

Service Delivery Plan For Integrated Home Visitation Services In Orange County

Final

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Executive Summary

This report proposes an explicit plan to create an integrated system of home visitation in Orange County. In formulating this plan, we drew wherever possible from evidence available in the literature on home visitation; unfortunately, the field offers little direction regarding integration across programs. To address this task, we started with eleven guiding principles. Working within these principles, the plan builds on the existing infrastructure in Orange County, as well as some of the future directions being considered by local service providers and agencies. There are two fundamental elements to the plan. First, it takes family resource centers (FRCs) as the basic underpinning of coordinated service delivery for home visitation. Second, the plan conceives of home visitation provided at three levels of intensity – low intensity, high intensity, and specialized home visitation programs – as a strategy to balance the needs of families of children 0-5 with the potentially high costs of home visitation.

We divide our service delivery plan into seven dimensions within three broad aims. This breakdown is designed to make the plan easier to conceptualize, but no dimension of the plan can be considered completely out of the context of the plan as a whole.

Designing an Integrating Structure for Home Visitation

Figure S.1 provides an overview of the major elements of our proposed structure for home visitation built into family resource centers. These elements constitute the first three dimensions around which our recommendations are organized:

Dimension 1: Strengthen Linkages Among the Primary Service Platforms

- Assign a Medi-Cal/Healthy-Families representative to each FRC as a link to health care providers
- Allot a school-readiness position to every FRC as a link to schools

Dimension 2: Manage Entry Into Home Visitation

- Identify/create a team within each FRC accountable for initial client contact
- Make this team also the contact point for programs outside the FRC
- Establish well-defined, systematic protocols to match clients with services
- Make cost consideration a vital element of client-service matching

Dimension 3: Triage Services

- Provide for low- and high-intensity home visitation services in each FRC
- Make the low-intensity program a part of the FRC referral team
- Constitute a multi-disciplinary team to staff the high-intensity program
- Use the FRC referral team to oversee referrals and client transfers to and from specialized home visitation programs outside FRCs
- Establish protocols for referrals and for confirmations of referral accommodation

Promoting Effective Service

A structure for organizing home visitation must be linked with a plan to assure that the system incorporates best practices, evaluates practices and responds to information on outcomes. These dimensions inform the next three sets of recommendations.

Dimension 4: Build in Evaluation of Program Success

- Expand measured outcomes to include variables describing the circumstances of children that home visitations are intended to impact
- Select outcomes capable of being directly influenced by service providers
- Include measured variables enabling cost/benefit analyses of home visitation services
- Convene define-it meetings involving home visitation providers and relevant funders to formulate these outcomes
- Relate measured outcomes to criteria delineating program and system success
- Provide timely reports summarizing outcomes to programs and funders
- Fund individual programs based on their achievement of outcomes to make each accountable for success

Dimension 5: Build in Information Collection and Storage

- Expand the OCERS database to incorporate home visitation outcome variables
- Provide for secure data exchange between OCERS and FRCs in reporting home visitation services coordinated through these centers
- Establish outcomes reports to FRCs and home visitation services
- Make provisions for gathering of data from home visitation programs outside FRCs and for reporting outcomes to these programs
- Develop plans for integrating information from involuntary home visitation programs managed by County agencies, such as Child Protective Services

Dimension 6: Incorporate Best Practices

- Establish work groups to develop protocols and related tools to handle referral and triage
- Explore technology options for referral tracking and other tasks common across programs
- Create a resource mapping for home visitation programs
- Establish regular meetings of home visitors to share outcomes and other information
- Conduct cross-training of home visitors

Closing Gaps in Coverage

Finally, the plan makes recommendations for closing gaps in service coverage.

Dimension 7: Reduce Gaps in Coverage of Home Visitation Programs

- Ensure availability of two levels of home visitation programs at each FRC
- Ascertain links of FRCs to special home visitation programs
- Create a “catchall” rest of county program to cover individuals living outside the service range of any FRC
- Establish protocols to identify future coverage gaps

Figure S.1 Proposed Structure For Home Visitation Services Linked With FRCs

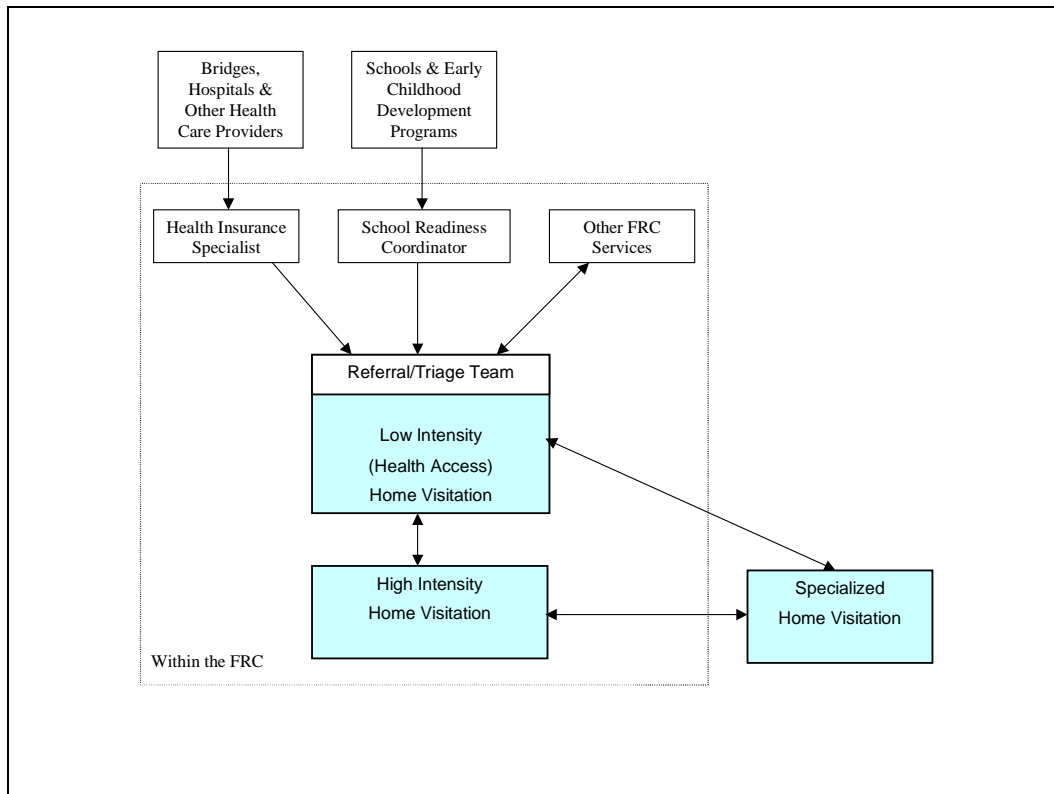


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1 Introduction

As part of its commitment to promote healthy child development and school readiness, the Orange County Children and Families Commission and Social Services Agency maintains the goal of creating an integrated quality service system. Efforts in this focal area include substantial support for home visitation programs, which are gaining popularity as an important strategy for delivering services to families with young children. The Commission-funded programs add onto a complex set of existing programs of this type funded by agencies such as Orange County Children and Family Services and the Health Care Agency. As the number of such programs proliferates, it becomes increasingly important to identify ways to integrate these programs into a coherent system of service delivery. In addition, the Commission is also refining its funding strategies to place additional emphasis on programs tied into key “platforms” of service access such as hospitals, schools and community-based family resource centers. This approach leverages the effectiveness of any individual program by linking it into the continuum of basic services for families. Support for home visitation programs must therefore be considered within the realm of this larger effort.

This document lays out a service delivery plan intended to improve the coordination of home visitation programs across the county. It represents the third phase of SPHERE’s project to develop an integrated quality service system in Orange County, where the first stages included a review of the literature on home visitation including a discussion of “best practices” (hereafter “Best Practices”) and a summary or inventory of current home visitation programs in Orange County (“Inventory”).¹ The service delivery plan detailed below draws on evidence from these

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

two previous reports, as well as on information gathered in focus groups and interviews with service providers, stakeholders, and clients and from visits to example programs in other counties. The focus group and interview participants are described on Table 1.1.

This report has three components: First, we describe the scope of our home visitation service delivery plan, placing programs that provide home visits within the broader context of service provision in Orange County. Second, we provide a list of principles that we have identified as necessary guides for achieving the primary goal of an integrated quality service system. Last, we break the service plan into seven main areas and offer a series of recommendations and options in each one. Together, they comprise a complete service delivery plan.

Table 1.1 Focus Group and Interview Participants

Focus Group and Stakeholder Meeting Participants

- Home visitors and supervisors from home visitation programs;
 - Family Resource Center staff including those offering home visits as part of case management and promotora services;
 - Non-mandatory family maintenance social workers;
 - English-speaking clients of home visitation programs;
 - Spanish-speaking clients of home visitation programs;
 - Program Directors and other informants/stakeholders, such as Marc Thibault of CS&O and Terry Carrilio of the Social Policy Institute at SDSU.
-

Key Informants

- Jeneane Brian, VNA Home Health Systems
 - Jennifer Burrell, School Readiness Consultant
 - Jessica Gamel, The Orangewood Foundation and FaCT
 - Gene Howard, The Orangewood Foundation
 - Pat Mangan and other staff, Sacramento County Birth & Beyond.
 - Stanley Pappelbaum and Searle Turner, Pappelbaum Turner and Associates
 - Iliia Rolan, consultant for Pappelbaum and Turner
 - Dena Rubin, The Orangewood Foundation and FaCT
 - Amy Starr, Healthcare Association of Southern California
 - John Webb, Social Services Agency and FaCT
 - Susan Zepeda, The HealthCare Foundation for Orange County
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2 Scope of Home Visitation Service Delivery Plan

This project seeks to present a path for the integration of home visitation services in Orange County. At one level, this task is driven by the need to guide future resource investments in home visitation programs. Thus, if we consider “home visitation programs” in isolation from the broader context of service provision, it is not unreasonable to restrict our discussion to voluntary stand-alone home visitation programs – those that use home visits as the central mode of service delivery. This was our approach in the first two steps of this project, which allowed us both to examine best practices and to identify the scope of “pure” home visitation programs in the county. However, the task of integrating home visitation service into the wider network of services for children zero to five immediately crosses this boundary and necessitates considering home visitation as an integral part of a coherent service delivery system.

A plan to integrate home visitation must acknowledge three dimensions of social service provision. First, it must address the full scope of home visitation programs, including the pure programs discussed earlier in addition to other varieties. Second, it must build home visitation as a strategy of service delivery into the three key platforms of service access: health care providers, family resource centers, and schools. Lastly, a plan must link in services other than home visitation that rely on different strategies to achieve the Commission’s outcomes.

As mentioned above, we initially concentrated on home visitation programs that used visits to the home as the central mode of service delivery; however, we now broaden our focus. There are three main types of programs that could potentially fall within the boundaries of a service delivery plan: “pure” home visitation programs, programs that use home visits as a supplementary mode of service delivery, and non-voluntary home visitation programs operated by county agencies such as the Social Services Agency. As home visitation has gained

popularity, it has been incorporated into a vast array of social service programs, typically as an added case management service. It is neither possible nor productive to draw up a complete list of all programs that provide at least one home visit, but we acknowledge that many such programs exist in Orange County and that the service delivery plan needs to build in this recognition. With respect to non-voluntary programs, it is essential to include these types of programs in any discussion of service integration because they are involved by legal necessity in cases where a child may be in physical danger. For example, the Child Welfare Services serves as the lead service agency in documented cases of child abuse or neglect.

Despite the variety of programs providing home visits, the pure home visitation programs remain a useful starting point in assessing home visitation resources in Orange County. Table 2.1 lists the eight primary lead agencies that deliver home visitation services, along with the programs that they direct.² As the table shows, three of the agencies – the Child Abuse Prevention Center, the Children’s Bureau of Southern California, and the Health Care Agency – each provide several different home visitation programs. Additionally, the Orangewood Children’s Foundation’s program called ProjectConnections.FRC Health Access is listed as one program, but it operates at six different family resource centers (and will soon function out of an additional four). In practice, the 17 programs listed do not represent entirely different models of home visitation, but they vary according to the populations that they target, the geographical areas to which they deliver services, and some of the primary goals.

Nine of the home visitation programs listed in Table 2.1 operate out of a family resource center. Case management is a characteristic element of most family resource centers; these centers in particular, incorporate home visitation as one strategy of service delivery. We make explicit the centers in Orange County that provide home visitation in Figure 2.1. Most of these

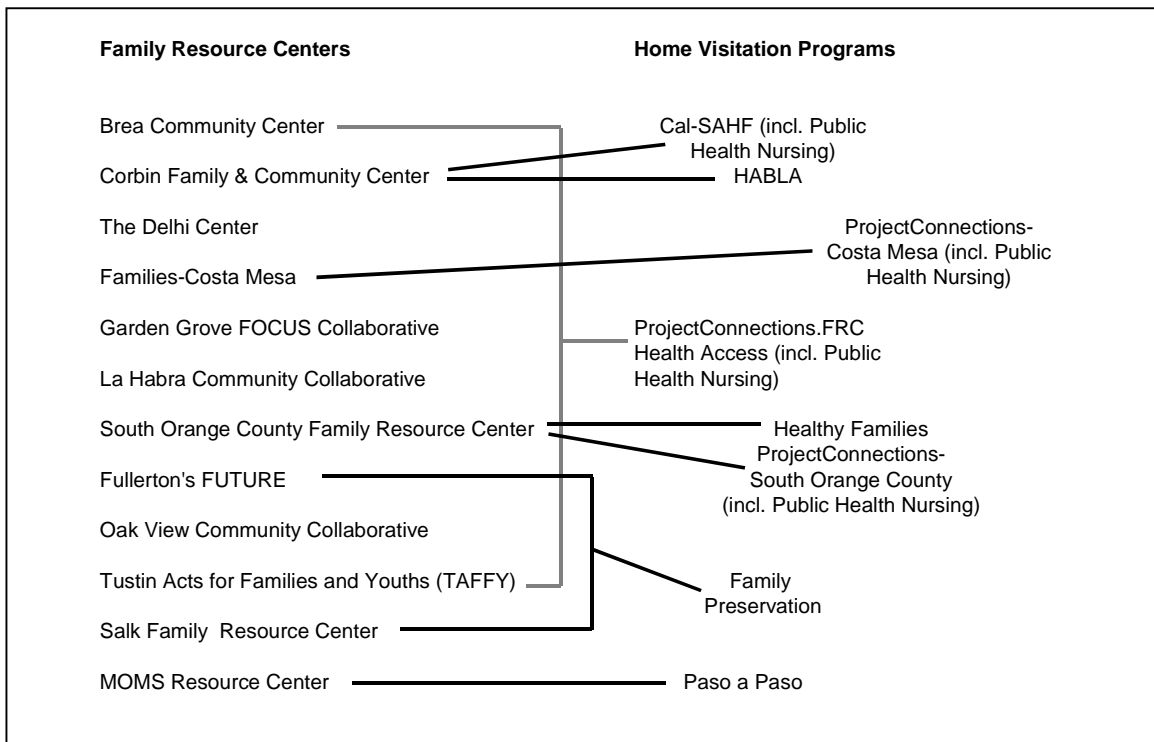
²Additional information on these programs can be found in the “Inventory.”

centers are connected with Orangewood’s ProjectConnections.FRC Health Access. A subset of these family resource centers also operates additional programs. For example, the Corbin Family & Community Center also operates Cal-SAHF and HABLA. We emphasize these current connections at this point because one core element of the service delivery plan that we detail below relies on family resource centers as an integrating force for both the flow of information and services in the county, as well as the entity linking health care providers to schools.

Table 2.1 “Pure” Home Visitation Programs in Orange County

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

Figure 2.1 Family Resource Centers in Orange County Providing Home Visitation



Lastly, we note that while the myriad home visitation programs and other social services not discussed explicitly may all work to achieve related goals, they do not necessarily represent duplicate services. Instead, they are complementary programs that undertake decisively different activities or similar activities in distinct geographical areas. Our main objective is to devise a service delivery plan for countywide integration of these numerous programs that exploits the complementary nature of these programs. Simultaneously, it will provide a mechanism to minimize duplication of services and target individuals into programs most suited to their needs.

3 Principles Guiding the Integration of Home Visitation Programs

Before turning to the specifics of our proposed plan, we stress that any service delivery plan must be able to answer the four following questions:

1. What defines the overall system?
2. What is the system expected to achieve?
3. How will one determine whether a component of the system succeeds or fails in its objectives?
4. What remedial mechanisms will be in place to overcome failures?

These four broad questions translate into eleven more explicit principles for the integration process, drawn in part from the best practices and inventory of programs developed previously. Some of the concepts listed below are obvious and straightforward. Others may be less apparent. They are not mutually exclusive and in many cases, there is significant overlap in the underlying purposes. Despite the transparency of some of these principles, we present the full list to establish the complete framework that we try to apply in our proposed service delivery plan. To the extent that these eleven standards are maintained, the four key questions will be answered.

Guiding Principles

- Principle 1** Establish criteria defining system and program success.
- Principle 2** Develop procedures for evaluating and improving the effectiveness of the system and individual programs.
- Principle 3** Provide system structure permitting/recognizing the independence of programs.
- Principle 4** Make maximal use of existing programs and resources.
- Principle 5** Use programs for the purposes for which they were designed.
- Principle 6** Allow for multiple trigger events and entry points into the system.
- Principle 7** Develop a flexible system that “triages” families and individuals to the services they need.

- Principle 8** Provide for the development of communication systems for coordinating services within and across programs and with other service providers.
- Principle 9** Allow for the primary management of cases to depend on clients' particular circumstances.
- Principle 10** Establish mechanisms for identifying unmet needs.
- Principle 11** Increase public awareness of available services and resources.

We expand on each of these principles in turn.

Principle 1 Establish criteria defining system and program success

Indicators to track progress toward the Children and Families Commission's goal of integration must be determined and explicitly defined. Moreover, they must focus on what home visitation as a strategy of service delivery is meant to achieve. Once established, a mapping between individual service programs and these indicators should be designed. This will help assign accountability to individual programs, help programs define their own responsibilities, and identify gaps in service provision. Ultimately, the Commission and County (as well as other funders) must specify measurable criteria to determine whether or not the goal of system-wide integration is being achieved.

A similar set of requirements exists at the program level. Program expectations and criteria for success must be identified for each individual program. There likely will be overlap across programs, but it is important to initially address each program separately. However, similarities across programs should be exploited with respect to indicators and outcomes chosen for evaluation. To the extent possible, the county should establish a common set of measurable outcomes for program evaluations. Furthermore, it

should strongly encourage funding sources to use similar measures in order to reduce the reporting requirements of programs.³

Principle 2 Develop procedures for evaluating and improving the effectiveness of the system and individual programs

Once the criteria for system-wide and program success are established, it is important to maintain ongoing evaluation. First, the Commission and County should develop procedures to determine whether existing programs are fulfilling their intended role in the overall system of service delivery. Second, it should include processes to use the established indicators to ascertain if individual programs are meeting their specified goals. Given the results of these assessments, modifications should be made as necessary.

In developing a structure for evaluations of program performance, the Commission and County should make efforts to improve data collection and storage and the capacity for data sharing among programs. Such improvements will facilitate evaluations, as well as help establish systems for reporting required information to funding sources. The ease of reporting requirements is directly related to the extent that recorded outcomes are well defined and uniform and that data collection and organization are technologically developed.

³ The Health Funders Partnership of Orange County, an effort to do shared funding of strategic initiatives, are currently moving toward shared or common application forms. In the future, they also hope to develop shared outcomes measures.

Principle 3 Provide system structure permitting/recognizing the independence of programs

An integrated system should allow each service program to maintain its own practices and procedures, yet at the same time create the structure that links these independent entities together. The diverse nature of programs in the county, striving toward similar goals yet often in distinct ways, suggests that maintaining the independence of programs is optimal. Autonomy and ownership – as well as accountability – of individual programs should improve service provision. At the same time, well-defined linkages between programs will allow the county to make full use of existing resources through integration. A common notion of integration includes a central gatekeeper who oversees the operation of all system members; however, an integrated system need not rely on such an agent. Alternatively, it can be organized in a way that allows independent programs to be entirely responsible for their own service delivery, yet neither isolated nor operating in a bubble. The strength of such a system depends on the extent of seamless coordination and hand-offs among programs.

Principle 4 Make maximal use of existing programs and resources

The initial focus of an integrated system should be placed on maximizing existing resources, rather than creating new services. This applies to both service programs and data collection systems. Since social services (especially home visitation) are expensive, it is important to ensure that existing resources are being used to their full potential. In general, new programs or services should be established only if gaps in service provision or coverage are identified. Moreover, if a program currently employs a data collection tool, the system should capitalize on this information source rather than impose

modifications be made. For example, the experiences of programs with existing data collection methods may benefit the Commission and County in their efforts to create data tools and capabilities for other programs. Additionally, existing data may provide insight into evaluations of system-wide objectives.

Principle 5 Use programs for the purposes for which they were designed

An integrated system of service provision must acknowledge and exploit the different objectives and activities of individual programs. It should recognize the specific purposes for which programs were designed, and use programs for these reasons, rather than to fill an existing but loosely related need. For example, a nursing program should not be relied upon to specifically improve school readiness, but rather should be used in cases in which health is a primary issue. Similarly, a literacy-based program, such as HABLA, is likely not the optimal mechanism to handle a substance abuse problem. Since programs that fall under the rubric of early intervention or social services geared at children less than five years vary immensely, it is essential that program objectives and capabilities are explicit and well-matched with both workers and clients.

In particular, staff credentials at a program should directly coincide with the intended outcomes of that program. “Best Practices” reveals that visitors of all different credentials – nurses, social workers, and paraprofessionals – can effect positive change, and that one particular visitor educational background does not dominate for all cases. However, it also shows that visitors who are trained specifically for the intended goal – such as public health nurses for health-related outcomes – are more successful in achieving their objectives.

In addition to fostering well-suited matches between visitors and program objectives, an integrated system must also match programs to client needs. Once a prioritized list of needs for an individual is assessed, the system must maintain protocols to determine which program or programs will best attend to these needs. Channeling clients into programs by default or simply because there is available space in a program should be avoided.

Principle 6 Allow for multiple entry points and trigger events

A system-wide plan for service provision must recognize the existence of multiple entry points into the system. Since clients in need of social support face a variety of stressors, including low incomes, teen pregnancy, substance abuse, domestic violence, child abuse, and insufficient housing, they can be propelled into the system in many different ways. Mobility is also high and individuals may be connected with the universe of home visitation at different points in their young children's lives. Moreover, a single client is often burdened by more than one of these problems, and thus it is likely that he or she may enter the system at several different places. For example, a new mother may be referred into the system at the hospital at the time of birth, by the Child Welfare Services for a previous case of child abuse, and due to either her or her partner's history of substance abuse. As a whole, the system must be able to handle such cases, meeting the full range of needs of a client, directing clients to appropriate services from any entry point, and facilitating communication between multiple service providers.

A system allowing for such coordination must include a procedure dictating the role of the point of entry for an individual or family – or the trigger event – in determining service provision. If an individual enters a system at one point or due to one

catalytic event, it may be easier (although not trivial) to determine the appropriate allocation of services and the primary overseer of this client. However, when an individual is directed into a system at several different points, it is important to establish where the client will be best served (possibly in several different programs), when and where the hand-off points among programs will be, and what force will unify the system. Likewise, if no clear trigger event propels a client into a system, the same questions must be answered.

Principle 7 Develop a flexible system that “triages” families and individuals to the services they need

An integrated system must include a mechanism ensuring that families and individuals are channeled into programs that are well-suited to their needs. In order to make sure that potential participants are “triaged” across services in the optimal manner, a system must specify principles for routing and allocating clients to particular services. It must have the ability to determine a client’s primary needs and direct them to the program (or programs) most capable of addressing these needs. Procedures for triage must apply at the time of entry into a system, as noted in Principle 6, but also throughout the course of service delivery as client needs evolve over time. In addition to guidelines for triage, a well-defined system must also include a mechanism that facilitates smooth hand-offs from one service provider to another.

Principle 8 Provide for the development of communication systems for coordinating services within and across programs and with other service providers

An integrated system must encourage the development of communication systems within and across programs and other service providers, and the strength of a system depends on its capacity for such communication. Different programs serving the same client will benefit greatly from the experiences of the other programs with this individual. Similarly, a single agency administering several different services will be stronger if all staff members are aware of the full range of services both available to and being used by an individual client. Moreover, sharing information about clients and activities will reduce potential duplication of services.

Another crucial aspect of system-wide coordination is the link between service programs and other major systems. The numerous home visitation programs do not operate in isolation. Rather they exist among many other private and county programs, including Bridges for Newborns and other health care systems, hospitals, family resource centers, schools, child protective services agencies, and other government organizations. An integrated system must recognize the integral role of home visitation programs in this broad array of services and work to establish open channels of communication among all relevant parties.

One crucial dimension of a successful communication system is a mechanism for the transfer of information. Broadly, this may be achieved through the sharing of data across programs, agencies, and other service providers, an area that is addressed in detail below.

Principle 9 Allow for the primary management of cases to depend on clients' particular circumstances

An integrated system must be flexible and individualized to a child or family's particular circumstances. Certainly, notions of a one-size-fits-all program of support should be avoided. Since participating families often face complex and multiple stressors, the system should maintain a comprehensive focus addressing the full range of family needs, rather than focus on a single domain of functioning. This principle is directly supported by "Best Practices," in which we noted that each client's service delivery plan should be flexible and tailored to individual goals and needs. Upholding this principle requires the system to have the capacity to identify which needs dominate and to determine how they should be prioritized in a service plan. Individual service plans need not involve only one program, rather they can (and should) be plans that integrate resources from a variety of support services for an individual client.

In identifying and prioritizing needs, some stressors or entry points into the system will be more evident than others. Despite the blatancy of some problems, a full assessment for a broader range of potential issues should be performed. For example, a new birth may be one of the more obvious stressors as it is typically visible to an outsider, but service providers should not let dominance of this one need mask other potential pressures facing a family.

Principle 10 Establish mechanisms for identifying unmet needs

An integrated system must furnish mechanisms to identify unmet needs. Mapping programs into system-defined indicators is one way to assess these potential gaps, yet those associations may not fully capture existing gaps. Because service delivery in

Orange County is largely arranged according to geographical areas of service provision, it is necessary to determine if there are any geographical service gaps. That is, to identify if there is an area in which individual needs exceed service provision. This could occur either if an area is not served at all, or if it is only served by a few (possibly geographically ill-matched) programs. Likewise, a system should have the capacity to determine whether there are programs or services that should optimally exist, but currently do not. For example, since programs are largely defined by the type of visitors they employ and the objectives they set, planners should assess whether the credentials of visitors serving a particular population are well matched to this population's needs. Moreover, areas or populations lacking a certain type of visitor and requiring such services should be highlighted.

Principle 11 Increase public awareness of available services and resources

Since public participation and awareness are key elements of a fully integrated system, efforts to market available services should be increased. Individuals in need will only be able to make use of existing resources if they know they exist. Currently, as indicated by participants in a client focus group, public awareness is limited. In particular, many clients had never heard of a family resource center, let alone knew of the various services offered at one.

4 Service Delivery Plan: Recommendations and Options

In this section we propose an explicit structure for a plan to create an integrated system of home visitation in Orange County. In formulating this plan, we paid particular attention to the infrastructure already in place in Orange County and attempted to anticipate future directions contemplated by local service providers and agencies. Our proposed plan is, of course, guided by the principles outlined in Sections 3. Where possible, we draw from evidence available in the literature on home visitation; unfortunately, the field offers little direction regarding integration across programs since existing evidence focuses on individual programs or specialized services.

This service plan takes family resource centers (FRCs) as the basic underpinning of coordinated service delivery for home visitation. There are at least six basic reasons for the choice of FRCs as a fundamental starting point:

- FRCs are already identified by the Commission as one of the primary platforms for service delivery;
- Through FaCT, FRCs have an established avenue for collaboration;
- Twelve FRCs have existing relationships with at least one home visitation program (see Figure 2.1);
- Connecting home visitation programs to FRCs builds in connections to a broad set of resources;
- Most FRCs already use multi-disciplinary case management to integrate services within the center; and
- Building on FRCs automatically addresses the issue of geographic coverage of home visitation programs.

A second fundamental element of our plan is a concept of home visitation provided at three levels of intensity: low intensity, high intensity, and specialized home

visitation programs. We discuss the concept of varying intensity levels in greater detail below (see also Table 4.2 on page 33). However, it is valuable to raise the issue up front because it underlies a number of other elements of the proposed plan. The variable intensity of service is intended as a balance between the needs of families and the high cost of home visitation as a service delivery approach. It also addresses the need for low intensity services available through a broad range of providers, while permitting higher intensity and/or specialized programs to remain more concentrated with a handful of expert providers. Thus some services may be directly operated out of a family resource center while others could be located elsewhere and associated through a tight bond.

We divide our service delivery plan into seven dimensions within three broad aims. This breakdown is designed to make the plan easier to conceptualize, but no dimension of the plan can be considered completely out of the context of the plan as a whole. Moreover, each of the following issues is a necessary component of a successful service delivery plan:

- | | | |
|---|---|---|
| 1. Linkage across platforms | } | Designing an integrated structure for home visitation |
| 2. Entry into system | | |
| 3. Triage of services | | |
| 4. Evaluation of program success | } | Promoting effective service |
| 5. Information collection and storage | | |
| 6. Identification and adoption of best practices | | |
| 7. Coverage gaps | } | Ensuring coverage |

Along each of these seven dimensions, this plan includes either a specific recommendation or a set of suggested options. In areas in which we feel a particular

procedure is fundamental or clearly superior, we provide this specific recommendation. In areas where we believe one plan element can be addressed with a variety of actions, we offer options, describing the benefits and disadvantages of the alternatives. The particular choice depends on the priorities of the Commission and affected parties. Across all the areas, we concentrate on suggesting concrete actions that the Commission and County can initially take to integrate the services in the county. In one sense, these are first steps toward a “grand plan of total integration.” In many instances, we also indicate supplemental options representing promising alternatives to consider in the future as the integration process evolves.

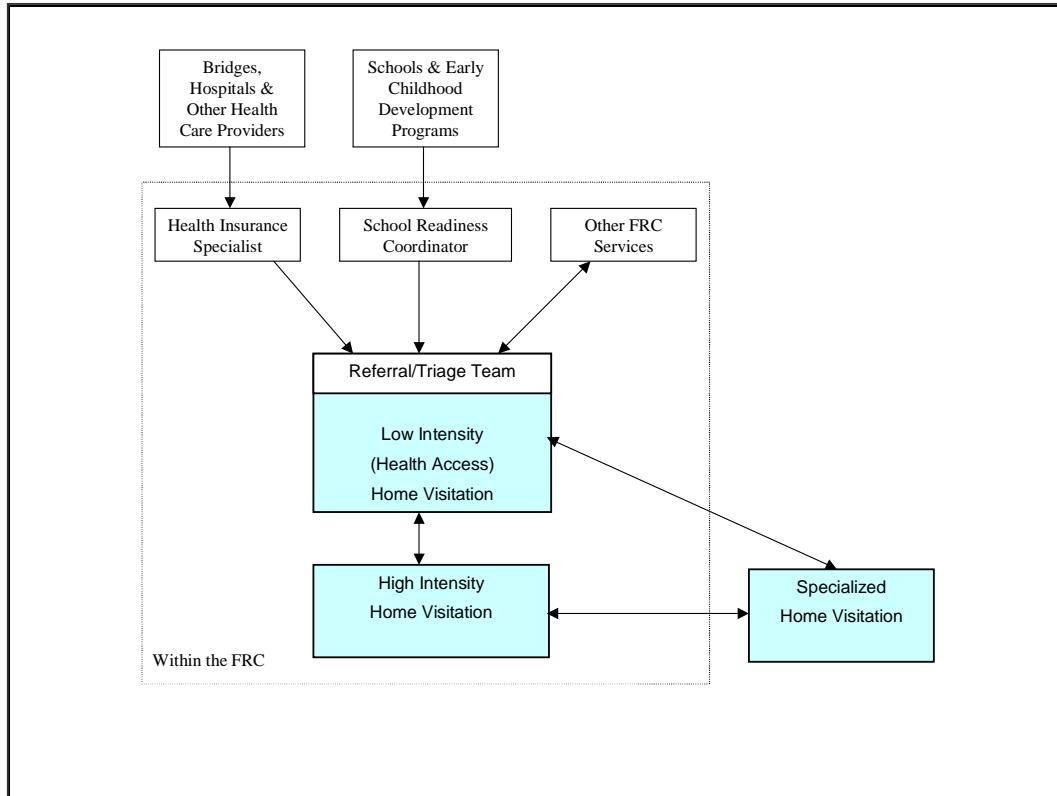
A. Designing An Integrated Structure For Home Visitation

By definition, an integrated service system involves different agencies working together toward common goals – in this case, in support of the healthy development of young children and their families. Naively, one might think to simply centralize the entire network of providers into one massive program under the leadership of one group. This is unrealistic in light of the existing infrastructure of independent and unique service providers who each bring strengths and experience to the system.

Therefore, as we noted above, our plan builds on an assumption that home visitation will be housed within family resource centers, starting with the existing relationships between home visitation programs and centers as mapped out in Figure 2.1. In this section, we suggest an overall structure for home visitation within each FRC. This structure would be common across FRCs, which would essentially divide the client base by geographic boundaries (see the discussion on coverage gaps below for the issue of clients outside the areas served by FRCs). Approaches to promote effective service

would be designed by home visitation staff across all the FRCs, providing consistency between the different local areas.

Figure 4.1 Proposed Structure For Home Visitation Services Linked With FRCs



An overview of our proposed structure is provided in Figure 4.1. The three shaded boxes represent home visitation programs, with low intensity and high intensity services linked and typically co-located with the FRCs, and with specialized services outside the FRCs, acting as county-wide resources. However, for home visitation to be effectively integrated, the plan must first identify the linkages to the other major service platforms, as well as develop a strategy for handling referrals and for triaging clients into appropriate levels of service. The first three dimensions of the plan address these issues.

Dimension 1 Linkages across platforms

Although not strictly part of the home visitation program integration, a necessary foundation for these programs is to first develop or strengthen the linkages among the three primary platforms of service delivery: health care providers, family resource centers, and schools. To ensure these linkages, we offer two concrete recommendations:

→ **Assign a Medi-Cal/Healthy-Families representative to each FRC**

→ **Allot a school-readiness position to every FRC**

These links are shown at the top of Figure 5.1. As described in more detail below, these personnel would perform two major functions: 1) delivering a specific service - health insurance coverage and educational or developmental activities, and 2) referral of families with children under five years of age who might benefit from home visitation services. The Medi-Cal/Healthy-Families representative serves as a primary provider of health insurance, and would, therefore, strengthen the link between FRCs and hospitals through the Bridges Program. Allotting a school-readiness person to each FRCs would establish communication between FRCs and schools and early education programs.

These “linkage personnel” offers a natural interface with the other platforms by enhancing the coordination among the three fundamental entities of service provision.

Conceptually, each FRC can be associated with more than one hospital through a county health insurance provider, and with more than one school through the school-readiness worker.

Recommendation 1: Link Health Care Providers to Family Resource Centers Through a Health Insurance Specialist

To foster the link between health care providers and family resource centers, we suggest that a Medi-Cal and/or Healthy Families worker is assigned to each family resource center. The chief role of this individual would be to coordinate with the FRC to enroll clients in health insurance programs, one of the objectives supported by the Commission. There are several reasons for using such an individual to create this link. First, he or she represents a safety net for uninsured infants and their families, individuals who may be propelled into the social services by this situation. For example, it is not uncommon that new mothers are unaware that their Medi-Cal coverage and provisions for their infant end after a three-month post-birth period. Many of these mothers fail to secure health insurance for their infants at the time of birth (through Bridges for Newborns, for example) and then find themselves in a medical emergency with no coverage several months later. Second, using contact about health insurance enrollment, this Medi-Cal representative may be able to identify families - specifically those with children younger than five - in need of additional services. Lastly, since health insurance coverage is a rather benign service, detached from the stigmas of many other social services, it may attract a much wider range of individuals to the centers. Moreover, placing health insurance enrollment at a family resource center may engage families in other services about which they might have not otherwise known.

Related Recommendations: We also have two additional suggestions - which may have more relevance after initial integration efforts are established - to strengthen the link between health care providers and family resource centers. First, since Bridges for Newborns is currently being redesigned, one possibility is to directly involve representatives from all (or several) family resource centers in the development stages. Second, it appears that the health care providers platform is often used to refer primarily to hospitals. However, the Commission and

County should consider adjusting the working definition to include other health care providers – such as pediatricians, clinics, and mobile health vans – who see individuals on a more regular basis. With the exception of births and emergencies, hospitals are generally appropriate only for very sick children. Strengthening the link with other primary health care providers would likely improve both targeting and triage methods.

Recommendation 2: Link Family Resource Centers to Early Education Providers Through a School Readiness Coordinator

To create the link between FRCs and early education providers, we recommend an approach similar to that for the health care providers-FRC link; that is, that a representative from a family resource center is assigned to each school. The major difference here is that it is a FRC employee who creates the link rather than a school employee. The role of this individual would be to increase the communication between the two platforms, and more specifically, to incorporate school-based services for children less than five into the FRCs service capabilities. Since a majority of home visitation programs service children younger than three, strengthening this link is a key element of improving services for children up to five years of age, the target population of Proposition 10. Using a family resource center worker, specifically, to create this link has several advantages. First, the FRC representative would enable a two-way communication channel between the schools and center. From the schools, she or he could gather information on families potentially in need of home visitation. Since teachers typically have a very good understanding of a student's needs and family circumstances, they may be able to identify troubled families, particularly those with younger siblings who might be eligible for home visitation services. In the other direction of information flow, she could share information on clients served in home visitation programs at the center that might be pertinent to early educational care providers. Second, linking a FRC worker to each school would provide this

worker with an indirect source of training on educational-based care. The intention would be for him or her to then implement these types of activities in the FRC as an accompaniment to any established school-based programs. Lastly, educational services – like health insurance – are a fairly innocuous service that might attract a new set of families to the family resource center who might benefit from additional services.

This recommendation builds on Orange County’s School Readiness Program’s pilot project to link schools with the 3% lowest Academic Performance Index (API) scores to a family resource center. Under this project, each participating FRC is intended to have center-based services for children less than five years that include educational activities such as active learning and developmental programs. Ultimately, all schools in the same service areas should be linked with their local family resource centers with similar intentions of service provision.

Dimension 2 Approaches to Manage Entry into Home Visitation

“Entry” as a general term is meant to represent the ways in which clients first contact the universe of social services. Entry begins the first stage of a client’s participation, and the way in which it is facilitated will have repercussions throughout his or her entire involvement with social services. For many social service programs, including home visitation, entry occurs through multiple referral sources and at multiple points. (See for example, those listed in Table 4.1.) It also occurs at different junctures for client families. Many families enter at the time of a crisis, often termed trigger events. While not a crisis, a birth may serve as a trigger event prompting a family to seek services. For other families, entry is a matter of outreach, screening or referrals.

Table 4.1 Potential Entry Points into the Universe of Home Visitation

Child Abuse Hotline
Child care providers
Clinics
Emergency rooms
Family resource centers
Hospitals
Housing complex
Mobile health vans
OB/GYN's
Planned Parenthood
Police
Schools
Self-referral
Social Services Agency
State preschool
WIC

A provision for managing entry is a critical aspect of any service delivery plan, and approaches to overseeing this activity are essential to integration efforts. Moreover, the way in which entry is managed will have impacts not only on the quality of service for individual participants, but also on the ways in which future triage among services is handled, the aggregate costs of service delivery, and the ability of an integrated system to function. Stated another way, because it is the first step of service delivery, the extent to which further steps are successful is directly dependent.

We suggest that Commission and County entry to home visitation be handled in conjunction with entry/enrollment into other FRC services that may involve case management, following a two phase process in dealing with entry to home visitation. As the first step, we propose that service integration efforts concentrate only on specific groups and points of entry. In particular, we view hospitals, schools, and services directly related to an FRC to be the first priority for formalizing an overall system for managing entry into case managed services generally and home visitation specifically. Thus the initial focus is on families who come to the

attention of the FRC because they have been referred with specific needs. Entry will, of course, eventually come through many sources and it is important to develop the capacity to handle this. Once the capability has been established with a core set of providers, additional entry points can be formally incorporated.

In the first phase, we suggest the Commission and County:

- **Identify/create a team within each FRC accountable for initial client contact**
- **Make this team also the contact point for programs outside the FRC**
- **Establish well-defined, systematic protocols to match clients with services**
- **Make cost consideration a vital element of client-service matching**

The following discussion offers several options for carrying out these recommendations. The particular options adopted depend on the priorities of the Commission and County; and, of course, attention must be paid to costs.

Recommendation 1: Establish “Referral Team” at Each Family Resource Center

A large pool of families may potentially benefit from home visitation of any intensity level. However, home visitation is only one of a number of services available through an FRC, and it is one of the more costly. For these reasons, it is important to be able to identify those families with needs best addressed using home visitation rather than other service approaches and moreover to identify the appropriate level of service intensity for each family. To do so consistently is not an easy task and success depends on the extent to which the job is solidly structured. Thus, we propose that each family resource center establish a group of people (or one person) – a “referral team” – to assume this responsibility for the FRC.

The referral team’s role would be to determine the first step in the service plan for each client newly referred to the FRC for home visitation or similar case managed services. (Families

using drop-in services such as parenting education or after-school activities would not fall into this responsibility area.) The referral team would also be responsible for documenting basic enrollment information (such as demographics and contact information) for every client that entered the FRC system, including to which service he or she was initially enrolled. This notion is similar to that of a “central gatekeeper” at each FRC, however, we refrain from using this phrase partly because of its current use in many other dimensions of service delivery and partly because this team’s emphasis is on matching clients to services rather than on controlling access.

Holding one team accountable for matching new FRC clients to the most appropriate services has many advantages. First, it leaves no ambiguity about who is held responsible for new clients and the allocation of home visitation resources. Second, it streamlines entry into the family resource center by concentrating it in one spot that systematically guides clients to services. Third, it creates an entity that anyone - another FRC worker, a representative from another platform, or any person that might engage with a potential client in crisis – can contact about an individual in need of services. Lastly, concentrating the first step of service delivery into one accountable spot facilitates data collection, ensuring that documentation of who came into the center and to what services they went is collected.

To operationalize this concept, it is important to start with small tangible steps. Initially, this so-called “referral team” would receive referrals from two primary sources: 1) linkage personnel from health care and educational providers – as discussed in the previous section – and 2) other service providers directly linked with the FRC, such as WIC, counseling services, or associated community police officers. Through their contact with potential clients for other purposes – for example, health insurance enrollment, school-based activities, or therapy – the linkage personnel or other service providers may be able to identify families in need of further

services. Furthermore, these individuals are likely to have contact with families containing children less than five years old and thus they will be particularly equipped to identify the target population of Proposition 10.

Recommendation 2: Consider Costs in Matching Clients to Services

One of the main jobs of the referral team will be to assure that families are well-matched to the initial service in which they are enrolled. This is important to assure the quality of service received by a client, but also to control the cost of service provision. Part of this capability derives from using home visitation programs – especially more intensive ones – sparingly and only for families who are most likely to benefit. Such a procedure, often referred to as targeting, is also supported by the literature on home visitation. “Best Practices” explains that these services should be directed at populations who have experienced measurable positive outcomes through home visits: specifically, teen parents, first time parents, and women with low psychological resources. (These populations are specifically noted in the literature, but this list should not be considered comprehensive.)

To meet this goal of targeting costly services to those who can benefit most, there is potentially a need for additional low intensity home visitation options. We discuss low intensity home visitation in more depth in our discussion of triage below, but these services could be an important step in the process of matching clients to services. For this reason, the low-intensity home visitation is shown as an extension of the referral team role in Figure 4.1. Low intensity home visits could be largely used as the first point of contact with client, a method to assess the immediate needs, take care of any pressing crises, and to establish a more comprehensive service plan. To do so, it is important that they are viewed by clients as non-threatening, enabling

FRC/home visitation staff to learn more about the family in the home setting. They would be less intensive and thus less expensive than more traditional long-term home visitation programs.

ProjectConnections.FRC Health Access is one example of a low intensity home visitation program. We suggest that the Commission and County consider the creation of additional types or variants on low intensity home visitation. One possible low intensity program (only loosely falling in the category of “home visitation”) is to rely on phone calls as the first mode of service delivery. Corbin Family and Community Center currently uses this strategy to handle clients who are on the wait list for its intensive home visitation program, Cal-SAHF. Phone calls are much less time and resource intensive than home visits, yet they are a way to assess a family’s needs and extend support and guidance. A second alternative is a variant on the promotora approach: the creation of home visitation programs that employ non-traditional visitors - such as elderly volunteers – to make the initial visits. (An example of such a program is the “Grandparent Visitation” program operating at the Del Paso Heights FRC in Sacramento County.) Workers of this nature may in fact be viewed by clients as less intrusive and more analogous to a friend than a service provider. Since many of the clients may be skeptical of any person outside the family – and particularly of one involved with the social services – these alternative types of visitors may be more successful in engaging clients and delivering services. Moreover, their success may be increased if they approach families with “benign” services such as WIC or health insurance enrollment.

Recommendation 3: Develop Systematic Protocols for Matching Clients to Services

The proposal to create a single team at each FRC for all initial client distribution places an extremely large responsibility on a small group of people. However, we do not suggest that this group make decisions in an ad hoc way; rather, we propose that a concrete list of systematic

protocols – a taxonomy determining in what cases home visitation and home visitation of what intensity is appropriate – is established to guide the team. There have been efforts in this area that can serve as resources. First, the literature, as summarized by “Best Practices,” illustrates particular demographic groups that are likely to benefit from home visitation. Examples of screening tools or guidelines for referral are also currently used in Orange County. The Public Health Field Nursing and Bridges for Newborns use referral guidelines to target potential clients and ProjectConnections.FRC identifies at-risk clients according to its definition of “overburdened.” Then, upon receiving a referral or an initial client contact, the group would screen the individual or family according to these well-defined rules to determine the proper course of service delivery, whether it is some sort of home visitation program or another service or collection of services. Again, we stress that care should be made to place a client in the most economically efficient service according to his or her needs, and the established procedures for client allocation should reflect this.

Future Steps: Integrating Additional Entry Points

After the proposed organization has been created and established systematic procedures to direct newly referred clients from the other platforms or linked FRC services, we suggest that efforts are made to integrate additional entry points. Examples of such places are listed in Table 4.1 and essentially include any place to which an individual in crisis might turn. As supplement referral spots are incorporated, the same mechanisms should be involved. That is, these places should be instructed to contact the referral team at the relevant FRC for their client. From there, responsibility would rest solely with this group to filter the client to the appropriate service provider. These entry points, which are outside the network of family resource centers, would be linked specifically through the referral teams. Entities making the referrals would face no

ambiguity regarding specific services to which they should direct this client; instead, they would only have to contact the referral team. Note that one entry point is self-referral, and to the extent that this occurs, the referral team would be the first point of contact for an individual seeking help independently.

Dimension 3 Approaches for Triage of Services

Our proposed strategy for managing entry into home visitation and other FRC services leads naturally into the issue of “triage.” Triage is the process by which children and families who have entered the social service system are directed to programs according to their needs. Triage not only matches clients to services based on their experiences, it also prioritizes which services require immediate attention. Successful mechanisms of triage are fundamental to a coherent integrated system of service delivery. They increase the quality of service provision and facilitate smooth transfers of clients between programs as their needs evolve. Moreover, they assure that limited resources – which will always be a concern – are used most effectively and efficiently.

To develop a coherent approach for triage in home visitation services in Orange County, we propose the Commission and County:

- **Provide for low- and high-intensity home visitation services in each FRC**
- **Make the low-intensity program a part of the FRC referral team**
- **Constitute a multi-disciplinary team to staff the high-intensity program**
- **Use the FRC referral team to oversee referrals and client transfers to and from specialized home visitation programs outside FRCs**
- **Establish protocols for referrals and for confirmations of referral accommodation**

The general idea underlying these recommendations is to use FRCs to coordinate home visitation services, with the lowest level implemented unless the referral team identifies a clear condition requiring expanded services. This condition might motivate referrals to the high-intensity team co-located in the FRC or to an outside home visitation program especially designed to treat the identified problem. While each FRC should have both varieties of home visitation programs as part of its structure, this does not mean that FRCs cannot share programs. Particularly in the case of the high-intensity home visitation programs, more than one FRC could rely on the services of this program with only some members of the team partially co-located at the different FRCs.

Recommendation 1: Establish Two Intensity Levels of Home Visitation at Each Family Resource Center

Clearly any method of triage relies on the availability of services and more specifically, on the availability of a wide variety of services. Orange County does not suffer from a lack of variety in home visitation programs, yet its distribution of services across the county is not uniform. That is, some areas are concentrated with specific services, while others have none. Since an integrated system requires that triage strategies are applied uniformly across the county, we recommend that each family resource center establishes the capacity to deliver home visitation services of three different levels of intensity: 1) low intensity, 2) high intensity, and 3) specialized. We envision the “capacity to deliver” to mean that a FRC does not necessarily have to directly operate the three unique levels of services, but rather that they must have very close association with the programs they may not oversee. For example, it is likely that the majority of family resource centers would co-locate with the first two levels of home visitation, but that almost all would contract with specialized services that are countywide and based out of another location.

Classifying programs into three broad categories reinforces the autonomy of individual home visitation programs allowing them to operate according to their own procedures, yet it also helps to organize all programs into a unified network. This classification also sets the stage for future development of home visitation programs without creating too much structure for actual service provision. While we suggest the necessity of a well-defined framework for directing clients to and from service programs, we recommend that once clients are enrolled within an individual program, such providers are given the freedom to serve the client as they determine. Having these three options available at each family resource center not only serves to expand the services available to individuals across the county, but it also creates a situation in which low intensity services can be used to their maximum capacity. It also establishes a logical framework of service progression according to intensity needs.

Table 4.2 defines our three categories of home visitation programs. *Low Intensity Home Visitation* uses short-term personalized outreach to clients to help at-risk children and families. As described above, these programs may also serve as an initial assessment for families where there is no prior indicator of specialized or critical concerns (suspected substance or child abuse, for example). Programs fitting into this category might rely on paraprofessional and volunteer visitors or even use phone calls as either an assessment strategy or as a way to check in with clients, rather than home visits. ProjectConnections. FRC Health Access, which uses promotoras and public health nurses as home visitors and relies on a Healthcare Coordinator to direct client traffic in the program, falls into this category. Because the main objectives of visitors in this program are related to health access, such as obtaining health insurance coverage, child immunizations, and assuring a medical home, this program may also represent a non-threatening first step for the referral team described above. On the other hand, ProjectConnections.FRC

Health Access might be considered as an upper bound on the intensity of services in this category; less intensive programs using alternative service strategies may be both more effective and economically advantageous in a considerable number of cases.

Table 4.2 Levels of Home Visitation Services

LEVELS OF HOME VISITATION SERVICES
<p>Low Intensity Home Visitation: Low intensity services that use personal outreach to help at-risk children and families who do not have specialized or critical concerns. These programs may rely on paraprofessional and volunteer visitors. In fact, such a program may not use home visits as a primary service strategy; programs that rely on workers to make phone calls either as an assessment strategy or as a way to check in with clients could also fit in this category.</p> <p><i>Example Program(s):</i> ProjectConnections.FRC Health Access</p>
<p>High Intensity Home Visitation: Programs that use home visits on a regular and long-term basis, likely with professionally trained visitors. The main objectives of these programs may be more comprehensive than pure health access related outcomes. They are also likely servicing families facing a larger sphere of stressors.</p> <p><i>Example Program(s):</i> ProjectConnections.FRC Home Visitation, Cal-SAHF, and the Health Care Agency’s Healthy Futures program</p>
<p>Specialized Home Visitation: These programs serve individuals with specialized stressors including substance abuse histories, documented child abuse cases, youths on probation, HIV positive mothers, low educated and illiterate families, and medically vulnerable infants. Some of these programs are voluntary, while others – such as those for cases of child abuse – are mandatory and used more as child protection rather than child abuse prevention.</p> <p><i>Example Program(s):</i> YFRC Intensive In-Home Services, PSASI/ACT, HABLA, and the Medically Vulnerable Infant Program.</p>

High Intensity Home Visitation programs typically use professionally trained visitors and make home visits on a regular and long-term basis, often following an established curriculum. Because they are likely serving families with a number of different stressor, these families often require more assistance. Thus, the objectives of these programs are often much broader than just health access related outcomes. In Orange County, programs such as ProjectConnections.FRC

Home Visitation and Cal-SAHF that use a multi-disciplinary team and provide home visits for up to three years and the Health Care Agency's Healthy Futures are examples. As client problems are identified through either initial referrals or assessments provided by low-intensity programs, it is valuable to have this additional layer of supportive services available as a strategy to serve FRC clients.

Lastly, each family resource center should be linked through its referral team with several more *specialized home visitation* programs – those that serve needs out of the scope of the more general intensive programs. These programs serve individuals with specialized stressors including substance abuse histories, documented child abuse cases, youths on probation, HIV positive mothers, low educated and illiterate families, and medically vulnerable infants. Some of these programs are voluntary, while others – such as those for cases of child abuse – are mandatory and used more as child protection rather than child abuse prevention. Specific Orange County examples of this type of program are the YFRC Intensive In-Home Services for youths on probation, PSASI/ACT for women with a history of substance abuse, HABLA for families with low education levels, and the Medically Vulnerable Infant Program for children who were discharged from the neonatal intensive care unit.

Recommendation 2: Use The Referral Team to Manage Referrals and Triage Across Services

In addition to the availability of a wide variety of services and service intensities, it is important to establish a way in which clients are transferred across these services. We have proposed the creation of a referral team at each family resource center that would welcome new clients and direct them to the appropriate first service step. We propose that this team also be responsible for handling referrals between programs that occur during the course of service delivery to an individual client. That is, if one program wants to refer a client to another

program - regardless of whether the referring agent knows to which specific program he or she want to refer the individual – he or she would contact the referral team at the associated FRC. The responsibility to move the client from one service to another would fall entirely on this team. Similar to the proposed approach to manage entry, this arrangement would organize referrals into one place and assign accountability for follow-up and documentation. This team would be responsible for knowing by which services - within the network of the platforms and FRC services – each family was being served.⁴ It would also prevent multiple channels of referrals across programs – in which everybody refers to everybody else – that may currently go ignored or become lost in the vast system.

Recommendation 3: Use multi-disciplinary teams to staff the high intensity program.

One key advantage of high intensity programs is the ability to address multiple stressors within families. As visitors have discovered, one of the unique features of home visitation programs is that visits designed to address one problem often reveal an assortment of related issues. In response, the Answers Benefiting Children (ABC) Initiative has incorporated multi-disciplinary teams in their model of home visitation to reduce child abuse. We recommend that wherever possible such multi-disciplinary teams be used in association with high intensity home visitation services. However, rather than hiring specifically for the multi-disciplinary teams, we suggest that FRCs explore possibilities for rounding out the skills of existing home visitors – for example, when the home visitation program relies on nurses – with the expertise of other FRC staff involved in case management, such as behavioral counselors. Thus, the home visitation

⁴ Future steps include widening this to out-of-network providers and services, but it is important to keep initial steps small and manageable. As additional entry points, we envision that they will also be integrated in the sense of referrals that we explain here.

builds on the strengths of the co-located FRC services and home visitation is integrated into other case management efforts.

Recommendation 4: Establish Protocols for Referrals and Confirmation of Referral Accommodation

It is important to establish systematic rules to determine when referrals are necessary and to where they should be made. We proposed that this job be centralized in one spot in each family resource center and accordingly under the sole direction of the referral team. However, similar to entry procedures, it is necessary to establish methodical protocols. To this end, we also recommend that the Commission and County consider creating a major resource mapping that would include all potential services available to a client at a particular family resource center. A mapping of this sort should be tailored to each FRC, including a section detailing countywide services that are available to any resident of Orange County and geographically specific services that are offered only to clients of that particular family resource center. We also suggest that the literature on home visitation and other strategies of service delivery are consulted.

In addition to protocols to determine transfers of clients between services, procedures to confirm that a referral that has been made has been picked up are vital. We suggest that the referral team is directly responsible for collecting this information, but the exact ways in which it is done must be determined and consistent systemwide. This is especially critical since some providers, such as specialized home visitation programs, will be serving clients from different FRCs. There are many methods to receive confirmation, such as phone calls, email messages, or web-based forms. Which approach is eventually adapted is not of utmost relevance, but the countywide implementation of the concept and practice is fundamental.

B. Ensuring Program Effectiveness

A structure for organizing home visitation in partnership with the family resource centers is only the first half of a service delivery plan. As funders, the Commission and the County both need assurances that the system of home visitation services works and adapts over time. This assurance depends on an ability to incorporate best practices, evaluate practices and respond to information on outcomes. These dimensions of ensuring program effectiveness are addressed in the following discussion.

Dimension 4 Approaches to Evaluate Program Success

Evaluation is vital to program funders, who rely on such information to determine expenditure priorities. It is also critical for individual programs, who can use evaluations to judge their own success and make adjustments to service strategies as appropriate. The ability to assess the degree to which home visitation services affect relevant outcomes is a critical element of any service delivery plan since it can determine whether or not home visitations achieve their primary objectives.

The perspective adopted by the Commission for monitoring the well-being of young children is particularly apt for judging the success of home visitation programs in Orange County. Only Prop 10 considers the life experiences of children in a comprehensive manner measuring outcomes from birth to the beginning of school. Many home visitation program target this time to enhance the development of children, but they and their traditional funders tend to focus on narrowly defined problems in a relatively static context. The perspective of the Prop 10 Commission offers a unifying framework for judging the effectiveness of home visitation services and for redirecting efforts that fail to have long-lasting impacts on children's lives.

While the benefits of evaluation are easy to understand, establishing mechanisms to achieve these benefits is far more difficult. To develop a process capable of assessing the performance of individual home visitation programs as well as the overall system, we recommend that the Commission:

- **Expand measured outcomes to include variables describing the circumstances of children that home visitations are intended to impact**
- **Select outcomes capable of being directly influenced by service providers**
- **Include measured variables enabling cost/benefit analyses of home visitation services**
- **Convene define-it meetings involving home visitation providers and relevant funders to formulate these outcomes**
- **Relate measured outcomes to criteria delineating program and system success**
- **Provide timely reports summarizing outcomes to programs and funders**
- **Fund individual programs based on their achievement of outcomes to make each accountable for success**

We elaborate these suggestions by addressing two sets of issues: first, the characteristics of the outcome indicators that will prove most useful for evaluation purposes, and, second, the ways in which summaries of these outcomes can be utilized to redirect services and achieve vital priorities.

Issue 1: Desirable Characteristics of Measured Outcomes

Data collected by home visitation services should reveal whether intended outcomes were achieved. This is not an innocuous requirement. Ultimately, in choosing a set of measures, the funding agencies must ask themselves whether they would be willing to judge a program's success based on these indicators.

A major challenge encountered in creating such indicators concerns the fact that home visitation programs have diverse focuses with multifaceted objectives, often supported by more than one funding source. While many home visitation programs are designed to focus services primarily on an isolated set of family members – such as a mother and her new infant – we have found that in practice, many programs are necessarily much broader in scope. Regardless of the stated mission and intended primary participants, most home visitation programs essentially constitute a family-focused service delivery, providing many services to several family members. This comprehensive focus is an integral strength of home visitation as a service strategy since the ability of a mother to meet the needs of a 0-5 year old child may be directly affected by the extent that she has to deal with problems of other children in the family.⁵ However, these multifaceted programs complicate the development of data elements designed to measure performance of an integrated service plan, as program services can vary greatly from intended activities. Meaningful evaluations of program success or effectiveness can be confounded by the complexity, both in identifying exactly what services are delivered and in capturing positive outcomes that may be outside the original design or that indirectly impact the primary goals.

Consequently, special care must be devoted to establishing outcome measures for tracking the success of home visitation services. Any particular funding agency, such as the Commission, must insure that their goals are represented among the formulated measures. To the extent possible, funding agencies should establish a common set of measurable outcomes for program evaluations and take what actions possible to reduce the reporting burdens of programs. Obviously, home visitation programs must play an integral role in the process, since they will

⁵ Participants in the client focus group were quick to point this out. For example, one woman noted that her family was propelled into the system by the birth of a new child and her substance abuse problems; however, as a way to improve the family environment for the newborn, her visitor focused a considerable portion of her time on the behavioral problems of the family's eight-year-old child.

have critical insights into how their services should be judged and in identifying what outcomes are measurable. Convening funders and providers is a beginning step in developing such outcomes, but the process should offer considerable flexibility allowing for revisions over time since any procedure is unlikely to get it right the first time and priorities change.

Selected measures must represent items that can be realistically affected by the services provided. It is impossible to perform a meaningful evaluation based on indicators measuring objectives that a program has little or no way of actually influencing. For example, while preventing infant death is clearly an important indicator of the well-being of Orange County children and is surely a motivation for supporting home visitation services, most programs will not have a measure impact on this variable since the baseline number of deaths is very small. This does not mean that infant deaths should not be a measured outcome; instead, it implies that other outcomes must be collected to more closely assess the effectiveness of individual programs.

Finally, sufficient indicators should be collected to perform cost-benefit analyses of individual programs. This would not only include sufficient information to determine the cost per client by categories served for each program, it would also require some valuation of beneficial outcomes. This will provide another dimension on which to judge program success as well as a way in which to compare different programs in the county. Such an analysis would be quite useful for funders and service providers alike.

Issue 2: Reporting Outcomes Defining Program and System Success

Ultimately, the Commission, the County and other funders must each specify the explicit criteria to identify whether they would view programs as successful. The purpose of evaluations are twofold: first, they present report cards indicating to both funders and programs how well

services are doing in terms of meeting various success criteria; and, second, they may reveal shortcomings in the criteria which would motivate revisions.

To serve this purpose, regular reporting of outcomes must be available to all parties, so all are made aware of each program's progress. This need not require continuous reporting, but it should be timely and regular so that programs can alter services to improve outcomes. For the Commission these reports can come in a variety of forms, including written summaries and/or tables or graphs available through the OCERS data system.

For funding agencies to ensure their goals receive priority, they must be willing to base future funding decisions on how programs score on the stated success criteria. Only when programs are made accountable for achieving success will they systematically do so. Programs may be effective in meeting the criteria of some funding agencies and not others. In such cases, satisfied agencies should continue their funding while others should diminish their commitments. Over time resources will be redirected to those services most effectively achieving the Commission's goals.

Dimension 5 Approaches for Information Collection and Storage

Evaluation of home visitation services is not possible without a readily accessible, and secure data system. The Commission has adopted such a system – OCERS (Outcomes Collection, Evaluation and Reporting Services) – through its contract with CS&O. Fortunately, this system already offers an informational organization well designed for tracking the influence of home visitation programs on the well being of young children at the time of intervention and later in life.

So, the primary steps required to cover this dimension of the service plan involves supplementing the OCERS database to incorporate information identifying the provision and impacts of home visitation services. To this end, we suggest the Commission:

- **Expand the OCERS database to incorporate home visitation outcome variables**
- **Provide for secure data exchange between OCERS and FRCs in reporting home visitation services coordinated through these centers**
- **Establish outcomes reports to FRCs and home visitation services**
- **Make provisions for gathering of data from home visitation programs outside FRCs and for reporting outcomes to these programs**
- **Develop plans for integrating information from involuntary home visitation programs managed by County agencies, such as Child Protective Services**

The critical task in implementing these recommendations involves getting the relevant data into the OCERS system. One can accomplish this task in two ways: either have a program or FRCs input it directly, or create a secure interface allowing a service provider to upload it from their existing systems.

Two fundamental challenges will undoubtedly complicate the carrying out of these recommendations. First, every agency – public and private – has its own way of collecting information, ranging from traditional paper and pencil to advanced electronic collection tools. Consequently, there exist many data systems already in use by home visitation providers in Orange County. Not surprisingly, each agency collects a different set of variables, many centered on families rather than children. Warehousing data in a single location and in a common format will not be feasible in the near future and is unlikely to ever be practical for many agencies. Most notably, government agencies, such as child welfare services, not merely have proprietary systems dictated by federal and state law, they contain extremely sensitive and highly confidential data that will never be shared. Multiple systems are not an immediate

barrier, but their existence requires attention. In particular, provisions should be made to admit and foster a decentralized data system recognizing individual data ownership with seamless sharing of some data elements. Many options exist for creating such interfaces using readily available technology.

Second, in sharing information across agencies, a critical challenge arises in maintaining data confidentiality. The recent passage of HIPAA Privacy Rules reinforces this need, and as data systems are created or updated, it will be necessary to assure that all regulations are satisfied. In light of these circumstances, many data elements are unlikely ever to be shared. Consequently, careful attention must be devoted to establishing protocols for home visitation programs and FRCs to collect data of varying degrees of confidentiality, with the aim of ensuring that the most-basic information can be exchanged across the relevant service providers and with funders. For some programs, such as PSASI/ACT (which serves substance abusing and HIV infected women), even revealing participation in the program is implicitly revealing confidential information highly protected by law.

Dimension 6 Approaches to Incorporate Best Practices

The best-planned structure will not result in good outcomes if the service delivery system cannot incorporate and build on the expert knowledge of existing staff as well as lessons from other programs. While the literature on home visitation programs does not offer suggestions on ways to integrate a collection of programs, it does provide valuable information on specific service elements and approaches. Therefore, it is likely that developing best practices will mix lessons, tools and procedures from the best regarded programs with a large number of newly developed or adapted approaches to meet the special needs of this decentralized system. Once practices are in place it is necessary to ensure not only that established practices and embedded

knowledge can be passed on to new staff, but also that the system can revise these practices based on outcomes reports and other feedback.

Many of the best practices will need to be incorporated into protocols and procedures associated with the system structure outlined in earlier dimensions of this plan. Specifically, we recommend that the Commission and the County support best practices by encouraging providers to:

- **Establish work groups to develop protocols and related tools to handle referral and triage**
- **Explore technology options for referral tracking and other tasks common across programs**
- **Create a resource mapping for home visitation programs**
- **Establish regular meetings of home visitors to share outcomes and other information**
- **Conduct cross-training of home visitors**

Below we offer more details on how these suggestions can help incorporate “best practices” into the service delivery plan.

Recommendation 1: Develop protocols and related tools

As described in earlier sections, much of the plan rests on channeling clients into programs that are best suited to their needs, a process that requires systematic protocols and ways of assessment or screening. At a minimum, we see three essential tools: 1) the referral teams need protocols for matching clients with home visitation services; 2) a basic assessment tool should be used by all low intensity programs to collect basic information for outcomes tracking but more importantly, to provide information used to triage clients into other levels of home visitation, and 3) protocols need to be developed for referring clients across programs and to confirm when referrals are acted on. In addition, it would be helpful to develop approaches to

avoid overlap of home visitation with other programs that serve the same clients. This will be a challenge in part because of the privacy issues, but also because of the mixed mandatory-voluntary nature of programs that families may be involved in. Incorporation of staff people from key agencies such as Children and Family Services, the Health Care Agency, and Probation into the multi-disciplinary teams based in FRCs is likely to be an important element.

We recommend that relatively small work groups be established to develop these protocols and screening tools. The first step for these work groups should be identifying existing approaches, so it might be helpful to make sure that these work groups include representatives from the most established programs. In general, we would suggest that the work groups be guided by the following concepts. First, protocols should impose the minimum administrative burden on programs. That means they must make sense within normal work flows and capture information as efficiently as possible with the least duplication. Second, uniform protocols are preferred over specialized versions for each program. Third, protocols should be flexible enough to account for different technological capacities in different programs and FRCs, although there is a clearly a trade off between this goal and the first two. Fourth, it is better to develop a basic protocol quickly and test it in the field, building in a revision process, rather than spending a longer time developing a more refined version, as long as revisions are kept to a minimum. Fifth, the needs of the evaluation should be a factor for consideration in the development of tools.

We recognize that the independence of the programs as well as the requirements of different funders or parent agencies may make it difficult to reach consensus on tools and protocols. Where complete consensus is not possible (on assessment instruments for example), we strongly encourage all programs to at least include a shared core of elements. Funders, such

as the Commission and the County, can help ensure this basic commonality. In addition, it may sometimes be appropriate to provide a consultant to help facilitate the process and to have responsibility for the timely development of necessary tools.

Recommendation 2: Explore technology options for referral tracking and other tasks common across programs

The complexity of FRCs and home visitation programs already leads to an incredible level of paperwork with numerous forms. To reduce both the paperwork and the probability of clients being lost in the system, we recommend that the Commission and the County help providers explore technology options especially for referral tracking and other tasks that involve client information passed from one program to another. The appropriate technology will depend on the sensitivity of the information, among other considerations, but in many cases, simple solutions involving email or very basic internet applications may be very useful.

Recommendation 3: Create a resource mapping for home visitation programs

One characteristic that often distinguishes experienced home visitors from new staff is knowledge about which resources are available to serve clients facing different challenges. Given the high turnover in visitor staff, we recommend that home visitation programs work to capture and expand on this knowledge by developing a resource mapping for each home visitation program associated with an FRC and for the proposed “rest of county” program. This resource mapping would provide not merely program names and numbers, but also eligibility requirements, details on services offered, and key contact people. This resource mapping will need to be updated on a regular basis.

Recommendation 4: Establish regular meetings of home visitors to share outcomes and other information

In addition to careful research, “best practices” can also be established through brainstorming and development sessions of people in the field. Thus, we suggest that the Commission and County establish regular meetings of service providers from different programs and agencies. These groups would give workers an opportunity to learn about all the services in operation in the county, as well as to share methods of service provision and experiences of success or failure. Moreover, home visitation is not an easy job and establishing a forum for visitors to share their experiences and bond with others in their situation may foster a better environment among visitors and create a sense of the programs’ respect for and appreciation of its workers. It is also worthwhile to point out that this is an idea that is strongly supported by current home visitors: after holding focus groups with home visitors, we were in fact asked if we could hold such a group on a monthly basis. These meetings could be open to all programs that include home visitation, not only the primary programs associated with FRCs.

One explicit use for these home visitation groups should be sharing, reviewing and responding to reports on outcomes. It is critical for review of outcomes to be integrated into an ongoing effort to improve program performance. A setting that puts one program’s outcomes in comparison to others can lead to a valuable discussions around using the data, including feedback on the comparability of definitions, time periods and other data elements that go into creation of the statistics, as well as understanding possible case mix differences that should be considered in acting on the outcomes indicators. Finally, a guided group discussion on outcomes can help programs that are not used to working with quantitative measures understand the potential use of these data.

Recommendation 5: Conduct cross-training of home visitors

There is an inherent balancing act in a system that permits program autonomy while seeking integration across programs. One approach to help this balance is to conduct cross training of home visitors. At a minimum, all new home visitors could receive a basic introduction to home visitation in Orange County. This strategy has been used successfully in Sacramento's Birth and Beyond Collaborative. This orientation training could cover those issues common to all programs including basic information on conducting a home visit, mandatory child abuse reporting, protocols for triage, data collection for outcomes reporting, and finding resources using the resource mapping. For more experienced visitors, cross training could be offered in connection with home visitor group meetings, where, for example, experts from specialized programs could describe their programs, how they serve clients, what clients may be appropriate to refer and so forth. It may be appropriate to provide specific training for other FRC staff members, especially the referral team, but also to jointly train all members of multi-disciplinary teams working with home visitors.

C. Closing Gaps in Coverage

The final dimension of the plan deals with ensuring that home visitation is available throughout the county, at appropriate levels of intensity, targeted to families in need.

Dimension 7 Approaches to Close Coverage Gaps

To assure quality service provision and to make the approaches to managing entry to and triage of home visitation services, it is necessary to have comprehensive coverage both geographically and in the range of services available. Building on FRCs as the foundation for integrating home visitation services defines areas of services according to the geographical boundaries of FRCs' catchment areas. Given this approach, there are three main types of

coverage gaps in Orange County that must be considered: 1) gaps at family resource centers in the three proposed intensity levels of home visitation, 2) gaps in areas not served by any family resource center, and 3) future gaps. We propose that the Commission and County implement steps to fill each of these gaps. In particular:

- **Ensure availability of two levels of home visitation programs at each FRC**
- **Ascertain links of FRCs to special home visitation programs**
- **Create a catchall program to cover individuals living outside the service range of any FRC**
- **Establish protocols to identify future coverage gaps**

Recommendation 1: Ensure Each FRC Has Connections to All Three Levels of Home Visitation

The service delivery plan we have outlined assumes that each family resource center offers or has a direct link with providers of three intensity levels of home visitation. Two of these levels – low intensity and generalized high intensity programs – ideally should be co-located in the center. Figure 2.1 mapped the existing relationships between family resource centers and home visitation programs. Three FRCs (Families-Costa Mesa, South Orange County FRC and Corbin Community and Family Center) currently offer low and high intensity programs. Therefore, we propose that an early priority in closing gaps in coverage should be ensuring each FRC has access to low and high intensity services. Especially while other aspects of the plan are being implemented, it may be preferable to link FRCs with already established programs, either by expanding coverage of programs serving other FRCs or creating ties with unaffiliated home visitation programs. That is, adding entirely new programs should be secondary to ensuring best practices at existing programs, as long as coverage can be accommodated within established programs.

That said, we do recommend the Commission and County consider creating some new home visitation services of different intensity levels according to the needs of different service areas. Most specifically, we first suggest that new very low intensity home visitation programs are created throughout the county. These may include less traditional visitors – such as the elderly or volunteers – or rely first on telephone calls before any home visits are made. Second, we have identified north Orange County as an area in which there is a clear lack and need for an intensive home visitation program. While there are three family resource centers in the area – Fullerton, Brea, and Garden Grove – none of them offer services of this type. Hence, we recommend that the Commission and County consider the creation of a new program in this area.

Lastly, in the case of specialized programs, the emphasis should be on building referral systems and associated links between FRCs and the existing specialized programs, using in part the resource mapping suggested earlier. However, comments from the field reflect the value of a literacy-based program such as HABLA and indicate these services are too limited. This specialized home visitation program falls in an area that may have greater need for the expansion or creation of new programs. However, any approach in this area should be coordinated with county-wide school readiness plans.

Recommendation 2: Create a “Rest of County” Home Visitation Program

While geographic areas with high concentrations of needy individuals can be targeted and included in the service areas of Orange County family resource centers, it is both financially difficult and inefficient to create family resource centers in every area in which there might be a client in need, such as an area that is not primarily disadvantaged, yet has a handful of at-risk families. Therefore, it is important that a comprehensive service plan includes an alternative way to provide services to individuals who live outside of the range of any family resource centers.

To this end, we recommend that a “rest of county” or “catchall” program be established to serve any client that lives outside FRC coverage areas. Home visitation is unusually well-suited to this approach, because it already entails sending workers out to potentially isolated clients. This supplemental program could be based out of one of the existing family resource centers, who might employ extra workers to cover the increased caseload. Alternatively, the catchall program could be formed through a collaboration of workers from different FRCs in the county. It could also be directly associated with or under the auspices of the Orangewood Foundation, which presently has a countywide presence through ProjectConnections.FRC.

While the organizing framework of this catchall program could be established in many different ways, there are some critical elements that must be included. First, in the context of our three categories of home visitation, the catchall program would be considered as a low intensity service plus. That is, it would perform basic home visits for a limited time and employ other services to assist its participants, particularly services that a FRC might generally provide. The program also requires a well-defined link with at least one intensive home visitation program – either through a visitor who actually works for the catchall program and serves these clients or through an agreement with an existing high intensity program assuring that clients outside the service range could enroll. Second, it is important that this program is linked with the other key platforms – health care and educational providers. If the catchall program is associated with one FRC, these linkages should be automatic since they will already be established at the FRC. If the program is more of a collaboration, it may be valuable to assign one FRC as the lead center to establish the links for this program. However, since the catchall program covers the entire county, these links will need to be developed with a larger number of hospitals, schools, and similar providers. Finally, it is important that referral teams at all family resource centers are

well-connected to this catchall program so that if they do receive a client either from the catchall program or from an outside source, then they will be able to facilitate smooth transfers or enrollments of clients.

Recommendation 3: Establish a Process to Identify Future Gaps

Lastly, while we have identified areas where the county is currently lacking coverage or services, it is important to establish a process to reassess emerging gaps in coverage, in terms of geographic areas, underserved demographic groups, or changing service needs. Monitoring the caseload in the “rest of county” program will help identify neighborhoods that may be targets for new FRCs or other concentrated services. An additional option to assess coverage capabilities of the county is to establish a semiannual meeting or email solicitation including representatives from all service programs with the explicit purpose of identifying potential coverage gaps. Another possibility is to call upon individuals most likely to have a countywide perspective, such as public health nurses and representatives from the Orangewood Foundation, in addition to workers involved with the proposed catchall program. Identifying additional service needs or demographic groups that are underserved is a somewhat larger task that will require monitoring of countywide demographics, needs assessments, and program outcomes data to identify whether program services appropriately meet the changing population of Orange County.

5 Concluding Comments

The recommendations and options for an integrated system of service delivery presented in Section 4 highlight the complexity of the goal at hand. However, when approached as a collection of dimensions, each with their own possibilities and needs, the goal becomes more manageable. While we have presented a series of recommendations and alternative methods, we reinforce the need for the Commission and the County to make the ultimate decisions regarding a plan to integrate service delivery programs. We believe that we have presented a list of options that, when put combined in any number of combinations, will work specifically toward Commission goals. Furthermore, it is important to stress that there is not one “right” way and several “wrong” ways to integrate the system—in fact, flexibility that allows for reevaluations and modifications and a commitment to the final goal may indeed be the only crucial components.