, confirmed that the Los Angeles County has a strong base of quality home visiting programs established. It reaffirmed the value of many of the structures already in place and the direction of collaborative efforts already underway, including but not limited to chosen home visiting models, data tracking, best practice implementation, and intake systems.

Research regarding single-entry portals (or "centralized intake") similarly reaffirmed local practices. While centralized intake has been implemented in other jurisdictions, the complexity and effectiveness of Los Angeles County's established recruitment pathways indicate that a single-entry portal is likely not an optimal fit. Implementing a centralized recruitment and intake model in Los Angeles would likely decrease family engagement (by distancing recruitment from currently functioning, trusted referral sources), would require significant funding that may be better invested in other aspects of our home visiting system, and would require authority over programs that in some instances the County government does not control.

Research regarding cultural competency also pointed to the value of expanding existing Los Angeles County practices. Some models already in use in Los Angeles County have research demonstrating their effectiveness with specific minority populations (See Appendix B: Summary of Outcomes). More importantly, research underscored that the most important consideration in achieving culturally competent programs is not the structural model, but rather the integration of reflective practices into program implementation, training, and ongoing staff support. These revelations underscore the value of existing reflective practices and community feedback loops

that current home visiting programs are pursuing, and point to the value of ensuring that we support these practices in our countywide workforce efforts.

The quality and effectiveness of home visiting programs can be expected to be directly related to the level of training and support that provider organizations and their staff receive. Recognizing this fact, and the efforts already being led by the Consortium's Best Practices Workgroup, the Planning Team explored how First 5 LA and the County departments can best collaborate with the Consortium and the diversity of home visiting models within Los Angeles County to support excellence in training, supervision, cultural competence, and other best practice implementation. The philanthropic community has supported training efforts in other arenas and we will seek their support for these efforts here. In addition, First 5 LA and DMH plan to open their trainings to home visitors from all models, regardless of funding source.

II. Coordinated System for Home Visitation Programs

The leadership of each of the County departments and organizations named in the motion convened to develop a shared understanding of and commitment to building optimal home visitation systems in Los Angeles County. In keeping with the Los Angeles County 2016-2020 Strategic Plan, Objective I.1.6, "Support the leadership of First 5 LA, in partnership with the County, the Home Visitation Consortium and others to build a universal voluntary system of home visitation services through a streamlined system of referrals, and improved integration of services," a common framework was created to serve as the foundation for inter-departmental and cross-sector collaborative planning. The resulting definitions, outlined in this section, integrated the expertise of the departments with the knowledge of the current Los Angeles County family service landscape gained during the research and stakeholder engagement processes.

Vision
Together, we aspire to achieve the following vision of high-quality home visiting supports for Los Angeles County families:

A system of voluntary, culturally-responsive home-based family strengthening services available to all Los Angeles families with children prenatal through age five that:

- optimizes child development,
- enhances parenting skills and resilience,
- safeguards maternal and infant health,
- prevents costly crisis intervention,
- reduces adverse childhood experiences, and
- demonstrates improved educational and life outcomes.

Under this vision, all Los Angeles families with young children would have access to trusted professional support and coaching in their home, so that they and their children may thrive.

Guiding Principles:

1. Universal access to effective prenatal and early childhood support is beneficial for children's health and development, for maternal health, for family well-being and for our community as a whole.

2. Some families can also benefit from intensive home visiting support to address complex sets of challenges.

3. Home visiting is a highly effective perinatal support resource; it attains numerous family well-being and health outcomes, reduces the need for crisis intervention, and triages families to the appropriate level of additional resources and community activities.

4. Home visiting is not the only effective perinatal and early childhood resource and it is not the sole or optimal fit for all parents; however, for parents who voluntarily participate in home visiting services, research shows it is one of the most impactful.

5. No wrong door: Families will have the opportunity to access resources through multiple paths. To maximize families' access to home-based support, we commit to building and refining referral pathways:

    a. that are attractive and easy to navigate from the family perspective (provided efficiently via trusted community providers),
    b. that are effective in finding and attracting "at-risk" and prenatal families in particular, and
    c. that are informed by process design principles, so that they work both for families and for staff in the departments involved.

6. Strong data tracking is essential to ensure highest quality services and optimal resource allocation.

7. Improving coordination can result in even better outcomes for our families and our community by ensuring (a) resources are maximized and (b) system connections are efficient and effective. Home visiting system coordination efforts should support, leverage, and be pursued in alignment with other change initiatives underway in Los Angeles County, including but not limited to the County Strategic Plan, Office of Child Protection's Prevention Plan, Help Me Grow, and other early childhood systems change initiatives.

8. There is a fundamental shortage of resources to meet the full potential need for home-based support in LA County. Expanded and more flexible financing is needed to meet community need. Adjustments should be made to current program recruitment and collaboration to ensure that existing funds are fully utilized, particularly for prenatal families.

Further exploration is underway to identify how additional infrastructure investments being underwritten by First 5 LA, County departments, the Consortium, and others may be expanded to support the teams and practices of all Los Angeles County home visiting models. In keeping with national research findings, this exploration will pay particular attention to cultural competency

and reflective practices. It will also include examination of investments required to meet the recruitment, career pathway, and training and education needs of the growing and evolving home visiting workforce. These efforts will also connect, leverage, and align with parallel County workforce development strategies.

III. Gaps in Services for High-Risk Populations and Strategies to Address Gaps

The Planning Team and the Los Angeles County Perinatal and Early Childhood Home Visitation Consortium (Consortium) collectively engaged in deep analysis of the Los Angeles County home visiting landscape in order to ground its planning in current local data and sound knowledge of nationwide best practices.

This analysis of current home visiting capacity and gaps revealed that Los Angeles County has a strong base of quality home visiting programs; however it also revealed a stark difference between the quantity of home visiting available and the full community need for such programs. This section summarizes those results (See Appendix C: Executive Summary - Home Visiting in Los Angeles County: Current State, Gaps & Opportunities for more detail on the findings of the gap research).

Current publicly-funded[1] home visiting programs in Los Angeles are funded through the contributions of five local governmental entities, plus numerous contracts awarded by the federal government to local non-profit organizations.

Funding Source	Models	Number & Type of Families Funding Can Serve
First 5 LA	Healthy Families America & Parents as Teachers; Welcome Baby	3,100 High-Risk Families/Yr 15,000 Families/Yr
Dept. of Public Health (MIECHV, TCM, MAA)	Nurse-Family Partnership Healthy Families America	1,210 High-Risk Families/Yr
Dept. of Mental Health (MHSA/PEI)		
Dept. of Children & Family Services (State Realignment)	Partnerships for Families	1,260 High- Risk Families/Yr
Federal Contracts (HRSA Healthy Start, Head Start)	Early Head Start Healthy Start	3,950 High-Risk Families/Yr

Collectively, these funding streams enable 55 local non-profit organizations to provide home visiting services to young Los Angeles County families, with the collective total capacity to help approximately 24,500 families per year, including the capacity to provide intensive services to approximately 9,500 high-risk families per year. Appendix D, "Home Visiting Providers in Los

[1] While the majority of home visiting programs in Los Angeles operate utilizing public funding, it is worth noting that there are additional smaller home visiting programs run by non-profit agencies utilizing philanthropic or grant dollars that are not included in the numbers herein. There are also additional family services provided in the home (such as home-based therapeutic interventions) that are not reflected here because they are either not preventative or not comprehensive.

Angeles County, By Program Model," enumerates the local non-profit organizations providing home visiting services and indicates the models each offers.

Comparing this capacity to the full community need for family support among prenatal and young families reveals a substantial gap in services for both high-risk populations and the general Los Angeles County population. The 2014 DPH LAMB survey data reveals an estimated 78,500 families in Los Angeles County each year exhibit at least one high-risk factor;[2] an estimated 33,000 exhibit two or more. Comparing this community need to the 9,500 spots currently available for at-risk families in Los Angeles shows only 12-29 percent of high-risk families accessing home-based family support in Los Angeles County. Comparison of existing preventive home visiting services available to the general population (termed "universal" services) with the annual number of births in Los Angeles County (130,000) reveals a similar need to improve the system of supports by expanding funding, as current funding only provides sufficient capacity to serve 12 percent of the full population.

Analysis of eligibility criteria and geographic disparities further pointed toward the need to strive for increased funding flexibility. All general population services and most high-risk, high-intensity services are geographically restricted. The vast majority of high-need services also have restrictions based on child age and family income/risk criteria that further restrict access. There are vast numbers of families who are therefore not able to access home visiting services simply due to geographic and other eligibility requirements currently in place in Los Angeles County.

Gap analysis also revealed opportunities to improve family impact through increased coordination around prenatal referrals. Due to restrictions on current funding that require families to enroll in many existing programs at birth or prenatally, building additional prenatal referral pathways from medical providers and County departments into home visiting programs would enable better leveraging of existing funding streams.

Finally, the Home Visiting Providers Community Roundtable revealed a need for improved perinatal mental health services for prenatal and post-natal mothers suffering from depression, anxiety, or other mood disorders (a particular sensitive high-risk population). In response, DMH has committed to partnering with the Consortium, DCFS, and other home visiting networks to increase perinatal mental health cross-training and resource coordination. DMH will leverage its trauma-informed models, screening components, training modules, Regional Navigators, and field-capable, home-based services as tools in these efforts. This work will build and strengthen the bridges between these resources and home visiting networks in Los Angeles County. With this improved perinatal mental health training and referral support, home visitors will have stronger capacity to help prenatal and post-partum mothers who are experiencing depression or other perinatal mood and anxiety disorders. Through the enhanced capacity these efforts will build, home visiting programs will be better positioned to achieve the desired outcomes of reducing the risk of adverse childhood experiences, improving maternal health, and improving

[2] Risk factors included in the analysis were as follows: depressed while pregnant, teen mom, used illicit drugs while pregnant, physically abused while pregnant, entered prenatal care after 3 months, less than a high school education, and homeless while pregnant. Risk factors were chosen based on a combination of Children's Data Network research regarding child abuse risk factors and the expertise of the Consortium Data Workgroup. Survey findings were extrapolated to the number of women who give birth every year in LA County for an estimate of population-level risk.

parental capacity to provide nurturing, developmental stimulation, and economic wellbeing to their families.

IV. Increase Access to Voluntary Home Visitation for High-Risk Families

Informed by research, home visiting provider agencies, and leadership of County departments, planning has already begun for increasing access to voluntary home visitation for families at high risk of involvement with the child welfare system, consistent with the recommendations of the Los Angeles Blue Ribbon Commission on Child Protection. Below are two examples of work already underway to increase access to voluntary home visitation for high-risk families:

County departments are working together to explore the process changes that would be required to create intentional referral pathways into home visiting programs, particularly for pregnant clients and high-risk clients. For example, the DPSS committed to developing a pilot in Region 5 (SPA 6) to refer pregnant applicants and Family Stabilization clients with children prenatal to five years old to home visiting supports (with financial support for the pilot underwritten by First 5 LA). DCFS has already collaborated with Early Head Start providers as part of its Early Education Partnership and built a "Head Start and Early Education Referral System" to connect DCFS clients to EHS services. They also already refer DCFS-supervised Pregnant and Parenting Teens (PPT) to home visiting services when applicable. DCFS is also interested in exploring the opportunity to also build linkages between Prevention and Aftercare and home visiting agencies (in line with the OCP Prevention Plan). Additional areas of interest among stakeholders include opportunities to increase referrals from medical providers and faith-based providers.

One of the key steps in refining these new pathways will be the leveraging, improving, and building out of electronic systems as needed to support effective referrals. DPH and the Planning Team intend to further engage the philanthropic community about opportunities to possibly underwrite his needed technological infrastructure. In addition, DPH will work closely with First 5 LA to explore whether adjustments might be made to existing program restrictions in order to expand the flexibility of entry into their programs.

DPH will continue to engage County departments, community members, Consortium workgroups, and home visiting provider agencies as may be appropriate to develop concrete implementation plans to move forward with these and new opportunities.

V. Collect, Share, and Analyze Standardized and Consistent Outcome Data

Substantial national and academic research has been performed validating the models chosen by Los Angeles County departments, as effective in improving child development, family safety, health, and other outcomes. Appendix B details the national research on outcomes affiliated with each model operating in Los Angeles County. In addition, current efforts led by the Consortium's Data and Best Practices Workgroups both have already integrated the leading best practices from other states, national models, Maternal, Infant, Early Child Home Visiting (MIECHV), and Pew Charitable Trusts into their data collection and peer quality support work (See Appendix E: Consortium Best Practice Recommendations and Appendix F: Home Visiting Program Outcome Indicators).

Having quality capacity and outcome data is essential to ongoing gap assessment and program evaluation. Recognizing the leadership that the Consortium's Data Workgroup has already provided in developing common outcome indicators (based on MIECHV and Pew Charitable Trusts' Home Visiting Campaign) for home visiting programs in Los Angeles County, the County departments have begun exploring the viability of implementing the indicators in all County-funded home visiting programs. This supports the goal of countywide data tracking. County departments also have also examined additional outcome measurement opportunities, including for long-term, data matching, data warehousing, and outcome analysis.

County departments have identified an interest in gaining greater clarity regarding how home visiting compares and relates to other family prevention and intervention strategies with similar measurable goals. These data tracking and investigation efforts require an infusion of funding, as well as development of protocols and data sharing agreements. DPH and the Planning Team will continue to work with the other County departments and organizations named in the Board motion to develop a data collection plan and budget for consideration by the philanthropic community.

VI. Framework to Maximize Resources by Leveraging Available Funding and Identify New Revenue Streams

Sustainability is one of the most pressing challenges facing the network of home visiting programs in Los Angeles County. In addition to the challenge of the unmet community needs identified above, current funding sources are declining. First 5 LA is the single largest funder of home visiting in Los Angeles County, investing approximately $38 million annually (based on FY16-17 budget). First 5 LA funding continues to decline with the loss of tobacco revenue, jeopardizing the long-term sustainability of existing service capacity in the system. In addition, DPH's FY 17/18 MIECHV funding for Nurse-Family Partnership and Healthy Families America has been reduced 45 percent.

Research regarding national funding trends revealed several key themes and opportunities for Los Angeles County. Potential funding streams include State Medicaid (e.g., Medicaid Waivers, Targeted Case Management and Medicaid Administrative Activities), Federal (e.g., Maternal, Infant and Early Childhood Home Visiting Program), mental health (Mental Health Services Act/Prevention and Early Intervention), child welfare (State re-alignment funds), and social services (Temporary Assistance for Needy Families) system (See Appendix G: Summary of Sustainability Research).

One of the most significant themes that emerged is the importance of pursuing and implementing multiple sustainability strategies simultaneously, in a blended and/or braided fashion, to achieve a truly universal system of home visiting. Targeted Case Management (TCM) and Temporary Assistance for Needy Families (TANF) were considered short-term opportunities to pursue in this initial assessment, with potential implementation of pilot work in FY17-18. Funding streams assessed as ripe for deeper exploration include Medicaid Administrative Activities (MAA), Mental Health Services Act-Prevention and Early Intervention (MHSA-PEI). Future Medicaid waivers were considered a long-term opportunity, given the level of planning, partnership and state-level buy-in required, though there may be opportunities to progress home visiting efforts through the current Los Angeles County waiver. Another strategy is MIECHV, a federal

allocation which will require continued advocacy with local, state, and national partners because funding is currently only authorized through September 2017.

A second important theme that emerged is the opportunity for Los Angeles County to maximize existing revenue streams, such as federal funds. The research done to date has identified various revenue sources that are not yet being fully maximized in the County, such as TCM, which is funded by a combination of local funds and federal Title XIX (Medicaid) funds. TCM services are the most commonly billed services by home visiting programs in the nation, but this strategy is not fully maximized in in Los Angeles County. Expansion of this strategy is now being explored with DPH, the administering agency. Other funding where there may be potential for similar maximization include MAA and MHSA-PEI.

A third theme is the need to explore new sources of funding for home visiting. In 26 states across the nation, TANF is a partial source of funding for home visiting programs. This strategy has not been tapped into to date in Los Angeles County, but workgroup members are currently in planning discussions with DPSS on a pilot effort that will inform the viability of using TANF for home visiting in Los Angeles County.

All County departments and organizations named in the Board motion are committed to continuing to explore opportunities to bring additional resources to support Los Angeles County programs. Additionally, the philanthropic community stands ready to partner with the County to complement the public funding where its investment can be catalytic. In this initial assessment, TCM and TANF were considered short-term opportunities to pursue, with potential implementation of pilot work in FY17-18. Funding streams assessed as needing deeper exploration include MAA, MHSA-PEI and child welfare funds. Another strategy is MIECHV, a federal allocation which will require continued advocacy with local, state and national partners because funding is currently only authorized through September 2017. Finally, funding streams to be assessed in the next phase include Early Head Start, Healthy Start, Early Periodic Screening Diagnosis and Treatment (EPSDT), Probation and Homelessness/Housing.

DHS has identified the 1115 waiver's Whole Person Care program as an opportunity to expand home visitation in Los Angeles County over the next four years. In partnership with DPH, the program will serve as a mechanism to test a blend of programs in an evidence-informed effort to reach some of the most vulnerable pregnant and parenting families. This expansion of the DHS prenatal program "MAMAs Neighborhood" seeks to fill gaps in the existing home visitation landscape and serve as a demonstration which can inform future state plan amendment proposals to secure sustainable funding streams.

Further analysis is needed to identify opportunities for blending and braiding of funding streams such as those listed above, coordinating resources in a more intentional manner to maximize leveraging opportunities and meet the collective outcomes for the system. All named County Departments and organizations are committed to partnering with the Consortium to track local, State, and national opportunities for advocacy that could increase funding for Los Angeles County programs or could support the maintenance of high-quality home visiting programming in Los Angeles County.

Moving forward, DPH and the Planning Team will invite new key stakeholders, including the Los Angeles County Office of Education (LACOE) to join in planning and advocacy efforts. In addition, future opportunities to advocate for federal funding, similar to the recent five-signature Board letter in support of MIECHV to Congress, will be identified to your Board as they develop.

DPH and the Planning Team recognize that sustainability will only be achieved and system changes will only be maintained if there is a clear long-term commitment by the County and others in the form of infrastructure and funding. One of the key outcomes that the Planning Team will seek to achieve during the next phase of work is the establishment of a strategy to support successful plan implementation, including infrastructure, leadership, and funding that County entities, First 5 LA, the Consortium, and others may be able to commit.

An update on progress will be provided to your Board by September 26, 2017. If you have questions or need additional information, please let me know.

BF:lma

Attachments

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors
Director of Mental Health
Director of Public Social Services
Director of Children and Family Services
Chief Probation Officer

Appendix A

HOME VISITING ROUNDTABLE, MARCH 17, 2017
EXECUTIVE SUMMARY OF COMMUNITY AGENCY INPUT

Countywide Trends

- Need for perinatal mental health services, including for post-partum depression.
- Changes to existing HV that would help:
  - Allowing earlier/later entry into HFA/PAT
  - Allowing enrollment in HFA/PAT outside geographic restrictions
  - Allowing enrollment in HFA/PAT through self-referral, not just through WB.
- Interest in learning billing options; training/TA needed; IT/billing system may be needed; some concern over how difficult and time-consuming process is.
- Interest and willingness to work to improve referrals; technological support desired, such as online database to lookup info, app, and/or feedback mechanism; desire in many SPAs for feedback loops to know whether referrals to HV peers were successful and to trouble-shoot if not.
- Need more education and partnership with pediatricians, ob-gyn, hospitals, HMOs/managed care.
- EHS in demand/full at current funding level; rise in minimum wage may prevent some families from accessing EHS. Additional non-federal funding would allow EHS to serve more low-income families above the 100% FPL federal eligibility restriction.
- Recent immigration related fears are causing clients to deny services; helping homeless families is a challenge in multiple SPAs.
- Interest in modernizing home visiting on multiple levels:
  - Advertising to younger parents
  - Electronic enrollment and referral processes, including non-traditional enrollment locations and client self-referral
  - Programs currently have varying levels of tech ability; interest in standardizing systems so that they can "talk" to each other
  - Apps for home visitors' and clients' use.
- HV staff, training, and program advertising should reflect the communities they serve and be presented in inclusive and non-stigmatizing ways; young and minority families are hard to reach because they don't see themselves in the programs.

Roundtable Evaluation Results

Evaluation Category	Participant Ratings	
	Mean	Median
Explanation of purpose of Roundtable	4.51	5
Background information on LA County home visiting need, availability & gaps	4.51	5
Opportunity to give strategic input into County planning	4.55	5
Overall meeting facilitation	4.61	5
Quality of the handouts/materials	4.25	4
The Roundtable as a whole	4.67	5
Location of meeting	4.2	4
Food Provided at meeting	4.47	5
There was an appropriate amount of time for briefing on current home visiting availability, need and gaps.	4.32	5
There was an appropriate amount of time for small group discussion.	4.42	5
Our group discussed/ recommended at least on strategy that I can commit to work on.	4.28	5
There was an appropriate amount of time for the whole group to reflect together.	4.17	4

Qualitative responses were generally positive without many trends or repeat comments. One comment that was repeated was the desire for clients to be able to have a voice at some point in our process.

Appendix B

LOS ANGELES COUNTY PERINATAL & EARLY CHILDHOOD HOME VISITATION CONSORTIUM

Mission:
To coordinate, measure and advocate for high quality home-based support to strengthen all expectant and parenting families so that the children of Los Angeles County are healthy, safe and ready to learn.

SUMMARY OF OUTCOMES:
What Research Proves Home Visiting Impacts

Report as of June 4, 2017

Big Orange Splot
A SOCIAL IMPACT ADVISORY FIRM

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Summary of Outcomes Research

The following table shows the impact of home visiting models on specific outcome areas, based on existing research, by each model type currently in operation in Los Angeles: Early Head Start ("EHS"), Nurse-Family Partnership ("NFP"), Healthy Family America ("HFA"), Parents as Teachers ("PAT"), Welcome Baby, Partnerships for Families ("PFF") and Healthy Start.

	EHS	NFP	HFA	PAT	Welcome Baby	PFF	Healthy Start
Increases Cognitive & Social Development	✓	✓	✓	✓	✓		
Improves School Performance		✓	✓	✓			
Improves Maternal Health		✓	✓	✓	✓		
Improves Child Health	✓	✓	✓	✓	✓		
Improves Mental Health	✓	✓			✓	✓	
Improves Family Safety & Parenting	✓	✓	✓	✓	✓	✓	
Increases Self-Sufficiency (Decreases use of Public Assistance; Increases Training or Employment)	✓	✓	✓				
Decreases Crime		✓					
Realizes Cost Savings		✓	✓	✓			

Details of Outcome Research by Impact Area and Model

The following tables outline the relevant existing research linking each applicable home visiting model in operation in Los Angeles with the individual impact areas listed above.

Increases Cognitive & Social Development	
EHS	▪ EHS showed positive impact on children's cognitive development by 36 months (Roggman, 2009). ▪ After a year or more of services, compared with a randomly assigned control group, 2-year-old EHS children performed better on measures of cognitive, language and social emotional development (Commissioner's Office of Research and Evaluation and The Head Start Bureau, 2001). o EHS children scored 90.1 on the Bayley Scales of Infant Development Index, compared with 88.7 for the control group. o A smaller percentage of EHS children scored in the at-risk range of developmental functioning (33.6 percent versus 40.2 percent in the control group). o Children were reported by their parents to have larger vocabularies and to use more grammatically complex sentences. ▪ Three-year-old EHS children performed significantly better on a range of measures of cognitive, language and social-emotional development than a randomly assigned control group (Administration for Family and Children, 2006). EHS children: o Scored 91.4 on the Bayley Mental Development Index, compared with 89.9 for control group children. o Scored 83.3 on the Peabody Picture Vocabulary Test, compared with 81.1 for the control. o Were significantly less likely than control group children to score in the at-risk range of developmental functioning. o Engaged their parents more, were less negative towards their parents, and more attentive to objects during play. Furthermore, EHS parents rated their children as lower in aggressive behavior than control parents did (Administration for Family and Children, 2006). ▪ EHS children were less likely to have delays in cognition and language functioning (Administration for Children and Families (2002b), 2002).
NFP	▪ NFP enrollees had higher cognitive and vocabulary scores at age 6 (Olds, et al., 2004).
HFA	▪ Rigorous studies report improvements in children's cognitive development at one and two years, and fewer behavior problems that can interfere with learning at two and three years (Healthy Families America, September 30, 2015).
PAT	▪ PAT children score higher on measures of achievement, language ability, social development, persistence in task mastery and other cognitive abilities (Drotar, Robinson, Jeavons, & Kirchner, 2009), (Pfannenstiel, 1989), (Pfannenstiel & Seltzer, New Parents as Teachers Project, 1985), (Pfannenstiel, Lambson, & Yarnell, 1991), (Wagner, Spiker, & Linn, 2002). ▪ 94% of children's language scores increased (Coalition, November 2016).
Welcome Baby	▪ Welcome Baby was associated with higher scores for children's communication skills and social-emotional skills, as measured by the ASQ Social-Emotional assessment tool at 12 months and the BITSEA at 24 and 36 months (Sandstrom, June 2015).

Improves School Performance	
EHS	▪ According to Health and Human Services' systematic review of the research on home visiting, several different home visiting models, including Early Head Start, Healthy Families America, Nurse Family Partnership, and Parents as Teachers all had a positive impact on child development and school readiness (Paulsell, 2010).
NFP	▪ NFP enrollees had higher grade point averages and test scores in math and reading at age nine (Olds et al., 2004 and 2007).
HFA	▪ Children who participated in Healthy Families America were half as likely to repeat first grade (3.5% vs 7.1%) as those who did not participate (Children Now, 2014). ▪ Children in HFA were more likely to be in a gifted program, fewer were retained in first grade, and fewer received expensive special education services (Healthy Families America, September 30, 2015).
PAT	▪ PAT children score higher on reading, math, and language in elementary grades (Drazen & Haust, 1995). ▪ Compared to non-PAT children, PAT children were shown to require half the rate of remedial and special education placements in third grade (Pfannensteil, Seitz, & Zigler, 2002) (Drazen & Haust, 1995). ▪ PAT parents are more likely to enroll their children in preschool, attend parent-teacher conferences, PTA/PTO meetings and school events, volunteer in the classroom, talk with their children's teachers, and assist their children with homework (O'Brien, Garnett, & Proctor, 2002) (Pfannenstiel, 1989) (Pfannenstiel, Lambson, & Yarnell, 1996). ▪ Teachers rated PAT children significantly higher than non-PAT children on multiple developmental indicators of school readiness (O'Brien, Garnett, & Proctor, 2002). ▪ PAT children score higher on standardized measures of reading, math, and language in elementary grades (Pfannensteil, Seitz, & Zigler, 2002). ▪

Improves Maternal Health	
NFP	▪ Several studies have shown that NFP increased the number of months between births. For example, Olds et al (1997) indicated a 28-month greater interval between birth of the first and second child (Kitzman H. O., 2000) (Olds D. K., 2004) (Olds D. K.-A., 2007) (Olds D. R., 2004). ▪ Several studies have shown that NFP helps reduce the number of children born to a mother (Kitzman H. O., 1997) (Olds D. K., 2004) (Olds & et al., Effects of Nurse Home-Visiting on Maternal Life Course and Child Development: Age 9 Follow-Up Results of Randomized Trial, 2007) (Olds D. R., 2002). One study showed 29% fewer subsequent live births (Kitzman H. O., 1997). Several studies have also shown that NFP reduces subsequent pregnancies (Kitzman H. O., 2000) (Kitzman H. O., 1997) (Olds D. K., 2004) (Olds D. R., 2002), including one study showed a 32% reduction in subsequent pregnancies (Kitzman H. O., 1997). ▪ One study demonstrated 7% fewer yeast infections among NFP mothers (Kitzman H. O., 1997). ▪ One study demonstrated 35% fewer cases of pregnancy-induced hypertension among NFP mothers (Kitzman H. O., 1997). ▪ One study demonstrated that NFP mothers had diets shown to be more in accordance with federal dietary recommendations versus the control group (Olds D. H., 1986). ▪ One study demonstrated a 44% reduction in maternal behavior problems due to substance abuse among low-income, unmarried NFP mothers (Olds D. K., 2010). ▪ One study showed the percentage of mothers dying from any cause was less among NFP participants than among a control group of mothers receiving only transport to prenatal appointments (Olds D. K., 2014). ▪ One study demonstrated a decrease in smoking among all NFP mothers who smoked at intake (Olds D. H., 1986). ▪ One study demonstrated a 79% reduction in preterm delivery in NFP mothers who smoked 5 or more cigarettes per day at registration (Olds D. H., 1986).
HFA	▪ HFA was shown to improve expectant mothers' linkage to primary care providers before birth (Lee, et al., 2009). ▪ HFA moms had 22% fewer birth complications (Galano J., 1999b). ▪ More moms in HFA reduced their alcohol use (Healthy Families America, September 30, 2015). ▪ A study of HFA mothers in Arizona showed greater contraception use among HFA mothers compared to the control group (Davis, March 2016). ▪ Young mothers enrolled in HFA Massachusetts program were significantly less likely than the control group of mothers (25% vs 36%) to have engaged in risky behaviors, including substance use, fighting, and unprotect sex in the preceding month, after 28 months of participation in the program (Francine Jacobs, November 12, 2015).
PAT	▪ A health literacy demonstration project conducted with Parents as Teachers programs in the boot-heel area of Missouri found significant improvements occurred in family planning (Carroll, Smith, & Thomson, 2015).
Welcome Baby	▪ The WB rate of return for postpartum care within 21-56 days of delivery (the HEDIS guideline) was 87.5%: higher than LA County's Medi-Cal plans, higher than the national Medicaid population, and higher than for patients covered by private insurance (Careaga, 2012).

Improves Child Health	
EHS	▪ EHS had small but statistically significant favorable impacts on the percentage of children who visited a doctor for treatment of illness (83% vs 80%), receipt of immunizations (99% vs 98%), and the likelihood of hospitalization for accident or injury (0.4% vs 1.6%), when compared to a control group (Administration for Children and Families, 2006, p. 1). ▪ EHS children were more likely than low-income children nationally to have health insurance (91% vs. 79%) (Administration for Children and Families, 2006, p. 2). ▪ EHS children were significantly more likely to receive Part C early intervention services due to higher rates of screening, referral and coordination with Part C partners (5.4% vs. 3.8%) (Administration for Children and Families (2002b), 2002, p. 1).
NFP	▪ NFP was shown to decrease emergency room visit use rates for child enrollees (Avellar & Supplee, 2013). ▪ Children in NFP are significantly more likely to be up-to-date on immunizations at 6, 18, and 24 months (Thorland, Currie, Wiegand, Walsh, & Mader, 2017). ▪ NFP moms exhibited longer inter-birth intervals (Olds & et al., 2007). ▪ An analysis by the Center for American Progress demonstrated that scaling the Nurse Family Partnership program to all eligible women in CA could prevent 2,735 infant deaths and 54,695 preterm births over 10 years (Herzfeldt-Kamprath, November 2015).
HFA	▪ Children in HFA had better access to health care, evidenced by rates of health insurance at ages one and two; connection with a primary care provider; and more completed Well-Baby visits (Healthy Families America, September 30, 2015) (Avellar & Supplee, 2013). ▪ HFA reduced the rate of low birth weight infants among women enrolled prenatally. Low birth weight is associated with higher infant mortality as well as substantial short- and long-term challenges to child health and development (Healthy Families America, September 30, 2015). A study of Healthy Families in New York demonstrated that women who receive home visiting services during pregnancy are nearly half as likely to deliver a low birth weight baby (Lee, et al., 2009). ▪ A study of HFA in Arizona showed that HFA mothers had higher rates of breastfeeding than the control group (Davis, March 2016).
PAT	▪ Children participating in Parents as Teachers were more likely to be fully immunized for their given age (Wagner, Iida, & Spiker, 2001) (Paradis, Sandler, Todd Manley, & Valentine, 2013). ▪ Children in Parents as Teachers were less likely to be treated for an injury in the year following their participation in the program (Wagner, Iida, & Spiker, 2001). ▪ A health literacy demonstration project conducted with Parents as Teachers programs in the Boot-heel area of Missouri found significant improvements occurred in the following health care literacy indicators: use of information, use of prenatal care, child well care, child sick care, child dental care, and child immunizations (Carroll, Smith, & Thomson, 2015).
Welcome Baby	▪ WB moms are 40%-60% more likely than a control group to exclusively breastfeed their babies at four months postpartum (Benatar & et al., 2012).

Improves Mental Health	
EHS	▪ Positive impacts were found for parent-child interaction and children's social-emotional development. Furthermore, among those families in which mothers were depressed at enrollment, EHS had even stronger favorable impacts on parent-child interaction (Administration for Children and Families, 2006, p. 1).
NFP	▪ NFP shows a treatment impact on an outcome correlated with depression; mothers in the intervention group had higher personal sense of mastery scores for the period from child age six months to child age six (Kitzman H. O., 1997); the paraprofessional home visitors group reported a greater sense of mastery and better mental health at child age four (Olds D. K., 2004) (Olds D. K., 2010) (Olds D. K.-A., 2007).
HFA	▪ A study of families enrolled in Healthy Families Arizona showed the Mental Health Index (which measures both psychological distress and psychological well-being) was higher in the Healthy Families group than in the control group (Davis, March 2016). ▪ In a study assessing the impact results from a randomized, controlled trial of Healthy Families Massachusetts, the only universal statewide home visiting program that specifically targets and wholly serves first-time young parents, it was found that HFA Massachusetts was successful in helping young, first-time mothers learn to control stress and in curbing externalizing and risky behaviors (Francine Jacobs, November 12, 2015).
Welcome Baby	▪ An evaluation of LA County's Welcome Baby program showed that moms had lower parenting stress and stronger maternal responsiveness at 36 months compared to the control (Urban Institute and University of California, Los Angeles).
PFF	▪ Participation in the LA County PFF program had a significant impact on reducing parental depression, mood swings, and aggression/anger, especially for prenatally enrolled moms (Reuter, Melchior, & Brink, 2016).

Improves Family Safety & Parenting	
EHS	▪ EHS was shown to reduce child welfare encounters between five to nine years of age, subsequent encounters, and substantiated reports of physical or sexual abuse (Green, et al., 2014). ▪ After a year or more of program services, when compared with a randomly assigned control group, the parents of EHS children scored significantly higher on many measures of the home environment, parenting behavior, and knowledge of infant-toddler development (Commissioner's Office of Research and Evaluation and The Head Start Bureau, 2001, p. iii). EHS parents: ○ engaged in important activities with their children more frequently than control group parents; for example, singing songs and nursery rhymes, dancing, and playing outside as well as creating a richer literacy environment for their children. ○ were more likely to read to children daily and at bedtime. ○ displayed more supportive parenting behaviors. ○ showed greater enjoyment, greater sensitivity, and less detachment, created more structure, and extended play to stimulate cognitive and language development. ○ were more emotionally responsive, displaying greater warmth, praise, and affection toward their children. ○ created more structure in their children's day by setting a regular bedtime. ○ were less likely to report having spanked their child in the past week than control group mothers. ○ were more likely to suggest using a positive discipline strategy when presented with hypothetical parent-child conflict situations, such as distracting the child or explaining to the child. In conflict situations, Early Head Start mothers were more likely to suggest only mild responses. ○ reported lower levels of family conflict and parenting stress (Commissioner's Office of Research and Evaluation and The Head Start Bureau, 2001, p. 6). ▪ Findings also suggest that EHS had reduced the stress of parenting (Commissioner's Office of Research and Evaluation and The Head Start Bureau, 2001, p. iii). ▪ EHS increased mothers' knowledge of infant-toddler development and developmental milestones (Commissioner's Office of Research and Evaluation and The Head Start Bureau, 2001, p. 6).
NFP	▪ NFP had a positive impact on reducing child maltreatment (Paulsell et al., 2010); the Nurse-Family Partnership home visiting program has been shown to reduce child maltreatment by 48% (Children Now, 2014). ▪ Center for American Progress estimated that scaling NFP to all eligible women in CA could prevent 196,902 incidents of intimate partner violence over ten years (Coalition, November 2016).
HFA	▪ According to Health and Human Services' systematic review of the research on home visiting, HFA had positive impacts on reducing child maltreatment (Paulsell, 2010). ▪ Five HFA studies show significant benefits in preventing adverse childhood experiences, including reduced child maltreatment, physical punishment, yelling, and improved use of non-violent discipline, based on parents' self-reports—a more comprehensive measure of child maltreatment than official cases (Healthy Families America, September 30, 2015). ▪ HFA has shown a reduction of domestic violence perpetrated by mothers (Healthy Families America, September 30, 2015). ▪ Results from a randomized trial found positive outcomes showing Healthy Families mothers read more frequently to their children, provided more developmentally supportive activities, and had less parenting stress than the control group (Greene, 2014).

Improves Family Safety & Parenting	
	▪ A Massachusetts study found mothers enrolled in the Healthy Families program reported less parenting stress than control mothers (Easterbrooks, 2012). ▪ An Arizona study found positive results in comparison to the control condition on use of safety practices, parenting attitudes (e.g., inappropriate expectations), reading to children, use of resources, reduced alcohol use, and greater maternal education and training (Davis, March 2016). ▪ A study of teen mothers enrolled in HFA in Massachusetts showed that parents enrolled in the program reported less difficulty with their children and less parenting distress after 28 months of participation in the program than teen parents in the control group (Francine Jacobs, November 12, 2015). ▪ A study of families enrolled in HFA Arizona showed that at six months the Healthy Families group had implemented more safety practices in the home, used more resources to meet family needs, scored higher on mobilizing resources, had higher quality the home environment, more regular routines, reduced chaotic household and increased reading to their child than the control group (Davis, March 2016).
PAT	▪ PAT families with very low income were more likely to read aloud to their children, tell stories, say nursery rhymes, and sing with their children (Wagner, Spiker, & Linn, The Effectiveness of the Parents as Teachers Program with Low-Income Parents and Children, 2002). ▪ Over 75% of PAT parents reported taking their child to the library regularly and modeling enjoyment of reading and writing (Pfannenstiel, Lambson, & Yarnell, 1996). ▪ PAT parents engage in more language activity and were more likely to promote reading in the home (Albritton, Klotz, & Roberson, 2004). ▪ PAT parents showed significant improvements over time in parenting knowledge, behavior, and attitudes (Owen & Mulvihill, 1994). ▪ PAT participation was related to 50% fewer cases of suspected child abuse and/or neglect (Drazen & Haust, 1993, August). ▪ Parents as Teachers had fewer documented cases of abuse and neglect compared to the state average in 37 diverse school districts across Missouri (Parents as Teachers National Center, Inc.). ▪ Short-term outcomes of PAT include: improved parenting practices; increased knowledge and practices of positive discipline techniques; more realistic expectations of age-appropriate developmental milestones; a home environment conducive to healthy child development; parent-child attachment; reduction of stress; fulfillment of basic needs; opportunities to interact with other parents; increased awareness and access to sources of information and support (Parents as Teachers National Center, Inc.). ▪ In another randomized trial, adolescent mothers in an urban community who participated in PAT scored lower on a child maltreatment precursor scale than mothers in the control group. These adolescent mothers showed greater improvement in knowledge of discipline, showed more positive involvement with children, and organized their home environment in a way more conducive to child development (Wagner, Iida, & Spiker, 2001).
Welcome Baby	▪ Welcome Baby moms demonstrated stronger teaching skills and affection towards their children at 36 months compared to the control group (Urban Institute and University of California, Los Angeles).
PFF	▪ PFF achieved reduced rates of re-referral to child protective services, substantiated allegations of maltreatment, DCFS case openings, and removal from the home over the length of the study (Brooks & et al., 2011).

Improves Self-Sufficiency (Includes Reducing Dependence on Public Assistance and Increasing Employment or Job Training)	
EHS	▪ EHS has been shown to positively impact parents' participation in education, job training activities, and employment (Admin. for Children and Families, 2006). ▪ After a year or more of program services, when compared with a randomly assigned control group, EHS parents were more likely to attend school or job training and to use employment-related services (The Commissioner's Office of Research and Evaluation and The Head Start Bureau Administration on Children, Youth and Families Department of Health and Human Services, 2001, pp. 1, 7). ▪ Note: 2001 research on EHS failed to show any impact on the percentage of parents employed, hours per week employed in all jobs, receipt of welfare benefits, or family income during the first 15 months after their participation in EHS (The Commissioner's Office of Research and Evaluation and The Head Start Bureau Administration on Children, Youth and Families Department of Health and Human Services, 2001, p. 7).
NFP	▪ NFP moms had less use of welfare and food stamps and fewer subsequent births than control group moms (Olds & et al., 2007). ▪ At age 19, daughters of NFP enrollees had fewer children and less reliance on Medicaid than children of moms in the control group (Eckenrode & et al., 2010). ▪ 31% of parents who entered the program without a high school degree attained a high school diploma or GED by the time their child turned 12 months old (Nurse Family Partnership National Service Office, Oct. 2015).
HFA	▪ HFA parents were five times more likely to enroll in school or training (LeCroy C. W., 2011). Most parents have not yet completed high school when they enroll in HFA, a critical step for future earning potential. HFA helps new moms find the motivation and resources to further their education, evidenced by three rigorous studies showing increased maternal education over one to three years in the program (Healthy Families America, September 30, 2015). ▪ A study of teen parents enrolled in HFA in Massachusetts showed that mothers enrolled in HFA were nearly twice as likely as control group mothers (17% vs 10%) to have finished at least one year of college (Francine Jacobs, November 12, 2015).
PFF	▪ 71% of PFF families' financial conditions improved while receiving services, as measured via initial and closing assessments using the Family Assessment Form (Brooks & et al., 2011).

Reduces Criminal Activity	
NFP	▪ At age 19, daughters of NFP enrollees were less likely to have been arrested and convicted than daughters of the control group (Eckenrode & et al., 2010).

Cost Savings of Home Visiting	
NFP	▪ A California-specific analysis of NFP estimated a net public savings of as much as $39,129 per family, in the form of fewer infant deaths, reduced child maltreatment, and fewer youth crimes in the long term (Children Now, 2014). ▪ Home visiting programs like NFP have been found to yield returns of $2.73 to $5.70 for each dollar invested (Ibid). ▪ For California, the ten-year cost savings of scaling NFP was estimated at $120,676,641 (Coalition, November 2016). ▪ If Medicaid were to fully fund the NFP program, the resulting savings per enrolled family to the federal and state governments would exceed the costs of providing the program to that family by the time the child turned 6 years old (Herzfeldt-Kamprath, November 2015).
HFA	▪ Every low birthweight or preterm birth costs states between $28,000 and $40,000 in medical care and other related costs. In New York's Healthy Families home visiting program, mothers who received home visits were half as likely to deliver low birthweight babies as mothers who were not enrolled (The PEW Center on the States, May 2010). ▪ In 2012, 33,655 babies (6.7% of all births) were born at a low birth weight in CA. Reducing this number by half could save the state as much as $673 million (Children Now, 2014).
PAT	▪ Parents As Teachers has an estimated benefit-cost ratio of $3.39 per dollar invested (Washington State Institue for Public Policy, February 2015).
Home Visiting in General	▪ For every dollar spent on home visiting efforts, at least $2 in future spending is saved (The PEW Center on the States, May 2010).

Summary & Details of Research on Program Efficacy with Specific Subpopulations and Cultures

Disproportionate representation in the child welfare system among racial and cultural minority families in the US remains a serious social issue. In response, researchers, policymakers, and practitioners are increasingly including an examination of *culture* as an integral part in developing child maltreatment prevention and intervention efforts. While the field has attempted to make—and has made—advancements in understanding the disproportionality of minority groups in the child welfare system, these advancements have only served to highlight the complex and multifaceted nature of culture, as well as its interaction with social stratification by race, ethnicity, and socioeconomic status. While it may not be realistic to imagine that all programs can be designed and evaluated for relevance to all cultural groups, nor that there are even a finite number of cultural groups in the US, the necessity of capturing and examining the dynamic nature of culture in relation to child maltreatment is clear (Megan Finno-Velasquez, 2015).

The findings of home visiting programs may be substantially impacted by cultural and community norms, including those of the racial/ethnic populations served as well as those of the communities in which studies have been conducted (Azzi-Lessing, 2013). That said, not all of the home visiting models have directly examined differential impacts for various racial/ethnic groups, nor have most studies addressed or discussed the substantial cultural differences that may characterize the different communities in which various programs operate. In many studies, the outcome analyses control for race, a common statistical approach, but one that might serve to mask positive outcomes that occur only within a particular subgroup (Greene, 2014).

The chart and narrative below shows studies that have been conducted related to a particular sub-population that have demonstrated a statistically significant impact on that sub-population. If a check mark is not shown for a particular sub-population for a home visiting model, it does *not* indicate that research proves the program ineffective on that sub-population, but rather more frequently that research has not been conducted on the impact of the home visiting model on that sub-population to date.

	EHS	NFP	HFA	PAT	Welcome Baby	PFF	Healthy Start
African-American	✓	✓					
Latino		✓		✓		✓	
Asian-Pacific Islander							
Indigenous			✓	✓			
Teen	✓		✓	✓			
Mothers with less than a GED/high school degree					✓		

Early Head Start:

- EHS impacts were particularly large for African American families, and those with a moderate number of demographic risk factors. The program also had positive impacts on two groups that other studies have reported as difficult to serve and have an impact on: teen parents and parents who were depressed at baseline (Administration for Family and Children, 2006, p. 2).

Nurse-Family Partnership:

- Beginning in 1990, a randomized, controlled trial was conducted in Memphis, Tenn. to study the effects of Nurse-Family Partnership on low-income, primarily African-American mothers living in disadvantaged, urban neighborhoods. In July of 2014, JAMA Pediatrics published a study that found for participants in Nurse-Family Partnership there were lower rates of preventable child mortality and all causes of death among mothers (Kitzman H. O., 1997).

Healthy Families America:

- A small randomized trial was conducted with one Apache and three Navajo communities where paraprofessionals delivered the program prenatally. Program participants showed positive impacts on measures of parent knowledge and maternal involvement when compared with a control group (Barlow, 2006).
- In a large randomized study of the Healthy Families America home visiting program being conducted in Oregon (Healthy Families Oregon, HFO), it was found that the program impact on parenting behaviors was larger for non-depressed mothers (Greene, 2014).
- The same Healthy Families Oregon (HFO) study found stronger program impacts on both parenting stress and depressive symptomology for mothers with three or more risk factors; these effects were particularly pronounced for mothers with four or five or more risk factors. Additionally, these highest risk HFO mothers were significantly less likely to endorse the use of harsh physical punishment, compared to control mothers. This is a potentially important finding in that it suggests that the program is acting to buffer the influence of these risk factors on these important psychosocial and parenting outcomes (Greene, 2014).

Parents as Teachers:

- PAT teen mothers showed greater improvement in knowledge about discipline and organized their home environment in a more appropriate way (Wagner, Iida, & Spiker, 2001).
- Parents in tribal communities report that PAT helps:
    - Increase the amount of time they spend with their child;
    - Become more involved with their child's education;
    - More effectively interact with their child; and,
    - Increase their understanding of child development (Research & Training Associates, Inc., 2012).
- In a randomized trial in Northern California, results showed that participation in Parents as Teachers by Spanish-speaking Latino families benefited them significantly in the area of self-help development (Wagner & Clayton, 1999).

Welcome Baby:

- A study by First 5 LA of mothers in Los Angeles showed that among all Welcome Baby participants, less educated mothers appear to experience significantly larger gains than more educated mothers in:
    - their engagement in home learning activities;

- the quality of child behavior observed during parent-child play;
- reduction of parental stress; and
- in the demonstration of encouragement and affection toward their children (Sandstrom, June 2015).

Partnership for Families:

- A study by First 5 LA of over 3400 families in Los Angeles County illustrated that Latino children whose families were fully engaged in PFF had the lowest percentage of re-referrals to DCFS (36% vs 52%) and DCFS case openings (8% vs 16%) when compared to families receiving no services among all ethnic groups participating in the study (Devon Brooks, November 30, 2011).

Recognizing the reality of incomplete research on program effectiveness specific to ethnic and other sub-populations, and moreover recognizing the complex interplay between demographic and other cultural dynamics active in the diverse communities that make up Los Angeles County, we must look beyond these studies to answer important questions about the role culture plays within home visiting programs.

To continue efforts to reduce disparities and improve outcomes for *all* children and families in Los Angeles, below are recommendations for how we may best move the field forward, based on formative analysis published by Megan Finno-Velasquez:

(1) ***Recalibrate the Conceptualization of Culture***: The key is to continue instilling the notion that a family's culture is a product of experiences that cannot be categorized *monolithically* with easily visible shared characteristics and features such as racial or ethnic labels. The examination of the role of culture in child maltreatment and family well-being necessitates a close look at each family's heterogeneous experience, beliefs, and practices across multiple contexts that are uniquely relevant to each family's functioning, with the goal of addressing cultural processes involved in prevention and intervention efforts in a more nuanced manner (Megan Finno-Velasquez, 2015).

(2) ***Replace the Notion of Cultural Competence with Cultural Reciprocity***: To effectively serve diverse families, practicing cultural reciprocity or humility may be more appropriate than cultural competence as currently institutionalized. Cultural reciprocity places responsibility on the professional to engage in self-reflection and dialogue to consider their own and the families' cultural norms and participate in collaborative exchange to provide effective services (Megan Finno-Velasquez, 2015).

(3) ***Refine Child Maltreatment Research to Integrate Diverse Cultural Groups***: Continuing efforts are needed to define and measure child maltreatment for diverse racial or ethnic and cultural groups, as well as to better understand differences and similarities in the causes of maltreatment among many types of families. From a research perspective, scholars may help to advance this goal by carefully articulating the definitions and operationalization of maltreatment and well-being constructs included in studies, as well as assumptions about the cultural relevance of these constructs for the study population. We should move towards explicitly stating the strengths and limitations of the measures used to capture culture as a construct. Work is needed, both within and across cultural groups, to understand how contexts, neighborhoods, federal family and immigration laws, local child welfare policies and practices, and family characteristics interact with parents' culturally bound beliefs and behaviors in the US. Research would benefit from carefully defining child neglect so as to clearly distinguish it from family poverty. Despite the risk poverty creates – both for child development generally and for child neglect specifically – more focused research and clearer definitions of neglect and risks for neglect within culturally diverse groups could contribute substantially to the ability of

policymakers and practitioners to address these issues and promote child well-being (Megan Finno-Velasquez, 2015).

(4) ***Enhance Intervention Design and Testing with Diverse Cultural Groups***: Existing interventions often rely on 20th century, European American, middle-class values. There may be a need to diversify the parenting styles and norms that are driving intervention development and normalization. Experts may wish to consider more rigorous and targeted testing of existing interventions with diverse cultural groups (Megan Finno-Velasquez, 2015).

(5) ***The Use of More Holistic and Innovative Strategies***: Maltreatment prevention interventions should address multiple stressors typically clustered together within a specific racial or ethnic group or community context, including economic and cultural stressors (Megan Finno-Velasquez, 2015).

(6) ***Diversify who is developing and evaluating such programs***: An intentional commitment to increasing the cultural and racial diversity of leading researchers, teachers, service providers, and policy makers in the field of child maltreatment and well-being may be critical to improving interventions and supporting the well-being of an increasingly diverse pool of families (Megan Finno-Velasquez, 2015).

(7) ***Focus on participant experience***: Research could be strengthened by placing greater emphasis on the process and experiences of diverse families throughout the implementation of interventions. Such research might document perceptions of cultural relevance or resonance, shared understandings and worldviews among program participants and providers, experiences of discrimination or empowerment, and overall client satisfaction with providers and services. Perhaps more importantly, longitudinal data could be utilized to understand whether the effects of parenting interventions and prevention on culturally diverse groups hold in the long term. This information, along with more data about families' origins and cultural identities, could be collected and analyzed within the context of implementation trials to better understand the role of culture in response to intervention. Moreover, while evidence-based programs may be effective in promoting positive parenting outcomes for families with diverse cultural beliefs and backgrounds, alternatives could exist that work just as well. These alternatives might not require assimilation and adoption of culturally relative practices that may force suppression of divergent cultural values (Megan Finno-Velasquez, 2015).

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Appendix C

Executive Summary
Home Visiting in Los Angeles County: Current State, Gaps & Opportunities

Home visiting[1] is a form of family support that includes parent coaching and comprehensive resource referrals provided by trained professionals in the home and community environment. It has been proven through research to be effective in reducing child abuse and neglect, improving child development, reducing preterm births, improving maternal and child health, increasing school readiness, reducing reliance on public financial benefits, and reducing crime. It is an invaluable model for improving family outcomes, preventing expensive crisis-based intervention, and triaging families to appropriate and needed services.

The Los Angeles Partnership for Early Childhood Investment and First 5 Los Angeles engaged Big Orange Splot, LLC, on behalf of the Los Angeles Perinatal and Early Childhood Home Visitation Consortium ("LACPECHVC"), to perform a deep analysis of the current home visiting landscape in Los Angeles, including current models, capacity, gaps and maximization opportunities. The purpose of this analysis was to provide a solid foundation of data with which to ground future planning and advocacy. This executive summary provides an overview of the key findings from that research.

Acknowledgments

Many thanks to our funders, LA Partnership for Early Childhood Investment and First 5 LA, without whom this research would not have been possible, as well as to Michaela Ferrari (LACPECHVC Coordinator); LACPECHVC Data, Referrals and Advocacy Workgroups; LA Department of Public Health MCAH; Gina Airey Consulting; and LA Best Babies Network, for their respective data and design contributions.

What home visiting models do we have here in LA?

Los Angeles County has both "universal" & intensive home visiting models. ***Universal home visiting models*** are shorter-term, less frequent models that focus on perinatal well-being, including preventing adverse health, parenting, and developmental outcomes, and screening to identify individuals in need of more intensive support. They are offered to all expectant and new parents in a community, regardless of family risk attributes. In Los Angeles County, one "universal" program —Welcome Baby—is active, but it is currently only available to mothers delivering at 14 of the County's hospitals.

Intensive models are longer term and more frequent. While the specific focus varies by program, intensive models typically include an emphasis on healthy child development, the prevention of child abuse or neglect, mental health, maternal health, and self-sufficiency. Intensive models are only available to parents who meet specific risk, income, geographic, and/or age criteria. The various intensive models have different curricula/methodology, staff requirements, frequency of client contact, length of services, entry requirements, intended outcomes, and actual outcomes as demonstrated through research. The LACPECHVC document "Program Details for LA County Home Visitation Programs" summarizes many of these differences.

[1] We define home visiting as follows: "Perinatal and early childhood home visiting is a multi-disciplinary, family-centered support and prevention strategy with services delivered by trained professionals in the home that: (1) is offered on a voluntary basis to pregnant women and/or families with children through the age of 5; (2) provides a comprehensive array of holistic, strength-based services that promote parent and child physical and mental health, bonding and attachment, confidence and self-sufficiency, and optimizes infant/child development by building positive, empathetic, and supportive relationships with families and reinforcing nurturing relationships between parents and children; and (3) is designed to empower parent(s) to achieve specific outcomes which may include: healthy pregnancy, birth and infancy; optimal infant/child development; school readiness; and prevention of adverse childhood and life experiences."

What outcomes have the models available in LA been proven to achieve?

Volumes of research illustrate the impact that different home visiting models have achieved in

- improving family safety and parenting,
- decreasing criminal activity,
- increasing child and maternal health,
- improving mental health outcomes,
- improving child cognitive and social development, and
- decreasing reliance on public assistance.

The table below provides an overview of the impact of home visiting models on specific outcome areas, based on existing research, by each model type currently in operation in Los Angeles: Early Head Start ("EHS"), Nurse-Family Partnership ("NFP"), Healthy Family America ("HFA"), Parents as Teachers ("PAT"), Welcome Baby ("WB"), Partnerships for Families ("PFF") and Healthy Start ("HS"). The accompanying report "What Research Proves about the Impact of Home Visiting Models Used In Los Angeles" provides an in-depth review of each program's impacts.

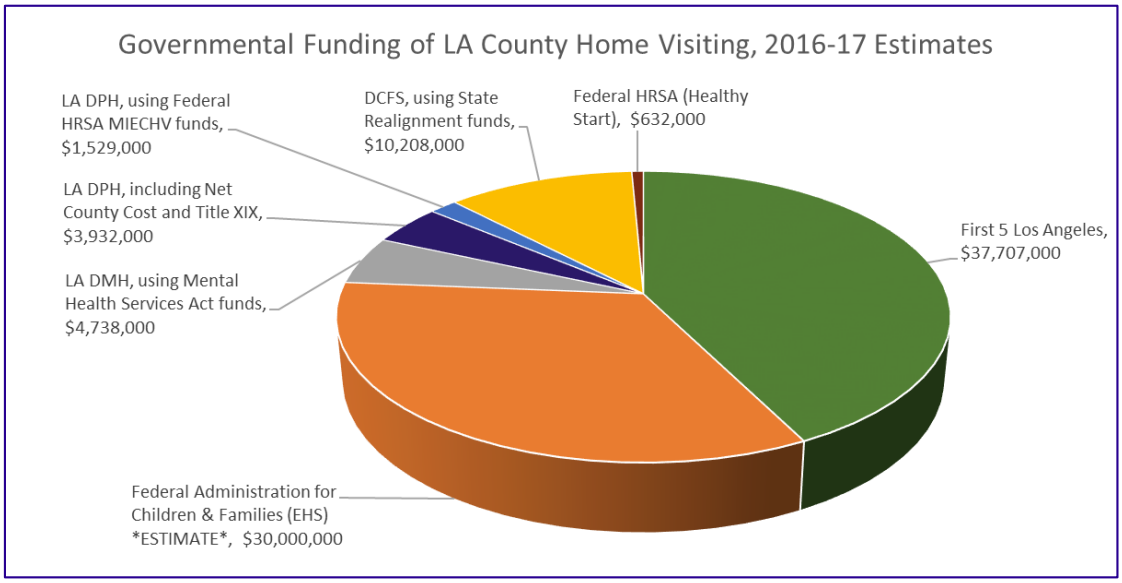
	EHS	NFP	HFA	PAT	WB	PFF	HS
Increases Cognitive & Social Development	✔	✔	✔	✔	✔		
Improves School Performance		✔	✔	✔			
Improves Maternal Health		✔	✔	✔	✔		
Improves Child Health	✔	✔	✔	✔	✔		
Improves Mental Health	✔	✔			✔	✔	
Improves Family Safety & Parenting	✔	✔	✔	✔	✔	✔	
Increases Self-Sufficiency (Decreases use of Public Assistance; Increases Training or Employment)	✔	✔	✔				
Decreases Crime		✔					

What is the current capacity of home visiting in Los Angeles?

Analysis of current home visiting capacity and gaps revealed that we have a strong base of quality home visiting programs established in Los Angeles. Current publicly-funded[2] home visiting programs in Los Angeles are funded through the contributions of five local governmental entities, plus numerous contracts awarded by the federal government to local non-profit organizations.

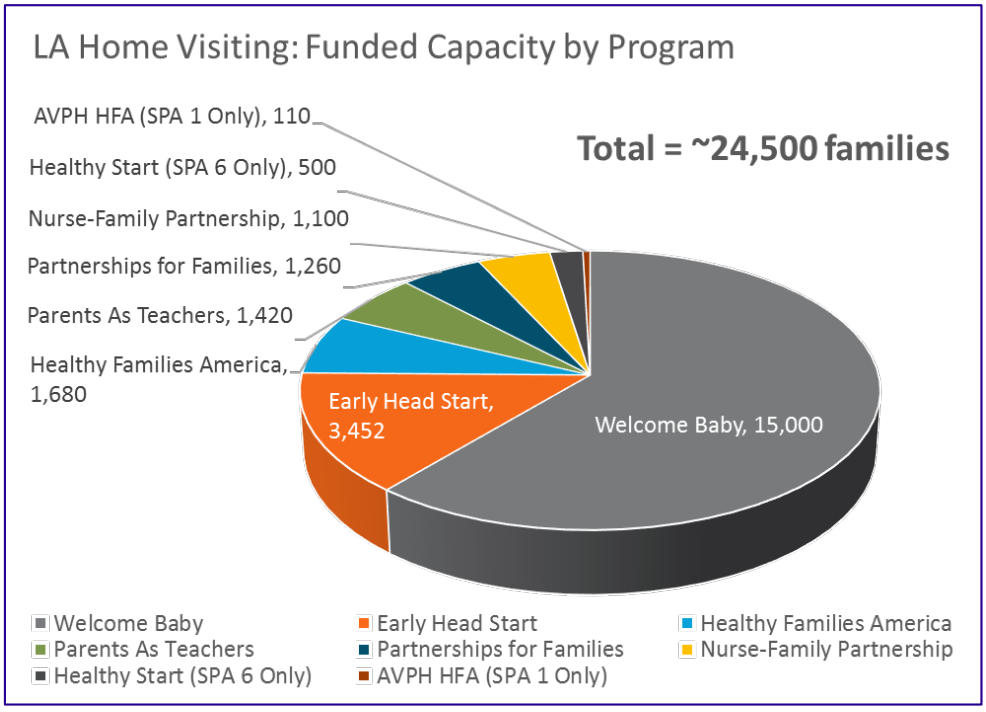
[2] While the majority of home visiting programs in Los Angeles utilize public funding, it is worth noting that there are additional smaller home visiting programs run by non-profit agencies utilizing philanthropic or grant dollars that are not included in the numbers herein. There are also additional family services provided in the home (such as home-based therapeutic interventions) that are not reflected here because they are either not preventative or not comprehensive.

Funding Source	Models	Families/Year
First 5 LA	Healthy Families America & Parents as Teachers; Welcome Baby	3,100 High-Risk 15,000 General
DPH (MIECHV, TCM, MAA) **Dept. of Mental Health (MHSA, PEI)**	Nurse-Family Partnership Healthy Families America	1,210 High-Risk
Dept. of Children & Family Services (State Realignment $)	Partnerships for Families	1,260 High- Risk
Federal Contracts (HRSA Healthy Start, Head Start)	Early Head Start Healthy Start	3,950 High-Risk



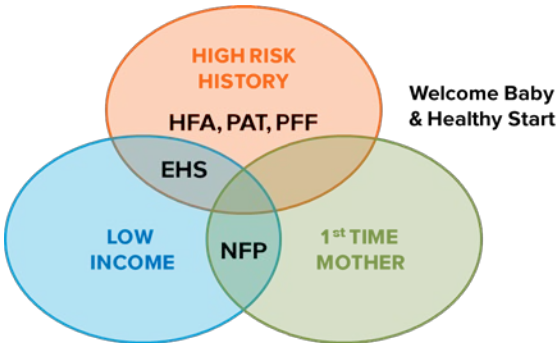
* Note: Federal ACF (EHS) funding is estimated based on comparative volume and intensity of services. Obtaining exact EHS home-base funding for LA County is not possible due to EHS contract structures.

Collectively, these funding streams enable 55 local non-profit organizations to provide home visiting services to LA families, with the collective total capacity to help approximately 24,500 families per year, including approximately 15,000 families from the general population and 9,500 high-risk families, who receive intensive services, per year. The accompanying report to this Executive Summary, "Home Visiting Providers in Los Angeles County, By Program Model," lists these local non-profit organizations and indicates the models each offers.



What eligibility restrictions currently limit access to home visiting?

Each Los Angeles-based home visiting model has different eligibility requirements including geography, age, income, and risk profile.



Geographic Restrictions: The programs that are restricted to a particular Service Planning Area ("SPA") include Healthy Start and Antelope Valley Partners for Health's Healthy Families America. Early Head Start is restricted by zip code. The programs restricted to Best Start Neighborhoods include Welcome Baby, Healthy Families America, and Parents as Teachers. Nurse-Family Partnership and Partnerships for Families are available to families who reside throughout Los Angeles.

Age Restrictions: Most intensive programs in Los Angeles require entry at or prior to birth. Nurse-Family Partnership is available for families entering before 28 weeks postpartum. Welcome Baby is available to families entering at or prior to birth. Healthy Family America and Parents as Teachers are only available to families entering at birth. Partnership for Families is available to general community members entering prenatally up to the child's first year. Entry into Healthy Start extends from the prenatal period through age 2. Early Head Start is available from the prenatal period to age 3.

Income and Risk Profile: Welcome Baby and Healthy Start programs are available to families of all incomes and risk profiles. Healthy Families America, Parents as Teachers, and Partnerships for Families are available only to families that have a history of high risk. Early Head Start is available to families that have a high risk history and who are low income. Nurse-Family Partnership is available to low-income, first-time mothers.

It is worth noting that, because of the combination of these factors, no home visiting resources are currently available for families with children ages one to three outside of the zip codes served by EHS or for those families who do not meet the EHS need-based criteria. Below is a table that crosswalks all of the eligibility requirements by model.

Model	Age Restrictions for Enrollment	Geographic Restrictions	Risk-based Restrictions
Welcome Baby	Prenatal or at birth	Best Start Communities	N/A
Welcome Baby "Light"	At birth	Non-Best Start Communities	Assessed as high-risk via hospital screening
HFA & PAT	Entry at birth	Best Start Communities	Assessed as high-risk via hospital screening
Early Head Start (EHS)	0-3; some prenatal	By zip code	At risk or in poverty (100%FPL)
Nurse-Family Partnership	By 28 weeks pregnant	N/A	1st time mom, 200% FPL or WIC/Medi-Cal eligible
Partnerships for Families	Prenatal to 12 mo., or referred by DCFS	N/A	History of domestic violence, mental health challenges, substance abuse, or an unsubstantiated closed DCFS referral
Healthy Start	Prenatal to 24 mo.	SPA 6 only	N/A
Antelope Valley HFA	Prenatal to 3 months	SPA 1 only	At risk

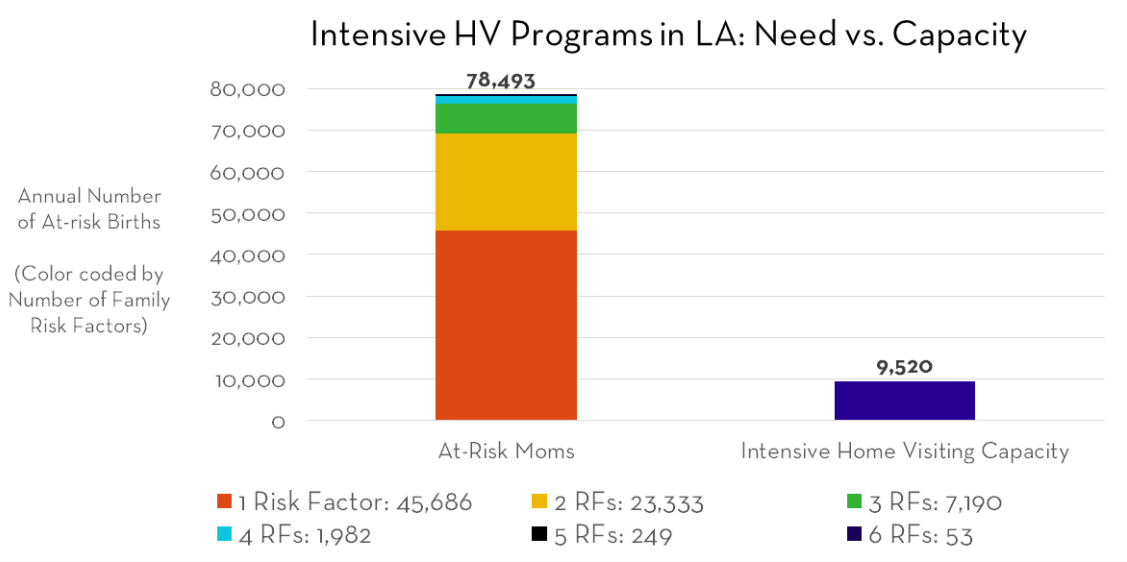
Are we currently maximizing our existing funded capacity?

Data, research, and interviews with home visiting providers revealed that we are very close to maximizing our current capacity. EHS, PFF and Antelope Valley HFA are generally operating at capacity, although recent changes in funding allocations may temporarily open up new capacity in some SPAs for PFF. Most of the models with unfilled capacity require prenatal or birth enrollment; these models include: Welcome Baby, HFA, PAT, and NFP. Healthy Start also has some unfilled capacity, but is only available in SPA 6. Efforts to increase coordination around prenatal recruitment might be the most helpful way to realize the full impact of Welcome Baby, HFA, PAT, NFP, and Healthy Start.

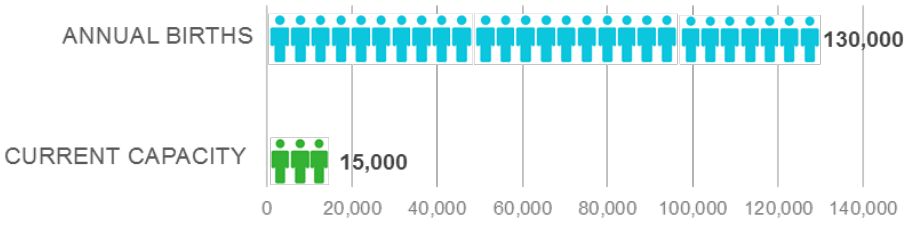
How does our current capacity relate to full community need?

Comparing current home visiting capacity to the full community need for family support reveals a substantial gap in services for both high-risk populations and the general LA population.

The 2014 Department of Public Health LAMB data reveals an estimated 78,500 families giving birth in LA County each year exhibit at least one high-risk factor;[3] an estimated 33,000 families exhibited two or more risk factors. Comparing this community need to the 9,500 spots currently available for at-risk families in Los Angeles documented above points to a current rate of only 12-29% of high-risk families accessing home-based family support in Los Angeles. The graph to the right demonstrates the gap between the need for intensive services in Los Angeles County and the number of families who receive intensive services on an annual basis.

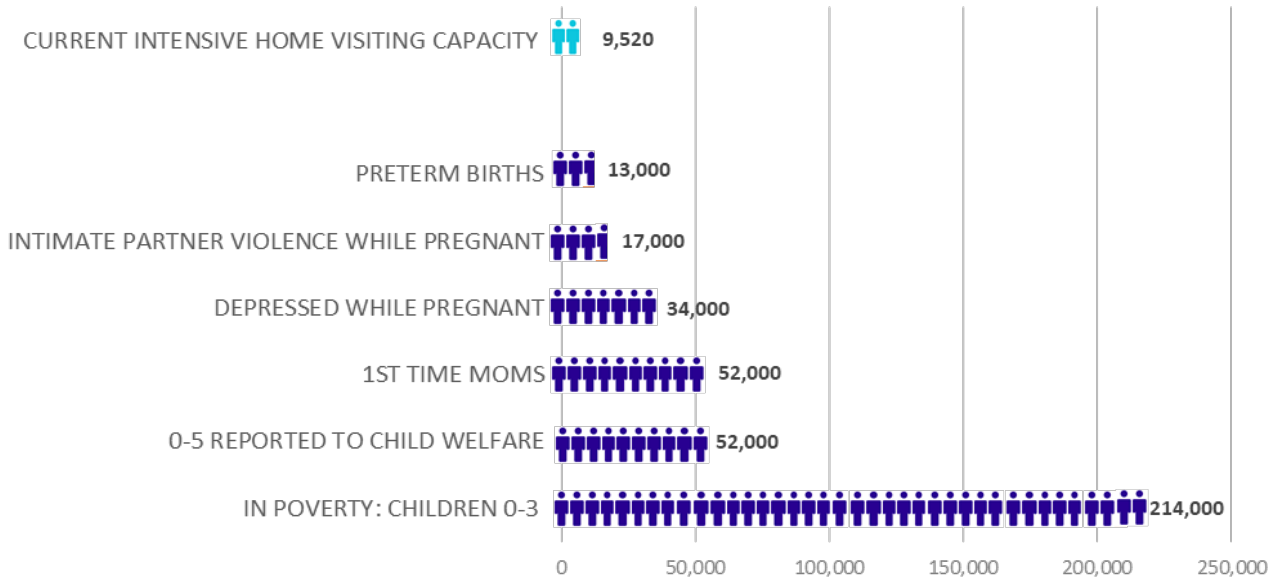


A comparison of the 15,000 families who receive "universal" preventative home visiting services with the 130,000 births annually in LA County reveals a similar need to improve our system of supports by expanding funding. Current funding provides sufficient capacity to serve 12% of the general population.



[3] Risk factors included in our analysis were as follows: depressed while pregnant, teen mom, used illicit drugs while pregnant, physically abused while pregnant, entered prenatal care after 3 months, less than a high school education, and homeless while pregnant. Risk factors were chosen based on a combination of Children's Data Network research regarding child abuse risk factors and the expertise of the LACPECHVC Data Workgroup. Findings from the LAMB survey were extrapolated to the number of women who give birth annually in LA for a population estimate.

The current capacity also falls short of the need for specific at-risk populations of interest. The current intensive home visiting capacity in Los Angeles County, as previously mentioned, is approximately 9,500 families per year, yet, each year in Los Angeles County there are 13,000 pre-term births, 17,000 mothers who experience intimate partner violence while pregnant, 34,000 mothers who are depressed while pregnant, 52,000 first time moms, 52,000 mothers who are reported to child welfare, and 214,000 children ages zero to three that are living in poverty. These figures show a stark contrast between need and capacity for the specific at-risk populations that LA home visiting programs seek to serve.



How well do our current programs meet the needs of our diverse LA community?

Research regarding cultural competency reaffirmed the value of already existing LA models. Some models operating in LA have research demonstrating their effectiveness with specific minority populations; the accompanying report "What Research Proves about the Impact of Home Visiting Models Used in Los Angeles" provides a summary of research relating to each program's impacts on specific subpopulations. More importantly, research underscored that the most important consideration in achieving cultural competency within programs is not the structural model, but rather the integration of reflective practices into program implementation, training, and ongoing staff support. These revelations underscore the value of existing reflective practices and community feedback loops that current home visiting programs pursue, and point to the value of ensuring that we support these practices in our Countywide workforce efforts.

What are our best opportunities for system improvement in Los Angeles?

One of the most prominent opportunities to improve the system of home visiting in Los Angeles is the identification of new funding streams to expand capacity for both at-risk and general populations. With the looming threat of reduced MIECHV and First 5 funds on the horizon, identification of long-term, sustainable funding streams will be essential. In addition, our analysis revealed the need to strive for increased funding *flexibility*. All general population services and most high-risk, high-intensity services are geographically restricted. The vast majority of high-need services also have restrictions based on child age and family income/risk criteria that further restrict access. There are vast numbers of families who are therefore not able to access home visiting services simply due to geographic and other eligibility requirements currently in place in LA.

The gap analysis also revealed opportunities to improve family impact through increased coordination around prenatal referrals. Due to restrictions on current funding that require families to enroll in many existing programs at-birth or prenatally, building additional prenatal referral pathways from medical providers and County departments into home visiting programs would enable us to better leverage existing funding streams.

Appendix D

Home Visiting Providers in Los Angeles County, By Program Model

	EHS	NFP	HFA	PAT	Welcome Baby	PFF	Healthy Start
Antelope Valley Partners for Health			✓		✓ [1]		
Baldwin Park Unified School District	✓						
Child Care Resource Center (CCRC)	✓			✓ [2]			
Child and Family Guidance Center			✓				
Children's Bureau			✓				
Children's Institute, Inc. (CII)	✓		✓ [3]			✓	
Citrus Valley Medical Center					✓ [4]		
Department of Public Health		✓					
El Nido Family Center	✓			✓ [5]			
Families in Good Health			✓				
Foothill Family Services	✓		✓				
Friends of the Family				✓			
Hope Street Family Center	✓						
Human Services Association	✓			✓			
Koreatown Youth and Community Center						✓	
Long Beach Unified School District	✓						
LA Biomed/South LA Health Projects			✓				
Los Angeles Child Guidance Clinic			✓				

[1] In partnership with Antelope Valley Partners for Health
[2] Multiple contracts: Lancaster/Palmdale, Pacoima/Panorama
[3] Multiple contracts: Broadway/Manchester, Long Beach/Wilmington
[4] In partnership with Citrus Valley Medical Center – Queen of the Valley Campus
[5] Multiple contracts: Watts/Willowbrook, Pacoima/Panorama

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LOS ANGELES COUNTY PERINATAL & EARLY CHILDHOOD HOME VISITATION CONSORTIUM

	EHS	NFP	HFA	PAT	Welcome Baby	PFF	Healthy Start
Los Angeles Education Partnership (LAEP)	✓						
Maternal and Child Health Access					✓ [6]		
Miller's Children's and Women's Hospital					✓ [7]		
Mountain View School District	✓						
Northridge Hospital Medical Center					✓ [8]		
Norwalk-La Mirada Unified School District	✓						
Options for Learning	✓						
Pacific Asian Consortium in Employment (PACE)	✓						
Pacific Asian Counseling Services			✓				
Palmdale School District	✓						
Para Los Niños						✓	
Pediatric Therapy Network	✓						
Penny Lane Centers						✓	
Plaza Community Services				✓			
Plaza de la Raza	✓						
Pomona Unified School District	✓						
Providence Holy Cross Medical Center					✓ [9]		
Providence Little Company of Mary					✓ [10]		
Providence Saint John's Child & Family Development Center						✓	

[6] In partnership with California Hospital Medical Center
[7] In partnership with Miller Children's and Women's Hospital
[8] In partnership with Northridge Hospital Medical Center
[9] In partnership with Providence Holy Cross Medical Center
[10] In partnership with Providence Little Company of Mary Medical Center San Pedro

	EHS	NFP	HFA	PAT	Welcome Baby	PFF	Healthy Start
Richstone				✓			
Southern California Indian Center						✓	
St. Anne's	✓						
St. Mary Medical Center					✓ [11]		
Shields for Families			✓	✓	✓ [12]	✓	✓
SPIRITT Family Services			✓			✓	
The Children's Clinic			✓				
The Help Group						✓	
The Whole Child				✓			
Torrance Memorial Medical Center					✓ [13]		
Training and Research Foundation	✓						
UCLA	✓						
University of Southern California	✓						
Valley Presbyterian Hospital					✓ [14]		
Vista del Mar Home-SAFE	✓						
Volunteers of America	✓						
Westside Children's Center	✓						
White Memorial Medical Center					✓ [15]		
Total Agencies Offering Model	**24**	**1**	**12**	**8**	**12**	**9**	**1**

[11] In partnership with St. Mary Medical Center
[12] Multiple contracts. In partnership with Centinela Hospital Medical Center, Martin Luther King, Jr. Community Hospital, and St. Francis Medical Center
[13] In partnership with Torrance Memorial Medical Center
[14] In partnership with Valley Presbyterian Hospital
[15] In partnership with White Memorial Medical Center

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A SOCIAL IMPACT ADVISORY FIRM

LOS ANGELES COUNTY PERINATAL & EARLY CHILDHOOD HOME VISITATION CONSORTIUM

Appendix E

Los Angeles County Perinatal and Early Childhood Home Visitation Consortium Best Practices Workgroup

Quality Standards for Home Visiting Programs

These recommendations are intended to promote the adoption of quality standards among new and existing home visiting programs, potential funders, policymakers, legislators, and members of the Consortium. Meeting these standards will help maintain high quality home-based support to strengthen all expectant and parenting families so that the children of Los Angeles County are healthy, safe, and ready to learn.

Mission:
To coordinate, measure and advocate for high quality home-based support to strengthen all expectant and parenting families so that the children of Los Angeles County are healthy, safe and ready to learn.

Domain	Recommended Quality Standards
1. Program Design and Structure	The home visiting program uses a well-defined model design that specifies the program's purpose, outcomes, duration, frequency of services, and curriculum.
2. Staff Qualifications and Training	Staff qualifications, program model, and curriculum training are clearly defined. An educational/training plan to meet any missing program model requirements is established, and ongoing professional development is required and monitored for home visiting staff, program supervisors, and directors.
3. Staff Supervision	An established structure is defined for program staff to implement reflective practice. The supervisor will be trained in reflective supervision. Staff receive individual and group "reflective supervision[i]" at regularly specified time intervals to build skills, reduce vicarious trauma[ii] from working with high-need clients, and monitor services provided to clients. The program follows model's standards with regard to supervisor-to-staff ratios and time intervals for regular supervision.
4. Fidelity to Model	Fidelity criteria are established and programs are monitored to document compliance with home visitation standards and fidelity criteria.
5. Monitoring, Evaluation, and Oversight	Performance monitoring and outcome evaluation methods and measures are clearly defined and implemented. Data are collected, evaluated, and shared with relevant audiences at regular intervals for program improvement and quality assurance purposes, as well as to demonstrate outcomes.

6. Cultural Sensitivity	The program has clearly defined policies, procedures, and staff hiring and training practices that address inclusivity and are responsive to the ethnic, cultural, linguistic, gender, racial, and social diversity of the community being served by the program.
7. Participant Recruitment and Enrollment	The following are well defined: recruitment, outreach, eligibility and selection criteria, enrollment/disenrollment methods, and retention. Guidelines for establishing transition plans for participants exiting/ending the program are in place.
8. Records and Auditing	Agency records are maintained and audit-ready for fiscal/program accountability and quality improvement, and are audited at regular intervals via an appropriate channel. The program maintains and follows a confidentiality policy to protect participants' privacy.
9. Community Linkage	Program agreements[iii] are in place and/or strong links with other home visiting programs and community-based services are demonstrated to address short- and long-term family needs.
10. Family Engagement	The program receives family/participant feedback on quality of services via specified methods at regular, defined intervals. Policies and procedures are in place to utilize findings to improve upon and continue meeting participant and family needs.
11. Community Engagement	The program receives community feedback via specified methods[iv] at regular, defined intervals to assess community needs, relevance of program services, and program quality. Policies and procedures are in place to share data transparently and utilize findings to ensure continued responsiveness to community needs.
12. Workforce Development	To strengthen the existing home visiting workforce, ensure preparedness of the future workforce, and encourage professional investment in the field of home visiting, the program should form collaborative partnerships[v] with universities, colleges, or other educational programs offering public health, social work, nursing, human services, early care and education, and mental health coursework.

13. Collaboration	The program shares knowledge, data, and best practices with other programs and stakeholders in the field to support advocacy efforts for the mutual benefit of the perinatal and early childhood professional community and the families they serve.

i Reflective supervision is defined as: "a collaborative relationship for professional growth that improves quality and practice by cherishing strengths and partnering around vulnerabilities to generate growth," Rebecca Shahmoon-Shanok. The three central elements of Reflective Supervision are regularity, reflection and collaboration. Reflective Supervision has a mentoring and monitoring component to ensure staff development and quality outcomes. The Reflective Supervisor who is successful at mentoring and monitoring must merge qualities of an effective, efficient administrative supervisor with the qualities of a thoughtful, responsive reflective supervisor.

ii Vicarious Trauma is defined by the American Counseling Association as follows: "The term vicarious trauma (Perlman & Saakvitne, 1995), sometimes also called compassion fatigue, is the latest term that describes the phenomenon generally associated with the 'cost of caring' for others (Figley, 1982). Other terms used for compassion fatigue are: secondary traumatic stress (Stemm, 1995, 1997); secondary victimization (Figley, 1982). It is believed that counselors working with trauma survivors experience vicarious trauma because of the work they do. Vicarious trauma is the emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured."

iii For example, a Memorandum of Understanding (MOU), Memorandum of Agreement (MOA), etc.

iv For example, parent and community advisory boards, local community needs assessments, confidential program participant and staff feedback, etc.

v For example, internships, career days, supplementary coursework, etc.

Appendix F

Los Angeles County Perinatal and Early Childhood Home Visitation Consortium
Data Workgroup

Home Visiting Program Outcome Indicators

These indicators are intended to measure short term outcomes for clients of all major LA County home visiting programs. They are based on the intended outcomes of the programs, national data collection efforts such as MIECHV and the Pew Home Visiting Project, and health care quality measures such as HEDIS.

Mission:
To coordinate, measure and advocate for high quality home-based support to strengthen all expectant and parenting families so that the children of Los Angeles County are healthy, safe and ready to learn.

1. **Breastfeeding**
    a. **Any breastfeeding and exclusive breastfeeding**
    b. **Initiation and three-, six-, and twelve-month intervals**
2. **Depression Screening**
    a. **Positive screens for depression**
3. **Well-Child Care Visits**
4. **Timely Postpartum Follow-up Visits**
5. **Mother's Insurance Status**
6. **Child ED/ER Visits**
7. **Child Maltreatment**
8. **Child Development**
    a. **Screening, referral, and Regional Center assessment**
9. **Adequate Prenatal Care**
10. **Postpartum Family Planning**

Appendix G

Summary of Sustainability Research

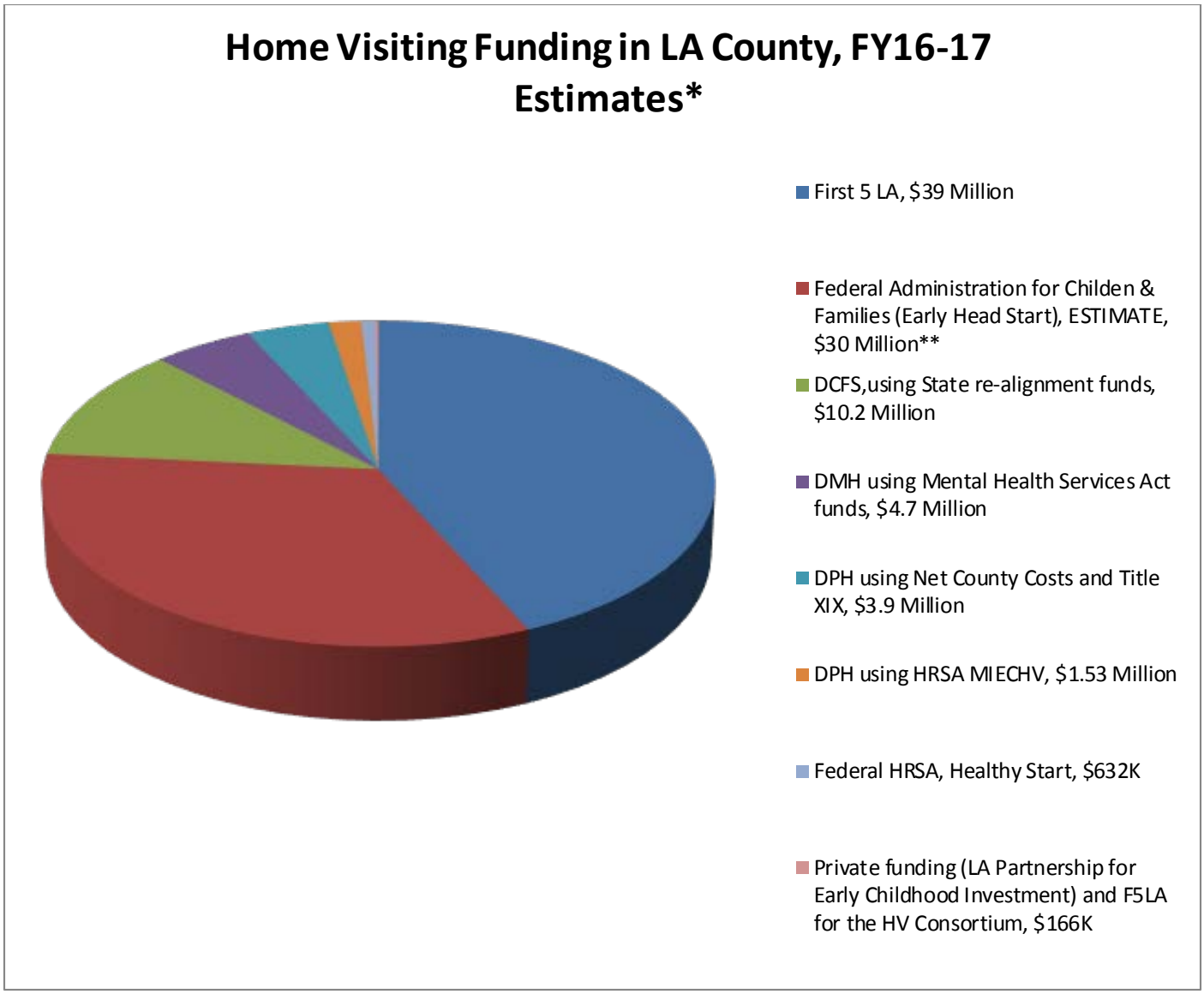
Background

Sustainability is one of the most pressing challenges facing the network of home visiting programs in Los Angeles. In addition to the challenge of the unmet community needs identified in the report, current funds cannot be sustained sources of support as First 5 LA tobacco tax revenue declines. First 5 LA is the single largest funder of home visiting in LA County investing approximately $39 million annually (based on FY 2016/17 budget). First 5 LA funding continues to decline with the loss of tobacco revenue, jeopardizing the long-term sustainability of the existing service capacity in the system.

The LA County Board of Supervisors motion on home visiting, passed in December 2016, states a number of priority recommendations, including a request for partners to, "Identify a framework to maximize resources by leveraging available funding and where possible identify new and existing but not maximized revenue streams." To that end, the named County agencies and community partners have committed to explore opportunities to bring additional resources to support LA programs. To date, a range of financing strategies to support expansion and sustainability of the proposed universal home visitation system in LA County have been identified and assessed. The following is an initial assessment and prioritization of the sustainability strategies explored to date, as well as some general themes that are emerging from this aspect of the work.

Current LA County Funding Landscape, FY16-17

In Los Angeles, we have a spectrum of home visiting models supported through a variety of locally and federally funded programs. As shown in the table above, collectively these funds for home visiting flow through First 5 LA, the Departments of Public Health, Mental Health, Children and Family Services and Early Head Start. A large proportion of funding for home visiting comes from First 5 LA, along with significant portions from the federal government through Maternal, Infant, Early Childhood Home Visiting Program (MIECHV), Mental Health Services Act/Prevention and Early Intervention (MHSA/PEI), Child Welfare/State re-alignment funds, as well as Healthy Start and Early Head Start. Private philanthropy has also funded aspects of home visiting such as the Los Angeles County Perinatal and Early Childhood Home Visitation Consortium (the Consortium), a network of approximately 50 perinatal and early childhood home visitation programs, working together to support the County's home visitation programs.



*DCFS-LA County Department of Children and Family Services, DMH-LA County Department of Mental Health, DPH-Department of Public Health, HRSA-Health Resources and Services Administration, MIECHV-Maternal, Infant and Early Childhood Home Visiting Program

**Head Start funds estimate based on the volume of families served and the approximate cost per family that other models experience. The caveat is that funds combine center based services and home based services into one financial package, so difficult to separate the home visiting from the child care.

Initial Assessment

To assess and prioritize sustainability strategies, current research and literature was reviewed as it relates to types of financing strategies used by home visitation efforts in other states and localities. Furthermore, information-gathering calls/interviews were conducted with key experts across the nation and in various jurisdictions [footnotes]. This information was assessed with an eye towards what may be applicable to and feasible in LA County.

One of the most critical overarching themes from the initial assessment of home visiting strategies in other states and localities is the importance of pursuing and implementing multiple sustainability strategies simultaneously, in a blended and/or braided fashion, to more fully meet the outcomes for a universal system of home visiting. Home visiting efforts in different states and localities have different intended outcomes and results, based on the specific needs of their target population. Programs are typically selected based on their ability and strengths in meeting those intended outcomes. For example, if an effort is aiming to meet the needs of families through primary care via the health system, funding for those programs may be more closely tied to Medicaid-related sources.

A related theme is that LA County entities should coordinate funding in a more intentional manner to maximize fund leveraging opportunities and meet the collective outcomes we seek through different models and for different target populations. In LA County currently, as depicted in the table above, home visiting efforts are funded by a diversity of sources through various sectors. While there are a number of significant and robust funding sources flowing through major systems in the County for home visiting, funding is not necessarily coordinated across those systems in a cohesive fashion. One example of statewide coordination on funding is in Washington State, where approximately five years ago, the state established a Home Visiting Savings Account (HVSA) in the Department of Early Learning, where the majority of home visiting funds for the state are received and administered, including MIECHV, TANF funds for HV, and private funding from the Gates Foundation. In this model, funds are coordinated and managed in a centralized manner.

Overall, another major theme is that Medicaid and other health system-related funding are natural, complementary funding streams for most home visiting efforts nationwide. While a number of states and jurisdictions, including LA County, already finance part of their home visiting programs using Medicaid, it remains a greatly underused option.[1] Strategies in this category include Medicaid waivers, Targeted Case Management, and Medicaid Administrative Activities. While they are all strategies to explore more in-depth, implementation "terms" will vary greatly across strategies. Pursuing a waiver for example, would be a long-term strategy because of the effort and partnership it will require, as well as buy-in at the state level, but it is one of the most sustainable strategies to pursue given potential impact.

There is currently an opportunity to partner with the Department of Health Services (DHS) to expand home visitation in LA County over the next four years through a Medicaid 1115 waiver, the Whole Person Care program. In partnership with the Department of Public Health's public health nurses, the program will serve as a mechanism to test a blend of programs in an evidence-informed effort to reach the most vulnerable pregnant and parenting families. This expansion of the DHS prenatal program "MAMAs Neighborhood" seeks to fill gaps in the existing home visitation landscape and serve as a demonstration which can inform future state plan amendment proposals to secure sustainable funding streams.

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[1] Medicaid and Home Visiting, Best Practices from States, Center for American Progress, January 2017. https://www.americanprogress.org/issues/early-childhood/reports/2017/01/25/297160/medicaid-and-home-visiting/

It is also important to note, particularly now, Medicaid and health system-related strategies are largely dependent on the federal policy environment. Should there be significant changes to Medicaid (ie. shift to a block grant structure, changes to pre-existing conditions provisions and/or Medicaid eligibility), the impact on these strategies in terms of their viability to support HV, may be compromised.

Another important theme that has emerged is that there is opportunity for LA County to further maximize existing revenues, such as federal funds. The research done to date has identified various existing revenue sources that are not being fully maximized in LA County, such as Targeted Case Management (TCM) – which is funded by a combination of local and federal Title IXI (Medicaid) funds. TCM services are the most commonly billed services by home visiting programs in the nation. In the 42 states where Nurse-Family Partnership (NFP) operates, 26 states receive some funding through Medicaid; in the majority of these states, the Medicaid funding is a TCM service. It is also important to note that Medicaid reimbursement for TCM is higher in CA than in many other states. [2]The TCM reimburses participating counties for the federal share of costs (up to 50%) for billable, case management services (ie. access to needed medical, social, educational or other services) provided to Medi-Cal beneficiaries in specific target populations.

Currently in LA County, only County employees (NFP providers and Public Health Nurses) can bill TCM. In order for CBOs to participate in the program, change in the current structure must occur. In LAC, DPH has discretion to make revisions to the structure as appropriate. As a direct result of the HV Board motion and planning group work, DPH and First 5 LA are currently engaged in planning efforts to strategize on a policy change within DPH to allow CBOs to participate in TCM billing, which could result in significant expansion of funding for home visiting services in LA County, particularly given the potential match rate on billable activities.

Other opportunities to maximize existing revenues include HV efforts and related supports through the Department of Mental Health/Prevention and Early Intervention (MHSA/PEI) and Department of Children and Family Services/State re-alignment funds). These County departments already fund HV services and there may be opportunities for expansion, with demonstrated impact. To this end, the motion planning group is currently examining, in partnership with these County departments, existing department resources and the potential eligibility of these funding sources to expand their support for home visiting.

Another important theme for LA County is to explore new sources of funding for home visiting, outside of the streams of funding programs currently tapped. One example of a high priority strategy in this regard is the Temporary Assistance for Needy Families (TANF), temporary financial assistance for pregnant women and families with one or more dependent children,

[2] Medicaid Financing of Early Childhood Home Visiting Programs: Options, Opportunities and Challenges, Pew Center on the States, National Academy for State Health Policy, 2012. http://www.pewtrusts.org/~/media/assets/2012/07/pcs_nashp_hv_medicaid.pdf

which helps pay for food, shelter, utilities, and expenses other than medical. TANF is a fixed block grant to the state (California receives approximately $5.3B per year), and funds can be used on a wide variety of activities. In 26 states across the nation, TANF is a partial source of funding for home visiting programs. This strategy has not been tapped into to date in LA County.

Locally, members of the motion planning group, including F5LA, have met with LA County Department of Public Social Services (DPSS) and Shields for Families, a Healthy Families America (HFA, a home visiting program) provider, to discuss a potential pilot opportunity where DPSS clients may be linked to this evidence-based home visiting program. In the proposed partnership, First 5 LA will support the expansion of HFA slots for these families through its existing efforts, for the pilot period, with the intent that DPSS would explore sustaining the services longer-term if measurable outcomes and improvements could be demonstrated.

Another important theme is that a given sustainability strategy is more viable when the outcomes of that strategy are aligned more closely to home visiting**.** For example, like TANF, home visiting is a proven two-generational support leading to young children's healthy development and family long-term success by connecting families to needed resources. Home visiting adds to a more holistic package of programs that can improve family economic self-sufficiency, a key outcome of the TANF program. Studies have found that more parents participating in home visiting programs work, are enrolled in education or training, and have higher monthly incomes. Home visiting complements the support provided by TANF caseworkers. Home visiting would allow families another source for referrals to much needed services and supports (such as child care), aiding in preparing the families for work-related activities, and ultimately, self-sufficiency.

It is also important to note that HV may be a model to help departments achieve their stated outcomes, thus elevating the value proposition of HV to those departments. For example, there are various efforts nationwide which point to the benefits of home visitation as it relates to prevention of criminal convictions and days spent in jail, for the mothers. Also noted are the benefits to the children who participated, in terms of their decreased future interactions with the criminal justice system. To this end, there is a value proposition of home visiting to County departments such as Probation.

Finally, advocacy is a critical component of long-term sustainability planning that should be implemented in parallel to the overall effort. The December 2016 home visiting board motion was an incredible milestone that continues to serve as a powerful statement of LA County's commitment to home visiting, and as a platform for advocacy for the collective effort at the state and federal levels. For example, the Maternal, Infant, and Early Childhood Home Visiting, or MIECHV, program, which represents the largest source of federal investment in home visiting, and a significant source of funding for LA County programs, is currently facing reauthorization in 2017. Over the course of the last several months, the HV Consortium, motion planning group members and advocates across the nation, have been working to advocate on behalf of reauthorization and doubling of funding over the next 5 years. As a demonstration of their support for MIECHV, on May 23, 2017, the LA County Board of Supervisors approved a

subsequent motion, introduced by Supervisors Kuehl and Hahn, to author a 5-signature letter in support of MIECHV to Congress.

To this end, the County Departments and organizations named in the motion are committed to bringing agency resources as it relates to policy/advocacy expertise, technical assistance and support, as well as contacts and connections to support this aspect of work. Also critical is continued partnership and engagement with the HV Consortium to support and strengthen the participating agencies' ability to stay abreast of and track local, state and national opportunities for advocacy that could increase funding for programs or could otherwise support the maintenance of high-quality home visiting programming in Los Angeles.

Methodology/Prioritization

Overall, a number of key factors, outlined below, have emerged as critical to assessing and prioritizing sustainability strategies. In particular, these factors relate to the entities/agencies either funding and/or implementing home visiting efforts:

- Leadership buy-in
- Capacity/infrastructure (ie. relevant electronic medical record/database system, staffing, equipment, physical space, etc.)
- Current participation in home visitation or related efforts
- Readiness and openness to change efforts
- Amount of effort and time required to implement the strategy
- Yield or return (monetary)
- Strong value proposition to the implementing agency or funder to support HV, ie. involvement would help progress the individual agency's vision and goals
- Supportive local, state or national policies impacting the strategy are in place or being considered through legislation
- Funding availability, ie. are the funds capped[3] or uncapped? If capped, are they being fully leveraged?

Summary and Next Steps

Funding streams investigated during this research included those within Medicaid (waivers, Targeted Case Management-TCM and Medicaid Administrative Activities-MAA), the federal Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), mental health (Mental Health Services Act/Prevention and Early Intervention-MHSA/PEI), child welfare (State re-alignment funds) and social services (Temporary Assistance for Needy Families-TANF) systems. One of the most significant themes is the importance of pursuing and implementing multiple sustainability strategies simultaneously, in a blended and/or braided fashion, to achieve

[3] Capped funding means funds are limited in some way. For example, if federal funds are allocated to states through either a block grant or based on per capita spending, this would represent a limit to the amount of funds that each state is eligible to receive. Uncapped means there is no limit to how much of these funds can be leveraged.

a truly universal system of home visiting. In this spirit, TCM and TANF were considered short-term opportunities to pursue in this initial assessment, with potential implementation of pilot work in FY17-18. Funding streams assessed as needing deeper exploration include MAA, MHSA-PEI and Child Welfare/State re-alignment funds, though it is important to note programmatic partnership in these areas is progressing as a result of the HV motion. Some opportunities considered long-term include Medicaid waivers, given the level of planning, partnership and state-level buy-in required, though there may also be opportunities to progress home visiting efforts via a current LA County waiver. Another long-term strategy is MIECHV, a federal allocation which will require continued advocacy with local, state and national partners because funding is currently only authorized through September 2017. Finally, funding streams to be assessed in the next phase include Early Head Start, Healthy Start, Early Periodic Screening Diagnosis and Treatment (EPSDT), Probation and Homelessness/Housing.

It is important to note sustainability research is occurring on a parallel track to the overall programmatic effort (ie. development of vision, goals, outcomes, needs and gaps for a universal home visiting system) and financing strategies are largely dependent on the latter programmatic parameters. Therefore, as these parameters are further clarified, it will help shape our sustainability priorities/plan.