

# HOME VISITATION PROGRAMS IN ORANGE COUNTY

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# 1 Introduction

Home visits are a vital aspect of social service delivery. Visiting clients in their homes allows much deeper understanding of family functioning, permits clients to receive services in a setting that is not only comfortable but the most appropriate for teaching skills such as infant care, and, in many cases, may be the only way to reach isolated members of the community. For this reason, the California Children and Families Commission included the number of families served by home visitation programs as a key indicator of increased capacity for parent support services to improve family functioning.

This report summarizes the major home visitation programs in Orange County. In Orange County, as elsewhere, home visits are provided by a number of different agencies, sometimes as one of many service strategies, sometimes as the core of the program. In referring to “home visitation programs,” we mean to limit our examination to those programs that provide home visits as the central mode of service delivery. Because home visitation may have a very different meaning when it is mandatory (typically where there has been child abuse or neglect), we also limit our focus to voluntary programs.

This summary has three components: First, we describe the agencies and programs addressed and the major relationships between these programs. This overview is provided in Section 2 of this report along with a description of the methodology for developing the information in this summary. Second, Section 3 compares the characteristics of these home visitation programs along the same dimensions used in our review of the national home visitation models.<sup>1</sup> Third, we match the goals of these programs to the outcomes and indicators listed in

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<sup>1</sup> See “In-Home Visitation Programs: A Review of the Literature” available from the Orange County Children and Families Commission, Orange County Families and Communities Together (FaCT), or the author.

the Orange County Children and Families Commission Strategic Plan, presented in Section 4 of this report. Since this summary is intended to assist in the development of a service delivery plan for home visitation programs in Orange County, we conclude in Section 5 with detailed information on the remaining steps to develop a service delivery plan.

## 2 Orange County Home Visitation Programs

Working with Families and Communities Together (FaCT), a partnership between the County of Orange Social Services Agency and numerous community-based organizations, we identified 17 home visitation programs for families with children, run by 8 different agencies. Each agency was asked to provide a basic logic model of the program, as well as additional information about program funding, goals and philosophy, data collection and reporting. The templates for this information are included in Appendix A. Where information was incomplete or unclear, we spoke with program contact persons to fill the gaps. By and large, however, the information in this report reflects program practices as reported by the programs themselves.

The 17 home visitation programs for which we received information are listed on Table 2.1, arranged alphabetically by the name of the lead agency for the program. Although we will look in greater depth at their target populations in Section 3, Table 2.2 presents an overview of the eligibility for these programs. In practice, these programs do not represent 17 different program models: some of these programs apply the same model to different target populations or geographical areas. In addition, some of the programs represent collaborations across two or more agencies. Before describing the characteristics of the programs, it is useful to understand the major connections between the programs, as well as relationships (where applicable) to the national models covered in our literature review.

### ***2.1. Interconnected Programs***

All of the home visitation programs serve families within a larger context of social service provision. However, the ProjectConnections program is particularly interconnected with three agencies that also offer other home visitation programs:

**Table 2.1 Home Visitation Programs Included in Study**

<b>Agency</b>	<b>Program</b>
Child Abuse Prevention Center (CAPC)	Tender Care Parenting
	Welcome Baby
	Suddenly Parents
	ProjectConnections–Costa Mesa
Children’s Bureau of Southern California (CBSC)	CalSAHF
	Healthy Families
	ProjectConnections-South Orange County
	Family Preservation
Community Service Programs (CSP)	YFRC Intensive In-Home Services
Health Care Agency (HCA)	Public Health Field Nursing
	Healthy Futures
	High-Risk Infant Program
	PSASI/ACT
MOMS	Paso a Paso
Orangewood Children’s Foundation (OCF)	ProjectConnections.FRC Health Access
UC Irvine	HABLA
VNA Home Health Systems	Medically Vulnerable Infant Program

**ProjectConnections.FRC:** ProjectConnections.FRC (Family Resource Center) was funded by the Children and Families Commission as an Early Action Program, with the Orangewood Children’s Foundation as the lead agency.<sup>2</sup> The basic ProjectConnections model offers health access services through 6 family resource centers: Oak View Family Center, South Orange County FRC, Families Costa Mesa, Corbin Family and Community Center, Delhi Community Center, and Fullerton’s Future Mobile FRC. Key to these services is home visitation provided by Public Health Nurses (PHN) drawn from the Orange County Health Care Agency (HCA), along with promotores and health care coordinators at each FRC. In two sites,

<sup>2</sup> Additional information on ProjectConnections.FRC was drawn from the evaluation plan and interim evaluation reports developed by the Lewin Group for the Orange County Children and Families Commission.

however, the basic model is augmented with more intensive home visitation services:

**ProjectConnections.Costa Mesa** run by the Child Abuse Prevention Center and

**ProjectConnections.South Orange County** run by the Children’s Bureau of Southern California.

**Health Care Agency Programs:** Some of the longest established home visitation programs are run by the Orange County Health Care Agency (HCA), which serves as the lead agency for four programs and also collaborates on ProjectConnections. At the most basic level, HCA operates the Public Health Field Nursing program, a function that arises out of the general public health mandate of the agency and hence includes a priority for communicable diseases (for any Orange County resident) as well as maternal and infant health. The HCA also runs Healthy Futures, the only Orange County program using the much-studied national Nurse Home Visitation Program model (the “Olds” model). Two additional HCA programs serve particularly high risk populations: the High Risk Infant Program and the Perinatal Substance Abuse Services Initiative ACT Program (PSASI/ACT).

**Child Abuse Prevention Center:** The Orange County Child Abuse Prevention Center (CAPC) provides intensive home visitation services associated with ProjectConnections at Families Costa Mesa, using a multidisciplinary team (nurse, child development specialist, chemical addiction counselor, and social worker). Such teams are also available to the highest risk families served in CAPC’s other two home visitation programs, Tender Care Parenting and Welcome Baby. Tender Care Parenting and Welcome Baby otherwise provide less intensive parenting support and education, using mainly volunteers. CAPC’s fourth program, Suddenly Parents, is specifically designed for relative caregivers of children removed from their homes by SSA.

**Children’s Bureau of Southern California:** Like CAPC, the Children’s Bureau of Southern California (CBSC) has an intensive home visitation program funded through ProjectConnections, in addition to three other home visitation programs: Cal-SAHF (also known as ABC/Great Beginnings), Healthy Families and Family Preservation. All four of the CBSC programs use essentially the same service model (although for different durations) to assist vulnerable children and prevent child abuse, except that the Family Preservation Program serves older children (see Table 2.2).

## ***2.2. Additional Home Visitation Programs***

In addition to those agencies that participate directly in ProjectConnections as well as operating their own home visitation services, four additional agencies each run a home visitation program included in this study:

**YFRC Intensive In Home Services through Community Service Programs:** The YFRC program run by Community Service Programs, Inc. (CSP) is unlike the other home visitation programs included in this summary in that it primarily serves older children, in particular, children referred for these services by the Probation Department. Although the youth served by this program do not typically fall into the Proposition 10 service group, they may qualify due to teen motherhood. In any case, they are partners with FaCT and represent part of the continuum of home visitation programs offered in Orange County.

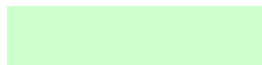
**Paso a Paso Program at MOMS:** The MOMS resource center provides case management services to clients from pregnancy through the first year of life. Their Paso a Paso program, funded in part by the Children and Families Commission, enhances their case management services with additional home visits (all MOMS clients get one home visit) to promote infant development.

**HABLA Program at UC Irvine:** The HABLA program, coordinated out of the UCI School of Social Sciences and in partnership with the Corbin Family and Community Resource Center, is a home visitation program also funded by the Orange County Children and Families Commission, with a special focus on language skills and school readiness.

**Medically Vulnerable Infant Program through VNA Home Health Systems:** The final home visitation program included in this summary is VNA's Medically Vulnerable Infant Program (MVIP). MVIP provides home visits for parent education and health support for the families of infants discharged from neo-natal intensive care units.

**Table 2.2 Eligibility for Orange County Home Visitation Programs**

Pr op 10 Ta rg et Po pu lati on	Child Abuse Prevention Center				Children's Bureau
	Welcome Baby	Tender Care Parenting	Suddenly Parents	Project Connections. Costa Mesa	Corbin CalSAHF
Early Pregnancy					
Third Trimester					
Birth	First time parents				
Six Months					
One		Families not eligible for Welcome Baby	Relative caregivers with child placed by CFS	Costa Mesa residents, no open CFS cases	Corbin catchment area residents, at risk for abuse or neglect
Two					
Three					
Four					
Five					
Six to Ten					
Eleven					
Twelve					
Thirteen to Seventeen					



Ages served, additional criteria (if any) noted



Must enter in this period to be eligible, although services extend beyond

### Eligibility for Orange County Home Visitation Programs (cont'd)

		Children's Bureau of Southern California			Community Service Programs	Health Care Agency
		Healthy Families	Project Connections. South Orange County	Family Preservation	YFRC	Healthy Futures
<b>Prop 10 Target Population</b>	Early Pregnancy					
	Third Trimester					
	Birth	South Orange County FRC catchment area residents, at risk for abuse or neglect	South Orange County FRC catchment area residents, at risk for abuse or neglect,	Residents of Tustin, Fullerton, Anaheim, or Oak View (in Huntington Beach), at risk for abuse or neglect		First time parents not past 28th week of gestation, meet poverty guidelines, receive Medi-Cal
	Six Months					
	One					
Two						
Three						
Four						
Five						
Six to Ten						
Eleven				On probation, participating in YFRC centers, with identified risks		
Twelve						
Thirteen to Seventeen						



Agencies served, additional criteria (if any) noted

Must enter in this period to be eligible, although services extend beyond

**Eligibility for Orange County Home Visitation Programs (cont'd)**

		Health Care Agency		MOMS	UC Irvine	VNA Home Health Systems
		High Risk Infant Program	PSASI/ACT	Paso a Paso	HABLA	MVIP
<b>Prop 10 Target Population</b>	Early Pregnancy					
	Third Trimester					
	Birth					
	Six Months	High risk infants	Pregnant women with history of substance abuse or HIV+			
	One					
	Two					
	Three				Santa Ana low inc.	
Four						
Five						
	Six to Ten					
	Eleven					
	Twelve					
	Thirteen to Seventeen					



Ages served, additional criteria (if any) noted

Must enter in this period to be eligible, although services extend beyond

### **3 Characteristics of Orange County Home Visitation Programs**

Following the structure of the review of national home visitation models, this section compares Orange County's home visitation programs across seven dimensions: 1) primary goals, 2) home services, 3) other services, 4) target population, 5) staff caseload, 6) staff credentials, and 7) duration and frequency of visits. The literature review also examined attrition rates and costs. No program reported an attrition rate; in the absence of an outcomes evaluation or sophisticated client tracking, these rates are difficult to calculate. Some but not all programs reported cost data. However, since the magnitude of the programs varies greatly, the cost information can only be understood if translated into a cost per client basis. Again, most programs have not developed careful estimates of this figure. For these reasons, we do not report costs or attrition rates in this summary.

The following subsections consider the seven elements in term, comparing and contrasting the 17 programs on each element. To see summaries of the 16 programs according to these elements, please refer to Tables A.1.a-p in Appendix B.

#### ***3.1. Primary Goals***

Table 3.1 lists the primary goals of the home visitation programs in Orange County as stated by the agencies and programs participating. Nearly all of these goals fall within the categories listed in the literature review, which include preventing child abuse and neglect, improving children's health status, ensuring access to health insurance and a medical home, promoting optimal child development and school readiness, improving parenting skills, and increasing access to community resources. In addition, some programs focus either on the child's health or the mother's health, while others emphasize the well-being of the entire family.

Note that the goals are listed as reported by each agency. At times, a program or agency may work toward a certain outcome or deal with a particular issue without explicitly stating it as a goal. For example, although only two agencies named as a goal decreasing the instances of child abuse and neglect, it is clear that all of these programs are concerned with decreasing child abuse among their clients, and all certainly take steps in that regard.

The most common goals relating specifically to child well-being are the improvement of child health, development, and school readiness. Some programs have more specific goals, such as increasing the number of children with up-to-date immunizations, preventing unnecessary hospitalizations, and increasing the successful completion of first grade, while others focus on the overall well-being of the child. A few programs emphasize increasing the amount of children covered by health insurance, and still fewer focus explicitly on preventing child abuse.

**Table 3.1 Primary Goals of Programs**

<b>Agency</b>	<b>Program</b>	<b>Stated Goals</b>
CAPC	Tender Care Parenting	<ul style="list-style-type: none"> <li>• Increase parenting skills</li> <li>• Connect families to community resources</li> </ul>
	Welcome Baby	<ul style="list-style-type: none"> <li>• Increase parenting skills</li> <li>• Improve parental bonding</li> <li>• Connect families to community resources</li> </ul>
	Suddenly Parents	<ul style="list-style-type: none"> <li>• Increase parenting skills</li> <li>• Connect families to community resources</li> </ul>
	ProjectConnections–Costa Mesa	<ul style="list-style-type: none"> <li>• Support and enhance families’ overall functioning</li> </ul>
CBSC	CalSAHF	<ul style="list-style-type: none"> <li>• Improve child health and development</li> <li>• Reduce interventions by child welfare, law enforcement, and juvenile court</li> <li>• Prevent adverse outcomes for children and families</li> <li>• Promote positive parenting and optimal child development</li> <li>• Improve maternal life course</li> </ul>
	Healthy Families	<ul style="list-style-type: none"> <li>• Improve child health and development</li> <li>• Reduce interventions by child welfare, law enforcement, and juvenile court</li> <li>• Prevent adverse outcomes for children and families</li> <li>• Promote positive parenting and optimal child development</li> <li>• Improve maternal life course</li> </ul>
	ProjectConnections-South Orange County	<ul style="list-style-type: none"> <li>• Improve child health and development</li> <li>• Reduce interventions by child welfare, law enforcement, and juvenile court</li> <li>• Prevent adverse outcomes for children and families</li> <li>• Promote positive parenting and optimal child development</li> <li>• Improve maternal life course</li> </ul>

<b>Agency</b>	<b>Program</b>	<b>Stated Goals</b>
CBSC	Family Preservation	<ul style="list-style-type: none"> <li>• Assure that parents have the knowledge, skills, and access to resources needed to help their children thrive cognitively, emotionally, socially, and physically</li> <li>• Strengthen parents' social support systems</li> <li>• Prevent child abuse</li> <li>• Ensure that young children thrive developmentally</li> <li>• Ensure that school-age children are successful in school</li> </ul>
CSP	YFRC Intensive In-Home Services	<ul style="list-style-type: none"> <li>• Help adolescent and family function more effectively and successfully as individuals, as a family unit, and as members of a community</li> </ul>
HCA	Public Health Field Nursing	<ul style="list-style-type: none"> <li>• Increase number of immunized children</li> <li>• Increase the numbers of individuals and families using the FRC services</li> <li>• Increase number of children and pregnant women who have health care insurance, a health care home, and who are using their health care homes</li> </ul>
	Healthy Futures	<ul style="list-style-type: none"> <li>• Promote a healthy pregnancy</li> <li>• Prevent pre-term births</li> <li>• Reduce the possibility of illness and injury</li> <li>• Enhance physical, intellectual, and emotional growth and family development</li> <li>• Enhance the overall quality of a young women's life choices</li> <li>• Promote effective utilization of chosen family planning methods and general health care services</li> <li>• Increase family awareness of community resources</li> <li>• Encourage utilization of resources for continuing education and/or entry into the workforce</li> </ul>
	High-Risk Infant Program	<ul style="list-style-type: none"> <li>• Prevent or minimize developmental disabilities or delays for high-risk infants</li> <li>• Promote optimal health and development</li> <li>• Reduce the incidence of infant mortality</li> <li>• Reduce the potential impact of handicapping conditions by early identification and interventions</li> </ul>
	PSASI/ACT	<ul style="list-style-type: none"> <li>• Increase access to and compliance of pregnant women with histories of substance abuse and/or HIV infection to prenatal care</li> <li>• Improve the clinical outcome of the pregnancies of women with a history of substance abuse and/or HIV infection</li> <li>• Promote optimal well child, growth and development, and women's health</li> <li>• Enhance client/family ability to meet basic socioeconomic and parenting needs</li> <li>• Increase access to alcohol/drug and behavioral health treatment programs</li> </ul>
MOMS	Paso a Paso	<ul style="list-style-type: none"> <li>• Increased maternal involvement for baby</li> <li>• Connect clients with community resources</li> <li>• Client utilizes medical care when appropriate</li> <li>• Client is more knowledgeable about health and safety for herself and her baby</li> </ul>
OCF	ProjectConnections.FRC Health Access	<ul style="list-style-type: none"> <li>• Ensure the overall physical, social, emotional, and intellectual health of children during the prenatal period to age 5</li> </ul>
UCI	HABLA	<ul style="list-style-type: none"> <li>• Enrich parent-child verbal interaction to increase the language skills of 2-year-old children in low SES and low education families to prepare them for entry into school</li> <li>• Increased school readiness for kindergarten</li> <li>• Successful completion of first grade</li> <li>• Ability to read by third grade</li> </ul>
VNA	Medically Vulnerable Infant Program	<ul style="list-style-type: none"> <li>• Prevent or minimize disabilities or delays for high-risk infants</li> <li>• Promote the infant's optimal health and development</li> <li>• Prevent unnecessary hospitalizations</li> <li>• Promote a family-centered system of care</li> <li>• Decreased incidence of child abuse and neglect</li> <li>• Reduce the need for special education services</li> </ul>

The most common parent- and family-related goals fall under improving parenting skills and linking families to resources such as public and private health insurance, food pantries, shelters, counseling, rehabilitation, welfare, and transportation services. Several programs focus on the health and well-being of the mother. Healthy Futures is unique in that it emphasizes the physical, social, and economic well-being of the mother. A significant number of these programs are explicitly focused on improving the health and well-being of the entire family.

A few programs have more narrowly focused goals than those listed above, generally tied to the unique population served. YFRC Intensive In-Home Services aims to improve the functioning of families with an adolescent who is on probation. PSASI/ACT emphasizes increasing the access to and compliance to prenatal care for women who have a history of substance abuse and/or HIV. Finally, HABLA focuses on enriching verbal interaction between the parents and children in order to promote early childhood development and school readiness.

### **3.2. *Home Services***

The home services provided by these home visitation programs include services very much like those offered by the national model programs. These services are described in Table 3.2. The most common service reported by Orange County programs is linking families with community resources, such as health insurance and food assistance. Many programs include a component addressing parenting skills, such as offering advice on parenting, modeling good parenting behavior, and counseling with the family. For example, CalSAHF home visitors model appropriate parenting and family living skills for the parents, while the Medically Vulnerable Infant Program provides education in health, nutrition, parenting, child development, and home safety. Almost all programs also include a needs assessment of the parent, child, or family, in order to determine which services are most appropriate and to measure progress.

Nearly half the programs provide services to improve the child’s health and development, including the HABLA program, which aims to improve school-readiness by providing toys and books to parents so that they can engage in verbal play with their children, and ProjectConnections-Costa Mesa, which uses a parenting curriculum to instruct parents in child development issues. Many of these include assessments of the child’s health and physical, mental, social, and emotional well-being. Finally, a few programs, most notably PSASI/ACT, provide services to improve parental health, such as referrals to drug and alcohol treatment programs and assistance in obtaining prenatal medical care.

**Table 3.2 Home Visitation Services**

<b>Agency</b>	<b>Program</b>	<b>Home Visitation Program Services</b>
CAPC	Tender Care Parenting Suddenly Parents	<ul style="list-style-type: none"> <li>• Provide parenting education</li> <li>• Complete comprehensive needs assessment and pre-test</li> <li>• Develop an Individualized Service Plan</li> <li>• Complete home safety checklist</li> <li>• Provide services to meet families’ needs</li> </ul>
	Welcome Baby	<ul style="list-style-type: none"> <li>• Provide parenting education focusing on newborn care and bonding</li> <li>• Complete comprehensive needs assessment and pre-test</li> <li>• Develop an Individualized Service Plan</li> <li>• Complete home safety checklist</li> <li>• Provide services to meet families’ needs</li> </ul>
	ProjectConnections–Costa Mesa	<ul style="list-style-type: none"> <li>• Complete needs assessment and service plan</li> <li>• Use parenting curriculum to address child development and behavior issues</li> <li>• Make referrals where appropriate</li> </ul>
CBSC	CalSAHF Healthy Families ProjectConnections.South Orange County Family Preservation	<ul style="list-style-type: none"> <li>• Complete family and nurse assessment to develop goals and service plans for the family</li> <li>• Provide counseling emphasizing communication, family relationships, and coping skills, as well as assistance in a crisis</li> <li>• Provide practical instruction and modeling of parenting and family living skills</li> </ul>
	(Same services for all programs)	<ul style="list-style-type: none"> <li>• Identify and locate critical survival resources</li> <li>• Facilitate family access to resources</li> </ul>
CSP	YFRC Intensive In-Home Services	<ul style="list-style-type: none"> <li>• Complete psycho-social assessment and comprehensive treatment plan</li> <li>• Provide case management services</li> <li>• Meet individually or with the whole family to address areas such as communication, conflict resolution, behavior, etc.</li> </ul>

<b>Agency</b>	<b>Program</b>	<b>Home Visitation Program Services</b>
		<ul style="list-style-type: none"> <li>• Work closely with other collaborators, such as probation officers, drug and alcohol counselors, etc.</li> </ul>
HCA	Public Health Field Nursing	<ul style="list-style-type: none"> <li>• Complete family-centered assessment</li> <li>• Provide case management</li> <li>• Serve as client advocate</li> <li>• Teach preventive health</li> <li>• Promote health care access</li> <li>• Make referrals to community resources</li> </ul>
	Healthy Futures	<ul style="list-style-type: none"> <li>• Employ OLDS model protocols</li> <li>• Conduct physical assessment</li> <li>• Conduct continual assessment of health status</li> <li>• Conduct assessment of personal health, environmental health, life course, maternal role, and friends and family</li> <li>• Make referrals to resources</li> </ul>
	High-Risk Infant Program	<ul style="list-style-type: none"> <li>• Complete family-centered assessment with special focus on infant health and development</li> <li>• Provide ongoing case management</li> <li>• Serve as client advocate</li> <li>• Teach preventive health</li> <li>• Promote health care access</li> <li>• Make referrals to community resources</li> </ul>
	PSASI/ACT	<ul style="list-style-type: none"> <li>• Coordinate prenatal and medical care</li> <li>• Offer transportation services</li> <li>• Provide assistance in applying for and obtaining Medi-Cal and other socioeconomic needs</li> <li>• Provide prenatal teaching</li> <li>• Conduct provider site visits</li> <li>• Make referrals to treatment programs</li> <li>• Conduct health and psycho-social assessments</li> </ul>
MOMS	Paso a Paso	<ul style="list-style-type: none"> <li>• Provide case management, including phone calls and home visits</li> <li>• Conduct instruction in bonding and infant behavior</li> </ul>
OCF	ProjectConnections.FRC Health Access	Same as Public Health Field Nursing
UCI	HABLA	<ul style="list-style-type: none"> <li>• Provide toys and books</li> <li>• Use toys and books to model verbal play and shared reading</li> </ul>
VNA	Medically Vulnerable Infant Program	<ul style="list-style-type: none"> <li>• Conduct comprehensive assessments</li> <li>• Provide health, nutrition, parenting, development, and safety education</li> <li>• Assist with health care coordination</li> <li>• Monitor infant health and offer necessary interventions</li> <li>• Make referrals to community resources</li> <li>• Conduct case management</li> <li>• Offer counseling and caregiver support</li> </ul>

### **3.3. *Other Services***

When we examined the other services offered in the national home visitation program models, we focused on out-of-home services directly associated with the home visitation program. This distinction is more difficult to draw with the Orange County programs, because (with the exception of HABLA) all the programs in our study are administered by agencies that direct other programs in addition to the home visitation services. In addition, some of the programs are specifically linked to family resource centers. For this reason, we split the other services into two tables: Table 3.3.A lists the other, non-home visitation, programs offered by each of our eight agencies. Table 3.3.B lists the other services offered at the family resource centers that participate in ProjectConnections.

Eight family resource centers are “Prop 10 Health Access Sites” offering services through the ProjectConnections program. The services other than ProjectConnections are listed on Table 3.3.B. In addition to home visits by public health nurses, ProjectConnections provides a health care coordinator and a promotora. Together, the health access services provided include: establishment and maintenance of links with community organizations and referral agencies; linkage of neighbors and community members with health and other services; educational workshops; health fairs; presentations in schools and community settings; development and distribution of culturally and linguistically appropriate program materials; assistance with Healthy Families/Medi-Cal, CalKids applications and a strategy for providing immunizations.

**Table 3.3.A Other Services Provided At Each Agency**

Agency	Other Programs/Services Provided
Child Abuse Prevention Center	<ul style="list-style-type: none"> <li>• Adopt-A-Social-Worker</li> <li>• Teen Voices/Teen Choices</li> </ul>
Children’s Bureau of Southern California	<ul style="list-style-type: none"> <li>• FRC Leadership/Coordination</li> <li>• NuParent Classes</li> <li>• Kinship Care Support Services</li> <li>• Parent Support Groups</li> <li>• Child Enrichment Activities</li> <li>• School-Based Counseling</li> <li>• Mental Health Treatment</li> <li>• Foster Care and Adoption</li> </ul>
Community Service Programs, Inc.	<ul style="list-style-type: none"> <li>• Victim Impact Awareness Group</li> <li>• Adolescent support group</li> <li>• Parent education group</li> <li>• Parent support group</li> <li>• Teen parenting group</li> <li>• Teen support group</li> <li>• Crisis intervention</li> </ul>
Orange County Health Care Agency	<ul style="list-style-type: none"> <li>• Behavioral and Public Health clinics and services</li> <li>• Regulatory Services (Environmental Health and Animal Care Services)</li> <li>• Institutional Health Care Services</li> </ul>
MOMS	<ul style="list-style-type: none"> <li>• Childbirth Preparation</li> <li>• Parenting Classes</li> <li>• Breastfeeding classes</li> <li>• Trimester classes</li> <li>• Postpartum classes</li> <li>• Infant development clinic</li> <li>• Resource Center</li> </ul>
Orangewood Children’s Foundation	<ul style="list-style-type: none"> <li>• New Connections</li> <li>• Family Connections</li> <li>• Results for Children</li> <li>• Foster Connections</li> <li>• Foster Youth Emanicipation Programs</li> </ul>
UC Irvine	<ul style="list-style-type: none"> <li>• none</li> </ul>
VNA Home Health Systems	<ul style="list-style-type: none"> <li>• Children’s Bereavement Program</li> <li>• Mother-Infant Groups</li> </ul>

**Table 3.3.B Other Services at ProjectConnections Family Resource Centers**

<b>SERVICE</b>	<b>Families Costa Mesa</b>	<b>Fullerton's Future</b>	<b>Garden Grove</b>	<b>Oak View</b>	<b>La Habra</b>	<b>South Orange Co.</b>	<b>Corbin</b>	<b>TAFFY</b>
Information & referral	■	■	■	■	■	■	■	■
Counseling	■	■	■	■	■	■	■	■
After-school activities	■	■	■	■	■		■	■
Relative support activities	■		■	■	■	■	■	■
Child development activities	■			■		■	■	■
Academic support	■			■				■
Emergency assistance	■	■		■	■		■	■
Outreach services	■	■	■	■		■	■	■
Parent education classes	■	■	■	■	■	■	■	■
Support groups	■	■		■	■	■	■	■
Youth development	■	■		■	■	■	■	■
Health education & services	■	■		■	■	■	■	■
Community development	■							
Case management					■			
Domestic violence services	■						■	
Mentor program	■							
Transitional shelter	■							
Basic Spanish literacy	■							
Medical & dental services	■						■	
ESL			■				■	
Family literacy				■				■
Adult education/computer classes							■	
Family safety education			■					
Family recreation activities			■					
Anger management						■		
Warmline						■		
WIC						■		
Child care education						■		
Legal advice clinic							■	
Daily living skills workshop			■					
Employment services		■	■				■	■

### **3.4. Target Populations**

Table 3.4 describes the populations targeted by the home visitation programs in Orange County. In contrast with the programs in the literature review, all of the programs in our study are targeted to their populations, meaning that anyone who fits into a certain demographic or population-based characteristic, such as a current or former substance abuser or parent of more than one child, is eligible to participate in the program. One program not included in our study, Bridges for Newborns, aims to screen all Orange County newborns for high-risk factors, but then refers families to Family Resource Centers for home visitation services.

Nearly all of the programs in our study set eligibility standards based on the age of the child. Most focus on families with children from birth to anywhere from 1 to 3 years of age. Nearly all the programs aim to target at-risk families, which usually means families in poverty, teen parents, single parents, and/or parents with substance abuse problems. Another criteria used to determine eligibility is place of residence. Although most programs operate throughout Orange County, many are specific to one or a cluster of neighborhoods. Finally, many programs have narrower target populations. For example, YFRC focuses on adolescents who are on probation, Healthy Futures targets first-time teen parents who are not past their 28<sup>th</sup> week of pregnancy, Suddenly Parents focuses on relative caregivers, and MVIP serves families with children who were discharged from an NICU.

**Table 3.4 Target Populations**

<b>Agency</b>	<b>Program</b>	<b>Target Population</b>
CAPC	Tender Care Parenting	<ul style="list-style-type: none"> <li>Families with children 6 months or older, or</li> <li>More than one child</li> </ul>
	Welcome Baby	<ul style="list-style-type: none"> <li>Families with children 6 months or younger, and</li> <li>First time parents</li> </ul>
	Suddenly Parents	<ul style="list-style-type: none"> <li>Relative caregivers with a child placed in their home by Children and Family Services</li> </ul>
	ProjectConnections–Costa Mesa	<ul style="list-style-type: none"> <li>Families that Reside in Costa Mesa, and</li> <li>Have children ages birth-5 years or women in their 3<sup>rd</sup> trimester, but</li> <li>Excludes those families with open County cases</li> </ul>
CBSC	CalSAHF	<ul style="list-style-type: none"> <li>Families that live within catchment area of Corbin Family and Community Center, and</li> <li>Have children ages birth-5 years, and</li> <li>Are at risk for child abuse and/or neglect</li> </ul>
	Healthy Families	<ul style="list-style-type: none"> <li>Families that reside in catchment area for South Orange County Family Resource Center (south of Irvine), and</li> <li>Have children ages birth-5 years, and</li> <li>Are at risk for child abuse and/or neglect</li> </ul>
	ProjectConnections-South Orange County	<ul style="list-style-type: none"> <li>Families that reside in catchment area for South Orange County Family Resource Center (south of Irvine), and</li> <li>Have children ages birth-5 years, and</li> <li>Are at risk for child abuse and/or neglect</li> </ul>
	Family Preservation	<ul style="list-style-type: none"> <li>Families that reside in Tustin, Fullerton, Anaheim, or Oak View in Huntington Beach, and</li> <li>Have children ages birth-12 years, and</li> <li>Are at risk for child abuse and/or neglect</li> </ul>
CSP	YFRC Intensive In-Home Services	<ul style="list-style-type: none"> <li>Youth aged 11-17 who are on probation, and</li> <li>Participants in programs at FRCs, and</li> <li>At least three profile factors</li> </ul>
HCA	Public Health Field Nursing	<ul style="list-style-type: none"> <li>Any individual in need of services (about half are maternal-child cases)</li> <li>Must not be eligible for other programs</li> </ul>
	Healthy Futures	<ul style="list-style-type: none"> <li>First-time teen parents who:</li> <li>Are not past 28<sup>th</sup> week of gestation, and</li> <li>Meet federal poverty guidelines, and</li> <li>Receive Medi-Cal</li> </ul>
	High-Risk Infant Program	<ul style="list-style-type: none"> <li>Families with children ages birth-24 months, and</li> <li>Infants at high risk for developmental disabilities or complications due to biological and/or environmental risk factors</li> </ul>
	PSASI/ACT	<ul style="list-style-type: none"> <li>Pregnant women who either:</li> <li>Have a history of substance abuse, or</li> <li>Are HIV positive</li> </ul>

<b>Agency</b>	<b>Program</b>	<b>Target Population</b>
MOMS	Paso a Paso	<ul style="list-style-type: none"> <li>• Pregnant women, or</li> <li>• Women with a child under 1 year of age</li> </ul>
OCF	ProjectConnections.FRC Health Access	<ul style="list-style-type: none"> <li>• FRC clients with children 0-5</li> </ul>
UCI	HABLA	<ul style="list-style-type: none"> <li>• Families that reside in Santa Ana, and</li> <li>• Are low-income,</li> <li>• Have low education levels, and</li> <li>• Have children ages 2-4 years</li> </ul>
VNA	Medically Vulnerable Infant Program	<ul style="list-style-type: none"> <li>• Families with children discharged from CCS paneled NICU who are:</li> <li>• Ages birth-3 years, and</li> <li>• Who are/were high-risk infants</li> </ul>

### **3.5. Staff Caseloads**

Caseloads per home visitor varied greatly among the programs in our study. Table 3.5 lists the staff caseloads at the participating programs. The number of home visitors varies greatly from program to program, as does the total caseload. The largest program by far is Public Health Field Nursing, which deals with as many as 15,000 maternal-child health clients per year. The smallest programs, including HABLA, YFRC, and ProjectConnections-Costa Mesa, tend to serve approximately 100 client families or less per year. For those programs that reported this data, caseloads averaged at about 25 families per home visitor. Some programs, such as the High Risk Infant Program, HABLA, and YFRC, have caseloads ranging from 2-8 families per home visitor. In contrast, visitors at Public Health Field Nursing manage 100 cases at a time, though many of these cases involve only one home visit and only about ½ of all cases are maternal-child related. Most programs reported that they did not maintain a waiting list because clients were served when they arrived at the program. The Suddenly Parents program reported a waitlist of 0-5 families, while Tender Care Parenting and Welcome Baby each reported 0-30 families waiting to participate. HABLA reported a wait list of approximately 60 families.

**Table 3.5 Program Caseloads**

<b>Agency</b>	<b>Program</b>	<b>Caseloads</b>
CAPC	Tender Care Parenting	<ul style="list-style-type: none"> <li>• 150 families</li> <li>• Waiting list varies from 0-30 families</li> <li>• 8 Casework Specialists each provide services to 40 families/year</li> </ul>
	Welcome Baby	<ul style="list-style-type: none"> <li>• 180 families</li> <li>• Waiting list varies from 0-30 families.</li> </ul>
	Suddenly Parents	<ul style="list-style-type: none"> <li>• 150 families</li> <li>• Waiting list varies from 0-5 families</li> <li>• 2 Casework Specialists</li> </ul>
	ProjectConnections–Costa Mesa	<ul style="list-style-type: none"> <li>• 100 families/year</li> <li>• No wait list.</li> <li>• Two full-time Home Visitors carry 27 families each year; two additional part-time visitors carry 20 and 26 families each</li> </ul>
CBSC	CalSAHF	<ul style="list-style-type: none"> <li>• 125 families</li> <li>• 20-25 families per home visitor</li> </ul>
	Healthy Families	<ul style="list-style-type: none"> <li>• 20 families</li> <li>• 1 full-time and 1 part-time visitor</li> </ul>
	ProjectConnections-South Orange County	<ul style="list-style-type: none"> <li>• 100 families/year</li> </ul>
	Family Preservation	<ul style="list-style-type: none"> <li>• 125 families</li> </ul>
CSP	YFRC Intensive In-Home Services	<ul style="list-style-type: none"> <li>• 5 families per full-time home visitor</li> <li>• 2-3 per part-time visitor</li> <li>• 100-120 families per year served</li> </ul>
HCA	Public Health Field Nursing	<ul style="list-style-type: none"> <li>• Approximately 15,000 maternal-child health clients per year</li> <li>• 100 clients per home visitor</li> </ul>
	Healthy Futures	<ul style="list-style-type: none"> <li>• 90-91 families</li> <li>• No wait list</li> <li>• 4 Public Health Nurses, each of whom carries a maximum of 25 client families</li> </ul>
	High-Risk Infant Program	<ul style="list-style-type: none"> <li>• 104 families</li> <li>• No wait list</li> <li>• 41 Home Visitors with an average caseload of 2.5 families</li> </ul>
	PSASI/ACT	<ul style="list-style-type: none"> <li>• 270 women/families served annually</li> <li>• 8 public health nurses with average caseloads of 35</li> <li>• No wait list</li> </ul>
MOMS	Paso a Paso	<ul style="list-style-type: none"> <li>• 1200 clients/year</li> <li>• No wait list</li> </ul>
OCF	ProjectConnections.FRC	<ul style="list-style-type: none"> <li>• 973 home visitation services per month</li> </ul>
UCI	HABLA	<ul style="list-style-type: none"> <li>• 100 clients served in the first year; approximately 200 clients/year thereafter</li> <li>• 18 part-time home visitors, each serving 3-8 families</li> </ul>

<b>Agency</b>	<b>Program</b>	<b>Caseloads</b>
VNA	Medically Vulnerable Infant Program	<ul style="list-style-type: none"> <li>• 1,100 families per year</li> <li>• Maximum of 262 families served per month</li> <li>• 12 home visitors with caseloads of 40-50 families</li> </ul>

### **3.6. Staff Credentials**

Table 3.6 describes the credentials held by the home visitors in each of the programs in our study that provided this information. Most of the programs in our study employed home visitors with nursing degrees or bachelor’s degrees in the human services field plus 1-3 years of experience working with children, counseling, or doing social work. The Medically Vulnerable Infant Program was unique in that it required visitors to be registered nurses with three years of experience in the NICU or licensed clinical social workers with 3 years of experience. Four programs utilized “paraprofessionals” who were trained in-house but were not required to have any additional credentials. Three of these programs—Tender Care Parenting, Welcome Baby, and HABLA, utilize volunteers while the fourth—Paso a Paso—hires and trains part- and full-time employees.

**Table 3.6 Staff Credentials**

<b>Agency</b>	<b>Program</b>	<b>Staff Credentials</b>
CAPC	Tender Care Parenting	<ul style="list-style-type: none"> <li>• Program Manager: BA in Human Services field and 1-2 years experience minimum</li> <li>• Casework Specialist: BA in Human Services field and 1-2 years experience</li> <li>• Intern: enrolled in college internship program</li> <li>• Volunteers: trained in-house.</li> </ul>
	Welcome Baby	<ul style="list-style-type: none"> <li>• Program Manager: BA in Human Services field and 1-2 years experience minimum</li> <li>• Casework Specialist: BA in Human Services field and 1-2 years experience</li> <li>• Intern: enrolled in college internship program</li> </ul>
	Suddenly Parents	<ul style="list-style-type: none"> <li>• Casework Specialist: BA in Human Services field and 1-2 years experience</li> </ul>

<b>Agency</b>	<b>Program</b>	<b>Staff Credentials</b>
	ProjectConnections–Costa Mesa	<ul style="list-style-type: none"> <li>• Team Leader: Masters in Social Work</li> <li>• Home Visitor: BA in Human Services field and 1-2 years experience</li> <li>• Chemical Addictions Specialist: BA in Human Services, 1-2 years experience, additional training in substance abuse treatment and recovery</li> <li>• Visiting Nurse: PhD, RN, or CPNP</li> </ul>
CBSC	CalSAHF	<ul style="list-style-type: none"> <li>• BA level with experience with children.</li> </ul>
CBSC	Healthy Families	<ul style="list-style-type: none"> <li>• BA level with experience with children or MA level.</li> </ul>
	ProjectConnections-South Orange County	<ul style="list-style-type: none"> <li>• BA level with experience with children.</li> </ul>
	Family Preservation	<ul style="list-style-type: none"> <li>• BA level with experience with children.</li> </ul>
CSP	YFRC Intensive In-Home Services	<ul style="list-style-type: none"> <li>• BA level with experience with adolescents or MA level. Several speak Spanish and one speaks Vietnamese.</li> </ul>
HCA	Public Health Field Nursing	<ul style="list-style-type: none"> <li>• Public Health Nurse I, II, and III and Supervising PHN: RN with a BA in Nursing and a Public Health Certificate; all PHN II and III are NCAST certified</li> <li>• Public Health Nurse Program Manager: same as PHN plus Master’s Degree in Nursing.</li> </ul>
	Healthy Futures	<ul style="list-style-type: none"> <li>• SPHN II and PHN III: BSN/PHN certificate, NCAST certified</li> </ul>
	High-Risk Infant Program	<ul style="list-style-type: none"> <li>• Coordinator and Home Visitors: RN, CPHN with BA in Nursing, NCAST certified.</li> </ul>
	PSASI/ACT	<ul style="list-style-type: none"> <li>• SPHN II: BSN, PHN</li> <li>• Senior Public Health Nurses: BSN, PHN</li> <li>• Community Health Assistant II: experience in HCA and community resources</li> <li>• Social worker assistant: experience with children and families and some undergraduate sociology coursework</li> </ul>
MOMS	Paso a Paso	<ul style="list-style-type: none"> <li>• CSP Certified, trained in-house</li> </ul>
OCF	ProjectConnections.FRC Health Access	<ul style="list-style-type: none"> <li>• PHN and SPHN: RN with BA in Nursing and Public Health Certificate, NCAST certified.</li> <li>• PHN Program Manager: same as PHN plus Master’s Degree in Nursing</li> </ul>
UCI	HABLA	<ul style="list-style-type: none"> <li>• UCI Students or community members with experience working with children</li> </ul>
VNA	Medically Vulnerable Infant Program	<ul style="list-style-type: none"> <li>• Registered nurses with 3 years NICU experience and licensed clinical social workers with 3 years of experience.</li> </ul>

### ***3.7. Duration and Frequency of Visits***

The duration and frequency of home visits to client families in participating programs varies greatly. At the greatest intensity, home visits are typically done once per week. Paso a

Paso provides 5 home visits at designated intervals (see Table 3.7) and HABLA provides bi-weekly visits. For other programs, including the Medically Vulnerable Infant Program and Public Health Field Nursing, the home visitor decides on the appropriate frequency of visits based on need. The duration of the visits varies greatly as well. The programs are evenly split between providing 3-6 months of visits, 6-12 months of visits, or over one year of home visitation services.

**Table 3.7 Frequency and Duration of Home Visits**

<b>Agency</b>	<b>Program</b>	<b>Frequency and Duration of Visits</b>
CAPC	Tender Care Parenting	<ul style="list-style-type: none"> <li>• 1 visit per week for 12 weeks</li> </ul>
	Welcome Baby	<ul style="list-style-type: none"> <li>• 1 visit per week for 12 weeks minimum, optional additional 12 weeks</li> </ul>
	Suddenly Parents	<ul style="list-style-type: none"> <li>• 6-16 visits</li> </ul>
	ProjectConnections–Costa Mesa	<ul style="list-style-type: none"> <li>• Weekly home visits for up to a year</li> </ul>
CBSC	CalSAHF	<ul style="list-style-type: none"> <li>• Weekly to monthly visits depending on need for up to 3 years.</li> </ul>
	Healthy Families	<ul style="list-style-type: none"> <li>• Weekly to monthly visits for 3-6 months</li> </ul>
	ProjectConnections-South Orange County	<ul style="list-style-type: none"> <li>• Weekly to monthly home visits for up to one year.</li> </ul>
	Family Preservation	<ul style="list-style-type: none"> <li>• Weekly to monthly visits for 3-6 months</li> </ul>
CSP	YFRC Intensive In-Home Services	<ul style="list-style-type: none"> <li>• 1-5 hours per week of visitation</li> </ul>
HCA	Public Health Field Nursing	<ul style="list-style-type: none"> <li>• Visits of 45 minutes-3 hours in length; nurse determines duration and frequency based on need.</li> </ul>
	Healthy Futures	<ul style="list-style-type: none"> <li>• Weekly visits for 4 weeks, bi-monthly visits from 5<sup>th</sup> week until delivers, weekly visits for 6 weeks after delivery, bi-monthly visits until child is 21 months, and monthly visits until the child is 24 months.</li> </ul>
	High-Risk Infant Program	<ul style="list-style-type: none"> <li>• Based on nurse’s assessment</li> </ul>
	PSASI/ACT	<ul style="list-style-type: none"> <li>• Services provided up to 1 year after delivery</li> </ul>
MOMS	Paso a Paso	<ul style="list-style-type: none"> <li>• 5 home visits (one during pregnancy, 1 at 2-6 weeks, and at 4, 8, and 12 months)</li> </ul>
OCF	ProjectConnections.FRC Health Access	<ul style="list-style-type: none"> <li>• As needed; determined by program staff.</li> </ul>
UCI	HABLA	<ul style="list-style-type: none"> <li>• Bi-weekly visits of 30 minutes for up to 2 years.</li> </ul>
VNA	Medically Vulnerable Infant Program	<ul style="list-style-type: none"> <li>• Once per week to once per month for 14 months or up to 3 years, depending on need.</li> </ul>



## 4 Prop 10 Outcomes

Our final task in this summary is to map the expected outcomes of the home visitation programs to the outcomes indicators identified in the Orange County Children and Families Commission framework. We include all programs in this mapping even though the Commission funds only a subset.<sup>3</sup> Table 4.1 presents this mapping, which was developed directly from basic logic models that we asked each program to submit. For consistency, we used only the information gathered in these logic models, which includes expected outcomes and indicators, to create the mapping. Therefore, since it is drawn from the conceptual goals described in program logic models, rather than the contractual requirements established by any funder, this mapping might not explicitly match the contracted goals for programs that are funded by the Commission.

The outcomes listed in this table are generally those (1) specifically mentioned by the programs in their logic models and (2) matching framework indicators. The list is therefore incomplete in two ways: First, there are many goals that programs did not specifically list in their expected outcomes, largely because they are outside the tracking ability of the programs. For example, almost all of the programs have the implicit or explicit goal of reducing child abuse or neglect. However, they will not be monitoring child abuse referrals so they will not be able to document what effect they may have had on this measure. For this reason, most of the programs do not explicitly include reduced abuse as an expected outcome.

Second, there are many expected outcomes of the programs that do not map to indicators from the framework. In some cases, these outcomes are still very consistent with goals of the Commission. Most notably, virtually all of these programs are conducting child health and development assessments, which are used to identify possible concerns for referral to specialists.

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<sup>3</sup> Because YFRC does not serve children 0-5, we do not include it here.

The framework includes indicators for increasing the number of both primary care physicians and child care providers who routinely conduct these assessments, but the list does not specifically include an indicator of the number of such assessments conducted generally. In other cases, the outcomes are valuable but have not been identified as specific priorities by the Commission. For all programs, the program summary tables in Appendix B list all expected outcomes as listed by the programs in the logic models provided for this report.

**Table 4.1 Mapping of Expected Outcomes from Home Visitation Programs to Prop 10 Indicators**

Category	Indicator	Welcome Baby	Tender Care Parenting	Suddenly Parents	Project Connections. Costa Mesa	Corbin CalSAHF	Healthy Families	Project Connections. South Orange County	Family Preservation	YFRC	Public Health Field Nursing	Healthy Futures	High Risk Infant Program	PSASI/ACT	Paso a Paso	Orangewood Project Connections	HABLA	MVIP
Prenatal Care	Increase to 90% women who begin prenatal care in first trimester and whose care is adequate																	
Low Birth Weight	Reduce low birth weight to no more than 5% of live births.																	
Low Birth Weight	Reduce very low birth weight to no more than 1% of live births.																	
Substance Exposed Infants	Increase abstinence from alcohol use by pregnant women.																	
Substance Exposed Infants	Increase abstinence from tobacco use by pregnant women by 75%.																	
Substance Exposed Infants	Eliminate use of illicit drugs by pregnant women.																	
Immunization	Increase age appropriate immunizations to at least 95%.																	
Child Mortality	Reduce rate of child mortality to 30 per 100,000 aged 1-5																	
Preventable Injuries	Reduce nonfatal unintentional injuries so that hospitalizations for this condition are no more than 754 per 100,000																	
Use Preventive Health Care	Increase use of occupant protection systems such as seat belts and child safety seats to at least 85% of motor vehicle occupants																	

Category	Indicator	Welcome Baby	Tender Care Parenting	Suddenly Parents	Project Connections. Costa Mesa	Corbin CalSAHF	Healthy Families	Project Connections. South Orange County	Family Preservation	YFRC	Public Health Field Nursing	Healthy Futures	High Risk Infant Program	PSASI/ACT	Paso a Paso	Orangetown Project Connections	HABLA	MVIP
Sudden Infant Death	Decrease number of SIDS cases.																	
Health Insurance	Increase to 100% number of children with health coverage																	
Well Child Care Visits	Increase proportion of babies 18 months and younger who receive recommended primary care services at appropriate levels																	
Well Child Care Visits	Increase to 95% the proportion of children who have a health care home.																	
Tobacco Exposure	Reduce to no more than 20% the proportion of children aged 5 and younger who are regularly exposed to tobacco smoke at home																	
Child Abuse	Decrease number of child abuse reports involving young children																	
Family Self Sufficiency	Improvement in the condition of OC families as gauged by the following socio-economic indicators: Formal Education of Parents																	
Family Self Sufficiency	Improvement in the condition of OC families as gauged by the following socio-economic indicators: Employment																	
Family Self Sufficiency	Improvement in the condition of OC families as gauged by the following socio-economic indicators: Social Capital/Support																	
Effective Programs	Percentage of parents who increased parenting skills and continued to use them six months after classes																	

Category	Indicator	Welcome Baby	Tender Care Parenting	Suddenly Parents	Project Connections. Costa Mesa	Corbin CalSAHF	Healthy Families	Project Connections. South Orange County	Family Preservation	YFRC	Public Health Field Nursing	Healthy Futures	High Risk Infant Program	PSASI/ACT	Paso a Paso	Orangewood Project Connections	HABLA	MVIP
Consumer Satisfaction and Awareness	Increase community awareness of services available																	
Consumer Satisfaction and Awareness	Increase in satisfaction in services received.																	
Increased School Readiness	Increased school readiness for kindergarten																	
Increased School Readiness	Increased successful completion of first grade																	
Increased School Readiness	Increased ability to read by the third grade																	

## 5 Next Steps

This summary of Orange County home visitation programs was compiled as the second step towards the development of a service delivery plan that offers suggestions on improving the coordination of home visitation across the county. The plan will draw on evidence from five sources: (1) the review of the best practices in the national model completed in April; (2) this summary; (3) additional written information provided by the programs; (4) focus group and interview findings; and (5) visits to example programs in other counties. To conclude, we provide more detail on the last three sources below.

In addition to basic information about the program characteristics, the programs provided us information on their triage strategies, data/client tracking systems, reporting requirements, and additional outcome indicators they would like to be able to collect. Because targeting clients to programs, client tracking, and outcome measurement are key to documenting the effectiveness of programs, we will include these issues as a key facet to be considered in developing an integrated service delivery strategy.

We will also draw on opinions and perspectives collected through interviews and focus groups with stakeholders in the county. We have already conducted focus groups with staff from the home visitation programs, with other FRC staff (including a number who do home visits as part of case management services), and with family maintenance social workers and supervisors from the Social Services Agency. We are in the process of scheduling one or two client focus groups to be held at MOMS in mid-July. In the next several weeks, we will also be conducting telephone interviews with managers/directors of the home visitation programs, program funders, SSA management and other stakeholders in the community.

Finally, two programs in other California counties have been identified as possible models to consider for particular elements of the service delivery plan. Therefore, we plan to visit Sacramento County's Birth and Beyond program and San Mateo County's Pre to Three Initiative to see how home visitation programs work in other counties.

The success of the final project will depend on the active participation of the stakeholders involved with home visitation programs in Orange County. We welcome comments on and corrections to this summary to ensure that it properly reflects the programs as they currently stand. As we continue to work with FaCT and the home visitation programs in Orange County and elsewhere, we also look forward to additional input on concerns regarding the current integration of these programs as well as suggestions or ideas for improving service delivery in this critical area.

## **A. Appendix: Templates for Program Summary Information**

## AGENCY WORKSHEET

1. Agency name:	
2. Contact person: Address Phone # Fax # Email address (if avail.)	
<b>AGENCY OVERVIEW</b>	
3. Agency mission (optional):	
4. Programs/services offered by agency	<ul style="list-style-type: none"> <li>a. In Home Visitation Programs                             <ul style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>...</li> </ul> </li> <li>b. Other programs/services                             <ul style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>...</li> </ul> </li> <li>c.</li> </ul>
5. Agency service area (specific cities, neighborhoods, or county-wide)	
6. Number of families served across all programs/services (specify monthly or annual)	

AGENCY-LEVEL ISSUES FOR INTEGRATION OF VISITATION PROGRAMS

\*\*\*\* FOR EACH VISITATION PROGRAM LISTED UNDER 4.A,  
PLEASE COMPLETE A PROGRAM WORKSHEET AND LOGIC MODEL. \*\*\*\*

<p>7. For agencies with more than one in-home visitation program, do these programs serve the same target populations?</p>	<p>If yes, list (by number from question 4) programs sharing target populations.</p>
<p>8. For programs serving the same client populations, what standards, if any, do you use for determining whether to move clients to more intensive programs? In other words, what are your standards for triaging across programs?</p>	
<p>9. For agencies with more than one in-home visitation program, do these programs share home visitor (professional or paraprofessional) staff? Do they share support staff (other than for agency-level administration)? Do they share data systems?</p>	
<p>10. Do you know of other agencies offering in-home visitation programs that should be included in this study?</p>	

## PROGRAM WORKSHEET

1. Program name:	
2. Agency name:	
3. Within this agency, visitation program ____ of ____	
<b>PROGRAM OVERVIEW</b>	
4. Primary goals of program:	
5. Other agencies collaborating to deliver this program:	<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> </ol>
6. Program funders:	<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> </ol>
<b>REPORTING AND DATA SYSTEMS</b>	
7. What are the reporting requirements (to funders or higher levels of this agency) for this program? (Describe the types of data required. If available, attach example reports.)	
8. Are client data recorded solely on paper, on paper with data entry of some information, some electronic/ some paper, or entirely electronically?	

<p>9. If electronic databases are used, describe each system used.</p>	
<p>10. What outcome measures do you routinely collect? Which database, if any, captures these outcomes?</p>	
<p>11. Are there outcome measures that you do not collect but think you should?</p>	
<p>12. Do you track individuals that leave your program? How?</p>	
<p><b>PROGRAM SUCCESS</b></p>	
<p>13. How does the agency determine whether the program is successful in meeting the goals described in question 4 above?</p>	
<p>14. What data, if any, does the agency's board consider in determining whether to continue this program?</p>	
<p>15. What outcomes do your funders consider in determining whether to renew or continue funding for this program?</p>	

**DRAFT LOGIC MODEL FOR HOME VISITATION PROGRAM**

<b>Target Populations:</b>	<b>Interventions:</b>	<b>Expected Changes:</b>	<b>Evidence of Change:</b>	<b>Resources:</b>
<p>Describe target population including:</p> <ol style="list-style-type: none"> <li>Detailed criteria for participation in program, by age, family structure, risk factors, geographic location</li> <li>Whether participation is voluntary or mandatory. If mandatory, what are the penalties for non-compliance?</li> <li>How clients are referred to the program, including agencies making referrals, whether self-referrals are accepted, outreach efforts</li> <li>Number of clients served in typical month.</li> <li>Are all clients served who are referred and meet the eligibility criteria? If not, what determines who is served? Is there a maximum capacity? How are priorities established across clients when not all clients can be served? Where do you refer clients you can't serve?</li> </ol>	<p>List each activity offered by this program, including number, timing, length and frequency of visits, services provided at those visits, referrals made to other services, follow up activities. Note any requirements regarding speed of response.</p> <p>Describe triage standards associated with different types of visitation within the program or varying degrees of intensity of services.</p> <p>If there are specific protocols or instrument used as part of the visit, describe them (or provide copies of the instruments).</p> <p>In addition to direct client services, list interactions/feedback to referring agencies (such as SSA) or other programs within your agency.</p> <p>How do clients exit the program? What determines "completion"?</p>	<p>For each activity listed under the interventions, describe what change to client well being is expected to result from this activity.</p> <p>Activities can have more than one expected change, or several activities may collectively lead to one expected change.</p>	<p>For each expected change, describe:</p> <ol style="list-style-type: none"> <li>The outcome measure used to determine client well being.</li> <li>The instrument, client file page or visit record that includes this outcome measure, preferably directly referring to question numbers or field names.</li> <li>Where relevant, the name of the data system that captures this data.</li> <li>If this outcome is not measured, but could be, describe data that would need to be collected to show evidence of change.</li> </ol>	<p>List the major resources devoted to this program, including:</p> <ol style="list-style-type: none"> <li>For each staff title, the number of staff at this level and the qualifications or credentials held by these staff.</li> <li>Caseload standards for each type of home visitor.</li> <li>Data systems used specifically for this program.</li> <li>Major materials, equipment or other miscellaneous resources used.</li> </ol> <p>If program funding is not blended with other agency funds, list all resources included in program budget.</p>

## **B. Appendix: Summary Tables by Program**

**Table B.1: Welcome Baby - Child Abuse Prevention Center**

<b>Program Name</b>	Welcome Baby
<b>Agency Name</b>	Child Abuse Prevention Center
<b>Other agencies participating</b>	GOALS Collaborative Health Care Agency UPPBeat
<b>Funders</b>	United Way GOALS Collaborative and Community Challenge Grant
<b>Philosophy of program</b>	The Orange County Child Abuse Prevention Center is committed to preventing and breaking the cycle of child abuse, domestic violence, and teen pregnancy in Orange County.
<b>Goals of program</b>	Increase parenting skills and improve parental bonding by providing in-home parenting education for 12 weeks to first-time parents of newborns and connect families to community resources.
<b>Target population</b>	Orange County families who are new parents with a child under 6 months old.
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	180 families
<b>Maximum capacity</b>	
<b># on wait list</b>	All clients who accept services are served. Families may be put on a waiting list which varies from 0-30 families long.
<b>Referral sources</b>	Families are self-referred and also referred by other community programs and teen parent schools
<b>Services provided</b>	In-home parenting education visits. First is a comprehensive needs assessment and a pre-test. Within the first few visits, an Individualized Service Plan is completed with the family to develop goals. In addition to providing services to meet the family's ISP goals, a home safety checklist is completed during the service period. Upon termination, a post-test is administered and a client satisfaction survey is mailed to the family.  Clients leave the program after 12 or 24 weeks of services have been completed.
<b>Duration and frequency of visits</b>	12 1-2 hour long visits, one per week. May be extended by an additional 12 weeks (12 visits) if the service plan goals have not been met and agreed to by the family.
<b>Center services provided</b>	Adopt-A-Social-Worker Teen Voices/Teen Choices
<b>Expected changes</b>	<ul style="list-style-type: none"> <li>- Increased parent/child bonding</li> <li>- Parents increase the safety of the home and knowledge of SIDS, car seat safety, and Shaken Baby Syndrome</li> <li>- Parents increase their knowledge of child development and daily care</li> <li>- Parents connect to appropriate community resources, including medical care</li> </ul>
<b>Staffing (number, qualifications)</b>	<p>Volunteer: number varies</p> <p>Intern: number varies, enrolled in a college/university internship program</p> <p>Program Manager: 1.8 FTE BA in Human Services field and minimum of 1-2 years experience Supervises volunteers and interns. Services provided to 100 families/year per 1 FTE</p> <p>Casework Specialist: 1FTE BA in Human Services field and minimum of 1-2 years experience Provides direct services to families. Services provided to 40 families/year</p>

**Table B.2: Tender Care Parenting - Child Abuse Prevention Center**

<b>Program Name</b>	Tender Care Parenting
<b>Agency Name</b>	Child Abuse Prevention Center
<b>Other agencies participating</b>	UPPBeat Cal-Learn Health Care Agency United Way
<b>Funders</b>	County of Orange Foundations and Private Donations United Way
<b>Philosophy of program</b>	The Orange County Child Abuse Prevention Center is committed to preventing and breaking the cycle of child abuse, domestic violence, and teen pregnancy in Orange County.
<b>Goals of program</b>	Increase parenting skills by providing in-home parenting education to families for 12 weeks and connecting families to community resources.
<b>Target population</b>	Orange County families with a child over 6 months old or more than one child.
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	450 families
<b>Maximum capacity</b>	
<b># on wait list</b>	All clients who accept services are served. Families may be put on a waiting list which varies from 0-30 families long.
<b>Referral sources</b>	Families are self-referred and also referred by other community programs. In addition, families are referred by the Orange County Children and Families Department. Referring agencies receive feedback on all referrals.
<b>Services provided</b>	In-home parenting education visits. First is a comprehensive needs assessment and a pre-test. Within the first few visits, an Individualized Service Plan is completed with the family to develop goals. In addition to providing services to meet the family's ISP goals, a home safety checklist is completed during the service period. Upon termination, a post-test is administered and a client satisfaction survey is mailed to the family. Clients leave the program after 12 or 24 weeks of services have been completed.
<b>Duration and frequency of visits</b>	12 1-2 hour long visits, one per week. May be extended by an additional 12 weeks (12 visits) if the service plan goals have not been met and agreed to by the family.
<b>Center services provided</b>	Adopt-A-Social-Worker Teen Voices/Teen Choices
<b>Expected changes</b>	<ul style="list-style-type: none"> <li>- Parents increase the use of appropriate non-corporal consequences for negative behavior</li> <li>- Parents increase the safety of children and the home</li> <li>- Parents increase their knowledge of child development</li> <li>- Parents connect to appropriate community resources, including medical care</li> </ul>
<b>Staffing (number, qualifications)</b>	<p>Volunteer: number varies</p> <p>Intern: number varies, enrolled in a college/university internship program</p> <p>Program Manager: 3.5 FTE, BA in Human Services field and minimum of 1-2 years experience, Supervises volunteers and interns.</p> <p>Casework Specialist: 8FTE, BA in Human Services field and minimum of 1-2 years experience, Provides direct services to families.</p> <p>Services provided to 40 families/year per 1FTE</p>

**Table B.3: Suddenly Parents - Child Abuse Prevention Center**

<b>Program Name</b>	Suddenly Parents
<b>Agency Name</b>	Child Abuse Prevention Center
<b>Other agencies participating</b>	None
<b>Funders</b>	County of Orange Children and Family Services
<b>Philosophy of program</b>	The Orange County Child Abuse Prevention Center is committed to preventing and breaking the cycle of child abuse, domestic violence, and teen pregnancy in Orange County.
<b>Goals of program</b>	Increase parenting skills by providing in-home parenting education to relative caregivers of County of Orange dependent children for 12 weeks and connecting families to community resources.
<b>Target population</b>	Orange County Relative Caregivers who have a dependent child placed in their home by Orange County Children and Family Services.
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	220 families
<b>Maximum capacity</b>	
<b># on wait list</b>	All clients who accept services are served. Families may be put on a waiting list which varies from 0-5 families long.
<b>Referral sources</b>	Orange County Children and Family Services only
<b>Services provided</b>	Orientation and in-home parenting education visits. First visit includes a comprehensive needs assessment, home safety checklist, and pre-test. Goals created by the RCG and CFS Senior Social Worker are discussed. Upon completion, a post-test is administered and a client satisfaction survey is mailed to the family.  Clients exit the program after services have been completed.
<b>Duration and frequency of visits</b>	2 orientation visits, 4 in-home parenting education visits and/or 12 in-home parenting education visits. All visits are 1-2 hours in length unless the family is being assisted with connecting to a resource.
<b>Center services provided</b>	Adopt-A-Social-Worker Teen Voices/Teen Choices
<b>Expected changes</b>	<ul style="list-style-type: none"> <li>- Relative Caregivers increase the use of appropriate non-corporal consequences for negative behavior</li> <li>- Relative Caregivers increase the safety of children and the home.</li> <li>- RCGs increase their knowledge of child development</li> <li>- RCGs connect to appropriate community resources, including medical care</li> <li>- RCGs increase their understanding of the Juvenile Dependency Court System</li> </ul>
<b>Staffing (number, qualifications)</b>	Casework Specialists: 2FTE; BA in Human Services field and minimum of 1-2 years experience; provides direct service to families.

**Table B.4: ProjectConnections.Costa Mesa - Child Abuse Prevention Center**

<b>Program Name</b>	ProjectConnections-Costa Mesa
<b>Agency Name</b>	Child Abuse Prevention Center
<b>Other agencies participating</b>	Families-Costa Mesa Hoag Hospital Newport-Mesa Unified School District
<b>Funders</b>	Orange County Children and Families' Commission
<b>Philosophy of program</b>	Committed to preventing and breaking the cycle of child abuse, domestic violence, and teen pregnancy in Orange County.
<b>Goals of program</b>	To provide home visitation services that support and enhance families' overall functioning
<b>Target population</b>	Costa Mesa families with children aged 0-5. Risk factors are teen pregnancy, substance abuse, domestic violence, poverty, isolation, and/or mental illness. No open county case can be accepted. These cases are referred to out other agency programs.
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	100 families/year
<b>Maximum capacity</b>	100 families/year
<b># on wait list</b>	none
<b>Referral sources</b>	Clients are self-referred and are referred by a variety of organizations including Families-Costa Mesa and collaborative partners, medical clinics, doctors, WIC, Planned Parenthood and self referrals are accepted. Outreach efforts include visits and presentations to numerous agencies, providers and parent groups.
<b>Services provided</b>	Weekly home visiting for at least one hour is provided to each family. During these visits, the following interventions occur: initial needs assessments and service plan is completed, a parenting curriculum is then used to address both child development and behavior issues. Referrals are made to FRC, WIC, Planned Parenthood, medical and dental clinics, food pantries, Medi-Cal, parenting groups, legal aid, etc. Each family can remain in the program for one year.
<b>Duration and frequency of visits</b>	Weekly home visits of at least one hour duration
<b>Center services provided</b>	Adopt-A-Social-Worker Teen Voices/Teen Choices
<b>Expected changes</b>	<ol style="list-style-type: none"> <li>1. Immunization and home safety checklist: reduce number of child deaths and disabilities due to preventable causes</li> <li>2. Initial Needs Assessment and Nurse Assessment: Increase access to early development assessments so that all chronic and disabling conditions are identified, assessed and managed.</li> <li>3. Weekly home visitations: increase access and availability to family support services and resources</li> <li>4. Parenting curriculum: increase parenting knowledge and skills to support child rearing and healthy choices.</li> </ol>
<b>Staffing (number, qualifications)</b>	<p>Staff Credentials:</p> <p>1 FTE Team Leader-MSW</p> <p>3.75 FTE Home Visitor-BA in the Human Services field and 1-2 years of experience. One home visitor is designated as the Chemical Addictions Specialist with additional training in Substance Abuse treatment and recovery.</p> <p>Visiting Nurse: PhD, RN, CPNP</p> <p>2FTE home visitors carry 27 families each per year, .75FTE carries 20 per year and 1 FTE HV/CAS carries 26 for a total of 100 families served/year.</p>

**Table B.5: CalSAHF – Children’s Bureau of Southern California**

<b>Program Name</b>	CalSAHF
<b>Agency Name</b>	Children’s Bureau of Southern California
<b>Other agencies participating</b>	Corbin Family and Community Center Bridges Program
<b>Funders</b>	OCAP FaCT CBSC Foundation
<b>Philosophy of program</b>	To assist vulnerable children to become caring and productive adults
<b>Goals of program</b>	<ul style="list-style-type: none"> <li>• Improve child health and development</li> <li>• Reduce interventions by child welfare, law enforcement, and juvenile court</li> <li>• Prevent adverse outcomes for children and families</li> <li>• Promote positive parenting and optimal child development</li> <li>• Improve maternal life course</li> </ul>
<b>Target population</b>	<p>Orange County families who meet the following criteria:</p> <ul style="list-style-type: none"> <li>• Live in the catchment area for the Corbin Family and Community Center</li> <li>• Families with newborns or children up to age five</li> <li>• Families must meet criteria that determines them to be “overburdened” or “at risk” for child abuse or neglect.</li> </ul>
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	125 families, 20-25 per home visitor
<b>Maximum capacity</b>	125 families
<b># on wait list</b>	
<b>Referral sources</b>	
<b>Services provided</b>	<p><b>Family and Nurse Assessment.</b> Family Support Counselor uses the FAF to assess family strengths and needs in 6 areas of family functioning. Nurse uses a specially designed nurse assessment. Families complete a group of self-report tools. Goals and service plans are developed with the family based on this information.</p> <p><b>In-Home Counseling.</b> Emotionally supportive problem solving, focused counseling emphasizing communication, family relationships, coping skills in the present in addition to assistance in a crisis.</p> <p><b>Teaching and Demonstrating.</b> Hands on practical instruction and modeling of parenting and family living skills. This includes holding, rocking, breast feeding, bathing, diapering, playing, stimulating development, child proofing, preparing nutritious meals and snacks, etc.</p> <p><b>Resource Brokering.</b> Identification and location of critical survival resources, facilitating family access to resources, facilitating communication among agencies providing services, coaching families on how to broker resources for themselves.</p> <p><b>24 Hour Availability.</b> Staff are available on a 24 hour a day basis using a pager and answering service system.</p>
<b>Duration and frequency of visits</b>	Weekly visits for the first 6 months, then frequency reduced with services extended for up to 3 years
<b>Center services provided</b>	<p>FRC Leadership/Coordination</p> <p>NuParent Classes</p> <p>Kinship Care Support Services</p> <p>Parent Support Groups</p> <p>Child Enrichment Activities</p> <p>School Based Counseling</p> <p>Mental Health Treatment</p>

Foster Care & Adoption	
<b>Expected changes</b>	<ul style="list-style-type: none"> <li>• Comprehensive family assessments leading to greater understanding of strengths and concerns on part of family and service providers</li> <li>• More individually tailored goals and service plans leading to greater family investment and participation in services</li> <li>• Parents increase their knowledge of child development, health, safety, and behavior management</li> <li>• Parents practice nurturing parent/child relationship skills</li> <li>• Parents provide an enriched environment for learning and language development</li> <li>• Parents maintain a safe home for infants and toddlers</li> <li>• Children will achieve developmental milestones appropriate to their age and ability</li> <li>• Children’s immunizations and well child care visits will be current</li> <li>• Parents report increased awareness of community resources</li> <li>• Parents strengthen their social support network and increase their social contacts</li> <li>• Parents feel supported by staff</li> </ul>
<b>Staffing(number, qualifications)</b>	Visitors all have B.A.'s and some experience with children

**Table B.6: Healthy Families – Children’s Bureau of Southern California**

<b>Program Name</b>	Healthy Families
<b>Agency Name</b>	Children’s Bureau of Southern California
<b>Other agencies participating</b>	South Orange County Family Resource Center Bridges Program
<b>Funders</b>	FaCT CBSC Foundation
<b>Philosophy of program</b>	To assist vulnerable children to become caring and productive adults
<b>Goals of program</b>	<ol style="list-style-type: none"> <li>1. to improve child health and development</li> <li>2. to reduce interventions by child welfare, law enforcement, and juvenile court</li> <li>3. to prevent adverse outcomes for children and families</li> <li>4. to promote positive parenting and optimal child development</li> <li>5. to improve maternal life course</li> </ol>
<b>Target population</b>	<p>Orange County families who meet the following criteria:</p> <ol style="list-style-type: none"> <li>1. Families must live in the catchment area for the South Orange County Family Resource Center – communities south of Irvine.</li> <li>2. Families with newborns or children up to age five</li> <li>3. Families must meet criteria that determines them to be “overburdened” or “at risk” for child abuse or neglect</li> </ol>
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	20 families
<b>Maximum capacity</b>	20 families
<b># on wait list</b>	
<b>Referral sources</b>	
<b>Services provided</b>	<ol style="list-style-type: none"> <li>A. Family Assessment. Family Support Counselor uses the FAF to assess family strengths and needs in 6 areas of family functioning. Goals and service plans are developed with the family based on this information.</li> <li>B. In-Home Counseling. Emotionally supportive problem solving, focused counseling emphasizing communication, family relationships, coping skills in the present in addition to assistance in a crisis.</li> <li>C. Teaching and Demonstrating. Hands on practical instruction and modeling of parenting and family living skills. This includes holding, rocking, breast feeding, bathing, diapering, playing, stimulating development, child proofing, preparing nutritious meals and snacks, etc.</li> <li>D. Resource Brokering. Identification and location of critical survival resources, facilitating family access to resources, facilitating communication among agencies providing services, coaching families on how to broker resources for themselves.</li> <li>E. 24 Hour Availability. Staff are available on a 24 hour a day basis using a pager and answering service system.</li> </ol>
<b>Duration and frequency of visits</b>	Weekly to monthly visits for 3 to 6 months.
<b>Center services provided</b>	
<b>Expected changes</b>	<ul style="list-style-type: none"> <li>• A1 Comprehensive family assessments leading to greater understanding of strengths and concerns on part of family and service providers</li> <li>• A2 More individually tailored goals and service plans leading to greater family investment and participation in services</li> <li>• B/C1 Parents increase their knowledge of child development, health and</li> </ul>

	<p>safety, and behavior management</p> <ul style="list-style-type: none"> <li>• B/C2 Parents practice nurturing parent/child relationship skills</li> <li>• B/C3 Parents provide an enriched environment for learning and language development</li> <li>• B/C4 Parents maintain a safe home for infants and toddlers</li> <li>• B/C5 Children will achieve developmental milestones appropriate to their age and ability</li> <li>• B/C6 Children’s immunizations and well child care visits will be current</li> <li>• D1 Parents report increased awareness of community resources</li> <li>• D2 Parents strengthen their social support network and increase their social contacts</li> <li>• E1 Parents feel supported by staff</li> </ul>
<b>Staffing (number, qualifications)</b>	BA level with experience with children or MA level. 1 full time and 1 part time visitor.

**Table B.7: ProjectConnections.South Orange County – Children’s Bureau of Southern California**

<b>Program Name</b>	ProjectConnections-South Orange County
<b>Agency Name</b>	Children’s Bureau of Southern California
<b>Other agencies participating</b>	1. South Orange County Family Resource Center 2. Bridges Program
<b>Funders</b>	Prop 10 CBSC Foundation
<b>Philosophy of program</b>	To assist vulnerable children to become caring and productive adults
<b>Goals of program</b>	1. to improve child health and development 2. to reduce interventions by child welfare, law enforcement, and juvenile court 3. to prevent adverse outcomes for children and families 4. to promote positive parenting and optimal child development 5. to improve maternal life course
<b>Target population</b>	Orange County families who meet the following criteria: 1. Families must live in the catchment area for the South Orange County Family Resource Center – communities south of Irvine. 2. Families with newborns or children up to age five 3. Families must meet criteria that determines them to be “overburdened” or “at risk” for child abuse or neglect
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	100 families/year
<b>Maximum capacity</b>	100 families/year
<b># on wait list</b>	
<b>Referral sources</b>	
<b>Services provided</b>	<ul style="list-style-type: none"> <li>• Family and Nurse Assessment. Family Support Counselor uses the FAF and the FAI to assess family strengths and needs in areas of family functioning. Nurse uses a specially designed nurse assessment. Goals and service plans are developed with the family based on this information.</li> <li>• In-Home Counseling. Emotionally supportive problem solving, focused counseling emphasizing communication, family relationships, coping skills in the present in addition to assistance in a crisis.</li> <li>• Teaching and Demonstrating. Hands on practical instruction and modeling of parenting and family living skills. This includes holding, rocking, breast feeding, bathing, diapering, playing, stimulating development, child proofing, preparing nutritious meals and snacks, etc.</li> <li>• Resource Brokering. Identification and location of critical survival resources, facilitating family access to resources, facilitating communication among agencies providing services, coaching families on how to broker resources for themselves.</li> <li>• 24 Hour Availability. Staff are available on a 24 hour a day basis using a pager and answering service system.</li> </ul>
<b>Duration and frequency of visits</b>	Weekly to monthly home visits for up to 1 year.
<b>Center services provided</b>	1. FRC Leadership/Coordination 2. NuParent Classes 3. Kinship Care Support Services 4. Parent Support Groups 5. Child Enrichment Activities

	6. School Based Counseling 7. Mental Health Treatment 8. Foster Care & Adoption
<b>Expected changes</b>	<ul style="list-style-type: none"> <li>• Comprehensive family assessments leading to greater understanding of strengths and concerns on part of family and service providers</li> <li>• More individually tailored goals and service plans leading to greater family investment and participation in services B/C1 Parents increase their knowledge of child development, health and safety, and behavior management</li> <li>• Parents practice nurturing parent/child relationship skills</li> <li>• Parents provide an enriched environment for learning and language development</li> <li>• Parents maintain a safe home for infants and toddlers</li> <li>• Children will achieve developmental milestones appropriate to their age and ability</li> <li>• Children’s immunizations and well child care visits will be current</li> <li>• Parents report increased awareness of community resources</li> <li>• Parents strengthen their social support network and increase their social contacts</li> <li>• Parents feel supported by staff</li> </ul>
<b>Staffing (number, qualifications)</b>	BA level with experience with children.

**Table B.8: Family Preservation – Children’s Bureau of Southern California**

<b>Program Name</b>	Family Preservation
<b>Agency Name</b>	Children’s Bureau of Southern California
<b>Other agencies participating</b>	Oak View Community Collaborative FRC TAFFY Collaborative Fullerton’s Future FRC Salk Family Resource Center
<b>Funders</b>	FaCT CBSC Foundation
<b>Philosophy of program</b>	To assist vulnerable children to become caring and productive adults
<b>Goals of program</b>	<ul style="list-style-type: none"> <li>• To assure that parents have the knowledge, skills, and access to resources needed to help their children thrive cognitively, emotionally, socially, and physically</li> <li>• To strengthen parents social support systems</li> <li>• To prevent child abuse among participating families</li> <li>• To assure that young children thrive developmentally and that school age children are successful in school</li> </ul>
<b>Target population</b>	Orange County families who meet the following criteria: <ol style="list-style-type: none"> <li>1. Families must live in Tustin, Fullerton, Anaheim or the Oak View community of Huntington Beach.</li> <li>2. Families with newborns or children up through age twelve</li> <li>3. Families must meet criteria that determines them to be “overburdened” or “at risk” for child abuse or neglect</li> </ol>
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	125 families
<b>Maximum capacity</b>	125 families
<b># on wait list</b>	
<b>Referral sources</b>	
<b>Services provided</b>	<ol style="list-style-type: none"> <li>A. Family Assessment. Family Support Counselor uses the FAF to assess family strengths and needs in 6 areas of family functioning. Goals and service plans are developed with the family based on this information.</li> <li>B. In-Home Counseling. Emotionally supportive problem solving, focused counseling emphasizing communication, family relationships, coping skills in the present in addition to assistance in a crisis.</li> <li>C. Teaching and Demonstrating. Hands on practical instruction and modeling of parenting and family living skills. This includes holding, rocking, breast feeding, bathing, diapering, playing, stimulating development, child proofing, preparing nutritious meals and snacks, child behavior management, household maintenance, etc.</li> <li>D. Resource Brokering. Identification and location of critical survival resources, facilitating family access to resources, facilitating communication among agencies providing services, coaching families on how to broker resources for themselves.</li> <li>E. 24 Hour Availability. Staff are available on a 24 hour a day basis using a pager and answering service system</li> </ol>
<b>Duration and frequency of visits</b>	Visits for 3-6 months
<b>Center services provided</b>	FRC Leadership/Coordination NuParent Classes Kinship Care Support Services

	Parent Support Groups Child Enrichment Activities School Based Counseling Mental Health Treatment Foster Care & Adoption
<b>Expected changes</b>	<ul style="list-style-type: none"> <li>• A1 Comprehensive family assessments leading to greater understanding of strengths and concerns on part of family and service providers</li> <li>• A2 More individually tailored goals and service plans leading to greater family investment and participation in services</li> <li>• B/C1 Parents increase their knowledge of child development, health and safety, and behavior management</li> <li>• B/C2 Parents practice nurturing parent/child relationship skills</li> <li>• B/C3 Parents support their children’s learning and academic success</li> <li>• B/C4 Parents maintain a safe and healthy home environment</li> <li>• D1 Parents report increased awareness of community resources</li> <li>• D2 Parents strengthen their social support network and increase their social contacts</li> <li>• E1 Parents feel supported by staff</li> </ul>
<b>Staffing(number, qualifications)</b>	BA level with experience with children

**Table B.9: YFRC Intensive In-Home Services – Community Service Programs, Inc.**

<b>Program Name</b>	YFRC Intensive In-Home Services
<b>Agency Name</b>	Community Service Programs, Inc.
<b>Other agencies participating</b>	Orange County Juvenile Probation (Agency that has contracted with us to provide services to minors and family) Behavioral Health: Children and Youth Services (Some overlap of services when indicated)
<b>Funders</b>	Orange County Probation Department
<b>Philosophy of program</b>	
<b>Goals of program</b>	To help the adolescent and his/her family members function more effectively and successfully as individuals, as a family unit, and as members of a community
<b>Target population</b>	<p>Our clients are drawn from the larger population of adolescents on probation, who are participating in a full day, multiagency program offered as one of 5 youth and Family resource centers in designated areas of Orange County. These adolescents are aged 11-17, have at least 3 of the following profile factors that place them at great risk of becoming chronic juvenile offenders:</p> <ul style="list-style-type: none"> <li>● Poor school behavior or performance</li> <li>● Chronic family problems</li> <li>● Drug or alcohol use</li> <li>● Pre-delinquency factors such as a pattern of running away and history of stealing and identification/association with gang members and/or delinquent peers</li> </ul> <p>Out of that larger population, the collaborative team members who work at the YFRC Centers, identify specific families that are in need of intensive in home services due to one or more of the following:</p> <ul style="list-style-type: none"> <li>● Immediate and/or multiple service needs including lack of housing, financial aid crisis, significant medical or other community resource needs, etc.</li> <li>● Significant counseling service needs for adolescent and entire family that may include individual counseling, family counseling, parent education, teen parenting skills, etc.</li> <li>● Lack of or limited connection to the YFRC staff and/or to community supports and services. Trust issues common</li> <li>● Language or acculturation issues in the family system that require more individualized support and services.</li> </ul> <p>When a particular minor and his/her family is identified by the Collaborative Team as appropriate for home services, the probation officer completes an intensive in home referral form and submits it to the in home supervisor for that center. The supervisor then makes a determination of case assignment based on language, needs, case load, and priority of needs.</p>
<b>Nature of client participation</b>	
<b># of clients served</b>	100-120 families per year served; 5 families per full-time home visitor
<b>Maximum capacity</b>	
<b># on wait list</b>	

<b>Referral sources</b>	Collaborative team members at YFRC Centers, Probation Officers
<b>Services provided</b>	<ol style="list-style-type: none"> <li>1. Assignment of In-Home Counselor who meets with adolescent and family. He or she completes a psycho-social assessment and a comprehensive treatment plan within first 21 days.</li> <li>2. Families are provided with up to 4 hours a week of direct services based on assessment, crisis intervention needs, etc. Average ideal is 1-5 hours of direct contact per week per family. In home counselors provide case management services via collateral contacts, community linkages, resource ?, client advocacy, etc.</li> <li>3. Counselors may meet individually with the adolescent, parent, or other family member as well as with the entire family to address areas such as communication, conflict resolution, behavioral ?, problem solving, goal setting, coping skills, family living skills, etc. Intensive in home services are provided for a ninety day period with evaluation of progress on ? of services at approximately one month intervals based on needs, participation level, progress, and ???.</li> <li>4. In home counselor: work closely with other collaborators at the site in providing services to these adolescents and their families. Other providers at each site include: Two Supervising Probation Officer, 3-4 Deputy Probation Officers, 6 Deputy Probation Counselors; 1-2 therapists, 2 drug and alcohol counselors, psychologist, psychiatrist; drug and alcohol counselors or job developers; 2 teachers and a teaching assistant. From CSP: parent educator, counselor, restorative/enrichment staff. Staffing are held weekly or particular adolescents based on Probation's system of 90 day reviews. All FRC staff are expected to attend discuss the status of the minor and his/her family, discuss progress/needs/plans</li> </ol> <p>Ongoing informal contact often occurs on a daily basis among collaboratives regarding progress, problems, needs, mini staff meetings are held for a particular adolescent as indicated when a special need arises.</p>
<b>Duration and frequency of visits</b>	1-5 hours per week of visitation
<b>Center services provided</b>	See service #4 above
<b>Expected changes</b>	<ol style="list-style-type: none"> <li>1. The adolescent and his/her family members will increase their level of trust.</li> <li>2. The family will show an increased understanding of the YFRC program and goals</li> <li>3. All significant family members will have a clearer sense of their strengths and needs</li> <li>4. There will be an increased knowledge of trust in and willingness to utilize support systems and resources</li> <li>5. There will be an improvement in family communication and quality of relationships</li> <li>6. There will be an increase in the adolescent's capacity to take more responsibility for his or her behaviors and demonstrate efforts to change those that are problematic.</li> </ol>
<b>Staffing(number, qualifications)</b>	<p>CSP Director, Program Director, Supervisor,  In Home counselors: 1.5 FTE  May be BA level with experience with adolescents or MA. Several speak Spanish and one speaks Vietnamese.  50% of staff time spent in direct services.</p>

**Table B.10: Public Health Field Nursing – Health Care Agency**

<b>Program Name</b>	Public Health Field Nursing
<b>Agency Name</b>	Health Care Agency
<b>Other agencies participating</b>	None
<b>Funders</b>	General County Funds Targeted Case Management
<b>Philosophy of program</b>	<p>Agency: The Health Care Agency is dedicated to creating and supporting an environment that promotes the achievement of optimal individual, family and community health.</p> <p>Service: Public Health Services: In partnership with communities, Public Health will create, support, and continuously improve an environment that promotes the achievement of maximum potential for personal and community health.</p> <p>Program: Our mission is to improve the health of our community by providing quality Public Health Field Nursing services.</p>
<b>Goals of program</b>	<ul style="list-style-type: none"> <li>- Improve the general health status of the population</li> <li>- Reduce infectious disease</li> <li>- Reduce non-infectious disease</li> <li>- Reduce violence and injury</li> <li>- Improve family and individual health</li> <li>- Reduce environmental threats to health</li> <li>- Assess and improve the quality of health care delivery systems</li> </ul>
<b>Target population</b>	Any Orange County individual following priority guidelines; First priority is children with a communicable disease, infants with more risk factors
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	Approximately 15,000 maternal-child health clients per year; 100 per home visitor
<b>Maximum capacity</b>	
<b># on wait list</b>	
<b>Referral sources</b>	Hospitals, physicians, clinics, CBOs, self-referral, family referral, other county programs and agencies.
<b>Services provided</b>	<p>Public Health Nurses, under the Public Health Division of the Orange County Health Care Agency, provide nursing services in the home and community, by providing family-centered assessment, case management, client advocacy, preventive health teaching, and health care access and community resources to at risk populations.</p> <p>Service Focus: Communicable Disease Investigation, Maternal Health (high-risk pregnancies/teen pregnancies/births), Infant and Child Health (high-risk infants/children), and Adult Health. See referral priority guidelines for response times.</p>
<b>Duration and frequency of visits</b>	45 minutes-3 hours in length; nurse determines length and frequency based on need
<b>Center services provided</b>	Behavioral and Public Health clinics and services Regulatory Services (Environmental Health and Animal Care Services) Institutional Health Care Services
<b>Expected changes</b>	See case forms and other program materials.

**Staffing (number, qualifications)**

- Public Health Nurse I, II, and III  
39 positions budgeted  
36.1 FTEs  
California State Registered Nurse with a Baccalaureate Degree in Nursing, and a Public Health Certificate  
All PHN II and III are NCAST Certified
- Supervising Public Health Nurse  
4 positions  
4 FTEs  
Same certification as PHN
- Public Health Nurse Program Manager I (Director Public Health Nursing)  
1 position  
Same credentials as PHN plus Master's Degree in Nursing

**Table B.11: Healthy Futures – Health Care Agency**

<b>Program Name</b>	Healthy Futures
<b>Agency Name</b>	Health Care Agency
<b>Other agencies participating</b>	Jr. high and high schools in Orange County Private health providers Community clinics Social services including CalLearn Adolescent and family life program
<b>Funders</b>	General County Funds Targeted Case Management
<b>Philosophy of program</b>	Agency: The Health Care Agency is dedicated to creating and supporting an environment that promotes the achievement of optimal individual, family and community health.  Service: Public Health Services: In partnership wit communities, Public Health will create, support, and continuously improve an environment that promotes the achievement of maximum potential for personal and community health.  Program: Our mission is to improve the health of our community by providing quality Public Health Field Nursing services.
<b>Goals of program</b>	<ol style="list-style-type: none"> <li>1. Promote a healthy pregnancy and prevent preterm births</li> <li>2. Reduce the possibility of illness and injury through anticipatory guidance</li> <li>3. Enhance physical, intellectual, and emotional growth and family development</li> <li>4. Enhance the overall quality of a young woman’s life choices</li> <li>5. Promote effective utilization of chosen family planning methods and general health care services</li> <li>6. Increase family awareness of the community resources</li> <li>7. Encourage utilization f resources for continuing education and/or entry into the workforce.</li> </ol>
<b>Target population</b>	First time pregnancy and/or planning to parent for the first time; teenagers, less than 20 years of age; not past the 28 <sup>th</sup> week of gestation; reside in Orange County, meeting federal poverty guidelines, receiving some form of Medi-Cal.
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	90-91 families, maximum of 25 families per public health nurse
<b>Maximum capacity</b>	100
<b># on wait list</b>	None
<b>Referral sources</b>	Public school system, teen mother programs, private medical providers, school nurses, community clinics, self referrals, probation services, Adolescent and Family Life, Cal-Learn, County pregnancy testing clinics.  Referrals prioritized by the month and day when they will reach their 28 <sup>th</sup> week of pregnancy; teens who are less than 16 are seen sooner or if there are other risk factors which make earlier contact needed.
<b>Services provided</b>	In home visits by PHNs trained in the implementation of the Olds Model protocols. Following the initial assessment visit, and description of the program by the PHN, the client is randomized, and will be either an Intervention (Olds Model) or Control Group (gen'l. Field Nsg) client. Services include physical assessment (initial, then at intervals where status has changed, i.e. delivery, etc.); continual assessment of health status, and assessing the 5 domains of the program: Personal Health, Environmental Health; Life Course;

	<p>Maternal Role and Friends and Family. Referrals to programs are made, p.r.n., i.e., W.I.C., Adol. Fam. Life; Family Planning; food resources; low cost/free clinics, etc. Response to clients for the initial assessments is made depending on the priority of the referral, those who will reach 28 wks. gestation soon will have a higher HV priority.</p> <p>The visitation to clients is per the Olds model; triage to additional services is per client need.</p> <p>Clients exit the program in a variety of ways: 1. Completion of the program at 24 mos. following infant's birth; 2. client declines further participation, 3. moving out of the catchment area; unable to locate, excessive missed appointments, child no longer in the custody of the parent. "Completion" is accomplished when the client has been available for the established or negotiated visitations from intake to dismissal.</p>
<b>Duration and frequency of visits</b>	The Intervention client will receive weekly home visits for the 1 <sup>st</sup> 4 week, bi-monthly visits from the 5 <sup>th</sup> week until delivery; weekly visits during the 6 weeks following delivery; bi-monthly visits until the child reached the age of 21 mos., then monthly visits until the child is 24 mos. The visits generally last from 45 minutes to 1 ½ hours.
<b>Center services provided</b>	Behavioral and Public Health clinics and services Regulatory Services (Environmental Health and Animal Care Services) Institutional Health Care Services
<b>Expected changes</b>	<ul style="list-style-type: none"> <li>• Promote a healthy pregnancy and prevent pre-term births including reduction of smoking and pregnancy induced hypertension.</li> <li>• Reduce possibility of illness and injury (intended and unintended through anticipatory guidance, linkage with a medical provider including obtaining childhood immunizations and decreasing non-emergent visits to the E.R.</li> <li>• Reduce subsequent unintended pregnancy during the first 2 years following delivery.</li> <li>• Encourage utilization of resources for continuing education and/or entry into the workforce, thus reducing the use of welfare</li> <li>• Increase family awareness of community resources</li> <li>• Enhance the overall quality of a young woman's life choices.</li> <li>• Enhance the physical, intellectual and emotional growth and development of the family.</li> </ul>
<b>Staffing (number, qualifications)</b>	<p>SPHN II, 1 FTE BSN/PHN Certificate; NCAST certified; trained in use of the Nurse Family Partnership protocols including P.I.P.E.</p> <p>PHN III, 4 FTE BSN/PHN Certificate, NCAST certified; trained in use of the Nurse Family Partnership protocols including P.I.P.E.</p> <p>Information Processing Technician (IPT), 1 FTE – provides clerical support and data entry</p>

**Table B.12: High Risk Infant Program – Health Care Agency**

<b>Program Name</b>	High Risk Infant Program (HRIP)
<b>Agency Name</b>	Health Care Agency
<b>Other agencies participating</b>	Field Nursing
<b>Funders</b>	General County Funds Targeted Case Management
<b>Philosophy of program</b>	
<b>Goals of program</b>	Prevent or minimize developmental disabilities or delays for high-risk infants and promote optimal health and development by providing home-based early intervention services to high-risk infants and their caregivers.  Provide and coordinate a delivery care system for high risk infants and their families to reduce the incidence of infant mortality and the potential impact of handicapping conditions by early identification and interventions.
<b>Target population</b>	Services are provided to high-risk infants and children birth to 24 months residing in Orange County.
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	104 families; 41 home visitors each have an average caseload of 2-3 families
<b>Maximum capacity</b>	All eligible candidates are offered services
<b># on wait list</b>	None
<b>Referral sources</b>	Hospitals, clinics, doctor’s offices, social services, CBOs, and self-referrals
<b>Services provided</b>	The intensity of services, the frequency of home visits beyond the minimum requirements, referrals, and follow-up activities are based on nursing assessment and family needs. Some of the screening tools used in the program are the Field Nursing Profiles and Nursing Care Plans, Denver Developmental Screening Test II (DDST II), Nursing Child Assessment Satellite Training (NCAST) Feeding and Teaching Scale, Sleep Activity Record, and Home Observation. Please refer to the attached Field Nursing Profiles and Nursing Care Plans, Nursing Interventions, Denver Developmental Screening Test II, NCAST Feeding and Teaching Scales, Sleep Activity Record and Home Observation Form. Currently, clients are discharged from the program at 2 years adjusted age. All reasonable efforts are made by the PHN to follow the client up to 2 years adjusted age.
<b>Duration and frequency of visits</b>	Based on nurse’s assessment
<b>Center services provided</b>	Behavioral and Public Health clinics and services Regulatory Services (Environmental Health and Animal Care Services) Institutional Health Care Services
<b>Expected changes</b>	The overall program activities and services are designed to meet the program goal and objectives. Each nursing intervention is focused on preventing or minimizing developmental disabilities and promoting optimal health. The measured outcomes will determine change and program success. The program’s measured outcomes are currently under review.
<b>Staffing (number, qualifications)</b>	1 Coordinator: Registered Nurse; Certified Public Health Nurse with a Bachelor’s Degree in Nursing. NCAST Certified 41 Home Visitors: Registered Nurse; Certified Public Health Nurse with a Bachelor’s Degree in Nursing. NCAST Certified. 1 Office Technician

**Table B.13: PSASI/ACT – Health Care Agency**

<b>Program Name</b>	Perinatal Substance Abuse Services Initiative/ACT Program
<b>Agency Name</b>	Health Care Agency
<b>Other agencies participating</b>	1. Health Care Agency/Behavioral Health/Alcohol and Drug Treatment Programs 2. Social Services Agency/Children and Family Services
<b>Funders</b>	1. Public Health – Targeted Case Management 2. Behavioral Health – Alcohol and Drug Treatment Programs 3. Social Services Agency/Children and Family Services
<b>Philosophy of program</b>	Agency: The Health Care Agency is dedicated to creating and supporting an environment that promotes the achievement of optimal individual, family and community health. Service: Public Health Services: In partnership with communities, Public Health will create, support, and continuously improve an environment that promotes the achievement of maximum potential for personal and community health. Program: Our mission is to improve the health of our community by providing quality Public Health Field Nursing services.
<b>Goals of program</b>	Increase access and compliance of pregnant women with histories of substance abuse and/or HIV infection to prenatal care. Improve the clinical outcomes of their pregnancies. Promote optimal well child, developmental and women’s health Enhance client/family ability to meet basic socioeconomic and parenting needs Increase access to alcohol/drug and behavioral health programs
<b>Target population</b>	<ul style="list-style-type: none"> <li>• Pregnant women with histories of substance abuse</li> <li>• Pregnant HIV infected women</li> <li>• Residents of the County of Orange</li> </ul>
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	270 women served annually
<b>Maximum capacity</b>	
<b># on wait list</b>	No waiting lists. All referrals of target population are accepted. Referrals taken any time during prenatal period
<b>Referral sources</b>	
<b>Services provided</b>	A. Coordination of Prenatal and medical Care by means of an in-home Case Management Team of Sr. Public Health Nurse case manager, Social Worker Assistant for transportation services, and Community Health Assistant for assistance in Medi-Cal and other program applications and follow through.
<b>Duration and frequency of visits</b>	Service provided throughout pregnancy to 1 year after delivery
<b>Center services provided</b>	Behavioral and Public Health clinics and services Regulatory Services (Environmental Health and Animal Care Services) Institutional Health Care Services
<b>Expected changes</b>	<ul style="list-style-type: none"> <li>• Pregnant women will obtain source of medical coverage for prenatal care i.e., Medi-Cal</li> <li>• Pregnant women will obtain and comply with prenatal care</li> <li>• Improved clinical outcomes of pregnancy</li> <li>• Medical home for mother and infant post delivery and at time of case closure</li> <li>• Access to care is expected for all clients.</li> <li>• Standard perinatal outcomes accepted by the obstetrical and pediatric medical community are used as a measure, i.e., GA at entry into prenatal care (PNC), # of PNC appts., Gestational Age (GA), Birthweight, prenatal drug exposure.</li> <li>• No level of alcohol and drug treatment has been established as a successful rate, but it is measured.</li> </ul>

	<ul style="list-style-type: none"> <li>• Decrease use of illicit drugs, alcohol, and tobacco during pregnancy and parenting</li> <li>• Infants will be born with negative urine toxicology screens</li> <li>• Decreasing child abuse reports filed at birth for prenatal substance abuse</li> <li>• Stabilization of socioeconomic, psychosocial, and support needs</li> </ul>
<b>Staffing (number, qualifications)</b>	<p>1 Supervising Public Health Nurse II: BSN, PHN  8 Senior Public Health Nurses: BSN, PHN  1 Community Health Assistant II: Bilingual Spanish, experience in HCA and community resources  2 Social Worker Assistants: 1 requiring bilingual Spanish, both requiring experience with children and families, and some undergraduate sociology coursework</p>

**Table B.14: Paso A Paso – MOMS Resource Center**

<b>Program Name</b>	Paso A Paso
<b>Agency Name</b>	MOMS Resource Center
<b>Other agencies participating</b>	None
<b>Funders</b>	OC Children and Families Commission, County of Orange
<b>Philosophy of program</b>	MOMS mission is to improve access to medical care, education, and support for women living in Orange County, from pregnancy through the first year after birth, positively impacting the health and well-being of women and their infants.
<b>Goals of program</b>	Provide education, support, and resources to pregnant and parenting women.
<b>Target population</b>	Orange County women who are pregnant or parenting with an infant <1 year of age.
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	1200 last year; 100 clients/month
<b>Maximum capacity</b>	
<b># on wait list</b>	None. They have been able to serve all clients referred to them
<b>Referral sources</b>	CBOs, Health Care Agency, Public Health Nursing, Doctor’s offices and clinics, their own classes, self referrals, word of mouth. Will refer to Life Steps for developmental assessment if appropriate.
<b>Services provided</b>	Maternal and Child Case Management Program. Clients receive community-based CM services, which include monthly phone calls and 5 home visits.
<b>Duration and frequency of visits</b>	5 home visits: once during pregnancy, once at 2-6 weeks, and at 4, 8, and 12 months of the infant’s age. The first infant visit (second of all visits) promotes bonding and reviews infant behaviors. The next three visits include reviewing an infant screening tool (Ages and Stages questionnaire) and discussing the promotion of infant development behaviors.
<b>Center services provided</b>	These services are provided at the center but are not necessarily a part of Paso a Paso: Childbirth prep, parenting, trimester, breastfeeding, and postpartum classes, infant development clinic, and resource center.
<b>Expected changes</b>	<ul style="list-style-type: none"> <li>• Increased emotional and verbal responses of mother to baby</li> <li>• Avoidance of restriction and punishment to baby</li> <li>• Organized environment of baby</li> <li>• Safe environment for baby</li> <li>• Increased maternal involvement with baby</li> <li>• Referral within 2 business days to Life Steps</li> <li>• Client knows how to apply for Medi-Cal or other funding sources</li> <li>• Client keeps her MD appointments, and knows when to seek medical attention</li> <li>• Client knows relief for common discomforts of pregnancy</li> <li>• Client is able to make healthy food choices</li> <li>• Client is aware of effects of substance exposure during pregnancy.</li> </ul>
<b>Staffing (number, qualifications)</b>	CSP certified, trained in-house.

**Table B.15: ProjectConnections.FRC – Orangewood Children’s Foundation**

<b>Program Name</b>	ProjectConnections.FRC
<b>Agency Name</b>	Orangewood Children’s Foundation
<b>Other agencies participating</b>	Family Resource Centers, Latino Health Access, County Public Health Field Nursing, HASC-Bridges Hospitals.
<b>Funders</b>	Children and Families Commission of Orange County, FaCT (SSA-In-kind); Seeking MMA leveraged funds.
<b>Philosophy of program</b>	
<b>Goals of program</b>	Healthy Children: ensure the overall physical, social, emotional, and intellectual health of children during the prenatal period to age 5.
<b>Target population</b>	Orange County. Targets FRCs. Some clients also served by In Home Visitation program. Referrals to more intensive home visitation programs where applicable, depending on risk level.
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	From 1/16/01-2/16/01, ProjectConnections-South Orange County provided 5,144 services to individuals. This number includes 973 home visitation services.
<b>Maximum capacity</b>	
<b># on wait list</b>	
<b>Referral sources</b>	PNH, Bridges for newborns, Promotora, Collaborative Member, offsite health encounters, current FRC, other agencies
<b>Services provided</b>	<ul style="list-style-type: none"> <li>• Establish and maintain linkages with other community organizations and mutual referral agencies</li> <li>• Actively link neighbors and community members with health and other services through other PHN, the Promotoras, and the FRC</li> <li>• Plan, conduct, and facilitate educational workshops and other activities</li> <li>• Participate in local health fairs</li> <li>• Refer families with children 0-5 to needed services throughout the country.</li> <li>• Conduct presentations in local schools and community settings</li> <li>• Develop and distribute culturally and linguistically appropriate program materials</li> <li>• Assist with Healthy Families/Medi-Cal, CalKids applications</li> <li>• Establish a means for providing immunizations</li> </ul>
<b>Duration and frequency of visits</b>	As needed; determined by program staff
<b>Center services provided</b>	New Connections Family Connections Results for Children Foster Connections
<b>Expected changes</b>	<p>(For home visitation component)</p> <ul style="list-style-type: none"> <li>• Increased access to early developmental assessments so that all chronic and disabling conditions are identified, assessed and managed</li> <li>• Increased access and availability to family support services and resources</li> <li>• Reduced number of child deaths and disabilities due to preventable causes</li> <li>• Increased percent of children born healthy</li> <li>• Increased parenting and knowledge and skills to support effective child rearing and health choices</li> <li>• Increase the number of children who receive all age appropriate</li> </ul>

	<p>immunizations</p> <ul style="list-style-type: none"> <li>• Increase the number of children with special needs who enter services as a result of assessments</li> <li>• Increase the number of parents who are knowledgeable of the health and nutrition needs of young children</li> </ul>
<b>Staffing (number, qualifications)</b>	Healthcare Coordinator, Promotora (training by Latino Health Access), PHN

**Table B.16: HABLA – University of California, Irvine**

<b>Program Name</b>	HABLA
<b>Agency Name</b>	University of California, Irvine
<b>Other agencies participating</b>	FACT and the Corbin Family and Community Center ABC Great Beginnings Children’s Bureau of Southern California
<b>Funders</b>	OC Children and Families Commission UCI
<b>Philosophy of program</b>	
<b>Goals of program</b>	Enrich parent-child verbal interaction to increase the language skills of 2-year-old children in low SES and low education families so as to better prepare them for entry into school.  Increased school readiness for kindergarten, successful completion of first grade and ability to read by third grade.
<b>Target population</b>	Low income families with 2-year-olds living in Santa Ana. Target families with low education levels.
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	82; 18 part-time home visitors serve 3-8 families each.
<b>Maximum capacity</b>	100
<b># on wait list</b>	Approximately 40
<b>Referral sources</b>	Corbin center, professional referrals from Health Care Agency, self-referrals through fliers distributed at local schools, clinics, and parishes.  Will refer to health and social service agencies at Corbin, Mitchell Child Development Center in Santa Ana Unified School System, and Regional Center as appropriate.
<b>Services provided</b>	Home visits described below to give toys and books that stay in the home and to use these to model verbal play and shared reading.
<b>Duration and frequency of visits</b>	30 minute, bi-weekly home visits for a 23 week period each of two years.
<b>Center services provided</b>	none
<b>Expected changes</b>	Increased parent-to-child language, increased shared reading, increased verbalization by child, primary language skills, especially expressive skills, speech and/or hearing therapy as needed, social agency or health intervention as needed.
<b>Staffing (number, qualifications)</b>	1 program director 2 site coordinators; supervising 18 part-time home visitors, who are UCI students or community members with experience working with children.

**Table B.17: Medically Vulnerable Infant Program – VNA Home Health Systems**

<b>Program Name</b>	Medically Vulnerable Infant Program (MVIP)
<b>Agency Name</b>	VNA Home Health Systems
<b>Other agencies participating</b>	None
<b>Funders</b>	Children’s Medical Services grant (DHS) VNA Home Health Systems
<b>Philosophy of program</b>	Provide competitive, innovative, cost-effective, high quality home care to residents of Orange County and other geographically appropriate areas on a not-for-profit basis.
<b>Goals of program</b>	<ul style="list-style-type: none"> <li>• Prevent or minimize disabilities or delays for high risk infants</li> <li>• Promote the infant’s optimal health and development</li> <li>• Develop and maintain a quality assurance program</li> <li>• Collect data on enrolled infants and their families for state reports.</li> <li>• Provide and coordinate a delivery care system for high-risk infants.</li> <li>• Prevent unnecessary hospitalizations</li> <li>• Promote a family-centered system of care by applying the principles of family-centered care</li> <li>• Decrease incidence of child abuse and neglect</li> <li>• Reduce the need for special education services</li> </ul>
<b>Target population</b>	<ul style="list-style-type: none"> <li>• High risk infants who meet state eligibility criteria requirements</li> <li>• Birth to 3 years of age</li> <li>• Must have been discharged from a CCS paneled NICU</li> <li>• All of Orange County and San Gabriel Valley in LA County.</li> <li>• May serve the same population as the Maternal Child Health Program</li> </ul>
<b>Nature of client participation</b>	Voluntary
<b># of clients served</b>	262 infants are receiving home visits per month 1,100 families per year, does not include home visitation to adults
<b>Maximum capacity</b>	Maximum is 262. New admissions will occur as space allows.
<b># on wait list</b>	At this time, all infants meeting the state criteria are enrolled in the MVIP.
<b>Referral sources</b>	Referred from hospital NICU’s and other professionals in the community.  If more than one visit per week is required, they may transfer them to the Maternal Child Health Program, where visits can be made up to three times per day.
<b>Services provided</b>	Comprehensive assessments completed at home visits by registered nurses, social workers, and physical and occupational therapists. Focus on health, nutrition, parenting, development, and safety. Frequency of home visits will vary depending on the acuity of the infant and family. The range of home visits is from one time per week to one time per month. Also includes health care coordination, monitoring and interventions, referrals, case management, education/counseling, and caregiver support.
<b>Duration and frequency of visits</b>	From one a week to once a month for 14 months-3 years
<b>Center services provided</b>	Agency also includes Children’s Bereavement program, Mother-Infant Groups, and the Maternal Child Health Program (another home visitation program)
<b>Expected changes</b>	<ul style="list-style-type: none"> <li>• Parents will have an increased understanding of the importance of well child checks and up to date immunizations.</li> <li>• Maintain CHDP well child visits schedule and AAP immunization schedule guidelines</li> </ul>

	<ul style="list-style-type: none"> <li>• Have referral information on available community resources for their family</li> <li>• Parents will have information on their child's development</li> <li>• Developmental delays will be addressed by referrals to the appropriate community agency for ongoing therapy needs</li> <li>• Parents will have information on strategies to provide a stimulating home environment.</li> <li>• Parents will have increased knowledge on care of a child with special health needs</li> <li>• Parents will begin to advocate with the delivery care system for special needs of their child</li> <li>• Child will reach his/her optimal health and development</li> </ul>
<b>Staffing (number, qualifications)</b>	<p>Staff is shared with the other home visitation program. Includes Program Coordinator, Health Care Coordinators (Registered Nurses), Social Workers, Physical Therapists, Occupational Therapists, Administrative Assistant. Health Care Coordinators and Social Workers must have 3 years of experience in addition to credentials.</p>