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July 18, 2018

TO: Each Supervisor

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

SUBJECT: **STRENGTHENING HOME VISITING IN LOS ANGELES: A
COMPREHENSIVE PLAN TO IMPROVE CHILD, FAMILY AND
COMMUNITY WELL-BEING**

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

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

The attached report presents the resulting plan: “Strengthening Home Visiting in Los Angeles: A Comprehensive Plan to Improve Child, Family, and Community Well-being.” This plan is the culmination of work and broad contributions by diverse stakeholders within both the Los Angeles County and national home visiting landscapes. Since shortly after the motion was passed, the leadership of all County Departments and organizations named have met regularly to build a common vision for planning and collaboration. Participants included Directors, Deputy Directors, and other high-level leadership. In addition, DPH convened a cross-agency research and advisory team to support the integration of best practices and other expertise into the planning process. Home visiting provider agencies also shared their wisdom and perspective during the planning process, both through participation at Consortium meetings and through Community Roundtable participation.

The plan outlines four areas of action to realize an optimal system of support in Los Angeles County.

1. *Coordination*: Building new technology and pathways to improve access
2. *Data*: Establishing common data to evaluate and convey shared impact
3. *Workforce*: Training and sustaining excellence
4. *Funding*: Expanding volume and flexibility of funding via Medicaid and County sources

The plan outlines these areas within the context of a shared, consensus-driven Vision and Principles, including that home visiting services represent one important resource within a broader set of family supports that we seek to coordinate for the betterment of families. Within each of the action areas, proposed next steps are delineated for DPH, the other County Departments, and partners within the nonprofit, business, and philanthropic communities to advance a coordinated system of home visiting programs in Los Angeles County. These next steps include creating electronic and telephonic referral tools; building new referral bridges from County departments and medical settings; pursuing recruitment, training, and career pathway development in order to bolster the strength of our workforce; increasing Medicaid leverage using Targeted Case Management; and applying other identified funding streams in order to expand LA’s home visiting capacity.

The action plan also includes a three-pronged approach to County-wide data management: 1) long-term outcome analyses utilizing data-matching with administrative data sets, led by First 5 and CDN and aligned with the OCP Prevention Plan evaluation framework; 2) annual common outcome indicator collection and analysis, led by the Consortium; and 3) annual assessment of home visiting capacity and utilization against community need. Through this three-pronged approach, the County will be well poised to measure both outcomes and capacity utilization, and thereby will be fully empowered to make quality improvement and investment adjustments to ensure that services optimally meet community needs.

The plan makes note of the Los Angeles County Health Agency’s commitment to health equity for all, and the recent launch of the AAIM Higher initiative by DPH to reduce the disparate rates in African-American infant mortality (AAIM). The document acknowledges the increased risk of poor birth outcomes experienced by African-American women regardless of other individual risk factors and assures alignment between the strategies for expanding universal access to home visiting for all families, and the need to target this high risk population for outreach and referral to intensive services to ensure equitable outcomes for all communities.

This plan will serve as a blueprint for transformation and a guide for building the coordination and strategic investment that is needed. Many components of these strategies have launched and numerous County departmental bridges have already been built. The data and funding expansion work is already underway, and DPH will continue to engage County departments, community members, Consortium

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workgroups, and home visiting provider agencies as appropriate to ensure concrete and coordinated implementation as we move forward this systemic effort. As we implement this plan, we will also continue to inform your Board of critical fiscal and policy issues.

If you have questions or need additional information, please let me know.

BF:lma

Attachment

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors

STRENGTHENING HOME VISITING IN LOS ANGELES COUNTY

A Plan to Improve Child, Family, and Community Well-Being



**LOS ANGELES COUNTY
DEPARTMENT OF PUBLIC HEALTH
& HEALTH AGENCY
JULY 2018**

Dedication

This report is dedicated to all the mothers and fathers of Los Angeles County, with gratitude for the love and resilience they share with our children each day.

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Executive Summary: Plan Purpose, Context, and Overview

This plan represents a collective promise to do better by Los Angeles County’s next generation.

We know the health and well-being of Los Angeles County’s future community members are deeply influenced by their experiences as children. While growth and development occur throughout childhood, the prenatal and early years are a critical period for early childhood intervention. The strategies laid out within this document embody more than just “next steps.” They embody a commitment by the County of Los Angeles, the County’s Department of Public Health, First 5 LA, and their community partners to provide the timely, powerful supports needed for our families and communities to thrive.

An optimal system of family supports would strategically layer an array of effective evidence-based, innovative, and community-responsive resources that assists in achieving strong outcomes for all families. In addition to offering high-quality interventions, this full suite of supports would be offered in a coordinated manner that would facilitate access for families to the full set of community resources each family may need. This plan focuses on the unique role of home visiting¹ within this system of care.

Home-based parenting support, termed “home visiting,” has received local, state, and national attention as an effective prevention strategy. It has been proven through research to be a valuable intervention for helping families to be strong, healthy, nurturing, and successful.² It has even been lauded as “transformative” in local parent focus groups.³ In general, home visiting improves family outcomes directly through coaching parents on topics such as parent-child relationships, maternal health, and child development. It also can play a key role as a connector within the broader human service delivery system, facilitating the efficient utilization of a full range of human services and basic community supports. When implemented with quality and fidelity, home visiting is a resource that helps families connect with health-promoting resources, nurtures relationships, promotes safety, and supports socioeconomic stability. In addition, it contributes to the health of the broader social support system by bridging clients to other needed services, identifying service gaps, and advocating for critical supports.

“The staff] always has great advice and resources! I like the visits and the activities we do according to my child’s age and development. Even though I’m not a first-time mom, there’s things I’ve learned that help me be a better parent and have new experiences with the baby.”

—Andrea, Child Care Resource Center PAT

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

² See Appendix A | Summary of Outcomes for full details of the research relating to home visiting outcomes.

³ See Appendix B | Excerpts from Focus Group Analysis for focus group findings.

Evidence-based home visiting has been a resource woven into our local landscape for over 30 years, with various home visiting programs being funded by a range of local and federal, public and private sources. Yet within Los Angeles County, there has never been a “system” that strategically connects these resources. Despite its strong models, Los Angeles has lacked the coordination needed to ensure that resources are allocated equitably and are sufficiently available throughout the region. The need to navigate among multiple home visiting programs with varied entry requirements, catchment areas, and service models has made it challenging for parents and professionals to link families to the programs that best meet their needs. This lack of coordination has impeded the most effective use of resources where they do exist. A better system of coordination and referral can increase the equitable allocation of resources and address existing gaps in home visiting services, especially for high-risk populations.⁴ It can help improve access for populations at higher risk of poor outcomes resulting from multi-generational marginalization by strengthening linkages to home-based support and other family support services.

Home visiting functions optimally within a larger system of family supportive services. A fundamental component of home visiting is assisting families to connect with additional specialized resources so that their comprehensive needs and goals may be met. As one prevention model, home visiting will not necessarily be the full solution for families at highest risk. Some families will need more focused interventions depending on the nature and severity of family challenges. Families in which there is a prevalence of substance abuse, for example, will need more intensive mental and behavioral health interventions that are directly linked with their needs, beyond the scope of the home visiting program. Yet, while home

“You helped me so much when I needed it the most. Being pregnant and depressed was something I never imagined I’d find myself feeling. Your visits got me through. Thank you for understanding me and knowing that I wasn’t losing my mind ... I learned how to be strong and take care of myself. And thanks to you and me, I feel better again and have my life back.”
—Candice, Northridge Hospital Medical Center Welcome Baby

visiting alone may not address all the needs of all families, building out a universal home visiting system is an innovative strategy for supporting both high- and low-risk families. Establishing a universal system helps foster a norm of parents seeking and accessing supports, which increases the identification and acceptance rates of families that may need intensive supports at the same time that it provides resources to all families. In

addition, home visiting can help high-risk families navigate to the additional supports they need. In a large urban area like Los Angeles, understanding how to access existing early childhood education health and social service systems can be a challenge even for the most experienced. Families with young children need access to different kinds of help as their children grow and change. In addition, when home visitors identify those additional resources to be in short supply, their voices can proactively inform policy and system changes (as this report illustrates via the example of mental health resources).

Recognizing the opportunities for improvement, the Board of Supervisors unanimously passed a motion on December 20, 2016, instructing the Department of Public Health (DPH), in collaboration with First 5 LA, the LA County Perinatal and Early Childhood Home Visitation Consortium (the Consortium), the Office of Child Protection (OCP), the Children’s Data Network (CDN), and the departments of Health Services (DHS), Mental Health (DMH), Public Social Services (DPSS), Children and Family Services (DCFS), and Probation, to “develop a plan to coordinate, enhance, expand, and advocate for high-quality home

⁴ High-risk may be defined in many ways, and in some cases has particular meaning specific to context. In keeping with the Board of Supervisors’ motion and collective County departmental priorities, the term “high-risk,” when used generally in this report, is inclusive of both risk of involvement with the child welfare system and risk of adverse health outcomes.

visiting programs to serve more expectant and parenting families so that children are healthy, safe, and ready to learn.” Specifically, the Board directed DPH to:

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

The value of an enhanced home visiting system was affirmed in the Los Angeles County 2016–2020 Strategic Plan, Objective I.1.6, which directs the county to “support the leadership of First 5 LA, in partnership with the County, the Home Visitation Consortium, and others, to build a universal voluntary system of home visitation services through a streamlined system of referrals and improved integration of services.” Similarly, the OCP prevention plan, *Paving the Road to Safety for Our Children* (Appendix C), identified home visiting as one of its seven core strategies for preventing child abuse. The OCP emphasized home visiting as part of an inclusive network of family supports, alongside early childhood education, prevention and aftercare services, and other systemic solutions. Home visiting also plays a role in meeting several priority areas and goals outlined in the 2015–2020 Los Angeles County DPH Community Health Improvement Plan (CHIP).

This home visiting system-building work is also intertwined with the County’s focus on reducing health disparities. In 2017, in response to stark disparities in health outcomes among African-American families and other Angelenos, the Los Angeles County Health Agency launched the Center for Health Equity. As referenced in the Center for Health Equity’s 2018 document *A Pathway to Equity: The Five-Year Plan to Close the Black-White Gap in Infant Mortality*, home visiting services can play an important role in reducing disparities in infant mortality and maternal and child health. Culturally responsive, high-quality home-based programs can help ensure that families are able to access needed health and social services and supports. In so doing, they can help to reduce the risk of preterm birth and other adverse health

outcomes.⁵ The potential for synergy between home visiting and other efforts makes the current report particularly timely: we have a unique opportunity to make home visiting an important component in a coordinated, comprehensive system of care serving families from preconception through early childhood.

This report addresses each of the elements listed in the December 2016 motion, laying out a plan for transforming the home visiting landscape in Los Angeles that is comprehensive in scope, integrated with other systems, and responsive to community challenges.

In response to Board motion directive I, the report summarizes key lessons learned from the review of national systems, including those related to single-entry portals and opportunities to expand home visiting capacity by better leveraging funding. These lessons are outlined in the “What National Research and Local Gap Analysis Taught Us” section of this report starting on page 18.

The “What National Research and Local Gap Analysis Taught Us” section also identifies current service capacity and gaps (directive III in the Board motion) using quantitative analysis and stakeholder input. Opportunities identified include (a) building new referral partnerships and infrastructure to support broader and easier entry into home visiting; (b) filling service gaps by expanding the accessibility and volume of both targeted universal (offered regardless of individual risk status to all residents in communities facing elevated population risk) and programs designed for more specific high-risk groups; (c) improving perinatal mental health support; and (d) piloting innovative models to better serve high-priority populations (including families at risk of child welfare involvement or imminent adverse health outcomes). Discussions of the current local home visiting landscape highlight gaps in services that are a function of multiple causes. As the volume of home visiting services has grown, funds have been prioritized to identify and serve high-risk populations based on criteria set by models and by various funding sources. While availability and access has grown for these populations, limitations still exist based on geography, age, and enrollment period.

Gaps also exist related to disproportionately poor outcomes among segments of the county population that have historically been disenfranchised and could benefit significantly from improved outreach and inclusion. Most notably, there are opportunities to improve outreach and responsiveness to the African-American community and other racial or ethnic minorities who suffer from higher infant mortality rates and preterm births. It is crucial to the success of the Los Angeles County Health Agency equity initiatives to acknowledge that African-American maternal and infant health outcomes remain significantly worse compared to other racial and ethnic groups, and that these differences are not explained by traditional “high-risk” characteristics— income, education, health insurance access, for example. The deeply rooted structural racism that continues to pervade the culture explains much of this problem, and addressing that

⁵ Published research demonstrating reductions in low birthweight, preterm birth, and infant mortality affiliated with home visiting programs include:

- (1) Lee, E., Mitchell-Herzfeld, S., Lowenfels, A., Greene, R., Dorabawila, V., DuMont, K. (2009). Reducing Low Birth Weight Through Home Visitation A Randomized Controlled Trial. *American Journal of Preventive Medicine*, Volume 36, Number 2, 154–160.
- (2) Olds, D. L., Kitzman, H., Hanks, C., Cole, R., Anson, E., Sidora-Arcoleo, K., Luckey, D.W., Henderson, C.R., Holmberg, J., Tutt, R.A., Stevenson, A.J., Bondy, J. (2007) Effects of nurse home visiting on maternal and child functioning: age-9 follow-up of a randomized trial," *Pediatrics*, 120 (4), e832–845.
- (3) Olds, D.K. (2014). Effects of home visiting by nurses on maternal and child mortality: Results of a 2-decade follow-up of a randomized clinical trial. *JAMA Pediatrics*, 168(9): 800–806.
- (4) Kitzman, H.O., et al. (1997). Effects of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: A randomized controlled trial. *Journal of the American Medical Association*, 278(8), 644–652.

underlying social determinant is essential to the ultimate success of these efforts. As a result of this uneven playing field, while this report describes a vision and a plan to create a system that provides universal access to a spectrum of home visiting services for all families in the county, it is appropriate and important to include strategies that recognize and target the disproportionate need among African-American families and that ensure that population is being adequately reached and served. With those caveats, home visiting as part of an integrated support network can enhance health and social equity for all families.

Responses to the challenges of improved countywide coordination (Board motion directive II) and improved access for families at high risk of child welfare involvement (Board motion directive IV) are addressed in the final section of this report. That section lays out steps to develop a more coordinated and effective system that is responsive to community needs, easy to access and navigate, and anchored in community-level partnerships. The proposed home visiting system includes new referral partnerships for high-priority populations, an enhanced electronic referral infrastructure, perinatal mental health supports, and expansions both of current evidence-based and of innovative services. Recommended areas for investment include coordinated referral technology, the development of new pathways that increase linkages from County programs to home visiting services for families at high risk of involvement with the child welfare system, and a commitment to universal screening and parent coaching in the prenatal and early postpartum period to improve timely access to needed services. A universal approach is recommended to help foster a norm of perinatal parent support, both to improve outcomes for the entire population and to reduce stigmatization based on what may be perceived as a deficit approach to targeting.

To address the need for improved data standardization (Board motion directive V), the plan proposes a multi-pronged approach in the “Our Proposed Solutions | Data” section on page 30 that includes (1) a long-term evaluation to assess program outcomes (including healthy births, child safety, family well-being, and cost-avoidance); (2) an annual analysis of program metrics, including but not limited to common indicators shared across all programs (Appendix B | Excerpts from Focus Group Analysis); and (3) the ongoing measurement of community need and subpopulation need, available capacity, and utilization, to inform continuous improvement of the overall system.

Strategies for better use of current funding and to add new resources (Board directive VI) are discussed in the “Our Proposed Solutions | Funding” section on page 37. These strategies can increase capacity for the more intensive home visiting models that are most appropriate for high risk families, as well as less intensive programs intended for universal use.

This proposed plan addresses two additional issues that are not explicitly mentioned in the Board directive but are closely linked to achievement of the aims that are addressed: 1) reinforcing linkages between home visiting and other family support system elements; and 2) recommendations regarding workforce development. The “Home Visiting’s Role in Our Broader System of Care” section (page 10) explores ways in which home visiting services work with other key community investments to support strong, healthy families. The “Our Proposed Solutions | Workforce” section (page 34) lays out important activities related to strengthening the home visiting workforce capacity that are essential to ensure optimal support for families. Many of the recommendations in this section (such as the creation of

“If I didn’t have this program, I wouldn’t know what to do. When I first got pregnant, I was so scared ... I was going to end up having an abortion ... But all the stuff that [she] has been teaching me, learning how to stop being stressed out ... stuff to bring me and my daughter closer together ... learning how to help [my daughter with] her language development. I never knew that until she taught me about it.”

—Eniya, Child and Family Guidance Center HFA

a perinatal mental health clinical support team and countywide training in implicit bias), are directly responsive to the current gaps identified in our system. Others relate to ensuring long-term workforce strength. In the closing section, the plan outlines recommended next steps, including commitments that County departments and partners have made to implementation, recommendations for countywide collaborative oversight, and opportunities for ongoing County support.

This plan, *Strengthening Home Visiting in Los Angeles County*, was developed at a time of widespread commitment to supporting families and improving outcomes for young families. It is intended to serve as a blueprint for transformation—a guide for building coordination and strategic investment that our families and future generations deserve. It will serve as a core framework on which to develop and layer more detailed implementation plans for County departments and partners to execute wherein universal home visiting may play a crucial role in a comprehensive set of strategies designed to maximize outcomes for young children and their families.

Acknowledgments

This report is the culmination of intense work and broad contributions by diverse stakeholders within the Los Angeles and national home visiting landscapes. A deep debt of gratitude is owed to all who helped to define our path toward the “North Star” of optimal family support in our community. This section attempts to capture our heartfelt thanks.

The leadership of all County departments and organizations named in the December 20, 2016, motion convened monthly to build a common vision for planning and collaboration, informed by the results of research and stakeholder input. Along with DPH leadership, participants included directors, deputy directors, and other high-level leadership of the departments of Children and Family Services, Public Social Services, Mental Health, Health Services, Probation, the Los Angeles County Office of Education, the Children’s Data Network (CDN), First 5 LA, the OCP, and the LA County Perinatal and Early Childhood Home Visitation Consortium (Consortium), represented by staff from its backbone agency, Los Angeles Best Babies Network (LABBN). Through these convenings, County departments established a shared commitment to collaborating with provider agencies, community members, and one another to achieve an optimal and integrated system of high-quality home visiting support in Los Angeles County. Without such leadership, this plan would not have been possible.

In addition, DPH convened a biweekly cross-agency research and advisory team to support the integration of best practices and broader stakeholder engagement within the planning. This team (which included representatives from DPH, First 5 LA, OCP, the Consortium, LABBN, and CDN) completed national and local research and provided dedicated ongoing support throughout this planning process. The guidance, time, and hard work of this group were invaluable to this plan’s development.

Numerous home visiting provider agencies shared their wisdom and perspectives during the planning process, both through their participation at Consortium meetings and through their Community Roundtable participation (see page 23). Parents shared their perspective via focus groups. Big Orange Splot, LLC, provided facilitation, research, and technical expertise to inform and support optimal planning. Ongoing national expertise was provided by Chapin Hall Senior Research Fellow Dr. Deborah Daro. The Doris Duke Fellows from Chapin Hall and doctoral students from the CDN and the Consortium contributed research on national models and the local home visiting landscape, respectively. This support was essential to ensuring that our plans integrated best practices and were responsive to local needs.

The health, business, and philanthropic communities also played important supporting roles. Senior leadership from Care First, Health Net, LA Care, and Health Care LA IPA lent their expertise both in individual interviews and as joint participants with DHS and DPH in Maternal Model of Care meetings hosted by First 5 LA. The Partnership for Early Childhood Investment funded the Consortium’s local landscape research. The Reissa Foundation supported the DPSS pilot in SPA 6. The Blue Shield Foundation and First 5 LA co-funded technical assistance support for the rollout of DMH expansion funding. The Carl and Roberta Deutsch Foundation underwrote DHS’s Mama’s Neighborhood focus groups. Representatives from the California Endowment, the Partnership for Early Childhood Investment, the Crail-Johnson Foundation, the W.M. Keck Foundation, the Reissa Foundation, and First 5 LA also lent their expertise as ambassadors for the philanthropic sector as part of an ad-hoc funders workgroup. This group helped develop and vet the proposals coming out of the County’s planning efforts, such as requests for data infrastructure and capacity-building. Collaborative partners also met with staff from the Los Angeles County Economic Development Corporation and the Los Angeles Area Chamber of Commerce, who lent guidance and expressed willingness to partner in support of future home visiting workforce development.

We deeply thank each of these entities for their contributions to this greater whole.

Vision and Guiding Principles

To frame the development of this plan, the leadership of each of the County departments and organizations named in the motion began by articulating a shared commitment to building an optimal home visitation system in Los Angeles County. Together, these collaborators developed a vision statement and guiding principles to serve as the foundation for inter-departmental and cross-sector collaboration around home visiting services for Los Angeles County families.

Our Vision

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

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

- Optimizes child development
- Enhances parenting skills and resilience
- Safeguards maternal and infant health
- Prevents costly crisis intervention
- Reduces adverse childhood experiences
- Demonstrates improved educational and life outcomes

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

Fundamental to these discussions was a recognition not only of the value of effectively connecting families to home visiting, but also of doing that in a way that is integrated within the broader set of family support programs available to parents. These tenets are reflected both in the Guiding Principles that stakeholders adopted (below) and the plans they collectively developed.

Our Guiding Principles

1. Universal access to effective prenatal and early childhood support is beneficial for all children's health and development, for maternal health, for enhancing parental capacity, and for our community as a whole.
2. Some families can also benefit from intensive home visiting support to address complex sets of challenges.
3. Home visiting has been proven through research to be an effective perinatal resource; it attains key family well-being and health outcomes, reduces the need for crisis intervention, and triages families to the appropriate level of additional resources and community activities.
4. Home visiting is not the only effective perinatal and early childhood resource and it is not the sole or optimal fit for all parents; however, for parents who voluntarily participate in home visiting services, research shows it is among the most impactful.

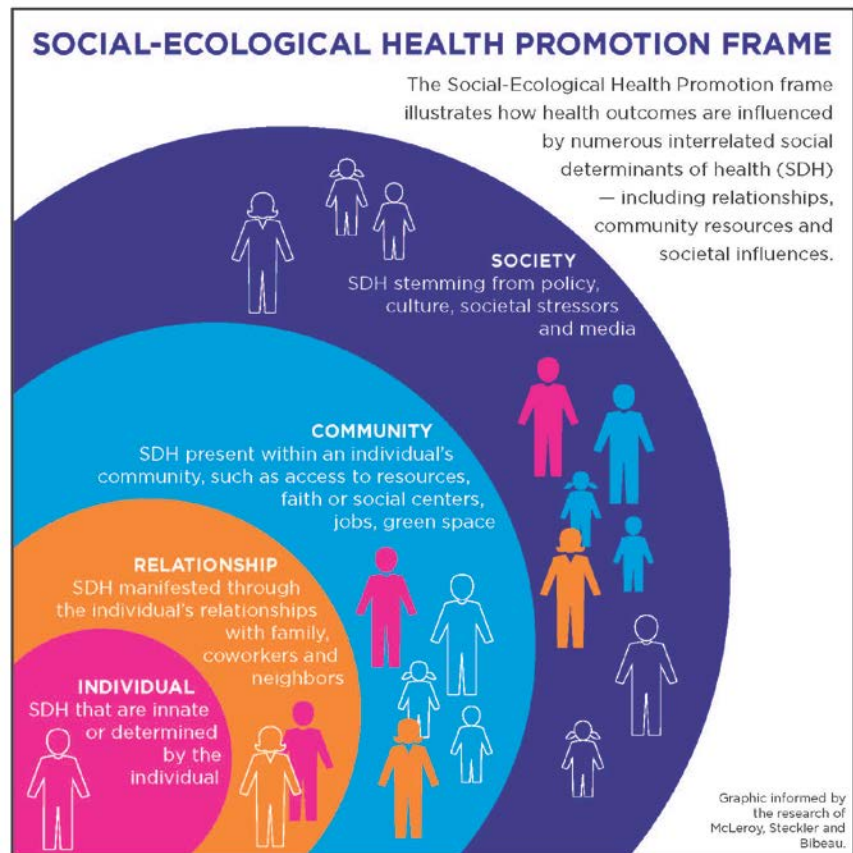
Families will have the opportunity to access resources through multiple paths. To maximize families' access to home-based support, we commit to building and refining referral pathways:

- a. That are attractive and easy to navigate from the family perspective (provided efficiently via trusted community providers)
 - b. That are effective in finding and attracting "at-risk" and prenatal families in particular
 - c. That are informed by process design principles so they work both for families and for staff in the involved departments
5. Effective data collection and coordination is essential to ensure the highest quality services and optimal resource allocation.
 6. Improving coordination can result in even better outcomes for our families and our community by ensuring that (a) resources are maximized and (b) system connections are efficient and effective. Home visiting system coordination efforts should support, leverage, and be pursued in alignment with other change initiatives underway in Los Angeles County, including but not limited to the County Strategic Plan, the Office of Child Protection's prevention plan, Help Me Grow, and other early childhood systems-change initiatives.
 7. There is a fundamental shortage of resources to meet the full potential need for home-based support in Los Angeles County. Expanded and more flexible financing is needed. Adjustments also should be made to current program recruitment and collaboration to ensure that existing funds are fully utilized, particularly for prenatal women, at-risk parents, and marginalized families.

Home Visiting’s Role in Our Broader System of Care

The County’s home visiting system coordination efforts will support, leverage, and be pursued in alignment with other change initiatives underway in Los Angeles County, including but not limited to the Health Agency’s health inequity initiatives, the County Strategic Plan, the Office of Child Protection’s prevention plan (Appendix C), Help Me Grow, and other early childhood systems-change initiatives.

As highlighted earlier, one of the guiding principles of this planning has been the knowledge that home visiting, while an important resource, is one of many valuable resources for families in Los Angeles. Family health and success are influenced by broad socioeconomic determinants,⁶ including environmental factors (such as access to safe housing, nurturing early care and education, parks, and nutritious foods) and experiences with trauma (including violence, abuse, and racism). At a systemic level, it is important that we are addressing all of these factors in balance—ensuring both service-level resources and a community-level ecosystem that supports universal well-being.



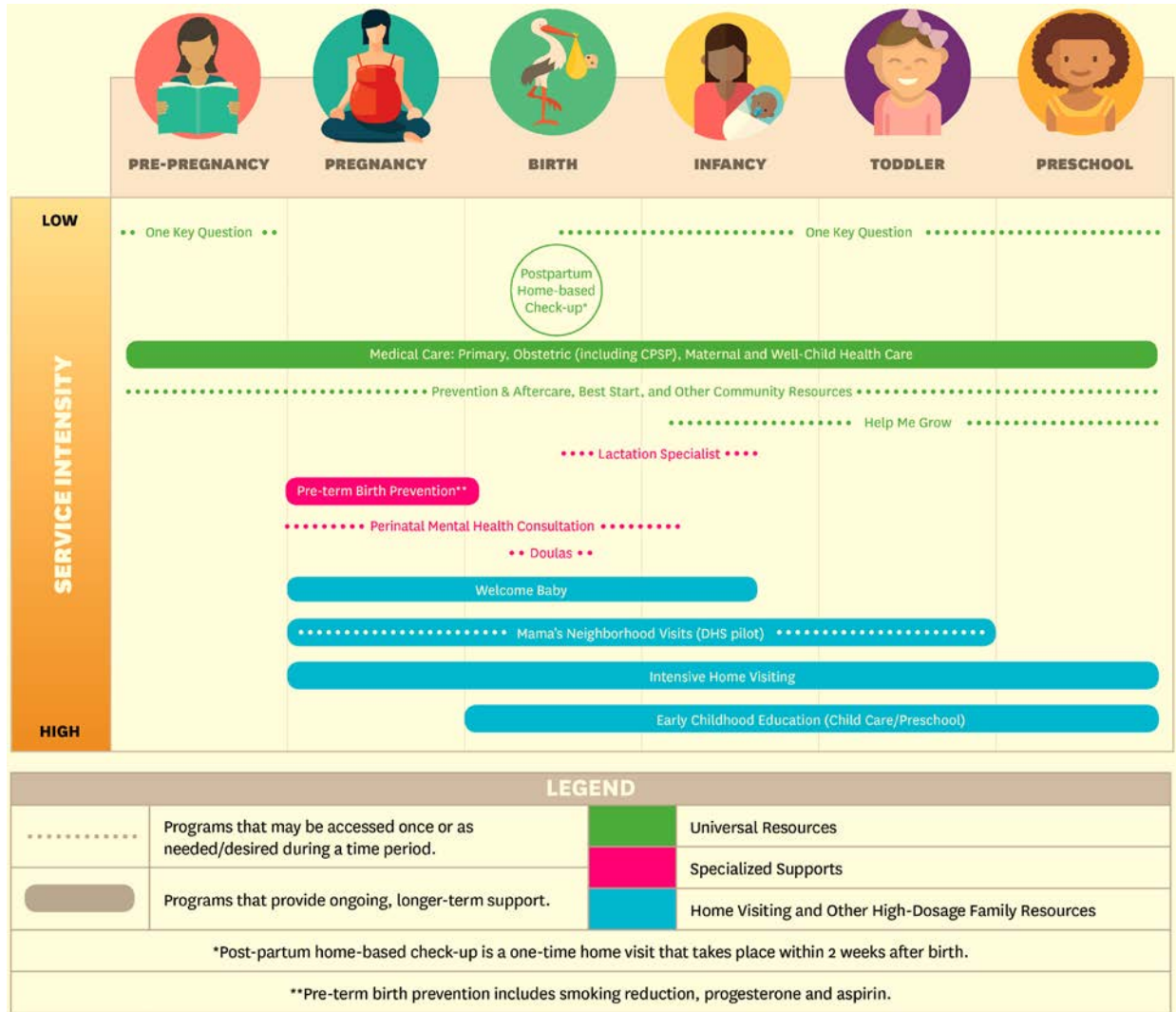
Other County investments are being pursued in parallel with this home visiting expansion. The alignment of these investments—particularly aligning resources to be timely, clear, and easily accessible from the family’s perspective—is crucial for our success.

The graphic on the following page illustrates how home visiting investments will align with some of these other investments to support families through their life course. It captures how home visiting models work together and in parallel with other prominent County, First 5 LA, and health sector resources to provide a spectrum of service options for families that spans from low-intensity, universal resources to high-intensity, long-term supports. It maps mainstream resources—primary health care (including the universal use of One Key Question®), early childhood education, and community supports (such as DCFS- and DMH-funded prevention and aftercare services, First 5 LA-funded Best Start Community resources,

⁶ Social-ecological health promotion concepts and graphic were informed by McLeroy, K. R., Steckler, A. and Bibeau, D. (Eds.) (1988). The social ecology of health promotion interventions. *Health Education Quarterly*, 15(4), 351–377.

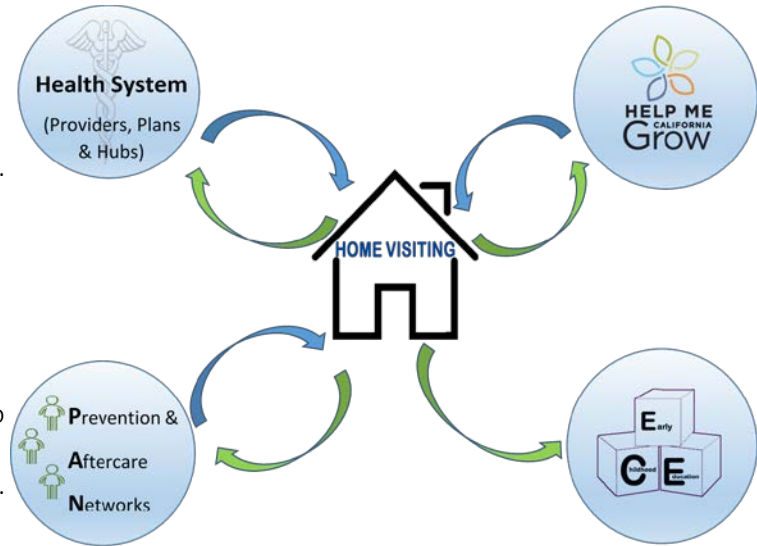
and Help Me Grow child development resources)—alongside interventions geared to address specific parenting scenarios (such as lactation specialists, doulas, pre-term birth interventions, and mental health consultation). It illustrates the piece of the puzzle that intensive home visiting models provide in the context of this whole—long-term, relatively more intensive support for families ready to engage with a trusted, trained coach to achieve family goals. It also maps how proposed concepts, such as a universal post-partum home-based check-up, fit within into health and service landscape.

It is important to note that the full set of dynamics and resources that influence family success extends far beyond what is captured in this chart.



These supports represent a web of mutually reinforcing resources connected by referral bridges. Home visiting both welcomes families from and ushers families to other system hubs within that web.

Because of these relationships, home visiting plays a valuable role in assessing the extent to which these resources are coming together to support families. If the balance of resources is off, home visiting agencies can be among the first to recognize which other resources are suffering capacity shortages most acutely.



Alignment of Home Visiting with County Health Equity Initiatives

Strategies that address health disparities and enhance home visiting investments will be mutually reinforcing. By strategically expanding access to home visiting, and by increasing the training and mental health resources available to home visitors, the County will be strengthening the impact that home visiting can have on infant mortality and birth disparities. At the same time, as the County’s Center for Health Equity deepens its focus on reducing infant mortality, it will be rolling out additional resources and trainings that strengthen the knowledge and skills of home visitors and other key workforce groups (medical providers, educators, agency staff). Home visitors will serve as an ongoing resource for disseminating knowledge about these new resources and helping families access them in a timely manner.

The following chart outlines some of the many ways in which home visiting investments are anticipated to support the County’s strategic initiatives on infant mortality, as outlined in its *Pathway to Equity* report.

<i>Pathway to Equity</i> Strategy	How Home Visiting Helps
One Key Question®	Home visitors will be trained on OKQ, enabling them to offer a reflective space for families to discuss family planning concerns or options, including dynamics between caregivers (including contraceptive coercion) that may be affecting family planning health.
Risk reduction	Home visitors provide ongoing referrals and support for smoking cessation and other risk-reduction goals (including stress management support).
Universal access to effective medical interventions	Home visitors associated with DHS’s MAMA’s Neighborhood Visits pilot will deliver medical interventions shown to reduce preterm births (including progesterone and low-dose aspirin) to patients for whom those treatments are indicated but inaccessible. In addition, all home visitors will help mothers become self-advocates in relation to perinatal health care and will support women in carrying out medically advised regimens.

<i>Pathway to Equity Strategy</i>	<i>How Home Visiting Helps</i>
Enhanced mental health services	Home visitors act as front-line mental health support for pregnant and parenting mothers, providing direct consultation for families (with the support of the enhanced mental health team described below), screening parents for depression and other perinatal mood disorders, and building bridges to more intensive therapeutic supports when appropriate.
Early referral to services	All home visitors in Los Angeles will be helping families use the validated instruments of the ASQ-3 and the ASQ-SE2 to assess child development, and will connect families in need of specialized services to the appropriate resources. Home visitors help families obtain transportation, child care, linguistic/cultural understanding, and other resources needed to attend appointments and follow through on medical or other advice.
Improving parent support, stress awareness, and self-confidence	In addition to providing direct support, home visitors play important roles in educating parents regarding the impacts of stress, stress reduction techniques, breastfeeding/parenting techniques, and community engagement activities so that parents feel confident and connected.

Alignment Among Home Visiting and Early Identification and Early Care and Education Systems

In well-coordinated early childhood systems, home visiting connects and refers families to health services, social services, and other family support systems. As part of this important connector role, home visitors can refer families to early identification and intervention (EI) supports to address a child’s developmental delays and behavioral concerns. It can also provide parent education on how to identify high-quality early care and education (ECE) options, and can assist families in navigating the significant complexities of ECE program enrollment—something that is essential both for child development and economic stability.

There is significant alignment between home visiting and EI’s desired outcomes, such as promoting healthy child development and school readiness. Approximately 1 in 4 children ages from birth through age six are at risk for developmental and behavioral delays.⁷ Despite this prevalence, only 21% of young children receive timely developmental and behavioral screenings in California.⁸ Home visitors help remedy this challenge. Home visitors monitor children’s development, conduct screenings at the recommended periodicity, and refer to appropriate intervention services when needed. They equip families with tools to encourage healthy development and knowledge to monitor developmental milestones. In addition, they encourage them to talk to their child’s health provider about healthy development. Home visiting programs can also act as an intervention support for children with or at risk for delays. Risk factors that prioritize families for more intensive home visiting (such as child maltreatment/neglect and parental substance use) are also predictors of developmental/behavioral delays in children. This presents an opportunity for home visitors to monitor these risk factors as early as pregnancy, identify children who

⁷ Bethell, C.D., et al. (2011). A National and State Profile of Leading Health Problems and Health Care Quality for US Children: Key Insurance Disparities and Across-State Variations. *Academic Pediatrics*, 11(3 Suppl), S22–33.

⁷ Macrides, P. & Ryherd, S. (2011). Screening for Developmental Delay. *American Family Physician*, 84(5):544–549.

⁸ Children Now (2018). 2018 California Children’s Report Card.

https://www.childrennow.org/files/9015/1975/3343/RC18_FINALonlineSPR.compressed.pdf

may be at risk for developmental/behavioral delays, and provide more intensive supports as needed. Evidence indicates that high-quality home visiting programs can improve child development.⁹

The strong alignment between home visiting and EII efforts has been strengthened through federal policy and funding. In 2017, the U.S. Department of Education (which administers the Individuals with Disabilities Education Act—Part C, or IDEA Part C, funding for early intervention services for infants and toddlers with disabilities) and the U.S. Department of Health and Human Services (which funds Maternal Infant Early Childhood Home Visiting), released joint guidance¹⁰ encouraging their grantees to better coordinate and collaborate across the two programs. The guidance recognizes that both funding sources require grantees to be embedded in a centralized or coordinated early identification, intake, screening, and referral system so that program providers are positioned to refer families to needed services in an appropriate and timely manner. The guidance also calls for integrated funding across early childhood sectors. One national example of this type of integrated funding in action is in Connecticut, which in 2013 established an Office of Early Childhood by combining programs and funding from five separate agencies including IDEA Part C, child abuse and prevention, EII, and home visiting.

In Los Angeles County, there have been many efforts to strengthen and better coordinate EII. DPH and First 5 LA are currently planning for the implementation of Help Me Grow (HMG) in Los Angeles County, a model that promotes local cross-sector collaboration to bolster the early screening and surveillance of developmental and behavioral delays for all young children. HMG seeks to coordinate existing systems that serve children with or at risk for delays and their families—such as home visiting—to ensure that families receive appropriate intervention services and supports. As of 2018, DPH has been recognized as the organizing entity for HMG—LA, which means it will be responsible for providing fiscal and administrative oversight for the long-term sustainability of HMG—LA and for facilitating cross-sector coordination to strengthen early identification and intervention in Los Angeles County.

DPH’s role as both the organizing entity for HMG and the lead agency for home visiting within Los Angeles County provides a unique opportunity for leveraging and aligning these two systems. For example, one prominent opportunity for synergy includes the potential to bridge referral technologies related to both efforts into one “go-to” resource for families and professionals. Another is the opportunity to support the maximization of federal and state funding streams to support both efforts.

Similarly, DPH is uniquely positioned to support synergy between these initiatives and early childhood education resources in Los Angeles, as a result of its new role overseeing the Los Angeles County Office for the Advancement of Early Care and Education. DPH’s position at the nexus of these three systems opens opportunity for cross-sector training, technological integration, financial leveraging, and other reforms to improve how these parts of our broader family support network come together to help families. These shifts present new opportunities to realign these systems to be more accessible, easier to navigate, more effective, and more responsive to families. In these three significant roles, DPH is uniquely positioned to help transform and better coordinate referral services and supports for the early childhood population.

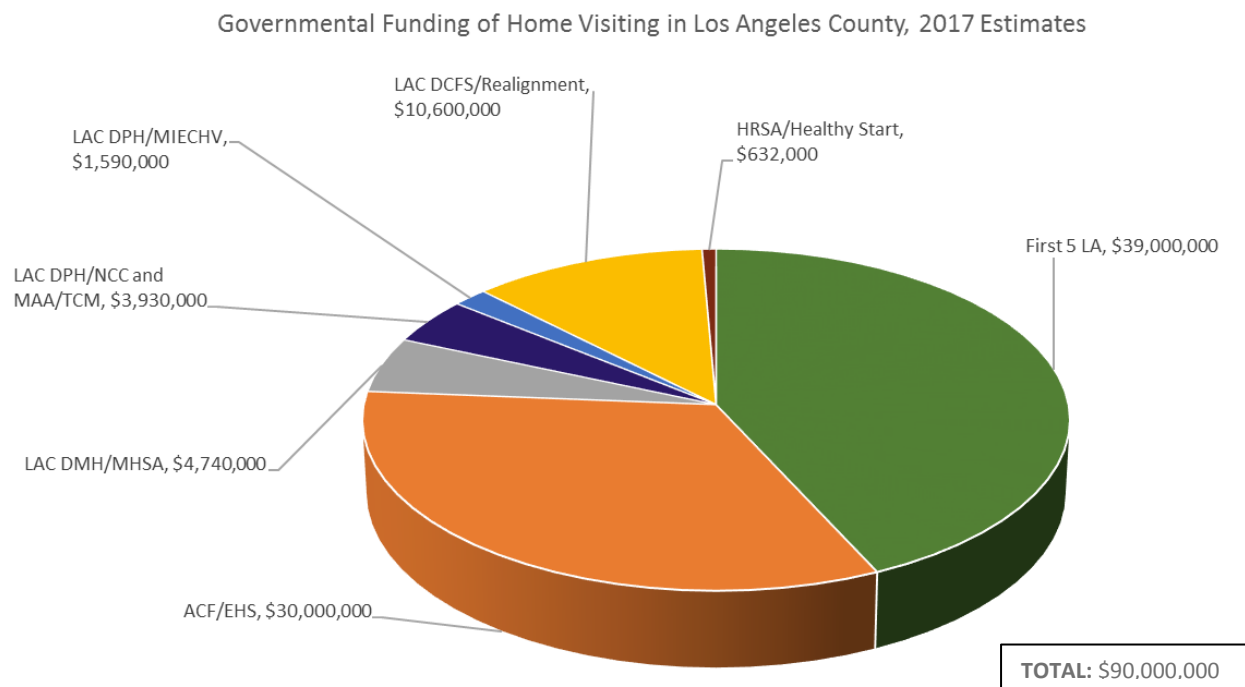
⁹ Supplee, L. & Adirim, T. (2012). Evidence-based home visiting to enhance child health and child development and to support families. *American Psychological Association*.

<http://www.apa.org/pi/families/resources/newsletter/2012/07/home-visiting.aspx>

¹⁰ U.S. Department of Education & U.S. Department of Health and Human Services. (2017). Collaboration and Coordination of the Maternal, Infant, and Early Childhood Home Visiting Program and the Individuals with Disabilities Education Act Part C Programs. <https://sites.ed.gov/idea/files/ed-hhs-miechv-partc-guidance.pdf>

Baseline Los Angeles County Home Visiting Investments

At the outset of this planning process, the baseline state of home visiting included a strong but disconnected foundation of publicly funded programs. As of 2017, publicly funded home visiting programs in Los Angeles were funded through the contributions of five local governmental entities, plus numerous contracts awarded by the federal government to local nonprofit organizations. The graph below illustrates these major public funding sources.^{11 12}



¹¹ Family interventions provided in the home (such as home-based therapeutic interventions) are not reflected here because they do not match the preventative home visiting definition above. Nonetheless, it is worth noting that a substantial amount of funding is also available for such services in Los Angeles, and comes alongside the funding displayed here to meet the full needs of our families, as may be appropriate based on each family's situation.

¹² Notes for "Governmental Funding of Home Visiting in Los Angeles County, 2017 Estimates":

**ACF/EHS*: The Federal Administration for Children & Families funds Early Head Start programs. This funding is estimated based on an extrapolation of actual capacity using comparative volume and intensity of services.

**LAC DMH/MHSA*: DMH supports home visitation programs using Mental Health Services Act (California Proposition 63) Prevention and Early Intervention funds.

**LAC DPH/NCC and MAA/TCM*: DPH uses County General Funds (Net County Cost) combined with Federal Title XIX (Medicaid) matching funds that can be claimed via the Medicaid Administrative Activities (MAA) and Targeted Case Management (TCM) programs.

**LAC DPH/MIECHV*: DPH also receives funds from the Federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program administered by the Health Resources & Services Administration (HRSA) Maternal Child Health Bureau.

**LAC DCFS/Realignment*: DCFS funds home visitation programs using state realignment funds.

**HRSA/Healthy Start*: The Health Resources & Services Administration (HRSA) Maternal Child Health Bureau administers the Federal Healthy Start program.

**First 5 LA*: First 5 LA receives funding from California's Proposition 10 tobacco tax and makes investments to optimize the health and early life experience of children from before birth through age five, including home visiting.

Collectively, these funding streams enable 55 local nonprofit organizations plus DPH Maternal Child and Adolescent Health (MCAH) to provide home visiting services with a total capacity for helping approximately 24,500 families per year, including intensive services to approximately 9,500 high-risk families per year. In addition, a handful of smaller home visiting programs are run by nonprofit agencies using philanthropic or grant dollars.¹³

All publicly funded models in Los Angeles focus their efforts on promoting healthy child development, addressing maternal mental and physical health, supporting nurturing family relationships, and assisting families in achieving self-defined goals (such as improved financial or relational stability). The specific foci, curricula, and restrictions of these programs vary by model. Each model has a defined curriculum, methodologies, staffing requirements, frequency of client contact, service length, entry requirements, intended outcomes, and actual outcomes as demonstrated through research. Eligibility for each model may be limited by model or by local funder to specific risk, income, geographic, and/or age criteria.

The majority of models operating in Los Angeles are restricted to families meeting a “high-risk” threshold based on family characteristics (such as poverty, substance abuse, or geography). Some of these thresholds are set based on national model guidelines; others have been established by local funders seeking to reach particular subsets of the population. These models offer services with high frequency (two to four visits per month) and longer duration (six months to five years). One model, Welcome Baby, screens families for level of risk and offers a lower frequency (six to nine contacts) to families who are identified as being at low or moderate risk, and refers families at higher risk and meeting geographic criteria to more intensive home visiting models. Welcome Baby has been implemented in 14 birthing hospitals delivering babies who live in some of the County’s highest-risk communities.

Los Angeles County currently has multiple federally designated “evidenced-based” programs, including Nurse-Family Partnership, Early Head Start, Healthy Families America, and Parents as Teachers (see Appendix C | *Paving the Road to Safety for Our Children* for more detail). The remainder of Los Angeles’ programs may be described as “evidence-informed,” as they adapt elements of evidence-based programs and implement them in alternative service models tailored to meet the needs of specific populations.

The following chart summarizes the models and capacity funded by Los Angeles County departments, First 5 LA, and the federal government as of June 2017.¹⁴

¹³ Based on simple calculations using the figures above, a rough estimate for the average cost of home visiting programs per family per year is \$3,675. However, program costs can vary widely based on the program model implemented with differing staffing patterns, frequency of visits, duration of service, and other factors. Los Angeles County has the opportunity to adjust overall cost and capacity to serve a greater number of families by making strategic decisions regarding which models to invest in primarily.

¹⁴ Appendix E | Executive Summary, Home Visiting in Los Angeles County provides additional details regarding the state of home visiting at the outset of our planning process.

Funding Entity	Models	Families/Year
First 5 LA	Welcome Baby Healthy Families America Parents as Teachers	15,000 general 3,100 high-risk
Federal Office of Head Start	Early Head Start	3,450 high-risk
Los Angeles County Department of Children and Family Services	Partnerships for Families	1,260 high-risk
Los Angeles County Department of Public Health	Nurse-Family Partnership Healthy Families America	1,210 high-risk
Los Angeles County Department of Mental Health		
Federal Health Resources and Services Administration	Healthy Start	500 high-risk

Also noteworthy at the outset of the planning process was the existence of a significant baseline of collaboration and infrastructure. Through the partnership of DPH, First 5 LA, LABBN, and community agencies, the Consortium has been acting as a bridge among programs for several years. Most notably, since 2015, with financial support from the Partnership for Early Childhood Investment and First 5 LA, Consortium members across multiple models have been collaborating to promote quality, coordination, measurement, and sustainability among home visiting agencies. Infrastructure already in place included data systems for each program that performed various types of outcome tracking, demographics, client interactions, and enrollment functionality. The Stronger Families database utilized by First 5 LA–funded programs provided a direct referral connection between hospital teams and home visiting provider agencies. Coordination, training, and technical support is provided to First 5 LA’s Stronger Families Network of Welcome Baby and home visiting agencies through the Family Strengthening Oversight Entity, which is managed and delivered by LABBN, Maternal Child Health Access, and PAC/LAC (Perinatal Advisory Council: Leadership, Advocacy, and Consultation). Telephonic support was in place for DPH’s Nurse-Family Partnership program. Along with the service investments outlined above, these existing leadership commitments, community collaborative efforts, philanthropic investments, and infrastructure elements contributed to a solid foundation that positioned Los Angeles well for the development and implementation of system-wide plans.

What National Research and Local Gap Analysis Taught Us

In keeping with the Board motion’s sections I and III, analyses both of national research and of the Los Angeles County home visiting landscape were used to ground this plan in nationwide best practices and current local data. Inputs included:

- 1) Guidance from national and local experts funded by the Office of Child Protection and First 5 LA
- 2) Extensive research funded by the Partnership for Early Childhood Investment and First 5 LA on behalf of the Consortium to support system improvement efforts
- 3) Expertise and insights shared by home visiting provider agencies, advocates, and prospective client families at Consortium-hosted community input sessions and First 5 LA funded focus groups

Based on these combined sources, seven priority system changes surfaced as opportunities to better meet community needs:

1. Develop a centralized, coordinated referral technology to help families and professionals navigate complex eligibility rules
2. Expand resources by better leveraging existing funding and by identifying new sources
3. Expand eligibility criteria to reach families excluded by criteria built into current evidence-based programs
4. Increase prenatal recruitment and marketing activities to broaden access and improve birth outcomes
5. Explore additional opportunities to ensure that home-based services are optimally supporting health equity, such as by piloting innovative models or strengthening workforce practices, based on data analysis and evaluation results
6. Improve perinatal mental health supports
7. Improve connections with and the leveraging of health care system resources.

Details of the learning garnered from each source are explained more fully below, including the single-entry portal, national best practices, gap analysis, and funding exploration required by the Board motion.

National Research

Our review of national models and best practices included interviews with leading researchers from Chapin Hall (at the University of Chicago) and the University of Southern California. This review affirmed the value of many of the structures already in place and collaborative efforts already underway, such as current data tracking, best-practices adoption, and referral improvement efforts being led by the Consortium.

Research regarding portals of entry helped to inform our recommendations relating to the creation of a coordinated electronic infrastructure to improve access for families. Single-entry portals (mentioned specifically in the Board motion, and sometimes called “centralized intake”) that require all applicants to

flow through one central application system have been implemented in some jurisdictions. Research found pros and cons to such systems that should be carefully weighed before pursuing such an investment, and that single-entry systems may be better suited to areas with less pre-existing infrastructure and more centralized authority.^{15 16} Los Angeles has a number of currently functioning referral pathways and enrollment systems. Requiring programs to fully forgo these existing paths and systems in order to adopt a single, centralized enrollment system poses three concerns: 1) there is a risk that existing working pathways are weakened; 2) the costs of changing enrollment and recruitment procedures to make this large a shift outweigh the anticipated benefits; and perhaps most importantly, 3) Los Angeles County does not have the authority to mandate participation by programs funded via federal or other non-local sources.

Research suggested that the optimal fit for Los Angeles would be a “coordinated” entry system, in which centralized technology and collaboration supports the broad and efficient engagement of families. Under this entry model, Los Angeles would benefit from coordinated referral technology that improves the connection of families from various gateways to the available programs that fit their needs. This type of centrally managed technological tool would help families identify and connect efficiently to the local programs for which they are eligible, so that they may easily choose and access the right resource for their family.

National-level research also identified valuable opportunities to expand funding, including:

- The use of untapped funding streams such as Temporary Assistance to Needy Families (TANF) and Mental Health Services Act—Prevention and Early Intervention (MHSA-PEI)
- The maximization of underutilized streams, such as Medicaid Targeted Case Management (TCM)
- Other health-sector strategies such as Medicaid waivers and the improved leveraging of health benefits available under Medi-Cal and private health plans.

Local Landscape Assessment

The assessment of local data in 2017 revealed three prominent “pain points” that systemic planning might help resolve:

- A lack of funds to meet the full community need
- Overly narrow eligibility criteria that limit access for families who could benefit from home visiting
- Under-developed prenatal recruitment

Funding Gaps

Comparing current home visiting capacity to full community need revealed substantial gaps in services for both high-risk populations and the general Los Angeles County population.

Using 2014 DPH Los Angeles Mommy and Baby project (LAMB) survey data and methodology informed by Children’s Data Network research, the number of families giving birth in Los Angeles County each year who exhibit at least two risk factors¹⁷ was estimated to be approximately 32,000. More recent

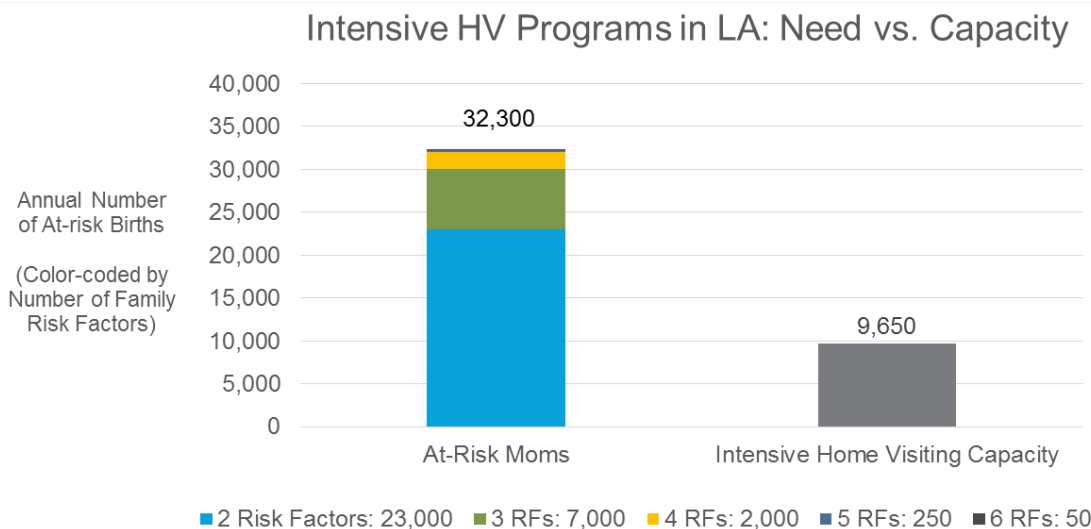
¹⁵ National Evidence-Based Home Visiting Model Alliance. (2017). C-Intake: Lessons Learned and Recommendations.

¹⁶ Maternal Infant and Early Childhood Home Visiting (MIECHV) Technical Assistance Center. (2014). MIECHV Issue Brief on Centralized Intake Systems.

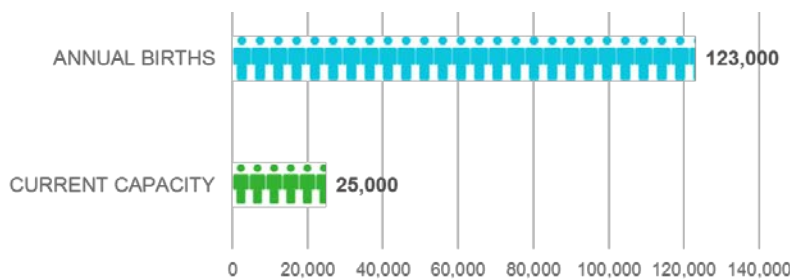
https://www.greatstartgeorgia.org/sites/default/files/miechv_issue_brief_centralized_intake.pdf

¹⁷ Risk factors in our analysis included: teen mom, depressed while pregnant, used illicit drugs while pregnant, physically abused while pregnant, entered prenatal care after three months, achieved less than a high school education, and being homeless while pregnant. Risk factors were chosen based on a combination of Children’s Data

calculations performed by First 5 LA in conjunction with the Children’s Data Network estimated that achieving this estimate of 32,000 intensive service slots would correlate to a systemic capacity to reach approximately 60% of all children projected to have a child protective services referral by age 5.¹⁸ Meanwhile, only 9,500 spots currently exist for intensive home visiting for these families in Los Angeles. The graph below illustrates this gap between the number of at-risk families and the volume of intensive services available on an annual basis.



Comparing the 15,000 openings for less-intensive home visiting services with the 123,000 births in Los Angeles County in 2016,¹⁹ one can see the substantial gap remaining to achieve a truly universal system. Current funding provides sufficient capacity to serve only 12% of the general population.



Eligibility Challenges

Each Los Angeles–based home visiting model has its own eligibility requirements based on geography, age, income, and/or risk profile.²⁰ In some cases, these eligibility restrictions have been established by the

Network research regarding child abuse risk factors and the expertise of the Consortium Data Workgroup. Findings from the LAMB survey were extrapolated to the number of women who give birth annually in Los Angeles County for a population estimate.

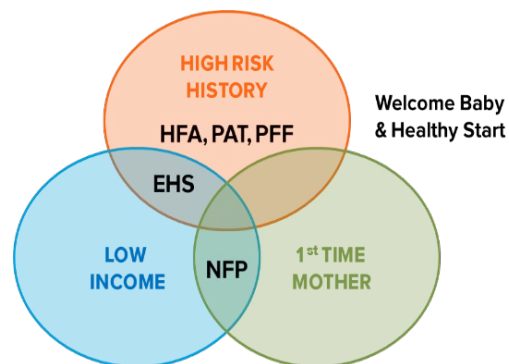
¹⁸ The full Children’s Data Network analysis may be accessed at <https://s3.amazonaws.com/childrens-data-network/LA+HV+Consortium+Presentation+4.5.2018.pdf>.

¹⁹ Los Angeles County birth rate data source: California Department of Public Health, Center for Health Statistics, OHIR Vital Statistics.

²⁰ *Geographic Restrictions:* Programs restricted to specific Service Planning Areas include Healthy Start and Antelope Valley Healthy Families America. Early Head Start is federally restricted by ZIP Code. Programs restricted to one of

local funding agency to focus resources on particular high-risk subpopulations; in others, by the national fidelity model. The combined impact of these restrictions is that many families are simply not able to access home visiting services because of local eligibility requirements. Substantial subsets of our population are left out of all home visiting programs.

Furthermore, the complexity of eligibility makes it very difficult for professionals and families to know which programs to reach out to for help. Without a centralized mechanism to match resources to family needs, even qualified families frequently miss out on available programs. This challenge will only be exacerbated as additional capacity is added to the system: when more services are available, it will be even more important for the complexity of eligibility to be ameliorated through technology or policy changes so that parents may efficiently connect with the best program for their family and so that resources are fully utilized.



Prenatal Outreach Opportunities and Birth Disparities

Our research also pointed to a need for greater prenatal outreach. Data in early 2017 and interviews with home visiting providers showed that the Los Angeles programs with unused capacity generally required prenatal or at-birth enrollment. Other programs were at full utilization or have since reached full capacity.

Furthermore, prenatal outreach is particularly important because it is key to supporting healthy birth-weights and to improving equity in birth outcomes. Across the lifespan, Los Angeles County exhibits sharp disparities in health and social outcomes among different racial and ethnic subgroups. Most notably, infant mortality in Los Angeles County is 10.4 per thousand live births for African-American residents, compared to 3.9 per thousand for Hispanic residents, 3.2 per thousand for White, and 2 per thousand for Asian/Pacific Islanders. In other words, an African-American newborn in Los Angeles County is more than three times as likely to die in the first year of life as a White newborn, and more than five times as an Asian/Pacific Islander.²¹ The following chart, from the Los Angeles County Center for Health Equity, shows these rates from 1996 to 2016. Events and exposure before, during, and following birth affect infant mortality rates.

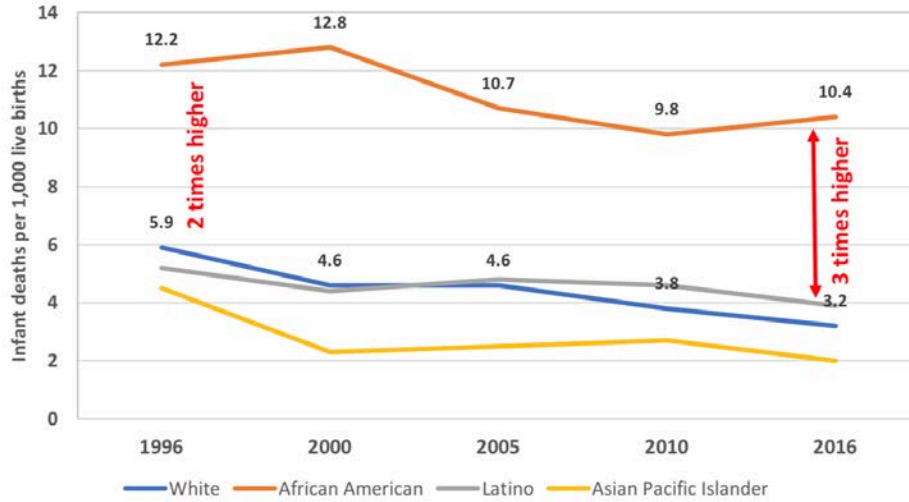
the 14 localized Best Start neighborhoods include Welcome Baby, Healthy Families America, and Parents as Teachers per local First 5 LA guidelines.

Age Restrictions: Most intensive programs in Los Angeles require entry at or prior to birth. Nurse-Family Partnership is restricted to families entering before 28 weeks gestation. Healthy Family America and Parents as Teachers are available only to families immediately after hospital delivery per local First 5 LA requirements. Partnerships for Families is restricted to families entering prenatally or up to the child’s first year. Welcome Baby is available only to families entering at or prior to birth. Entry into Healthy Start extends from the prenatal period through age two. Early Head Start is available from the prenatal period through age three.

Income and High-Risk Restrictions: Welcome Baby services are available to families of all incomes and risk profiles. Healthy Start is available to families who fit a demographic profile defined in each program’s funding application based on a community history of risk. In Los Angeles County, Healthy Families America, Parents as Teachers, and Partnerships for Families are available only to families that have a history of high risk. Early Head Start is available to families that have a high-risk history and who are low income. Nurse-Family Partnership is available to low-income first-time mothers.

²¹ Center for Health Equity, Los Angeles County Bureau of Health Promotion. (2018). A Pathway to Equity: A Framework to Close the Black-White Gap in Infant Mortality. <http://paclac.org/wp-content/uploads/2018/06/IM-Brief.pdf>

Infant Mortality by Race/Ethnicity Los Angeles County, 1996 to 2016



The following table also illustrates this point, comparing rates of low birthweight and very low birthweight neonates in addition to infant mortality rates among different races or ethnicities.²² The significantly higher rates of both conditions among African-Americans again describe a situation not simply attributable to traditional socioeconomic or environmental risk factors. A growing and consistent body of research points to the toxic effects of chronic stress caused by exposure to pervasive structural racism. A model that measures and sums individual risk factors to assign those who would benefit from more intensive home visiting models may fail to consider this underlying cultural and societal issue, which places African-American women at higher risk for poor birth outcomes regardless of other individual characteristics.

**Infant Mortality and Very Low and Low Birthweights
Los Angeles County, 2016**

Mother's Race/Ethnicity	Total Live Births	Infant Mortality		Low Birthweight Less than 2,500 grams		Very Low Birthweight Less than 1,500 grams	
		Total	Deaths per 1,000 Live Births	Total	%	Total	%
African American	8,425	88	10.4	985	11.7	210	2.5
Asian	19,608	40	2.0	1403	7.2	166	0.8
Latina	67,666	261	3.9	4556	6.7	772	1.1
White	22,808	73	3.2	1429	6.3	194	0.9
County-wide Total	122,941	495	4.0	8,783	7.1	1,430	1.2

²² Source: California Vital Statistical Birth and Death files, 2016; created by LACDPH MCAH Programs, Research, Evaluation and Planning Unit

These data point to opportunities to improve health outcomes through more intentional efforts to engage disenfranchised populations during pregnancy and between pregnancies. For example, building non-stigmatizing pathways into home visiting from medical providers, community-based organizations, health plans, early learning settings, and County Departments could improve our ability to reach such families, and thereby to affect birth outcomes. We also may be able to improve health equity via other efforts, including but not limited to piloting other innovative models. Last but not least, building a culturally responsive workforce can optimize perinatal and early childhood care and foster health and social equity.

Community Provider Roundtable and Parent Focus Groups

Over 90 local home visiting providers and advocates gathered at a Community Roundtable hosted by the Consortium to share their expertise and input regarding community needs and opportunities for system improvement. Key insights included:

- The need for improved perinatal mental health training, connections, and clinical supports for pregnant and new mothers suffering from perinatal mood and anxiety disorders
- A confirmation of the need for more flexible eligibility and funding to make home visiting services available to all families for whom they are a fit
- Interest in exploring medical billing options
- Interest in technological infrastructure to improve efficiency, outreach/engagement, referrals, billing, and outcome tracking
- A desire to strengthen ties with the medical community

Focus groups of current and prospective home visiting participants were conducted by SocialQuest and First 5 LA to gain community member perspectives. These sessions reaffirmed the themes enumerated earlier (see Appendix B | Excerpts from Focus Group Analysis). Parents cited the transformative impact of home visiting: those who commit to home visiting often experience deep, life-changing benefits and many wish they could have more visits. They also emphasized that home visiting acted as a gateway for them to other needed supports, such as housing and mental health counseling. At the same time, they pointed to the disappointment and frustration of current “leaky” referral pathways and eligibility complexity. They underscored the need for greater social support to counteract isolation and depression during the perinatal period. Parents also identified other opportunities for innovation and improvement, including improving the engagement of families (by better communicating the benefits of home visiting when offering programs and by increasing word-of-mouth promotion), increasing the use of texting, and greater father engagement.

Our Proposed Solutions

Four key areas for system change were identified as key to realizing an optimal system of support in Los Angeles County:

1. **Coordination:** Building new processes, technology, and pathways to improve access
2. **Data:** Establishing common data elements across programs to guide continuous quality improvement, measure results, and convey shared impact
3. **Workforce:** Recruiting, training, and sustaining excellence
4. **Funding:** Expanding the volume, flexibility, and capacity of our funding infrastructure



This section delineates the recommendations of the County Departments and their partners within each of these action areas, and the commitments that stakeholders have made to move those recommendations forward.

Coordination

This section delineates recommended strategies for realizing a coordinated system of supports that expectant and parenting mothers can access easily and early, and that provides the right combination and intensity of services to meet families' needs. It outlines key steps to achieving our vision of a system that provides access to families through multiple environments, including but not limited to County, medical, and community environments. It does so recognizing that home visiting services represent one important resource within a broader set of family supports that we seek to coordinate for the benefit of our families.

The concepts proposed herein build on national research on single-entry portal and coordinated entry systems, and the local gap analysis requested by the Board of Supervisors. This section highlights both technological and organizational opportunities. It brings together the strengths of governmental, medical, and community service providers both as referral pathways into home visiting *and* as resources to meet each family's needs.

The three strategies that emerged as most valuable for improving access to home visiting—especially for those Los Angeles County families who are most vulnerable—were:

- Building a coordinated referral infrastructure that includes centralized technology
- Increasing pathways from County programs into home visiting and other community supports to better meet the needs of high-risk populations
- Embedding universal prenatal and postpartum screening and access to home visiting within the primary health care system, leveraging and building upon existing health supports.

Bringing together the public and private sectors around these three system changes is a critical first step in helping Los Angeles County children and families thrive.

Coordinated Referral Technology

Investments in referral technology and related infrastructure could address the challenges currently faced by providers and families attempting to access appropriate services. Current challenges identified by stakeholders include:

1. The diversity of programs and variability of eligibility criteria across programs make it challenging for referring agencies and health care providers to know which programs to offer families (which programs they are eligible for, which are located in their geography, and which are the appropriate fit for the family's needs).
2. The large volume of provider agencies across the county, along with the insufficient distribution²³ and dynamic nature of programs, makes it hard for referring agencies to maintain the up-to-date contact information and forms required to efficiently connect people with programs.
3. There currently is no shared²⁴ way for referring agencies to track or check real-time program enrollment or capacity; when programs are full, parents become frustrated, losing momentum and general trust in the resources being offered.

²³ Hasenfeld, Chen, Garrow & Parent. (2013) Spread thin: Human service organizations in poor neighborhoods. *The State of the Nonprofit Sector in Los Angeles Report*. UCLA Luskin School of Public Affairs Center for Civil Society. https://www.socalgrantmakers.org/sites/default/files/resources/The%20State%20of%20the%20Nonprofit%20Sector%20in%20Los%20Angeles%20Report%202013_Human%20Services%20Orgs.pdf

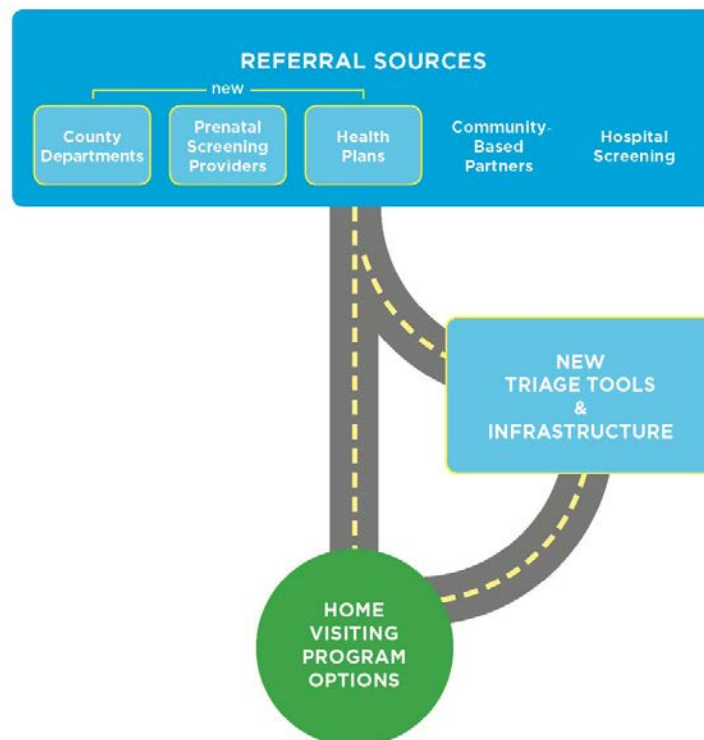
Building a coordinated electronic referral system, with affiliated telephone hotline, would help to resolve these challenges. DPH, the Consortium, and First 5 LA are ready to collaborate to develop and maintain this needed electronic system. This effort is anticipated to take place in two phases. Phase I is the development of electronic eligibility and program information look-up (“triage”) functionality. Phase II is the integration of this functionality into broader DPH, First 5, and other electronic and telephonic referral systems.

The Consortium, DPH, and the Center for Strategic Public-Private Partnerships (CSPPP) are already collaborating on Phase I, transitioning the Consortium’s existing manual referral directory into an electronic format. This electronic build is being made possible through the joint sponsorship of several philanthropic foundations with the coordinating support of the CSPPP. This step will address many of the difficulties professionals have in determining the correct program to meet their client families’ circumstances and accessing the contact information and forms needed.

First 5 LA has also committed funding for DPH to engage in a one-year planning process to define the exact scope, system integration, resource requirements, and sustainability plan of Phase II. This planning year will allow sufficient time to clarify the optimal set-up to meet community members’ needs, including but not limited to possible integration with Help Me Grow infrastructure, First 5 LA’s Stronger Families referral mechanism, and other relevant systems. Such connections could help resolve the third challenge listed above—parent frustration—by enabling parents and referring professionals to know in real time whether or not agencies have the capacity to take on new families, before encouraging parents to enroll.

To accompany this electronic system, a telephonic resource for referral support will be established. Because of DPH’s existing commitment to managing a hotline for both Nurse-Family Partnership and Help Me Grow, DPH is well positioned to provide this new resource. In fact, there is a benefit to merging all home visiting resources into existing systems—broadening their purpose rather than creating another stand-alone system. Leveraging and expanding existing resources offers a more streamlined referral system, providing professionals and families seeking services with one central resource rather than multiple numbers to call.

NEW REFERRAL PATHWAYS & TOOLS



²⁴ At this time, the Stronger Families database provides this capability for First 5 LA–funded Welcome Baby, HFA, and PAT programs only.

New Pathways and Access for At-Risk Populations

The second key area of focus is the need for increased system-wide capacity to offer home visitation to families at high risk of involvement with the child welfare system, consistent with both the recommendations of the Los Angeles Blue Ribbon Commission on Child Protection and the Board of Supervisors' motion.

To address this need, multiple County Departments have committed to pilots, process changes, and investments to create and improve referral pathways into home visiting programs for high-risk, pregnant, and parenting clients.

In response to concerns about narrow eligibility criteria, DPH piloted an expansion of its Nurse-Family Partnership program criteria in Service Planning Areas (SPAs) 1, 3, and 8, accepting not only first-time parents but also parents who are already raising other children. It anticipates spreading this expansion countywide in the upcoming year.

DPSS launched two pilots to explore opportunities to connect its most at-risk families to preventative supports:

- A pilot in SPA 6 that refers Family Stabilization families with children from before birth to age three to the Prevention & Aftercare Network and home visiting supports (with financial support underwritten by First 5 LA)
- A pilot in SPAs 1 and 3 in which a DPH Public Health Nurse is paired with a clinical social worker to offer interventions, referrals, and services, including home visiting, to eligible California Work Opportunity and Responsibility to Kids (CalWORKs) families in crisis

These pilots illustrate creative cross-departmental collaboration and are potential models for the expansion of access to intensive home visiting services for DPSS families. Both pilots demonstrated great success in engaging parents and connecting them with resources. In fact, the SPA 6 pilot was able to fill all funded home visiting spots faster than was anticipated, and provided learning that informed state-level home visiting funding discussions. Building off the early success of these pilots, DPH and DPSS are dedicated to the expansion of these services Countywide in fiscal year (FY) 2018–2019, so that Family Stabilization clients in all SPAs will have access to referrals and health and home visiting support.

DCFS and DMH have committed to utilizing MHSA-PEI funds to help build linkages for families who have had a child abuse report filed that does not meet the statutory criteria for an in-person response, and who would like to be connected to community services. Research has demonstrated that such families are at higher risk for re-reporting and the later removal of children into foster care. DCFS is working with its Prevention & Aftercare Network partners to build intentional bridges for these families to connect to home visiting agencies and other supports. DMH is funding expanded resources for Prevention & Aftercare Networks to provide these linkages, as well as exploring ways to improve access to home visiting for DCFS-connected families who utilize Los Angeles County Medical Hub Clinics and other community supportive services. In addition, DCFS has collaborated with Early Head Start (EHS) providers to build a "Head Start and Early Education Referral System" to connect DCFS clients to EHS services. DCFS also refers DCFS-supervised pregnant and parenting teens to home visiting services when applicable.

DHS has also launched a pilot funded through its Section 1115 Whole Person Care waiver. The focus of this pilot is the creation of new home visiting offerings for high-risk²⁵, Medi-Cal–eligible clientele. This program is being built as an extension of DHS’s existing MAMA’s Neighborhood, which has set the standard of care for perinatal health support in Los Angeles through its success in recruiting vulnerable women and having an impact on their psychosocial and medical well-being. This pilot enables DHS to fill a gap it had identified in its existing service reach, allowing it to engage a very high-risk population to whom it must bring services to achieve retention in clinical and other supports. DHS is building out connections to these resources in the context of additional comprehensive prenatal and extended post-partum services.

Probation plans to train its investigation, supervision, and triage staff to connect pregnant and parenting families to home visiting supports. It anticipates rolling out training to approximately 500 staff beginning in early FY 2018–2019.

To support the inflow of at-risk families coming from these new County referral pathways, and to ensure more equitable access to services for at-risk families in general, DMH has identified MHPA-PEI funds that it is reallocating to new prevention programming, including funding for home visiting services in FYs 2018–2019 and 2019–2020. The focus of this investment will be the expansion of services for families at risk of child maltreatment and/or adverse birth outcomes. After this initial two-year period, DMH will review and determine future investment plans based on outcomes and on the availability of funding.

The expanded home visiting services funded through MHPA-PEI will be rolled out in collaboration with DPH, with DPH as the program operations and oversight lead. DPH and DMH have chosen the Nurse-Family Partnership, Healthy Families America, and Parents as Teachers models for this expansion because of their fulfillment of MHPA evidence-based criteria specifically in relation to the prevention of child maltreatment. They have also chosen to invest in two new, innovative models that seek to reach specific at-risk populations: MAMA’s Neighborhood Visits, which will serve high-risk Medi-Cal eligible families interfacing with the County medical service system, and Family Stabilization Support, which will serve DPSS Family Stabilization clients. DPH, DMH, and DPSS are committed to these services being operational in early FY 2018–2019.

DMH and DPH will use this expansion opportunity to address the eligibility-driven access issues outlined in the “What National Research and Local Gap Analysis Taught Us” section starting on page 18. Healthy Families America and Parents as Teachers programming will be open to families in all areas of the county and will not be restricted to families referred from hospitals (consistent with national model guidelines), as with currently funded programs. Further, it will allow high-risk families living outside First 5 LA–designated Best Start communities to be offered one of these more intensive home visiting programs. MAMA’s Neighborhood Visits will also be offered countywide. As mentioned earlier, Nurse-Family Partnership funding will be open not only to first-time parents (the restriction prior to the commencement of this planning process), but also to families expecting additional children. These modifications will add the flexibility needed to connect previously excluded at-risk families to the right home visiting program for their family.

Universal Screening, Achieved via Medical System Integration

The third pillar of improving access for families is the implementation of universal prenatal and post-partum screening, triaging, and resources. This approach ensures access to the most intensive services for families who would most benefit from these supports, while providing opportunities for all families to

²⁵ High-risk as defined by DHS includes homeless, at risk of homelessness, incarceration, domestic violence exposure, substance abuse, severe and persistent mental illness, or experiencing a medically high-risk pregnancy.

get off to a strong start. The goal of this type of “targeted universalism” is to achieve an outcome-driven division of resources, providing each family with the level of assistance they need to succeed.^{26 27}

This build-out of universal supports is crucial to ensuring health equity, as it assures that access to strength-based supports are open to all families, including specific populations who may not have had access to or elected to engage in prior service options. It de-stigmatizes maternal support, making key resources (such as lactation, perinatal mental health, and community referrals) part of standard practice.

This effort will have an intentional prenatal outreach emphasis for three reasons: (1) because of the importance of prenatal supports in reducing disparities in infant mortality; (2) because of the research demonstrating women’s increased receptiveness to making healthy changes during pregnancy; and (3) because of the immense body of research demonstrating the impact that prenatal health can have on life-long, multi-generational health and other outcomes.

“When we talk about universal services, we don't talk about giving everybody the same thing. We talk about giving people the level of service that they need. And that service may come from a publicly funded service. It may come from their own informal support system. It may come from their neighbors and friends. It's about linking families up to resources ... looking at the context in which families live and asking if we can enrich that context with a set of services and a set of welcoming opportunities to receive services in ways that will really make a difference.”

—Dr. Deborah Daro, Chapin Hall

By building partnerships with the health sector, such as with health plans and Comprehensive Perinatal Services Program (CPSP) leadership, we aim to ensure that *all* mothers are connected with timely prenatal supports. This integration with the medical system will augment the bridges being built between home visiting and social service settings—such as DPSS, DCFS, Women, Infants and Children(WIC), and other pathways referenced above—to ensure universal access for all Los Angeles County families. This connection will include screenings and “warm hand-offs” to appropriate home visiting supports, as well as other important resources such as obstetric care, WIC nutrition supplements, and public assistance options. Pre-existing integrated screening mechanisms in each of these various environments will be leveraged whenever possible to avoid duplicative inquiries regarding sensitive information. These mechanisms will be used in conjunction with the new coordinated infrastructure to efficiently connect families to appropriate resources, using common factors to triage appropriately within the context of each environment.

The second universal outreach point we aim to make is at birth. Under this vision, all families would be offered the opportunity for at least one post-partum home-based coaching session to ensure that the transition into parenting is healthy and successful. This visit, scheduled automatically as part of the hospital discharge process, would include breastfeeding support, connections to pediatric care, maternal mental health screening, trauma screening, and referrals to resources as may be appropriate. Recognizing that family needs and/or interest in participation may change during pregnancy, families would also be (re)screened during this visit for their eligibility for home visiting. Families would then be offered services

²⁶ Powell, J.A. (2008). Post-Racialism or Targeted Universalism, *Denver University Law Review* 86, 785. “Targeted universalism” is the strategy of using population-specific interventions to achieve universally desired outcomes.

²⁷ Powell, J.A., Menendian, S., Reece, J. (2009). The importance of targeted universalism, *Poverty and Race*, 18 (March-April).

appropriately matched to their level of need and interest. Families with multiple risk factors could be offered the opportunity for up to five years of intensive home-based support to help realize optimal child development, family well-being, and life goals.

Under this vision, all pregnant women and families with young children in Los Angeles County would have access to trusted professional support and coaching in their homes—right-sized based on their needs and preferences—so that they and their children thrive.

Page 31 illustrates this model for universal access in Los Angeles.

To move this vision forward to reality, County leaders and First 5 LA have developed strategic partnerships with health plan leaders, who are increasingly interested in improving coordination with community-based service providers. First 5 LA has taken the lead on this health sector partnership development. It hosted multiple forums to gain health plan input and leverage their expertise as we build a system of care for mothers and infants that incorporates home visitation. Interviewees and participants included senior-level health plan leaders in health education, care management, and medical services. These interviews and gatherings yielded significant information from the plans on their perspectives regarding the value of home visitation and their current initiatives to provide enhanced pre and post-natal support. In partnership with DPH and DHS, First 5 LA will continue to nurture the relationships with health plan leaders established during this planning process. These efforts will aim to further unite health plan resources and County maternal and child health services under a shared agenda of ensuring timely prenatal care and reducing birth inequities.

Data

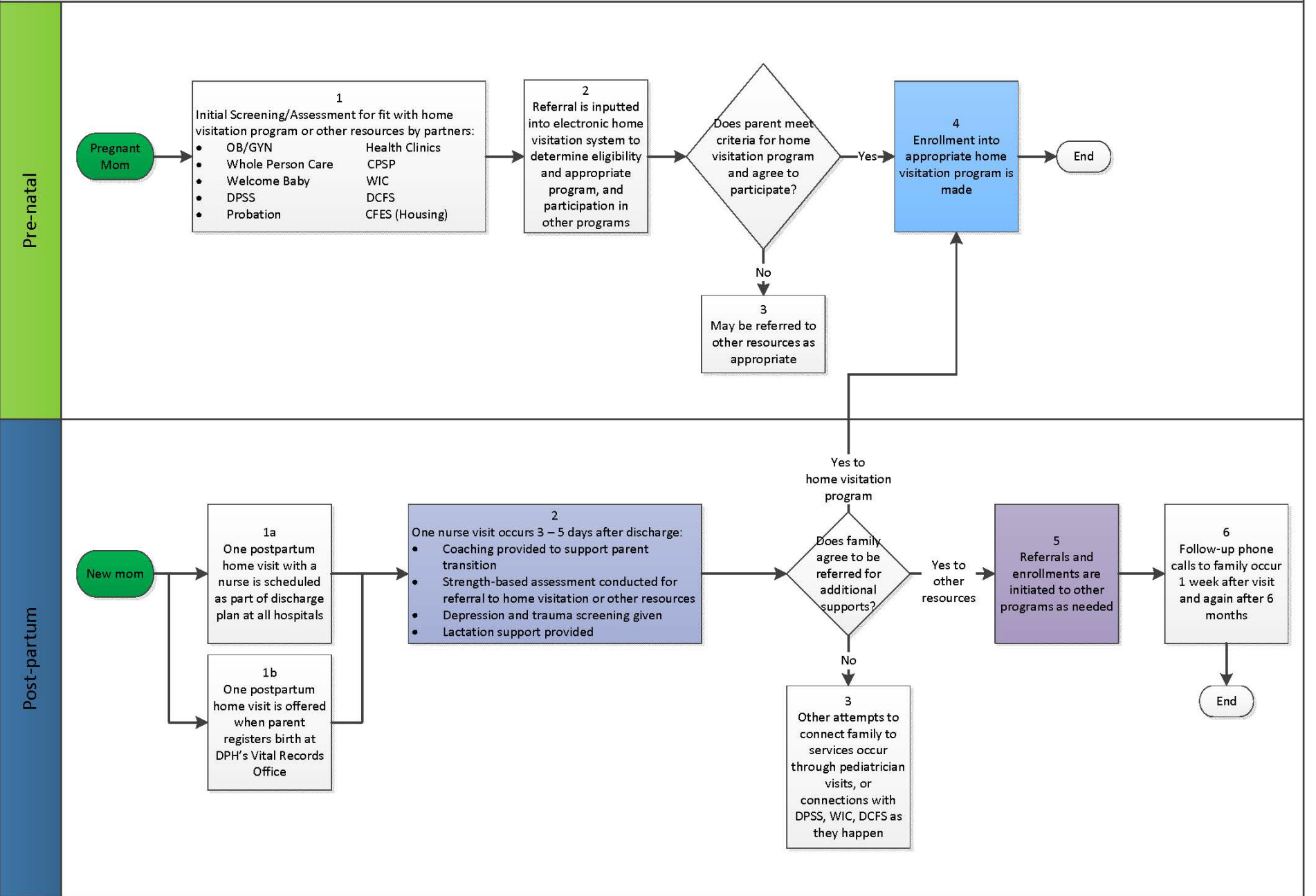
Three interrelated purposes exist for collecting, analyzing, and reporting data on home visiting: 1) performance measurement; 2) continuous quality improvement; and 3) capacity development and resource planning. Some elements related to each of these purposes are already in place both at the individual program level (as supported by current home visiting funders) and at the countywide collaborative level (led primarily by the Consortium to date). The countywide home visiting system envisioned in this plan will build on these existing data systems. It will also align its efforts with the work underway through the Office of Child Protection to develop a countywide child maltreatment prevention measurement system.

We envision three major outcome domains—healthy births, safe children, and strong families—each of which would include multiple indicators and measures that could be used to understand results at the family, program, community, and system levels. A fourth domain focusing on finance is also proposed to help decision-makers track cost savings and cost avoidance. National research by the respected nonpartisan group Washington State Institute for Public Policy and other academics have found various home visiting models to yield between \$0.12 to \$20.25 for every dollar invested;²⁸ by incorporating an ongoing analysis of cross-departmental cost/benefits associated with home visiting programs into the Institute’s research and evaluation strategies, we will gain invaluable information to inform future strategic investment and operational planning.

²⁸ Perrigo, J.L., & McCroskey, J. (2018). “Home visiting models: What do we know about cost effectiveness?” Unpublished manuscript, Suzanne Dworak-Peck School of Social Work, University of Southern California, United States. Detailed WSIPP cost-benefit reports may also be accessed at <http://www.wsipp.wa.gov/BenefitCost>.

Universal Home Visitation Model for Los Angeles County

As of 1/26/18



To fulfill this crucial system need, we propose a three-pronged approach to performance measurement and information management:

1. Measurement and reporting on system-wide results in the four key domains—healthy births, safe children, strong families, and cost savings/avoidance
2. Regular tracking of programmatic reporting, including the core set of common indicators developed by the Consortium (Appendix D), as well as other potential standardized measures such as the Protective Factors Survey and parent feedback mechanisms
3. Ongoing analysis of administrative data to map program capacity, track system resource utilization, and assess needs and gaps (e.g., based on geography, underserved groups, and/or program selection criteria).



Roles and Metrics

First 5 LA, in partnership with the Children’s Data Network (CDN), has made a commitment to the long-term countywide population-level measurement of results and will be leading our long-term countywide evaluation efforts. Using data-matching with available administrative datasets, partners will analyze the impact that countywide home visiting has on healthy birth, child safety, and family well-being metrics. It will also examine cost savings and cost avoidance achieved via the County’s investment in home visitation. This analysis will be directly tied to and aligned with measurement of child abuse prevention efforts within the County, as called for by the Office of Child Protection in its prevention plan (Appendix C).

The Consortium’s Data Workgroup has already provided leadership in developing common outcome, process, and descriptive “indicators” for tracking program performance across all home visiting programs in Los Angeles County (based on Maternal, Infant, and Early Childhood Home Visiting, or MIECHV, program data reporting requirements; the Pew Charitable Trusts’ Home Visiting Campaign; Healthcare Effectiveness Data and Information Set (HEDIS) quality measures; and the data currently being collected by home visiting programs in the region). The Board of Supervisors’ motion specifically calls for the leveraging of these indicators as a mechanism for achieving a common data platform for all Los Angeles County home visiting programs. In keeping with this directive, these indicators (Appendix D) will serve as a framework for shared outcome reporting and ongoing quality improvement across County, First 5 LA,

and other programs. The Consortium will continue to play the lead in this reporting effort, developing an online data visualization platform for easy review and use of the data. The Department of Public Health, First 5 LA, DCFS, and the Los Angeles County Office of Education will meanwhile play key roles in ensuring timely data contribution and the use of the information for quality improvement.

Additional standardized measures of family well-being or program effectiveness may also be adopted as our system evolves, including but not limited to a Protective Factors survey (which will be required for all DMH, DPH, and First 5 LA–funded programs as of July 2018). Each model also utilizes parental feedback loops (including exit surveys, focus groups, and/or parent advisory boards) and model-specific outcome analyses to inform continuous quality improvement.

Last but not least, to ensure that our investments are being optimally distributed over time, we propose that DPH, First 5 LA, CDN, and the Consortium partner to provide an ongoing assessment of home visiting program availability and usage compared to community needs. This assessment will entail monitoring the geographic, demographic, and linguistic distribution of community need and comparing that need to local home visiting program capacity and utilization. It also may include the assessment of additional measures of system health, such as the need for linkage to other resources, the success rates of such linkages, and participant retention. Having this type of high-quality capacity, utilization, community need, and gap assessment data is essential to achieving optimal resource allocation—not only for home visiting services, but also for related community-based family supports. By monitoring this pulse of resource availability and utilization, we will have the information we need to make informed future decisions about where resource adjustments and innovation may be needed.

Outcome Framework

Through commitment to the approaches outlined above, the County will be able to keep an ongoing watch on how well County home visiting programs are contributing (as part of the larger family support system) to crucial community-level outcomes, including ensuring healthy births, safe children, strong families, and cost savings/avoidance.

The following overarching outcome framework was developed to cross-walk how both long-term and annual data tracking efforts may come together to help us track, evaluate, and learn from our home visiting system. This framework was informed by input from the aforementioned County partners and developed in collaboration with the OCP Prevention Plan Evaluation Team and Children’s Data Network leadership. Because the OCP countywide prevention measurement system with which we hope to align our home visiting evaluation work is not yet in place, this section describes an overall approach to measurement and data management rather than specifying a finalized measurement plan.

The chart on page 34 illustrates our four outcome domains, with proposed measurement methodologies and sample suggested metrics that could be affiliated with each outcome area. Steps needed before a specific measurement scheme is adopted would include system mapping, the analysis of existing data sets, and a cross-validation of possible measures.

Outcome Areas	Measurement Method	Sample Suggested Metrics ²⁹
Healthy Births	Children’s Data Network	<ul style="list-style-type: none"> • Decrease in health disparities among racial subgroups • Reduction in pre-term births^I, low birthweight^{H,I}, infant mortality^I, severe maternal morbidity
Safe Children	Children’s Data Network & Consortium Indicators	<ul style="list-style-type: none"> • Decrease in child protective service referrals^C • Decrease in substantiated abuse and neglect^C • Decrease in removals^{I,C} • Increase in DCFS Hotline referrals to community supports • Decreased emergency room visits^{I,H}
Strong Families	Consortium Indicators and other measures of <i>Maternal & Child Health</i>	<ul style="list-style-type: none"> • Increase in well-child visits,^{I,H} post-partum visits,^{I,H} prenatal visits,^{I,H} immunizations,^H and insurance rates^I • Increased breastfeeding rates^I • Increased maternal depression screening^I • Improved postpartum family planning rates^I and increased inter-pregnancy intervals • Improvement in California Maternal Quality of Care/ California Maternal Data Center (CMQCC/CMDC) measures
	Protective Factors (<i>includes Parenting and Family Financial Strength outcomes</i>)	<ul style="list-style-type: none"> • Increased parent knowledge of child development^P • Increased parent resilience^P • Improved social and emotional competence of children^P • Improved access to concrete supports in times of need^P • Increase in parental social support^P
	Consortium Indicators & Help Me Grow/TBD measures of <i>Early Childhood Development</i>	<ul style="list-style-type: none"> • Increased screening and access to Regional Center services for child developmental delays^I • Improved 6-year-old math and language scores
Cost Savings/ Avoidance	Children’s Data Network and Consortium Indicators	<ul style="list-style-type: none"> • Exact cost savings and avoidance metrics will be determined by the Prevention Plan Evaluation Team. Metrics will be informed by County input (may include measures such as decrease in ER use and NICU/ICU stays, long-term special education needs, decrease in long-term use of public assistance, decrease in criminal involvement, others)^C
^C Indicates outcome that could be part of Children’s Data Network evaluation ^I Indicates outcome or related process measure is tracked as part of LACPECHVC Indicators ^H Indicates outcome is a HEDIS measure, CHIPRA measure, and/or a health plan priority ^P Indicates outcome is tracked as part of the Protective Factors survey		

Workforce

Crucial to the success of these systems-change efforts is the recruitment, training, and preservation of a strong workforce. This domain is particularly important as we seek to activate home visiting as a resource for achieving health equity. To optimally help our diverse community, including high-risk, marginalized communities, we must be intentional about building a diverse and culturally humble workforce. As we expand funding for services, we need to simultaneously expand the volume and skills of our workforce.

²⁹ For the purposes of this table, suggested metrics include a sample of measures currently collected in different systems. Some focus on service processes and are important for quality improvement, while others reflect program outcomes. Only a subset are currently collected regularly for all families participating in home visiting programs.

Quality is essential; we must provide support to our teams to ensure that they are able to thrive and mature amid all these dynamic changes. As we launch new models, referral pathways, clinical resources, billing mechanisms, and data practices, we need to provide ample support to our staff.

Five workforce investments will be pursued to meet these needs:

- Increased perinatal mental health cross-training and clinical support
- Capacity-building and practice improvements to increase cross-cultural humility, improve engagement, and reduce implicit bias
- Recruitment of additional home visitors and program leadership from communities that mirror the diversity of our families
- Investigation into turnover and salary rates, accompanied with solutions to address any challenges identified
- An analysis of long-term opportunities to bolster the home visiting field by exploring opportunities for community members, students, and others to access career ladders and roles in the home visiting workforce

Perinatal Mental Health Capacity Building

The first of these efforts is already underway. DMH has committed to partnering with the Consortium, DCFS, and other home visiting networks to increase perinatal mental health cross-training and resource coordination. DMH and the Consortium have already launched trainings and training needs-assessments in four SPAs, and will be rolling resources out to all SPAs over the upcoming year. DMH will leverage its trauma-informed models, screening components, training modules, regional navigators, and field-capable home-based services as tools in these efforts. This work will build and strengthen the bridges between these resources and home visiting networks in Los Angeles County.

DPH and DMH have also committed to utilizing DMH-PEI funds to establish a centralized team of clinical social workers to provide therapeutic supports to home visiting clients and staff, as well as other professionals. With this improved perinatal mental health training, referral, and direct clinical support, home visitors will have a stronger capacity to help prenatal and post-partum mothers who are experiencing depression or other perinatal mood and anxiety disorders. Through the enhanced capacity these efforts will build, home visiting programs will be better positioned to achieve the desired outcomes of reducing the risk of adverse childhood experiences, of improving maternal health, and of improving parental capacity to provide nurturing, developmental stimulation, and economic well-being to their families.

Improving Cultural Humility, Engagement, and Implicit Bias

To address the inequities in our current health and social service delivery system, we must recognize and ameliorate the implicit bias and lack of cultural humility that have acted as barriers to effective family support. We will train and transform our workforce from leadership to front-line so that our full approach—including model structure, family connection/outreach, engagement, and ongoing service relationships—are more responsive to and respectful of the diverse perspectives, histories, and cultures of our population.

In 2017, the Los Angeles County Health Agency launched the Center for Health Equity (CHE), which is housed within DPH.³⁰ CHE's mission is to ensure that everyone in Los Angeles County has the resources and opportunities needed for optimal health and well-being throughout their lives; it strives to advance racial, social, economic, and environmental justice in partnership with committed County partners, local organizations, and community members. CHE includes the Institute for Cultural and Linguistic Inclusion and Responsiveness, which aims to improve cultural humility and respect, particularly within the County's health care delivery system. The principles, tools, trainings, and other resources offered by the Institute align with broader initiatives to improve cultural and linguistic respect and can inform efforts to improve the responsiveness of the home visiting workforce.

DPH, DMH, First 5 LA, and other partners are committed to providing training for the home visiting workforce on cultural humility, implicit bias, and other health equity related topics. The partners are also committed to identifying policy changes that may be needed to support our staff teams in providing optimal support. One step that has already been taken to support this effort has been the funding by First 5 LA of research and focus groups to inform future efforts. The results from focus groups of African-American mothers regarding the perceptions of service delivery systems and programs, and of research regarding how African-American women engage with clinical services, will be used to inform future program design and policy efforts that will frame the services our workforce delivers.

Recruitment

The third of these efforts is also already underway. The departments of Public Health, Mental Health, Health Services, and Public Social Services are in the process of rolling out a substantial expansion of Nurse-Family Partnership, Healthy Families America, Parents as Teachers, MAMA's Neighborhood, and Family Stabilization services in Los Angeles. As part of this effort, DPH will provide direct hiring and training for new Nurse-Family Partnership, Family Stabilization, and MAMA's Neighborhood Visits staff, and will also underwrite recruitment and training resources for Healthy Families America and Parents as Teachers. Los Angeles Best Babies Network will coordinate and deliver trainings and technical assistance to support high-quality practice during this staff expansion. To further health equity goals, there will be targeted efforts to increase diversity in the home visiting workforce, such as the inclusion of more people of color and individuals with a variety of language skills. This create not only more equitable employment opportunities for persons from many different communities, but a better alignment of the workforce with the population of clients being served can improve trust, bonding, effectiveness of communication, and overall outcomes for these families.

Human Capital Management

The fourth workforce investment is being led by First 5 LA, which is underwriting research on turnover and salaries among Los Angeles County home visitors, informed by the efforts of the Consortium. This research will then be utilized by the Consortium, DPH, First 5 LA, and partnering agencies to assess the adequacy of current workforce salaries and supports. Where systemic concerns or opportunities are identified, partners will work collaboratively to implement solutions that will guarantee a secure, dedicated, and well-maintained workforce.

Career Pathway Development

The Consortium, County, First 5 LA, and community partners are additionally interested in developing long-term workforce development opportunities. These explorations would include opportunities to create intentional career pathways into and within the home visiting field, opportunities to integrate pathways for community members into the field, and potential partnerships with higher education

³⁰ <http://publichealth.lacounty.gov/CenterForHealthEquity/>

institutions. With sufficient investment, the Consortium is particularly well positioned to lead this type of system-wide workforce development, as it operates as a strong platform for cross-model exploration, collaboration, and high-quality workforce support.

DPH is especially interested in the paraprofessional components of this exploration as an opportunity to improve engagement with and outcomes among disenfranchised community members. During the upcoming year, DPH will be examining opportunities to expand on the paraprofessional workforce in the system by increasing investments in the *promotora*, doula, and/or family partner–based models that employ trained paraprofessionals and community members in various perinatal support roles. These paraprofessional options are intended to provide more diverse resources to better meet the unique preferences of our community. These models would offer lower-intensity alternatives—provided by trusted community members—to “hard-to-reach” families who might otherwise not accept assistance. Focusing primarily on prenatal and post-partum health outcomes, they represent an opportunity for Los Angeles to innovate and reduce health disparities. They also have the additional benefit of providing career-ladder opportunities for community members who may not have a post-secondary or graduate education but who have valuable lived experience.

Funding

A key directive of the Board motion is “to identify a framework to maximize resources by leveraging available funding, and where possible, identify new and existing, but not maximized, revenue streams to support home visiting expansion.” To this end, current research was reviewed and key experts interviewed on the types of financing strategies used by home visitation efforts in other states and localities. National resource-maximization strategies were assessed with an eye toward what may be feasible in Los Angeles County. Based on this work, several opportunities were identified.

Achieving scale is indeed one of the most pressing challenges facing the network of home visiting programs in Los Angeles County. As delineated above, research comparing the capacity of home visiting in the region to community need revealed a shortage of resources for both intensive and universal services. Furthermore, sustainability is a challenge. First 5 LA is currently the largest funder of home visiting in Los Angeles County, having invested approximately \$39 million in FY 2016–2017. First 5 LA funding continues to decline with the loss of tobacco revenue, however, jeopardizing the long-term sustainability of existing service capacity in the system.

Opportunities identified to maximize resources in Los Angeles included:

- Leveraging previously untapped local funding streams, such as MHSA-PEI
- Improving the leveraging of federal funding streams by augmenting current billing and contracting mechanisms
- Ensuring that service providers have the appropriate training and technical assistance to participate successfully in federal fund leveraging
- Pursuing new or untapped state and federal sources, such as TANF funds and Medicaid Waivers
- Implementing multiple financing strategies simultaneously, in a blended and/or braided fashion
- Implementing advocacy strategies in parallel to sustainability efforts to ensure long-term outcomes are met

- Coordinating investments across funders in an intentional manner to maximize impact—including synchronizing how home visiting investments are utilized in concert with other health and social sector investments

Because of the varying levels of “readiness” of these opportunities, our framework recommends these opportunities be pursued in two phases.

Phase I: Immediate Term Opportunities to Expand Funding for Home-Based Services

To realize our vision for home visiting in Los Angeles, it will be necessary to both maximize available leveraging opportunities and identify new sustainable revenue streams. Strategies for expansion that are currently in various stages of execution include:

- DMH Mental Health Service Act (MHSA) investment
- Medicaid Targeted Case Management (TCM) expansion
- Temporary Assistance for Needy Families (TANF) investment
- Medicaid waivers

As explained earlier, DMH MHSA fund allocation is a major strategy that partners have committed to support both intensive services and innovative pilots in 2018. DPH and DMH will be utilizing MHSA-PEI dollars in FYs 2018–2019 and 2019–2020 to expand funding for evidence-based Nurse-Family Partnership, Healthy Families America, and Parents as Teachers models and for new MAMA’s Neighborhood Visits and Family Stabilization services. They anticipate services launching July 2018. After this initial two-year period, DMH will review and determine investment based on availability of funding.

Targeted Case Management expansion is a key strategy being implemented in 2018 to maximize federal revenue for home visiting. TCM uses a combination of local funds (such as First 5 tobacco tax revenue) to leverage Federal Title XIX (Medicaid) funds. TCM services are the most commonly billed services by home visiting programs in the nation, but this strategy had not been fully maximized in Los Angeles County because of local restrictions. The Department of Public Health, recognizing that federal funds were being left on the table, has now made the requisite policy adjustments to enable participation by non-County entities including community-based organizations. In early 2018, First 5 LA and DPH partnered on a pilot with five First 5 LA–funded home visiting grantee sites to test the applicability of this strategy. The results of the pilot, which ended in April, demonstrate a strong alignment between home visiting models and TCM. The early financial projections also point to a considerable TCM federal return. Based on these promising findings, the pilot will be expanded to the remaining 16 First 5 LA grantee sites in a phased approach throughout the course of FY 2018–2019.

In 26 states across the nation, TANF is a source of funding for home visiting programs. This past year there were multiple bills and proposals to similarly dedicate TANF funds to home visiting at the California state level, thanks in no small part to the advocacy of First 5 LA and its partners. Multiple local entities, including DPSS, took part in educating state-level decision-makers regarding the valuable role home visiting can play in strengthening families and helping parents to access benefits. As proposals were discussed, a collective voice from Los Angeles County informed policymakers. Numerous organizations, including the Consortium, adopted official support positions. The pilots launched in Los Angeles County by DPSS (described in the Coordination section) helped pave the way for state-level investment by demonstrating the viability and value of such investment. As a result, a set-aside has been included in the 2018–2019 California Budget for a two-year pilot of TANF-funded home visiting across the state. This new state funding increases home visiting resources in California substantially; Los Angeles County is well

positioned to draw a significant portion of these funds. Los Angeles County's tracking and communication of results from this first-time state investment will be critical to supporting long-term sustainability.

Medicaid waivers represent both a short- and long-term strategy. As discussed earlier, DHS identified the Medicaid Section 1115 waiver's Whole Person Care program as an opportunity to expand home visitation in Los Angeles County over the next four years. In partnership with DPH, the program will serve as a mechanism to test a blend of programs in an evidence-informed effort to reach some of the region's most vulnerable pregnant and parenting families. The expansion of the DHS prenatal program MAMA's Neighborhood will not only fill short-term gaps in the existing home visiting landscape, but will also serve as a demonstration that can inform future state plan amendment proposals to secure sustainable medical funding streams.

In addition to expanding funding for home visiting programs, it will also be important to leverage County departmental supports to augment home visiting during Phase I. For example, although DCFS's Partnerships for Families program is included among the home visiting models described in this report, other DCFS family-centered services programs are not. It would be worthwhile to assess whether or not DCFS programs such as Family Preservation, Child Abuse and Neglect Prevention, Intervention and Treatment (CAPIT), Adoption Promotion and Support Services, and Relative Support Services could be better aligned with evidence-based home visiting models. A recent analysis of funding for DCFS family-centered services contracts in 2016–2017 showed annual expenditures of over \$50 million dollars. Lessons learned from evidence-based home visiting models could help to improve results for participating families, and extend the current system. Similarly, DMH programs (such as Wraparound, Full Service Partnership, Parent-Child Interaction Therapy, and Triple P) and health-focused programs led by the Health Agency offer additional supports in parallel to and/or layered on top of home visiting. Optimizing linkage and synergy among these programs will be important to fully maximizing the impact of our resources in Los Angeles.

Phase II: Additional Opportunities to Offset Costs and/or Expand Equitable Universal Perinatal Support

Over the next year, while Phase I implementation is underway, the partners will continue to explore additional opportunities to expand the resources available to support all families universally in their prenatal health and post-partum well-being. Such exploration will include an examination of partnerships that may provide new access ports, potential venues for screening/assessment, and/or potential cost offsets.

These potential Phase II opportunities include:

- Comprehensive Perinatal Services Program (CPSP)
- Women, Infants and Children (WIC)
- Private and public health plan partnership
- Expansion of state-approved extended health benefits for perinatal care
- Medicaid reimbursement
- Hospital community benefits funding
- Other potential Medi-Cal and health system-sponsored opportunities

The first three of these are leveraging and relationship-building opportunities. CPSP, health plan benefits, and WIC are all resources currently available to low-income families in Los Angeles, but they are not utilized by all families who are eligible. CPSP providers offer prenatal screening, prenatal and postnatal health education, and resources to Medi-Cal families, including in the home. WIC offers lactation, nutrition, and referral services. Health plans offer telephone referrals and other supports. Two health plans also offer home visiting specifically. Health Net has been piloting home visiting services in the

Antelope Valley. Molina Health Plan’s Care Connections program offers free in-home postpartum visits by a nurse practitioner. The providers who deliver these services all are well positioned to provide prenatal screening and referrals to intensive home visiting where appropriate. They also each provide valuable low- and medium-intensity perinatal support services (such as lactation, nutrition, coaching, and resources), with CPSP in particular having the capacity to provide those services in the home environment.

TCM and hospital community benefits are both monetary resource opportunities. Similar to the expansion of TCM for intensive services, described above, TCM may be utilized to expand the funding of low- or medium-intensity programs such as Welcome Baby. Hospital community benefits are another potential funding source to underwrite low-intensity perinatal supports.

An important part of our plan will be partnerships with health sector and other players to deeply analyze and build upon these opportunities. Engaging health plan leadership, WIC leadership, and hospital leadership is a crucial step to ensuring that the home visiting system we build both fully leverages and smoothly integrates with health sector and other existing perinatal resources. In partnership with these leaders, we will further clarify the optimal prenatal screening and referral mechanisms, the suite of services available to low- to moderate-risk families, and the alignment of funding streams that will best finance those resources.

In late FY 2018–2019, learning from Phase I implementation will be integrated with learning about these potential Phase II partnership and funding opportunities. Phase I implementation is anticipated to garner important knowledge that will help inform Phase II implementation priorities—including but not limited to a clarification of workforce needs (through the salary and career-ladder studies), a clearer definition of Los Angeles County’s birth disparities investments, and a more accurate quantification of cost savings/avoidance related to certain strategies (such as TCM billing expansion). This knowledge will be combined with learning about the health sector and other opportunities listed above as next steps are determined.

Together, these two components will inform a second potential rollout of investments that could begin as early as FY 2019–2020.

The following table summarizes these Phase I and Phase II opportunities.

Current Funding	Phase I Expansion	Phase II Opportunities
<ul style="list-style-type: none"> • DCFS • DMH • DPH • First 5 LA • Federal Administration for Children & Families (Early Head Start) • Federal HRSA (Healthy Start) 	<ul style="list-style-type: none"> • DMH MHSA-PEI funds • Expanded Title XIX TCM billing • DHS/Whole Person Care Medicaid waiver • CalWORKs funds 	<ul style="list-style-type: none"> • Medi-Cal and health system opportunities • Hospital community benefits • CPSP • Existing health plan benefits • WIC • Probation

Where Do We Go From Here?

The Department of Public Health and its partners (County departments, First 5 LA, the Consortium, the Children’s Data Network, health sector leaders, and home visiting providers) are ready to implement the key elements outlined in the attached plan—building centralized referral tools, bolstering the strength of our workforce, solidifying common data practices, and rolling out new funding streams. These elements, including the specific commitments enumerated below, are anticipated to be completed during FY 2018–2019, with the exception of the Phase II referral technology build-out anticipated in FY 2019–2020. The partners will also continue to look for connections to integrate this home visiting work with other nascent related work underway in the county, such as prevention plan implementation, reduction in birth disparities, Help Me Grow, and early childhood education efforts.

County Departmental Commitments

The following are commitments made by each department to support the implementation of this plan.

Department of Public Health

- Building and maintaining coordinated telephonic and electronic referral infrastructure (including supporting a Phase I eligibility tool build being led by the Consortium and leading the Phase II integrated build)
- Launching DMH-PEI funded evidence-based service expansion
- Providing public nursing staff to be part of integrated teams in both the DHS MAMA’s Neighborhood Visits pilot and DPSS’s Family Stabilization program
- Expanding the Nurse-Family Partnership program to provide greater support in SPA 6 (in line with the Center for Health Equity’s goals) and to enlarge the geographic reach of its expansion pilot so that non-first-time parents may access services throughout the county
- Collaborating with DMH to provide centralized clinical perinatal mental health services to home visiting clients
- Exploring and piloting innovative models for supporting highest-risk families and communities experiencing adverse health equity outcomes, including but not limited to infant mortality
- Ensuring that training resources are in place for the full home visiting workforce related to implicit bias and the smooth ramp-up of newly funded services
- Partnering with First 5 LA to expand TCM billing to First 5 LA-funded Healthy Families America and Parents as Teachers providers
- Pursuing an ongoing assessment of community need and service utilization, in partnership with First 5 LA, the Consortium, Children’s Data Network, and other stakeholders

Department of Mental Health

- Funding service and infrastructure expansions using DMH-PEI funds during FYs 2018–2019 and 2019–2020
- Establishing a centralized perinatal mental health clinical support team
- Ensuring that training resources are in place for the full home visiting workforce related to trauma-informed care and perinatal mental health

Department of Health Services

- Fully launching MAMA’s Neighborhood Visits, including establishing an evaluation for the program and realizing strong workforce development for its new teams

- Establishing a multidisciplinary collaborative care model for case management that includes a partnership with DMH and expanded paraprofessional roles within its home visiting teams
- Exploring the implementation in DHS of a doula program for women delivering babies, in partnership with community-based doula organizations
- Unifying DHS's prenatal care delivery with the Office of Diversion and Reentry, the Los Angeles County Sheriff's Department, Juvenile Court Health Services, and Probation to minimize care gaps and maximize engagement in home visiting programs

Department of Public Social Services

- Expanding the Family Stabilization pilot countywide, in partnership with DPH and DMH
- Pursuing new state funding, as may be approved in the Governor's budget, to support expansion of home visiting services for CalWORKs beneficiaries

Department of Children and Family Services

- Ensuring that Partnerships for Families home visitors are trained to administer ASQ and PHQ-9 screenings, to align screening and data practices with countywide efforts
- Modifying data-tracking system to capture countywide data indicators
- Participating in countywide data-sharing to support a cross-model, collective evaluation
- Integrating home visiting referrals into the suite of community resources made available to families through Prevention & Aftercare network navigators, both for families within the general population and for families who have been the subject of DCFS Child Abuse Hotline calls

Probation

- Providing training for probation staff to connect pregnant and parenting families to home visiting support and to recognize this as an essential component of case planning efforts
- Integrating home visiting referrals into the array of services made available to adult probationers, probation youth, and their families
- Combining resources and efforts with County stakeholders to explore new and innovative models for supporting parents/pregnant youth detained in probation facilities or in short-term residential treatment programs (STRTPs)

LACOE

- Participating in countywide data-sharing to support cross-model, collective evaluation
- Continuing to partner to bridge Early Head Start and other home visiting-related resources

Office of Child Protection

- Supporting coordination across departments as home visiting system changes roll out
- Continuing to support the alignment of home visiting data initiatives with other County child abuse prevention evaluation efforts
- Continuing to support alignment of home visiting with other prevention strategies such as ECE and Prevention & Aftercare Network investments
- Providing consulting support for plan implementation as needed

In addition, the following commitments have been made by partnering entities:

First 5 LA

- Continuing state and federal advocacy to expand resources and support for home visiting in Los Angeles County

- Leading health sector engagement, developing clarity on how health systems and social systems can best partner to support family well-being
- Funding focus groups and research to help partners better understand the experiences and perspectives of African-American families when interfacing with the health and social sectors
- Partnering with DPH to ensure that home visiting providers are supported in a smoothly coordinated expansion of Healthy Families America and Parents as Teachers
- Partnering with DPH to expand Targeted Case Management participation countywide in 2018; providing necessary capacity-building and technical assistance support for 21 First 5 LA grantee agency sites to join the TCM platform
- Providing funding to support SHIELDS for Families, Inc., to provide home visiting to 50 DPSS clients via the pilot mentioned above, and support future expansion of home visiting services that may be funded through state budget allocation
- Partnering with DPH to explore optimal integrated referral system development, including evaluating opportunities to integrate community resources, home visiting, Help Me Grow, and other family resources into existing and/or new infrastructure
- Providing funding for Children’s Data Network–led long-term evaluation and actively participating in countywide data-sharing to support a cross-model, collective evaluation
- Providing state- and federal-level education to policymakers
- Funding Los Angeles Best Babies Network as a critical body for enhancing quality and workforce development for existing and new programs
- Funding a home visiting workforce salary and turnover analysis

LA County Perinatal and Early Childhood Home Visitation Consortium

- Providing timely ongoing feedback from home visiting providers and advocates regarding system gaps and needs (both within home visiting and within the broader community)
- Leading the data-indicator collection and analysis
- Leading the development of the Phase I online home visiting eligibility functionality
- Partnering with other entities to support best practices and a high-quality workforce
- Continuing to support the home visiting workforce through training, advocacy, and support
- Working with DMH to coordinate perinatal mental health training and referral supports for home visitors across programs

Children’s Data Network

- Leading long-term evaluation efforts, including an integration with the OCP Prevention Plan Evaluation

Los Angeles Best Babies Network

- Leading workforce development and program quality initiatives
- Coordinating trainings for new MAMA’s Neighborhood Visits, Healthy Families America, and Parents as Teachers staff
- Providing backbone staffing for the Consortium to help coordinate its data, best-practice, referral, and advocacy efforts

Center for Strategic Public-Private Partnerships

- Leading the integration of philanthropic expertise and resources into ongoing implementation
- Coordinating the sponsorship of the electronic referral eligibility technology build-out
- Coordinating the sponsorship of DMH expansion technical assistance by the Blue Shield Foundation

Guidance Body and County Leadership

To support ongoing systems-level coordination and quality improvement efforts, DPH proposes to initiate and host a long-term home visiting system guidance body. This body would include the following types of representation: home visiting clients, County departments that fund or refer into home visiting, nonprofit provider agencies (including representation across models and levels within these organizations), Consortium members, evaluators, independent advocates, health plans, hospitals, and other partners (such as WIC, housing, disability, employment, education, or philanthropy). In addition to this direct representation, the guidance body will also leverage existing resources (such as parent advisory boards, exit surveys, focus groups, Consortium workgroups, and other provider groups) to garner and integrate parent and provider voices. This body would be responsible for ongoing system monitoring, adjustment, and advocacy, as well as the identification of opportunities to deepen the connections between this home visiting work and other nascent related work underway in the County (such as prevention plan implementation, reduction in birth disparities, Help Me Grow, and early childhood education efforts).

DPH will also monitor and pursue system improvements outside of this guiding body, not only within DPH's own programs, but also as a champion and coordinator with its County partners.

Recommendations for Consideration by the Los Angeles County Board of Supervisors

- Adopt the policy that all County-funded home visiting programs will utilize validated screenings for maternal depression and infant-toddler development.
- Support the establishment of a countywide electronic referral system.
- Adopt the policy that all County-funded home visiting programs will participate in countywide data-sharing and analysis, as outlined above.
- Consider piloting universal postpartum support for mothers delivering at Los Angeles County birthing hospitals in FY 2018–2019, including requiring that a home and/or virtual visit be offered as part of the postpartum discharge of all mothers delivering at a piloting County DHS-operated hospitals.
- Consider establishing linkages between all County prenatal medical providers and home visiting family supports.



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

SUMMARY OF OUTCOMES: What Research Proves Home Visiting Impacts

Report as of June 19, 2017



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Summary of Outcomes Research

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

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

Details of Outcome Research by Impact Area and Model

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

Increases Cognitive & Social Development	
EHS	<ul style="list-style-type: none"> ▪ EHS showed positive impact on children's cognitive development by 36 months (Roggman, 2009). ▪ After a year or more of services, compared with a randomly assigned control group, 2-year-old EHS children performed better on measures of cognitive, language and social emotional development (Commissioner's Office of Research and Evaluation and The Head Start Bureau, 2001). <ul style="list-style-type: none"> ○ EHS children scored 90.1 on the Bayley Scales of Infant Development Index, compared with 88.7 for the control group. ○ A smaller percentage of EHS children scored in the at-risk range of developmental functioning (33.6 percent versus 40.2 percent in the control group). ○ Children were reported by their parents to have larger vocabularies and to use more grammatically complex sentences. ▪ Three-year-old EHS children performed significantly better on a range of measures of cognitive, language and social-emotional development than a randomly assigned control group (Administration for Family and Children, 2006). EHS children: <ul style="list-style-type: none"> ○ Scored 91.4 on the Bayley Mental Development Index, compared with 89.9 for control group children. ○ Scored 83.3 on the Peabody Picture Vocabulary Test, compared with 81.1 for the control. ○ Were significantly less likely than control group children to score in the at-risk range of developmental functioning. ○ Engaged their parents more, were less negative towards their parents, and more attentive to objects during play. Furthermore, EHS parents rated their children as lower in aggressive behavior than control parents did (Administration for Family and Children, 2006). ▪ EHS children were less likely to have delays in cognition and language functioning (Administration for Children and Families (2002b), 2002).
NFP	<ul style="list-style-type: none"> ▪ NFP enrollees had higher cognitive and vocabulary scores at age 6 (Olds, et al., 2004).
HFA	<ul style="list-style-type: none"> ▪ Rigorous studies report improvements in children's cognitive development at one and two years, and fewer behavior problems that can interfere with learning at two and three years (Healthy Families America, September 30, 2015).
PAT	<ul style="list-style-type: none"> ▪ PAT children score higher on measures of achievement, language ability, social development, persistence in task mastery and other cognitive abilities (Drotar, Robinson, Jeavons, & Kirchner, 2009), (Pfannenstiel, 1989), (Pfannenstiel & Seltzer, New Parents as Teachers Project, 1985), (Pfannenstiel, Lambson, & Yarnell, 1991), (Wagner, Spiker, & Linn, 2002). ▪ 94% of children's language scores increased (Coalition, November 2016).
Welcome Baby	<ul style="list-style-type: none"> ▪ Welcome Baby was associated with higher scores for children's communication skills and social-emotional skills, as measured by the ASQ Social-Emotional assessment tool at 12 months and the BITSEA at 24 and 36 months (Sandstrom, June 2015).

Improves School Performance	
EHS	<ul style="list-style-type: none"> ▪ According to Health and Human Services’ systematic review of the research on home visiting, several different home visiting models, including Early Head Start, Healthy Families America, Nurse Family Partnership, and Parents as Teachers all had a positive impact on child development and school readiness (Paulsell, 2010).
NFP	<ul style="list-style-type: none"> ▪ NFP enrollees had higher grade point averages and test scores in math and reading at age nine (Olds et al., 2004 and 2007).
HFA	<ul style="list-style-type: none"> ▪ Children who participated in Healthy Families America were half as likely to repeat first grade (3.5% vs 7.1%) as those who did not participate (Children Now, 2014). ▪ Children in HFA were more likely to be in a gifted program, fewer were retained in first grade, and fewer received expensive special education services (Healthy Families America, September 30, 2015).
PAT	<ul style="list-style-type: none"> ▪ PAT children score higher on reading, math, and language in elementary grades (Drazen & Haust, 1995). ▪ Compared to non-PAT children, PAT children were shown to require half the rate of remedial and special education placements in third grade (Pfannensteil, Seitz, & Zigler, 2002) (Drazen & Haust, 1995). ▪ PAT parents are more likely to enroll their children in preschool, attend parent-teacher conferences, PTA/PTO meetings and school events, volunteer in the classroom, talk with their children’s teachers, and assist their children with homework (O'Brien, Garnett, & Proctor, 2002) (Pfannenstiel, 1989) (Pfannenstiel, Lambson, & Yarnell, 1996). ▪ Teachers rated PAT children significantly higher than non-PAT children on multiple developmental indicators of school readiness (O'Brien, Garnett, & Proctor, 2002). ▪ PAT children score higher on standardized measures of reading, math, and language in elementary grades (Pfannensteil, Seitz, & Zigler, 2002). ▪

Improves Maternal Health	
NFP	<ul style="list-style-type: none"> ▪ Several studies have shown that NFP increased the number of months between births. For example, Olds et al (1997) indicated a 28-month greater interval between birth of the first and second child (Kitzman H. O., 2000) (Olds D. K., 2004) (Olds D. K.-A., 2007) (Olds D. R., 2004). ▪ Several studies have shown that NFP helps reduce the number of children born to a mother (Kitzman H. O., 1997) (Olds D. K., 2004) (Olds & et al., Effects of Nurse Home-Visiting on Maternal Life Course and Child Development: Age 9 Follow-Up Results of Randomized Trial, 2007) (Olds D. R., 2002). One study showed 29% fewer subsequent live births (Kitzman H. O., 1997). Several studies have also shown that NFP reduces subsequent pregnancies (Kitzman H. O., 2000) (Kitzman H. O., 1997) (Olds D. K., 2004) (Olds D. R., 2002), including one study showed a 32% reduction in subsequent pregnancies (Kitzman H. O., 1997). ▪ One study demonstrated 7% fewer yeast infections among NFP mothers (Kitzman H. O., 1997). ▪ One study demonstrated 35% fewer cases of pregnancy-induced hypertension among NFP mothers (Kitzman H. O., 1997). ▪ One study demonstrated that NFP mothers had diets shown to be more in accordance with federal dietary recommendations versus the control group (Olds D. H., 1986). ▪ One study demonstrated a 44% reduction in maternal behavior problems due to substance abuse among low-income, unmarried NFP mothers (Olds D. K., 2010). ▪ One study showed the percentage of mothers dying from any cause was less among NFP participants than among a control group of mothers receiving only transport to prenatal appointments (Olds D. K., 2014). ▪ One study demonstrated a decrease in smoking among all NFP mothers who smoked at intake (Olds D. H., 1986). ▪ One study demonstrated a 79% reduction in preterm delivery in NFP mothers who smoked 5 or more cigarettes per day at registration (Olds D. H., 1986).
HFA	<ul style="list-style-type: none"> ▪ HFA was shown to improve expectant mothers' linkage to primary care providers before birth (Lee, et al., 2009). ▪ HFA moms had 22% fewer birth complications (Galano J., 1999b). ▪ More moms in HFA reduced their alcohol use (Healthy Families America, September 30, 2015). ▪ A study of HFA mothers in Arizona showed greater contraception use among HFA mothers compared to the control group (Davis, March 2016). ▪ Young mothers enrolled in HFA Massachusetts program were significantly less likely than the control group of mothers (25% vs 36%) to have engaged in risky behaviors, including substance use, fighting, and unprotected sex in the preceding month, after 28 months of participation in the program (Francine Jacobs, November 12, 2015).
PAT	<ul style="list-style-type: none"> ▪ A health literacy demonstration project conducted with Parents as Teachers programs in the boot-heel area of Missouri found significant improvements occurred in family planning (Carroll, Smith, & Thomson, 2015).
Welcome Baby	<ul style="list-style-type: none"> ▪ The WB rate of return for postpartum care within 21-56 days of delivery (the HEDIS guideline) was 87.5%: higher than LA County's Medi-Cal plans, higher than the national Medicaid population, and higher than for patients covered by private insurance (Careaga, 2012).

Improves Child Health	
EHS	<ul style="list-style-type: none"> ▪ EHS had small but statistically significant favorable impacts on the percentage of children who visited a doctor for treatment of illness (83% vs 80%), receipt of immunizations (99% vs 98%), and the likelihood of hospitalization for accident or injury (0.4% vs 1.6%), when compared to a control group (Administration for Children and Families, 2006, p. 1). ▪ EHS children were more likely than low-income children nationally to have health insurance (91% vs. 79%) (Administration for Children and Families, 2006, p. 2). ▪ EHS children were significantly more likely to receive Part C early intervention services due to higher rates of screening, referral and coordination with Part C partners (5.4% vs. 3.8%) (Administration for Children and Families (2002b), 2002, p. 1).
NFP	<ul style="list-style-type: none"> ▪ NFP was shown to decrease emergency room visit use rates for child enrollees (Avellar & Supplee, 2013). ▪ Children in NFP are significantly more likely to be up-to-date on immunizations at 6, 18, and 24 months (Thorland, Currie, Wiegand, Walsh, & Mader, 2017). ▪ NFP moms exhibited longer inter-birth intervals (Olds & et al., 2007). ▪ An analysis by the Center for American Progress demonstrated that scaling the Nurse Family Partnership program to all eligible women in CA could prevent 2,735 infant deaths and 54,695 preterm births over 10 years (Herzfeldt-Kamprath, November 2015).
HFA	<ul style="list-style-type: none"> ▪ Children in HFA had better access to health care, evidenced by rates of health insurance at ages one and two; connection with a primary care provider; and more completed Well-Baby visits (Healthy Families America, September 30, 2015) (Avellar & Supplee, 2013). ▪ HFA reduced the rate of low birth weight infants among women enrolled prenatally. Low birth weight is associated with higher infant mortality as well as substantial short- and long-term challenges to child health and development (Healthy Families America, September 30, 2015). A study of Healthy Families in New York demonstrated that women who receive home visiting services during pregnancy are nearly half as likely to deliver a low birth weight baby (Lee, et al., 2009). ▪ A study of HFA in Arizona showed that HFA mothers had higher rates of breastfeeding than the control group (Davis, March 2016).
PAT	<ul style="list-style-type: none"> ▪ Children participating in Parents as Teachers were more likely to be fully immunized for their given age (Wagner, Iida, & Spiker, 2001) (Paradis, Sandler, Todd Manley, & Valentine, 2013). ▪ Children in Parents as Teachers were less likely to be treated for an injury in the year following their participation in the program (Wagner, Iida, & Spiker, 2001). ▪ A health literacy demonstration project conducted with Parents as Teachers programs in the Boot-heel area of Missouri found significant improvements occurred in the following health care literacy indicators: use of information, use of prenatal care, child well care, child sick care, child dental care, and child immunizations (Carroll, Smith, & Thomson, 2015).
Welcome Baby	<ul style="list-style-type: none"> ▪ WB moms are 40%-60% more likely than a control group to exclusively breastfeed their babies at four months postpartum (Benatar & et al., 2012).

Improves Mental Health	
EHS	<ul style="list-style-type: none"> ▪ Positive impacts were found for parent-child interaction and children’s social-emotional development. Furthermore, among those families in which mothers were depressed at enrollment, EHS had even stronger favorable impacts on parent-child interaction (Administration for Children and Families, 2006, p. 1).
NFP	<ul style="list-style-type: none"> ▪ NFP shows a treatment impact on an outcome correlated with depression; mothers in the intervention group had higher personal sense of mastery scores for the period from child age six months to child age six (Kitzman H. O., 1997); the paraprofessional home visitors group reported a greater sense of mastery and better mental health at child age four (Olds D. K., 2004) (Olds D. K., 2010) (Olds D. K.-A., 2007).
HFA	<ul style="list-style-type: none"> ▪ A study of families enrolled in Healthy Families Arizona showed the Mental Health Index (which measures both psychological distress and psychological well-being) was higher in the Healthy Families group than in the control group (Davis, March 2016). ▪ In a study assessing the impact results from a randomized, controlled trial of Healthy Families Massachusetts, the only universal statewide home visiting program that specifically targets and wholly serves first-time young parents, it was found that HFA Massachusetts was successful in helping young, first-time mothers learn to control stress and in curbing externalizing and risky behaviors (Francine Jacobs, November 12, 2015).
Welcome Baby	<ul style="list-style-type: none"> ▪ An evaluation of LA County’s Welcome Baby program showed that moms had lower parenting stress and stronger maternal responsiveness at 36 months compared to the control (Urban Institute and University of California, Los Angeles).
PFF	<ul style="list-style-type: none"> ▪ Participation in the LA County PFF program had a significant impact on reducing parental depression, mood swings, and aggression/anger, especially for prenatally enrolled moms (Reuter, Melchior, & Brink, 2016).

Improves Family Safety & Parenting	
EHS	<ul style="list-style-type: none"> ▪ EHS was shown to reduce child welfare encounters between five to nine years of age, subsequent encounters, and substantiated reports of physical or sexual abuse (Green, et al., 2014). ▪ After a year or more of program services, when compared with a randomly assigned control group, the parents of EHS children scored significantly higher on many measures of the home environment, parenting behavior, and knowledge of infant-toddler development (Commissioner's Office of Research and Evaluation and The Head Start Bureau, 2001, p. iii). EHS parents: <ul style="list-style-type: none"> ○ engaged in important activities with their children more frequently than control group parents; for example, singing songs and nursery rhymes, dancing, and playing outside as well as creating a richer literacy environment for their children. ○ were more likely to read to children daily and at bedtime. ○ displayed more supportive parenting behaviors. ○ showed greater enjoyment, greater sensitivity, and less detachment, created more structure, and extended play to stimulate cognitive and language development. ○ were more emotionally responsive, displaying greater warmth, praise, and affection toward their children. ○ created more structure in their children's day by setting a regular bedtime. ○ were less likely to report having spanked their child in the past week than control group mothers. ○ were more likely to suggest using a positive discipline strategy when presented with hypothetical parent-child conflict situations, such as distracting the child or explaining to the child. In conflict situations, Early Head Start mothers were more likely to suggest only mild responses. ○ reported lower levels of family conflict and parenting stress (Commissioner's Office of Research and Evaluation and The Head Start Bureau, 2001, p. 6). ▪ Findings also suggest that EHS had reduced the stress of parenting (Commissioner's Office of Research and Evaluation and The Head Start Bureau, 2001, p. iii). ▪ EHS increased mothers' knowledge of infant-toddler development and developmental milestones (Commissioner's Office of Research and Evaluation and The Head Start Bureau, 2001, p. 6).
NFP	<ul style="list-style-type: none"> ▪ NFP had a positive impact on reducing child maltreatment (Paulsell et al., 2010); the Nurse-Family Partnership home visiting program has been shown to reduce child maltreatment by 48% (Children Now, 2014). ▪ Center for American Progress estimated that scaling NFP to all eligible women in CA could prevent 196,902 incidents of intimate partner violence over ten years (Coalition, November 2016).
HFA	<ul style="list-style-type: none"> ▪ According to Health and Human Services' systematic review of the research on home visiting, HFA had positive impacts on reducing child maltreatment (Paulsell, 2010). ▪ Five HFA studies show significant benefits in preventing adverse childhood experiences, including reduced child maltreatment, physical punishment, yelling, and improved use of non-violent discipline, based on parents' self-reports—a more comprehensive measure of child maltreatment than official cases (Healthy Families America, September 30, 2015). ▪ HFA has shown a reduction of domestic violence perpetrated by mothers (Healthy Families America, September 30, 2015). ▪ Results from a randomized trial found positive outcomes showing Healthy Families mothers read more frequently to their children, provided more developmentally supportive activities, and had less parenting stress than the control group (Greene, 2014).

Improves Family Safety & Parenting	
	<ul style="list-style-type: none"> ▪ A Massachusetts study found mothers enrolled in the Healthy Families program reported less parenting stress than control mothers (Easterbrooks, 2012). ▪ An Arizona study found positive results in comparison to the control condition on use of safety practices, parenting attitudes (e.g., inappropriate expectations), reading to children, use of resources, reduced alcohol use, and greater maternal education and training (Davis, March 2016). ▪ A study of teen mothers enrolled in HFA in Massachusetts showed that parents enrolled in the program reported less difficulty with their children and less parenting distress after 28 months of participation in the program than teen parents in the control group (Francine Jacobs, November 12, 2015). ▪ A study of families enrolled in HFA Arizona showed that at six months the Healthy Families group had implemented more safety practices in the home, used more resources to meet family needs, scored higher on mobilizing resources, had higher quality the home environment, more regular routines, reduced chaotic household and increased reading to their child than the control group (Davis, March 2016).
PAT	<ul style="list-style-type: none"> ▪ PAT families with very low income were more likely to read aloud to their children, tell stories, say nursery rhymes, and sing with their children (Wagner, Spiker, & Linn, The Effectiveness of the Parents as Teachers Program with Low-Income Parents and Children, 2002). ▪ Over 75% of PAT parents reported taking their child to the library regularly and modeling enjoyment of reading and writing (Pfannenstiel, Lambson, & Yarnell, 1996). ▪ PAT parents engage in more language activity and were more likely to promote reading in the home (Albritton, Klotz, & Roberson, 2004). ▪ PAT parents showed significant improvements over time in parenting knowledge, behavior, and attitudes (Owen & Mulvihill, 1994). ▪ PAT participation was related to 50% fewer cases of suspected child abuse and/or neglect (Drazen & Haust, 1993, August). ▪ Parents as Teachers had fewer documented cases of abuse and neglect compared to the state average in 37 diverse school districts across Missouri (Parents as Teachers National Center, Inc.). ▪ Short-term outcomes of PAT include: improved parenting practices; increased knowledge and practices of positive discipline techniques; more realistic expectations of age-appropriate developmental milestones; a home environment conducive to healthy child development; parent-child attachment; reduction of stress; fulfillment of basic needs; opportunities to interact with other parents; increased awareness and access to sources of information and support (Parents as Teachers National Center, Inc.). ▪ In another randomized trial, adolescent mothers in an urban community who participated in PAT scored lower on a child maltreatment precursor scale than mothers in the control group. These adolescent mothers showed greater improvement in knowledge of discipline, showed more positive involvement with children, and organized their home environment in a way more conducive to child development (Wagner, Iida, & Spiker, 2001).
Welcome Baby	<ul style="list-style-type: none"> ▪ Welcome Baby moms demonstrated stronger teaching skills and affection towards their children at 36 months compared to the control group (Urban Institute and University of California, Los Angeles).
PFF	<ul style="list-style-type: none"> ▪ PFF achieved reduced rates of re-referral to child protective services, substantiated allegations of maltreatment, DCFS case openings, and removal from the home over the length of the study (Brooks & et al., 2011).

Improves Self-Sufficiency (Includes Reducing Dependence on Public Assistance and Increasing Employment or Job Training)	
EHS	<ul style="list-style-type: none"> ▪ EHS has been shown to positively impact parents’ participation in education, job training activities, and employment (Admin. for Children and Families, 2006). ▪ After a year or more of program services, when compared with a randomly assigned control group, EHS parents were more likely to attend school or job training and to use employment-related services (The Commissioner’s Office of Research and Evaluation and The Head Start Bureau Administration on Children, Youth and Families Department of Health and Human Services, 2001, pp. 1, 7). ▪ Note: 2001 research on EHS failed to show any impact on the percentage of parents employed, hours per week employed in all jobs, receipt of welfare benefits, or family income during the first 15 months after their participation in EHS (The Commissioner’s Office of Research and Evaluation and The Head Start Bureau Administration on Children, Youth and Families Department of Health and Human Services, 2001, p. 7).
NFP	<ul style="list-style-type: none"> ▪ NFP moms had less use of welfare and food stamps and fewer subsequent births than control group moms (Olds & et al., 2007). ▪ At age 19, daughters of NFP enrollees had fewer children and less reliance on Medicaid than children of moms in the control group (Eckenrode & et al., 2010). ▪ 31% of parents who entered the program without a high school degree attained a high school diploma or GED by the time their child turned 12 months old (Nurse Family Partnership National Service Office, Oct. 2015).
HFA	<ul style="list-style-type: none"> ▪ HFA parents were five times more likely to enroll in school or training (LeCroy C. W., 2011). Most parents have not yet completed high school when they enroll in HFA, a critical step for future earning potential. HFA helps new moms find the motivation and resources to further their education, evidenced by three rigorous studies showing increased maternal education over one to three years in the program (Healthy Families America, September 30, 2015). ▪ A study of teen parents enrolled in HFA in Massachusetts showed that mothers enrolled in HFA were nearly twice as likely as control group mothers (17% vs 10%) to have finished at least one year of college (Francine Jacobs, November 12, 2015).
PFF	<ul style="list-style-type: none"> ▪ 71% of PFF families’ financial conditions improved while receiving services, as measured via initial and closing assessments using the Family Assessment Form (Brooks & et al., 2011).

Reduces Criminal Activity	
NFP	<ul style="list-style-type: none"> ▪ At age 19, daughters of NFP enrollees were less likely to have been arrested and convicted than daughters of the control group (Eckenrode & et al., 2010).

Cost Savings of Home Visiting	
NFP	<ul style="list-style-type: none"> ▪ A California-specific analysis of NFP estimated a net public savings of as much as \$39,129 per family, in the form of fewer infant deaths, reduced child maltreatment, and fewer youth crimes in the long term (Children Now, 2014). ▪ Home visiting programs like NFP have been found to yield returns of \$2.73 to \$5.70 for each dollar invested (Ibid). ▪ For California, the ten-year cost savings of scaling NFP was estimated at \$120,676,641 (Coalition, November 2016). ▪ If Medicaid were to fully fund the NFP program, the resulting savings per enrolled family to the federal and state governments would exceed the costs of providing the program to that family by the time the child turned 6 years old (Herzfeldt-Kamprath, November 2015).
HFA	<ul style="list-style-type: none"> ▪ Every low birthweight or preterm birth costs states between \$28,000 and \$40,000 in medical care and other related costs. In New York’s Healthy Families home visiting program, mothers who received home visits were half as likely to deliver low birthweight babies as mothers who were not enrolled (The PEW Center on the States, May 2010). ▪ In 2012, 33,655 babies (6.7% of all births) were born at a low birth weight in CA. Reducing this number by half could save the state as much as \$673 million (Children Now, 2014).
PAT	<ul style="list-style-type: none"> ▪ Parents As Teachers has an estimated benefit-cost ratio of \$3.39 per dollar invested (Washington State Institute for Public Policy, February 2015).
Home Visiting in General	<ul style="list-style-type: none"> ▪ For every dollar spent on home visiting efforts, at least \$2 in future spending is saved (The PEW Center on the States, May 2010).

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

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

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

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

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

Early Head Start:

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

Nurse-Family Partnership:

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

Healthy Families America:

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

Parents as Teachers:

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

Welcome Baby:

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

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

Partnership for Families:

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

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

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

- (1) **Recalibrate the Conceptualization of Culture:** The key is to continue instilling the notion that a family's culture is a product of experiences that cannot be categorized *monolithically* with easily visible shared characteristics and features such as racial or ethnic labels. The examination of the role of culture in child maltreatment and family well-being necessitates a close look at each family's heterogeneous experience, beliefs, and practices across multiple contexts that are uniquely relevant to each family's functioning, with the goal of addressing cultural processes involved in prevention and intervention efforts in a more nuanced manner (Megan Finno-Velasquez, 2015).
- (2) **Replace the Notion of Cultural Competence with Cultural Reciprocity:** To effectively serve diverse families, practicing cultural reciprocity or humility may be more appropriate than cultural competence as currently institutionalized. Cultural reciprocity places responsibility on the professional to engage in self-reflection and dialogue to consider their own and the families' cultural norms and participate in collaborative exchange to provide effective services (Megan Finno-Velasquez, 2015).
- (3) **Refine Child Maltreatment Research to Integrate Diverse Cultural Groups:** Continuing efforts are needed to define and measure child maltreatment for diverse racial or ethnic and cultural groups, as well as to better understand differences and similarities in the causes of maltreatment among many types of families. From a research perspective, scholars may help to advance this goal by carefully articulating the definitions and operationalization of maltreatment and well-being constructs included in studies, as well as assumptions about the cultural relevance of these constructs for the study population. We should move towards explicitly stating the strengths and limitations of the measures used to capture culture as a construct. Work is needed, both within and across cultural groups, to understand how contexts, neighborhoods, federal family and immigration laws, local child welfare policies and practices, and family characteristics interact with parents' culturally bound beliefs and behaviors in the US. Research would benefit from carefully defining child neglect so as to clearly distinguish it from family poverty. Despite the risk poverty creates – both for child development generally and for child neglect specifically – more focused research and clearer definitions of neglect and risks for neglect within culturally diverse groups could contribute substantially to the ability of

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

- (4) **Enhance Intervention Design and Testing with Diverse Cultural Groups:** Existing interventions often rely on 20th century, European American, middle-class values. There may be a need to diversify the parenting styles and norms that are driving intervention development and normalization. Experts may wish to consider more rigorous and targeted testing of existing interventions with diverse cultural groups (Megan Finno-Velasquez, 2015).
- (5) **The Use of More Holistic and Innovative Strategies:** Maltreatment prevention interventions should address multiple stressors typically clustered together within a specific racial or ethnic group or community context, including economic and cultural stressors (Megan Finno-Velasquez, 2015).
- (6) **Diversify who is developing and evaluating such programs:** An intentional commitment to increasing the cultural and racial diversity of leading researchers, teachers, service providers, and policy makers in the field of child maltreatment and well-being may be critical to improving interventions and supporting the well-being of an increasingly diverse pool of families (Megan Finno-Velasquez, 2015).
- (7) **Focus on participant experience:** Research could be strengthened by placing greater emphasis on the process and experiences of diverse families throughout the implementation of interventions. Such research might document perceptions of cultural relevance or resonance, shared understandings and worldviews among program participants and providers, experiences of discrimination or empowerment, and overall client satisfaction with providers and services. Perhaps more importantly, longitudinal data could be utilized to understand whether the effects of parenting interventions and prevention on culturally diverse groups hold in the long term. This information, along with more data about families' origins and cultural identities, could be collected and analyzed within the context of implementation trials to better understand the role of culture in response to intervention. Moreover, while evidence-based programs may be effective in promoting positive parenting outcomes for families with diverse cultural beliefs and backgrounds, alternatives could exist that work just as well. These alternatives might not require assimilation and adoption of culturally relative practices that may force suppression of divergent cultural values (Megan Finno-Velasquez, 2015).

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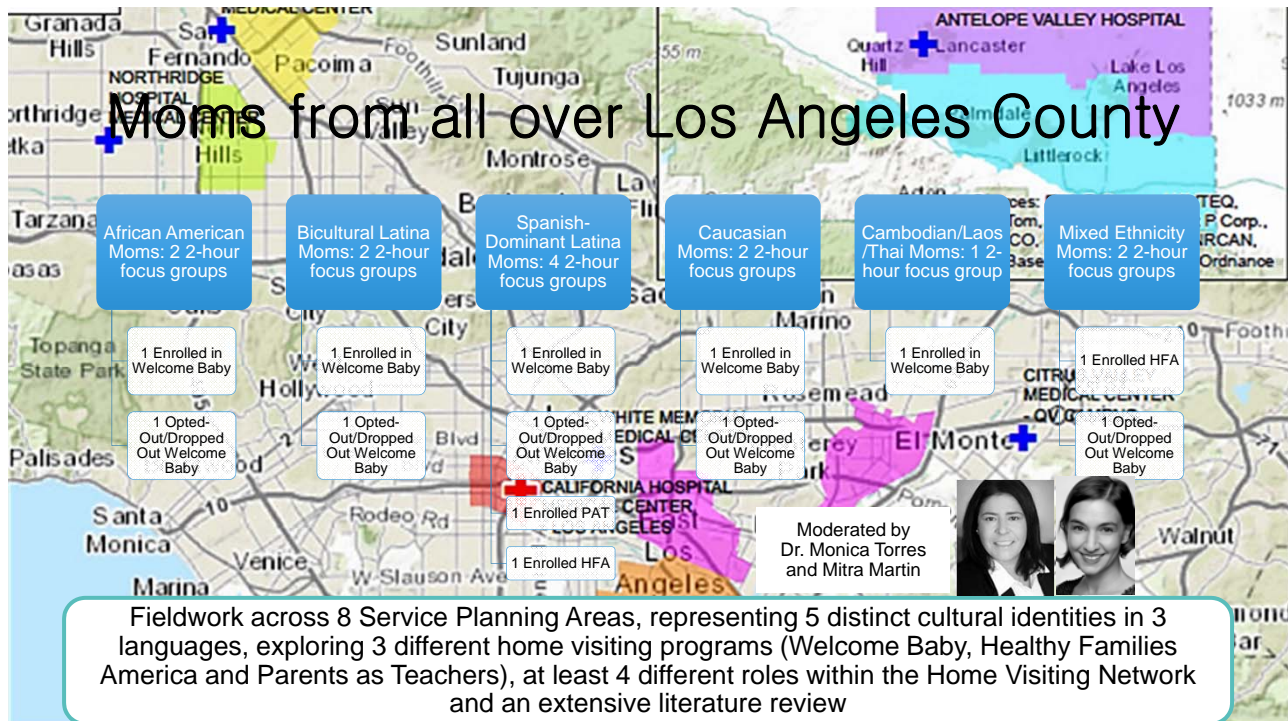
APPENDIX B



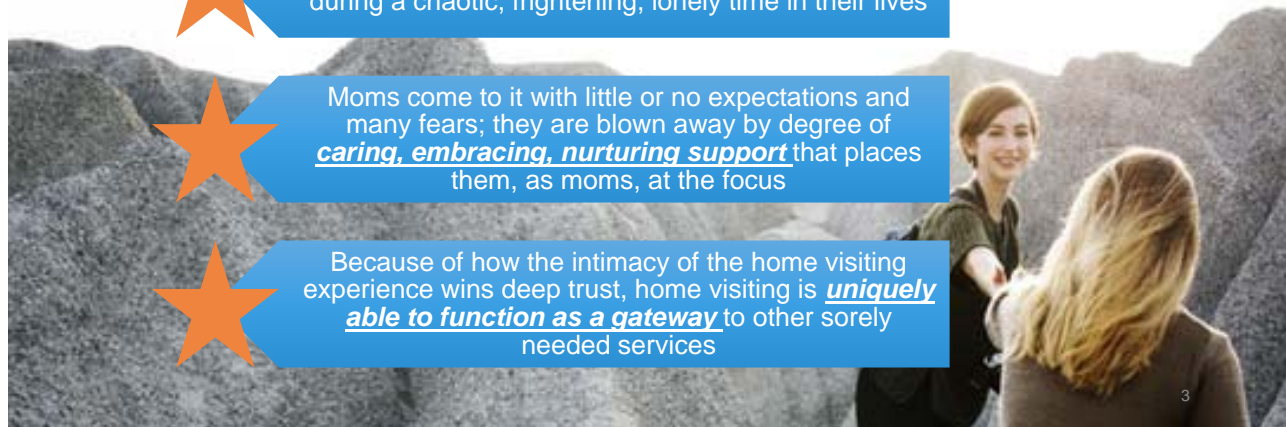
Excerpts from:

Findings from
Home Visiting
Qualitative
Research Study
January 2018

Prepared by:



Home visiting is a truly potent approach



Creates what is for many **the only meaningful and empowering interpersonal bond in their life**, during a chaotic, frightening, lonely time in their lives

Moms come to it with little or no expectations and many fears; they are blown away by degree of **caring, embracing, nurturing support** that places them, as moms, at the focus

Because of how the intimacy of the home visiting experience wins deep trust, home visiting is **uniquely able to function as a gateway** to other sorely needed services

Top findings related to programs

- Those who enroll and commit experience deep, often transformative, benefits from home visiting; many want more visits

Transformative program 1
- Too many different people involved in early stages of program can weaken its coherence and the client's commitment

Handoff gaps 2
- By earning deep trust in a vulnerable time, home visiting functions as a gateway to other basic needs supports, especially housing support and mental health counselling

Basic needs 3
- Yet, lack of smooth referral pathways can lead to frustration and disappointment

Leaky referrals 4
- Text messaging between visits is an increasingly important tool for augmenting program: providing logistical help, nudges to follow up on referrals, and emotional support

Text power 5
- Nearly all moms feel isolated postpartum and wish for facilitated contact with other moms like them

Isolated moms 6
- Many moms believed that the father of the baby wanted to learn more and be more involved, but didn't know how.

Dads need something 7

Top findings related to enrollment



5

PAVING THE ROAD TO SAFETY FOR OUR CHILDREN: *A Prevention Plan for Los Angeles County*



Los Angeles County Office
of Child Protection (OCP)

JUNE 2017

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Purpose of This Plan

What parents want for their children is what Los Angeles County wants—for every child to be healthy, to be growing and thriving in a strong family, and to be supported by a safe and nurturing community.

For children who come into contact with the child welfare system, however, this vision can seem unattainable. Many have already experienced some level of harm and trauma, and their families need intensive services to keep from entering (or going deeper into) the system.

In April 2014, in response to a tragic child death, the Los Angeles County Blue Ribbon Commission on Child Protection released a detailed report for improving the county's child protection system. It recommended the creation of the Office of Child Protection (OCP) to increase coordination and accountability, and to oversee the development and implementation of a comprehensive countywide prevention plan for reducing child maltreatment.

The OCP addressed this complex charge, in part, by studying the tremendous growth in community-based child- and parent-focused networks that Los Angeles

County has seen over the past decade. These networks include organizations and individuals working together to build solid relationships and to share knowledge, best practices, new ideas, and perspectives. The ongoing success of these networks, coupled with their ever-stronger relationships with family-serving County departments, now presents an historic and unique opportunity for enhancing the protection and well-being of all children in our region.

This plan is our strategy for making the most of this moment. Many County departments and a wide array of partners contributed to the development of this plan, which is a blueprint for partnering with our region's diverse communities to coordinate and expand existing prevention-focused networks to further strengthen families, prevent child maltreatment, and reduce unnecessary burdens on the child welfare system.

Every one of us must "own" prevention. Keeping it at the forefront of all of our minds and every part of our work is the single most important way we can keep our children safe. We share responsibility for achieving this vision; it requires each of us to think differently about how we engage and support families, as well as how we engage and support each other.



What We Mean By Prevention

We believe that connecting families early on to positive family supports will reduce the number of children and families touched by the child welfare system, as well as decrease the length and intensity of interactions for those who must be involved.

By lessening families' contact with child welfare, we also hope to limit their involvement with other systems. A single child abuse hotline call—even when the allegation is not substantiated, a case is not opened, and the child is not removed from the home—can predict a family's later connection to other County systems. (A forthcoming study, for example, found that 83 percent of probation youth had previous referrals to child welfare, 43 percent of them before the age of five.¹) This is especially true when families are not linked to supportive voluntary services at the time of the initial investigation. For families with very young children, research shows that home visitation and early care and education programs have significant effects on the prevention of child maltreatment and a family's reliance on other intensive services.

This plan's definition of "prevention" includes:

- Support for concrete needs like food and housing
- Opportunities for social, recreational, and community connections that reduce isolation and build personal support systems
- Access to economic and employment prospects
- Assistance in navigating the broad and often confusing array of available education, health, mental health, and other services

Research and experience show that a community-based family-strengthening approach offering these key elements can improve parenting skills, enhance child development, increase economic stability, and build a strong foundation for positive future outcomes. That approach should be coupled with improved access to formal government services, when needed, to provide families with a full spectrum of support. Formal services can't meet every need—there simply aren't enough of them—and informal community supports may not be intensive enough to address some families' complex demands. A balance is best.

We want to encourage a culture where communities are equipped to provide families the types of support and connections that reduce their need for more intensive services, and where it is both accepted and expected for families to reach out for help when necessary.²

While this plan begins by focusing on the family supports and services shown to have a positive effect on preventing child maltreatment, it is admittedly a starting place. Our goal is to expand community-based prevention efforts more broadly over time.



¹ Herz, D., Chan, K. (2017). *Los Angeles County Juvenile Probation Outcomes Study, Part II: Assessing the Experiences of Probation-Involved Youth Exiting from Out-of-Home Placements Across Two Cohorts*. California State University, Los Angeles.

² *Child Maltreatment Prevention: Past, Present and Future*. Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/issue_briefs/cm_prevention.cfm

What We Know

Research suggests that child welfare systems experience pressure because families are not getting the support they need early enough, and because some are referred back to the system over and over again.

- One-third of the children in Los Angeles County's Department of Children and Family Services system are age four and under. A recent national study estimates that 37.4 percent of all children will have a protective services investigation by age 18.³
- Of all the babies born in Los Angeles County during 2006 and 2007, 14.6 percent were reported to child protective services before age five, although the majority of these referrals were not serious enough to warrant opening a case. This suggests that people may not know what to do, whom to trust, or where to find help when they suspect a problem is developing.
- As a recent article noted, "The longer that instability lasts, the harder it is for a family to rise back up. At that point, placing children in foster care may be the only option available to us. But what these families really need is [earlier] intervention . . . when they are beginning to struggle but are still relatively stable, and when the intervention wouldn't involve breaking up families."⁴



³ Kim, H., Wildeman, C., Johnson-Reid, M., & Drake, B. (2017). "Lifetime prevalence of investigating child maltreatment among U.S. children." *American Journal of Public Health*, 107 (2), pp. 274–280.

⁴ McGrath Tierney, M. "From Family Data to Neighborhood Outcomes." *Stanford Social Innovation Review*, November 29, 2016.

Some key early intervention strategies have demonstrated success in improving child outcomes and reducing child maltreatment.

The **Strengthening Families Approach** works to increase family strengths, enhance child development, and effectively nurture young children, especially in times of stress. It is based on engaging families, programs, and communities in building five critical protective factors for families⁵—shown below—through community-based supports. It is the “most well-established and broadly used” approach for reducing the risk of child maltreatment.⁶ See page 24 for further information.

The Five Protective Factors



Parental Resilience: the ability to manage and bounce back from all types of challenges that emerge in every family’s life



Social Connections: connections to networks of support essential to parents



Concrete Support in Times of Need: connecting to services to meet basic needs, as well as to address crises that may emerge



Knowledge of Parenting and Child Development: accurate information about child development and appropriate expectations for children’s behavior



Social and Emotional Competence of Children: a child’s ability to interact positively with others, self-regulate, and communicate effectively

- **Home visitation programs** connect to families at the very earliest stages possible, offering critical support to expecting and new parents. With a combination of parenting information, coaching, and connections to key services, home visitation has been proven to increase parenting skills, enhance child health and development, raise high school graduation rates, lessen juvenile justice involvement, and reduce child maltreatment.⁷
- **High-quality early care and education programs** (child care or preschool) that include support for families can also help to prevent maltreatment. For example, participants in the Chicago Parent Child program, which includes a half-day preschool program for three- and four-year olds along with comprehensive family services, had significantly lower rates of substantiated abuse and neglect.⁸
- Some **community-level child abuse prevention strategies** also have promising results—highlighting the voices of parents, mobilizing volunteers, engaging a broad range of community residents, and improving connections among economic development, health care, and social service sectors.⁹

Ensuring that prevention-oriented services are available, culturally competent, and accessible in local communities can provide support for families before problems escalate. In turn, knowing that community-based agencies are ready and willing to help also bolsters the child welfare system—strengthening the families it serves, increasing opportunities for family economic development, assisting social workers in their search for appropriate service referrals, and helping parents navigate local health, education, and family service systems.

⁵ “The Protective Factors Framework.” Center for the Study of Social Policy. www.cssp.org.

⁶ Child Welfare Information Gateway (2014). *Protective factors approaches in child welfare*. Washington, DC: U.S. Department of Health and Human Services.

⁷ “Home Visiting.” Children Now Issue Brief. On high-school graduation rates, see, for example, *Research Spotlight on Success: Healthy Families America Promotes Child Health and Development*, Healthy Families America, 2008, www.healthyfamiliesamerica.org.

⁸ Reynolds, A.J., Mathieson, L.C., & Topitzes, J.W. (2009). “Do Early Childhood Interventions Prevent Child Maltreatment? A Review of Research.” *Child Maltreatment*.

⁹ Daro, D. & Dodge, K. (2009). “Creating community responsibility for child protection: possibilities and challenges.” *Future of Children*, 19(2), 67–94.



Key Los Angeles County Prevention Investments

Prevention Initiative Demonstration Project (PIDP)

In 2006, the Los Angeles County Board of Supervisors directed the establishment of a comprehensive prevention system. This included developing a pilot for implementing the Strengthening Families Approach (page 24) through community-based networks.

As a result, the Department of Children and Family Services (DCFS) established PIDP in 2007. This project built upon existing community networks in each of the County's eight Service Planning Areas (SPAs), applying community-organizing approaches to strengthen families' protective factors and increase their economic stability. (Appendix A on page 22 presents more details on the PIDP program.)

Independent evaluations of PIDP conducted in 2009 and 2010 found a "strong and significant pattern of improvements for families in terms of social support (reported by parents in all eight SPAs), decreased re-referrals to [DCFS] (in one of the three areas tested), and more timely permanency for [system-involved children] (in all of the three areas tested)."¹⁰ Evaluators also recommended that the County encourage cross-departmental efforts to share funding and support for prevention.

During the OCP's development of this plan, it became clear that a number of County departments support programs that align very well with PIDP prevention-

related goals. They include community-based programs funded through County contracts and projects operated by County staff who partner informally with community-based service providers. Mapping the status of these programs would be a very helpful next step in building cross-departmental support for prevention.

Although PIDP was successfully implemented across the County, the establishment of an entity for coordinating additional prevention resources and efforts beyond the network funded by DCFS did not materialize.

Prevention and Aftercare Networks (P&As)

Because of PIDP's effectiveness in engaging and strengthening families, DCFS institutionalized its community-based networks in 2015 and established ten countywide Prevention and Aftercare networks (P&As).¹¹ These include a broad range of public, private, and faith-based member organizations—groups that bring resources to the shared goal of preventing child abuse and neglect, along with designated lead agencies responsible for convening, organizing, and leading local grassroots efforts.

The P&A organizations are part of a critical web of providers across the county that effectively reach out to and engage parents, assisting them as they navigate often-complex systems of services. In so doing, providers develop relationships with these parents, building upon their natural assets through the Strengthening Families Approach. Those relationships in turn create trusting environments that encourage parents to disclose family needs and access appropriate services earlier, as family stressors occur.



¹⁰McCroskey, J., Pecora, P.J., Franke, T., Christie, C.A., & Lorthridge, J. (2012). "Strengthening Families and Communities to Prevent Child Abuse and Neglect: Lessons from the Los Angeles Prevention Initiative Demonstration Project." *Child Welfare*, 91(2): 39–59.

¹¹Eight of the P&As are based in SPAs and two serve countywide populations: Asian/Pacific Islander and American Indian families.

Best Start Community Partnerships

While not part of the P&A networks, another important parent-focused community-based network also exists across the county, known as the Best Start Community Partnerships. First 5 LA¹² has been investing resources in 14 communities, bringing together parents, caregivers, providers, and other stakeholders to improve child outcomes and to engage and mobilize residents around issues that positively affect child and family well-being.

A significant number of the providers involved in the Best Start efforts also participate in the P&A networks, and this plan presents a unique opportunity to build on these networks' effective parent engagement. Both have adopted the Strengthening Families Approach mentioned on page 6, which has shown tremendous success in improving outcomes for children and reducing child maltreatment.

IN PRACTICE: Jennifer's Story

Jennifer had a history of postpartum depression. After she had her third child, signs of depression showed up once again and verbal abuse became a factor in her parenting. But the children ran the house and they did what they pleased, causing Jennifer to become even more frustrated.

A parent educator conducted a visit and became concerned about her behavior and the risk of child neglect due to Jennifer's depression. The newborn cried for minutes and was not attended to by his mother, while the oldest daughter, who was 4 years old, grabbed a knife from the counter to open a treat. The parent educator had to remove the knife from the child because Jennifer showed no signs of responding to the situation. As a mandated reporter, the parent educator had to call DCFS, which opened a case and came to Jennifer's home. She was upset and wanted to quit the home visiting program, but the parent educator did not give up and soon Jennifer began to turn her parenting around.

Realizing that she needed help and that help was there for her, Jennifer allowed the parent educator to help safety-proof her home, teach her about boundaries and discipline, as well as support her during the open DCFS case. Now she is seeking a brighter future for her children, including going back to school and contacting other referrals provided by the parent educator, which Jennifer had previously refused to contact. Her depression has also decreased, making her parenting techniques even more successful. At this time, there are no longer any signs of neglect in the home and her parent educator continues to support her when needed. – Richstone Family Center, Best Start Community Home Visiting provider

American Job Centers of California (AJCCs)

The Workforce Development, Aging and Community Services (WDACS) department administers Los Angeles County's portion of the largest workforce development system in the state—American Job Centers of California (AJCCs). The AJCCs are a network of centers structured in alignment with economic development and regional planning efforts to coordinate and partner with workforce development stakeholders. The purpose of the system is to prepare an educated and skilled local workforce that supports the three policy objectives outlined in the California State Workforce Board's state plan for 2016–2020:

- Fostering demand-driven skills attainment
- Enabling upward mobility
- Aligning, coordinating, and integrating programs and services to economize limited resources

The AJCC network prioritizes services to target populations and individuals with significant barriers to employment, including those who are homeless, English language learners, veterans, public assistance recipients, current and former foster or probation youth, and re-entering the community from incarceration, as well as those with basic-skills deficiencies or disabilities. Services are provided through strategically located centers and partnerships that bring together resources from the business community, employers, educational institutions, the State of California's Employment Development Department and Department of Rehabilitation, other County departments, and six other Workforce Development Boards. Given the important role that economic stability plays in the well-being of children and families, it is critical that we find every opportunity to ensure that the AJCC network is strongly connected to the other community-based networks already established.

Health Neighborhoods

The County departments of Mental Health (DMH) and Public Health (DPH) have partnered with numerous community organizations to establish "Health Neighborhoods" to improve access to coordinated health and mental health care across Los Angeles County. Participants in this network have committed to work with local agencies to identify available services, make cross-agency referrals for families more seamless, share information as legally permissible, and coordinate services so that families needing care can easily and efficiently receive the support they need.



¹²First 5 LA is a leading public grant-making and child welfare advocacy organization.

Medical Hubs

Over the past several decades, the Department of Health Services (DHS) has established seven Medical Hubs across the County to provide high-quality coordinated health care for children who touch the child welfare system. Services have historically included medical assessments of suspected child abuse or neglect, comprehensive medical exams for children entering out-of-home care, ongoing well-child care and sick visits, and linkages to pediatric specialty care for children with complex medical needs. In coordination with DCFS and DMH, the County has recently brought additional support to the Hubs to ensure that any identified social, mental health, and/or developmental needs are also addressed. As the reach and impact of the Hubs is expanded through further interdepartmental collaboration, the County's health-related agencies and the Office of Child Protection are exploring opportunities to connect these Medical Hubs more significantly with other community-based prevention-oriented networks.

Los Angeles County Community Child Abuse Prevention Councils

In 1989, the California Legislature passed the Child Abuse Prevention Coordinating Act, requiring each county to create child abuse prevention councils to promote intervention and prevention activities. In Los Angeles, 12 community-based councils were formed. These, too, have adopted the Strengthening Families Approach and have been working within their communities to reduce child abuse and neglect and to educate the public about abuse and family violence issues.

Landscape Analyses

In 2015, the Advancement Project (a civil rights organization in Los Angeles) conducted a study that looked at referrals to the DCFS child protection hotline by ZIP Code, analyzed the availability of prevention supports in different ZIP Code areas, and identified "hot spots" of high-need communities that would benefit from additional network and community connections. Findings indicated that ZIP Codes 90044, 90003, and 93535 had the highest numbers of DCFS referrals coupled with the lowest number of available prevention supports (see Appendix C: Los Angeles County "Hot Spot" ZIP Codes on page 26). Casey Family Programs has also launched a landscape analysis to identify existing services and supports around six high-need DCFS regional offices.

The recently released child care needs assessment study, *The State of Early Care and Education in Los Angeles County*, also provides an up-to-date analysis of the

landscape of early care and education (ECE) services in the county. Its recommendations raise important issues about the cost of child care and the quality of existing services, and also offer ideas on providing essential supports for the ECE workforce.

Together, these analyses will inform our efforts as we map existing networks and prevention resources and determine how best to enhance and connect them so families in our most vulnerable neighborhoods have timely access to the assistance they need.



What We Heard



Because the premise of this plan builds upon the considerable work of the P&A and Best Start providers in establishing their extensive community networks, we conducted a “listening tour” of six key providers in both networks to learn more about what is working well and what should be improved upon. Twelve consistent themes emerged:

- When we are building stronger families, it's important to understand that children exist within families, and families exist within communities.
- The “five protective factors” from the Strengthening Families Approach (see page 6) are extremely important to successful prevention efforts.
- Economic stability for families is critical, yet it is the most challenging element to achieve.
- Parents need help in connecting to and navigating systems or networks of support.
- Establishing trusted relationships with parents is essential to connecting them to the right services and supports.
- Building authentic partnerships—so that parents are equal participants in building community-based networks of support—is fundamental.
- Trusting relationships take time, and they are an essential precondition to families' accepting and participating in voluntary supportive services.
- While cost is not the main barrier to increasing prevention efforts, flexible funding and some specific additional resources are still needed (for example, mental health, economic stability, informal community events, child care, transportation).
- Connections for communities and community-based organizations to schools and County departments are necessary but inconsistent.
- Connecting existing networks greatly enhances the array of resources available to families, and should be more intentional.
- Categorical funding is often challenging, particularly when it leads to competing reporting requirements that create barriers to providing services.
- Though extensive data exists, a standardized, consistent way to measure and report prevention factors is critical and very much needed.



What We Want

Informed by research, experiences across the County, and best practices, we now have an important opportunity to leverage existing partnerships to prevent child maltreatment. This is not about creating a whole new system of supports, but rather about strategically connecting and leveraging what is known to have a positive effect on prevention that already exists in our communities.

Create a “Network of Networks”

As mentioned, Los Angeles County is home to a number of successful networks, including Prevention and Aftercare (P&As), Best Start Community Partnerships, the community child abuse prevention councils, Medical Hubs, Health Neighborhoods, and other established and emerging groups with a similar family-strengthening focus. Along with important relationships identified by community partners, these networks can be both expanded and more deliberately connected with each other to focus on prevention. By bringing these providers together with faith-based organizations, home visiting programs, early education services, school districts, and other community entities, County leadership can support shared planning with communities and provide more seamless ways for families to access services before their issues can escalate. Community-based organizations and partners can play a critical role in building trust so that families are comfortable reaching out to those supports.

This connected infrastructure of networks can and must be culturally competent and responsive and must support equitable access for families of color, immigrants, expecting or parenting youth, and others facing challenges that undermine child and family well-being. These networks, rooted within the communities where families reside, are responsive to on-the-ground community issues and needs. They can share promising practices, new and innovative ideas for serving families in the child welfare system—particularly those aimed at reducing the overrepresentation of African-American and American Indian families and of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth—and pilot-test new partnerships between community groups and government, as well as innovative strategies for preventing child maltreatment. Community-based networks can identify holes in the local safety net, and providers can be held accountable for meeting family and community needs.

Support Earlier Access to a Range of Services and Supports

In addition to encouraging early access to services, these community networks also have a proven record of establishing trusting relationships and safe environments in which parents can establish social connections, build economic stability, identify family needs, access necessary services, and receive support in navigating complicated service systems. Networks have a unique role to play by serving families holistically across multiple disparate systems of supports.

Building upon those strengths, the County can partner with communities to create a system of SPA-level navigation hubs, particularly focused on high-need/low-resource “hot spots,” so families can find the help they need and so County staff know where to refer them. To do this, we need to improve cross-agency information-sharing and bring best practices in family engagement to County and community partners alike. This includes ensuring that both County departments and their community-based partners are prepared to understand the effects of trauma on families and how to appropriately respond to signs of trauma—an approach known as Trauma-Informed Care.

The County can also more intentionally and effectively use existing resources by connecting the roll-out of any new funding for family-focused services to these existing networks, rather than adding separate systems unconnected to them. In addition, given the significance to prevention of home visitation and early care and education services, those programs should be strongly integrated into these networks.

Evaluate the Effectiveness of Our Prevention Efforts

As we intentionally connect and strengthen these community-based networks, we must find ways to measure our efforts. That ability is essential to knowing whether we are having the desired effect of preventing child maltreatment, and can also help us tell the story of how investments in prevention work most effectively. We need to incorporate the five protective factors that strengthen families (see page 6) into residents’ experiences at the community level, as well as assess changes in family involvement with the child welfare system.



What We Will Do

Our Seven Strategies

1. Map out and then weave together existing prevention networks.

- We will undertake an inventory of the P&A networks (including lead agencies and providers), the First 5 LA Best Start communities, the emerging DMH/DPH Health Neighborhoods, Los Angeles County's Medical Hubs, and Workforce Development, Aging and Community Services' (WDACS') America's Job Centers of California (AJCCs) networks, as well as the aligned work being done by the 12 community child abuse prevention councils, the Inter-Agency Council on Child Abuse and Neglect, 211, and other identified city- or school-district-sponsored family-focused community-based networks. We will also assess ways to connect other civic or philanthropic efforts that support prevention for the same families and communities. This will give us an opportunity to see if there are gaps in service providers across the County, as well as to identify possible connecting points where we can be more deliberate in "networking the networks."
- We will map the array of prevention-oriented programs and services currently funded or organized by County government with three objectives in mind:
 - » Aligning the work of County departments with this plan
 - » Identifying key stakeholders to participate in governance and funding discussions
 - » Identifying services that should be better aligned with the P&A networks
- We will help community-focused networks link with each other and establish new connections among themselves. The goal is for these networks to weave together, making it easier for families to access services and supports that strengthen their protective factors, delivered by trusted providers, within their own communities.

2. Expand the capacity of the Prevention & Aftercare networks.

Because of the P&A networks' demonstrated efficacy in developing robust linkages and implementing key prevention strategies across the County, we will partner with them to implement this plan and rely on them to serve as the leads for expanding prevention efforts that support families and strengthen neighborhoods and communities.

- We will work to support the capacity of the P&A networks to serve families early on—particularly those at risk of entering the child welfare system. While many of these agencies already provide home visiting and early care and education services (or connect to agencies that do), we want to increase their capacity to connect interested families to these and other important services.
- We will explore avenues to expand the capacity of the P&A networks to connect families to a broader array of opportunities for workforce preparation, employment, and financial stabilization (community colleges, WorkSource Centers, etc.).
- We will build on the work of First 5 LA in developing trauma-informed care approaches and infusing them into our work with families, understanding the effect that environment has on a family's well-being and capacity to thrive.



3. Create a universal home visitation system.

In response to a motion from the Los Angeles County Board of Supervisors in December 2016, the Department of Public Health—in partnership with the OCP, First 5 LA, the Los Angeles County Perinatal and Early Childhood Home Visitation Consortium, the Children's Data Network (CDN), the Los Angeles County Office of Education (LACOE), and the departments of Mental Health, Public Social Services, Children and Family Services, Health Services, Public Library, and Probation—will develop a plan for creating a Countywide voluntary universal system of home visitation services so that all families who are interested can be connected to supports early on that strengthen their protective factors. Using various eligibility requirements and funding streams, this system will strategically expand capacity and improve integration across these critical programs, and help home visitation providers assist families in connecting to other services they need. More intentionally linking these programs to community-based networks will provide a proven prevention resource.

IN PRACTICE: Mary's Story

Mary has been in a home visiting program for two years. She's a full-time mom with two boys, ages 4 and 1. The older child has been diagnosed with autism and the other has language delays and possibly autism. Mary is grateful for the home visiting program because it allows her to learn more about her sons' development and to pursue personal and family goals that otherwise wouldn't have been established.

Most of all, parent educators have given her significant encouragement and hope. Mary now believes her children, and she, are capable of making their dreams a reality. She realizes that although her children may have a disability, they can still be successful in life and tries to teach them this every day through education and encouragement. She has learned that although she cannot be a perfect parent, she strives to better herself and is eager to learn different parenting practices so that she may be able to enhance the life of her family. Mary can truly see the positive outcomes, and feels she can now advocate for her children to receive the services they not only need, but deserve.

—Richstone Family Center

4. Improve access to early care and education (ECE) programs.

We will call on stakeholders to enhance partnerships among the County's Office for the Advancement of Early Care and Education, the Los Angeles County Education Coordinating Council, LACOE, school districts, First 5 LA, the Child Care Alliance of Los Angeles, and others to work on improving access to ECE for those families interested in participating. Many ECE programs have complicated enrollment processes with short and narrow enrollment windows that may not align with the child care

needs of vulnerable biological families, resource families, or relatives who work or go to school. Immediate goals include mapping ECE resources, providing information on this complex system to County departments and their community partners, helping families served by County departments access and navigate the ECE system, linking entities specializing in ECE to P&A networks and family-serving County departments, and enhancing the ability of the Department of Children and Family Services to make referrals electronically and track whether or not services are received. Over the longer term, we hope to develop strategies for utilizing existing ECE resources more efficiently regardless of funding source, and for seizing opportunities to expand the quality and availability of ECE services in communities with the largest gaps between supply and demand. As with the approach to home visitation described in strategy 3 above, shared planning is needed to align and maximize resources, given varying funding streams and eligibility criteria.

5. Monitor the overall well-being of communities.

Building upon the landscape analyses conducted by the Advancement Project and Casey Family Programs (see Appendix C: Los Angeles County "Hot Spot" ZIP Codes, page 26), plus the child care needs assessment study discussed earlier, we will continue to look at the well-being of communities across Los Angeles with an eye toward elements that prevent child maltreatment—social connections, economic stability, access to behavioral health services, etc. Our review will include a "Portrait of Los Angeles" (made possible by a Productivity Investment Fund grant recently awarded to the OCP) that will systematically measure health and longevity, educational attainment, and economic stability in Los Angeles County neighborhoods. This will help us better understand how to more specifically target family-strengthening prevention efforts in different communities, as well as provide a consistent way of measuring economic stability, which the P&As identified as a need.

6. Develop standardized measures of prevention to evaluate our efforts.

We will establish a standard set of indicators to measure our investments in prevention and to assess individual, community, and population-level impacts. Because prevention providers routinely knit together multiple funding sources to support their work, we will also recommend ways to standardize and streamline the different reporting requirements of County departments and other funders. This includes building on other data-collection efforts like the "Portrait of Los Angeles" and work being done by the Children's Data Network.



As mentioned earlier, recent analyses from the CDN are beginning to describe the experiences of children and families with multiple systems over time, clarifying interactions and overlaps between services that may not be visible from the perspective of a single system at any one point in time. The CDN should also be able to help in evaluating this countywide prevention plan by tracking changes in child abuse reporting and involvement with the child welfare system, assessing the impact of preventive services on deeper system involvement, and analyzing the effect of pilot projects or planned changes in community-based service delivery designed to reduce continuing or recurrent involvement with deeper-end, more intensive public service systems. These data will inform both the further implementation and expansion of our prevention efforts and the most effective use of our resources moving forward.

7. Implement prevention strategies identified by County departments.

We will continue to work with County departmental leadership to identify and implement ways in which the County can show greater ownership over its role in prevention efforts by building upon family-focused community-based networks and connecting them to important County systems and services. Representatives of County departments on the OCP prevention workgroup have identified many such opportunities, a number of which are already moving forward (see below).



Los Angeles County Department Commitments to and Efforts in Prevention

Based on the work of the OCP prevention workgroup and recent meetings with County leaders, the rest of this section lists activities underway to advance our work on prevention.

Department of Public Health (DPH)

- The department will report back to the Board of Supervisors on ways to make voluntary home visiting services universally available across Los Angeles County.
- DPH will connect its SPA-based Area Health Officers to the P&A providers for each SPA to strengthen their relationships with these networks.
- It is connecting to the emerging consortia of the Department of Mental Health's Health Neighborhood networks.
- It will work with DMH to enhance access to postpartum depression services and supports.
- DPH will outstation public health nurses in two Department of Public Social Services (DPSS) offices serving low-income mothers enrolled in California Work Opportunity and Responsibility to Kids (CalWORKs) to help connect them to home visitation and other social services as needed.
- The department is coordinating its text-messaging campaign, *La Familia*, with First 5 LA's family-strengthening campaign and others to incorporate prevention efforts.
- DPH will partner with a Best Start community that has identified the issue of child welfare or prevention as its priority focus to find ways to support local efforts.

Department of Mental Health (DMH)

- DMH is working to coordinate the three-year cycle of its Mental Health Services Act planning for the use of Prevention and Early Intervention (PEI) funding with the larger prevention efforts being coordinated by the OCP.
- The department will maximize opportunities to connect its funding of mental health providers (through PEI or the Mental Health Services Act's Innovations funding) with existing P&A networks. If barriers exist to those providers being included in DMH funding, the department will work with others to provide assistance to those community-based organizations to enhance their ability to compete for DMH funding.



- It is mapping its constellation of providers and specialty services (such as birth to five, dual-diagnosis, early intervention, intensive services) across Los Angeles County to improve access for high-need populations and provide accurate information to its partnering agencies and community referral sources (DCFS, DHS Medical Hubs, DPH).
- DMH will support the development and implementation of the CalWORKs Family Stabilization pilot project being led by DPSS and help connect families who want them to mental health services.
- The department is expanding its System Leadership Team, which makes recommendations to the DMH director on the use of PEI dollars, to include entities focused on child welfare and prevention, including the OCP and First 5 LA.
- As the pilot demonstrates some success, DPSS will partner with First 5 LA, DCFS, and the OCP to consider approaching the California Department of Social Services, if necessary, for CalWORKs and child welfare waivers or other flexibility needed to enhance services to this population. The ultimate goal will be an effective, truly integrated support program for DPSS and DCFS (or pre-DCFS) families that can then be expanded to other communities.
- Given the high overlap of caseloads across these departments, the OCP will work with DPSS and DCFS to explore (with others) a research project to identify early indicators present in DPSS-involved families that could lead to possible DCFS involvement.
- As DPSS continues to implement the state-mandated online CalWORKs assessment tool, it will work with DCFS and the OCP to identify systemic barriers to employment that are also early indicators of potential DCFS involvement.

Department of Children and Family Services (DCFS)

- DCFS identified the benefit of mapping its own categories of providers to ensure intradepartmental connections among those funded through different solicitations. Once this is complete, those providers will be mapped against other networks, including the First 5 LA Best Start community partnerships and the Health Neighborhood providers.
- The department will strengthen the relationships between DCFS regional offices and the lead P&A providers in each SPA. Once points of connection are identified, DCFS can incorporate the standardized reporting on prevention measures into its contracts.
- DCFS will conduct an evaluation of the effectiveness of prevention efforts provided through the P&As.

Department of Public Social Services (DPSS)

- Working with First 5 LA, the OCP, DCFS, and SHIELDS for Families, Inc., the department has begun to map how mothers served by DPSS' CalWORKs Family Stabilization program resources might be connected to SHIELDS for Families (the lead P&A network provider in SPA 6) to access needed supports not covered by DPSS' existing array of welfare-to-work services. The purpose of this pilot is to find ways to enhance DPSS connections to community-based P&A agencies to better serve low-income parents with barriers to employment. This effort will also connect to the local Best Start community partnership to further enhance parent connections to community-based supports.

Workforce Development, Aging and Community Services (WDACS)

- WDACS will ensure that the prevention and aftercare networks (P&As) become an integral part of the countywide workforce system—the America's Job Centers of California (AJCCs)—to prioritize referrals for at-risk families, DCFS families, and youth.
- It will pursue collaborative partnerships with DCFS, Probation, DPH, and LACOE to use data to identify employment and education service gaps for youth, at-risk families, and DCFS families, and determine how to mobilize services to mitigate those gaps.
- Once this stage is complete, WDACS will partner with the Los Angeles Unified School District (LAUSD) to co-locate three Pupil Services Attendance counselors at select AJCCs to identify and connect opportunity youth from 17 LAUSD high schools to access workforce services. ("Opportunity youth" are defined as youth between the ages of 16 and 24 who are neither in school nor employed.) WDACS will work with LACOE and others to expand this re-engagement strategy to the other 80 school districts in Los Angeles County, prioritizing those with high concentrations of foster youth. It will also explore developing a Memorandum of Understanding with LACOE for data-sharing that will further support this effort.





- In September 2017, to further the Purposeful Aging Initiative, WDACS will launch (in partnership with the Public Library, Probation, and DCFS) a mentor-based tutoring pilot through which Title V–Senior Community Services Employment program participants will mentor youth who will then jointly provide tutoring to other youth.
- In partnership with various County departments and other external stakeholders, WDACS will establish a multidisciplinary approach to improve outcomes that promote economic stability and permanency for youth, at-risk families, and DCFS families.
 - It will work with DCFS, Probation, LACOE, and DPSS to align multiple case and service plans in the areas of employment and education. Currently, youth and certain families are required to have a case plan, a transitional independent living plan, a needs and services plan, a welfare-to-work plan, and an AJCC equivalent, but these plans are not jointly created or maintained (with the exception of shared DCFS and DPSS families).
 - In conjunction with DCFS, Probation, DPSS, and the Children’s Law Center, it will initiate referrals to prioritize workforce services for AB 12 youth at age 19 (DCFS non-minor dependents, for instance), ensure that the court requires their participation in workforce services, and prioritize referrals for other family members in need of employment, in support of the DCFS case plan.
- It will work with Probation and LACOE to formalize a process to enroll all youth at probation camps into AJCC services prior to their release. This will improve youths’ overall outcomes through education, training, career planning, work experience, and job readiness, and also reduce the likelihood of recidivism.
- WDACS will incorporate a prevention strategy as a required approach in the Performance Partnership Pilot (P3) strategic plan. The P3 is a major multi-partner effort to increase countywide coordination and collaboration across a broad group of dense systems—education, workforce, social services, child welfare systems, local municipalities, and community-based organizations—to streamline access to services and improve outcomes that promote economic stability.

Child Support Services Department (CSSD)

- CSSD recognizes that economic stability and connections to resources are critical to strengthening families. The department will partner with the P&As to periodically co-locate volunteer staff at sites within each of the 10 networks, and also explore opportunities to co-locate volunteer staff at additional community-based organizations.
- The department will periodically co-locate volunteer staff at the DPSS CalWORKs Family Stabilization pilot’s district office and explore partnerships to expand co-location to additional County offices to ensure that families are aware of services available to assist them with child support.



- CSSD will train its staff on connecting clients to preventive and supportive services within their communities.
- It will distribute information at all of its regional offices about supports available through the P&As.
- It will explore options to partner with the County Library to periodically co-locate volunteer staff at library facilities to expand its reach to families who may need CSSD services.

Public Library

- The Library will expand its Family Place programming so that, by the end of 2018, 86 libraries will host the program. Family Place builds strong bonds between children and their parents while promoting early literacy and connecting families to resources and services. All Family Place parent/child workshops feature a community resource specialist (nutritionist, pediatrician, behaviorist, etc.) who meets informally with parents to offer additional services and resources, as requested.
- Beginning in the fall of 2017, the Library will implement a new outreach program, The Reading Machine, in partnership with other County departments—DPSS, DCFS, DMH, the CSSD, the Natural History Museum of Los Angeles County, DPH, LACOE, Probation, and the OCP—to provide mobile early literacy and caregiver-support services. The program will deploy two vans to targeted sites within nine at-risk neighborhoods, and serve parents, home day care providers, and youth. Caregivers will learn how to engage in meaningful play activities that help them identify developmental issues with their young children, and will receive information on additional available County services.
- In 2017, with financial support from DMH, 10 Library staff will be trained in the evidence-based parent-support program Triple P—the Positive Parenting Program. One Triple P librarian will host multi-session parenting workshops at 52 libraries so that foster parents can satisfy their parenting class requirements. The remaining nine librarians will be trained to conduct one-to-one interactions with parents on developing simple strategies to address common childhood issues such as toilet training, tantrums, sleep problems, getting along with other children, and more.
- All library staff who interact with youth will be trained to use Touchpoints, a parent support model that builds parents' confidence in being their child's first teachers and also helps maintain parent-child relationships during periods of family stress.
- Library staff at Los Padrinos Juvenile Hall are implementing programs to help teen parents at the facility understand the importance of early literacy. Board and picture books are being purchased so that youth can take the books home to use with their children. These staff are also in the process of exploring an adapted version of the Family Place program at the Hall to facilitate parent-child bonding.
- This year, in partnership with the Department of Parks and Recreation, the Library will expand its *Lunch at the Library* summer program—which introduces parents to resources and materials that support caregiving and promote literacy—from 7 libraries to 13 libraries. It will also open its doors to children age 2 through 18 who are in need of a free meal (access to school lunch programs being limited in the summer). Three to five new lunch sites will be added each year thereafter to expand access to free meals for these children.
- The Library hosts bullying prevention and personal safety programs to help youth learn how to protect themselves and be more aware of their environment. The programs started at 10 libraries in 2014 and will expand to all 87 libraries by the fall of 2018, so that youth throughout the county can learn valuable safety and confidence-building skills.

Department of Parks and Recreation (DPR)

- DPR will work with area schools and community partners to expand parent educational opportunities that create networking opportunities for families and expose parents/caregivers to local resources that support healthy parenting via workshops, informational fairs, and educational classes.
- The department will collaborate with DMH to expand pilot park-therapy programs where families can access free mental health education and wellness programs at park facilities, with the goal of developing this model in other high-need areas.
- Parks and Recreation will partner with the P&As, providing a quarterly brochure of DPR programs—camps, teen clubs, lunch/snack programs, Tiny Tots, sports programs, and special events—while utilizing social-media tools and engaging area school districts to distribute information intended to bring the community together and promote child and family resiliency.





- DPR will build a robust youth council program that invests in youth leadership, creates a space for youth voices in governance by engaging youth in decision-making, and exposes teens to civic engagement and volunteer opportunities. Youth councils will host an annual Youth Summit to gather teen community leaders from throughout Los Angeles County to engage one another and strengthen their leadership skills.
- The department will expand programs such as Parks After Dark to build social cohesion, connect families to resources, lessen crime, and thereby build resilient communities. Programs that create opportunities for families to interact in healthy ways in home and community life will be offered by DPR's community partners.
- The department will partner with First 5 LA and the P&As to provide early-childhood and other parenting information at all park facility public counters.
- DPR will introduce and train staff in trauma-informed approaches to build resiliency in children through its Tiny Tots and after-school programs.

Department of Health Services (DHS)

- DHS Medical Hubs will work with the P&As to ensure that children and families in contact with DCFS are referred to services within those networks, as necessary, to address any needs identified during the on-site assessment process.
- The department's MAMA's Neighborhood program will partner with both DCFS and Probation to identify

pregnant adolescents and facilitate direct referrals to prenatal care and other psychosocial services related to healthy outcomes.

- Through DHS' Whole Person Care pilot program, the department will partner with Probation and DMH to identify high-risk youth with medical, mental health, or substance-use disorders in juvenile camps or halls who would benefit from community-based re-entry support. The goal will be to improve these youth's access to and use of clinical and support services to reduce recidivism.
- The department's Women's Health Programs and Innovation unit will provide support and training to Medical Hub staff and to Probation, juvenile court health services, DCFS, and Sheriff's Department staff on issues related to adolescent sexual health, contraception, pregnancy-options counseling, prenatal care, terminations, and sexually transmitted infection prevention.
- DHS Medical Hubs will focus on providing teen-friendly services, including training nursing staff on non-directional contraception counseling and training clinicians on providing access to all FDA-approved contraception options during teen visits.

Probation Department

- Probation will partner with DPR and the Department of Health Services to expand opportunities that meet the needs of youth and families through a myriad of services (health, mental health, substance abuse, tutoring, legal clinics, etc.) offered in community-based neighborhood service hubs.
- It will partner with WDACS to fully implement a vocational/employment program for probation youth, with specific emphasis on youth transitioning back to the community.
- Over the next 180 days, Probation will create a family-finding unit able to locate family members early in the judicial process, both to increase support for youth and also to enhance the probability of youth being placed with a relative should the need for out-of-home care arise.
- Over the next 180 days, Probation will review current protocols/policies and develop more suitable community-based placement options for youth awaiting re-placement and/or a court hearing that might normally lead to detention in juvenile hall.



- Over the next 120 days, Probation will partner with LAUSD to expand educational opportunities for probation youth by offering credit-recovery services to credit-deficient youth in nontraditional community-based hubs. This effort will allow for youth to be dually enrolled, attending school during normal hours and accessing credit-recovery services after school to increase graduation rates and create post-graduation plans that include continued education/vocational opportunities.
- The department will expand partnerships with community-based organizations to provide traditional support services through the Juvenile Hall Family Resource Centers.
- It will work with faith-based organizations to expand opportunities for families to engage in pro-social networks and support groups, and will explore mentorship opportunities for youth transitioning from camp and from the Division of Juvenile Justice back into their communities.



Los Angeles County Office of Education

- A statewide initiative is currently being rolled out across Los Angeles County that engages school districts in a multi-tiered system of support (MTSS). The four pillars of this system address administrative leadership, an integrated educational framework, family and community engagement, and inclusive policy structure and practice. To support these four MTSS pillars, LACOE will work collaboratively and collectively across the county to strategically leverage already existing practices that are known to have a positive effect on prevention in our communities.
- LACOE will continue to partner with federal entities to increase the number of Early Head Start and other infant/toddler services available to children and families

in Los Angeles County.

- LACOE will further provide early learning support by actively engaging various partners and networks throughout the county and by hosting the California Preschool Instructional Network and Early Childhood Education Professional Learning Community.
- LACOE's Division of Special Education (DSE) will be more aggressive in its approach to increase public awareness of important services that exist for children with special needs or suspected needs, through public service announcements, ads in print media, 211, and so on. In addition, DSE will strengthen its partnerships with school districts and Regional Centers to provide technical support for meeting the needs of children birth to age five in general-education settings who are suspected of having special needs. (Early intervention programs can prevent referrals to special education programs before age three.)
- LACOE will guide school districts in transitioning probation students with Individualized Education Programs (IEPs) to comprehensive school campuses by helping districts understand these students' unique challenges and the need to address them by the student's 30-day change-of-placement IEP meeting.

Through the Eyes of Community Residents

An essential attribute of using a network model to implement prevention is that activities take place in neighborhoods, often sponsored by grassroots organizations that are accepted as fellow community members, close to and trusted by local residents. Individuals may not even realize they are participating in a "prevention program," but might tell instead of their personal connection to a specific worker or team who partners with them to help meet challenges and recognize their own abilities. They are more likely to see the organization itself not as a place they come to for appointments, but as a safe space where they make social connections, have fun with other neighborhood folks, share a meal, share opinions, share information, and engage in activities with their families.

As the prevention elements called for by this plan come to scale, residents will experience trusted community members encouraging them to link with their neighbors to find and access beneficial resources and supports. The organizations making up the prevention networks will be seen as places for friends and families to gather—places that advocate for fairness and equity, where everyone is welcome.



Where Do We Go From Here?

Create a Governance Structure to Align Prevention Efforts

To maintain the momentum of the many efforts described in this document and to ensure appropriate focus and accountability, the OCP will institutionalize a formal governance structure for overseeing the implementation of this plan along with other prevention efforts. This structure will connect and coordinate existing networks and entities with important roles to play, and will include leaders from County departments and community partners, including service providers, community-based organizations, the faith-based community, education, law enforcement, resident and youth representatives, and those from the philanthropic sector who focus on prevention. We will also look to non-traditional external partners and find ways to ensure that parent voices continue to inform our work.

The purpose of this governance structure will be to better align and prioritize efforts, not to replicate or supersede existing frameworks.

Identify Ongoing Funding Streams

An ongoing funding stream for prevention implementation will be identified by more effectively using existing funding, leveraging resources, and exploring the possibilities for braiding and/or pinpointing new public and private funding opportunities.

Convene a Data Advisory Committee

We will assemble an advisory group of researchers and data experts to develop a standardized set of measures to capture our investments in prevention. This group should also recommend ways that the County can implement standardized reporting on prevention and make prevention data more publicly available. County departments can use these standards as they fund prevention efforts, so we have a comprehensive view of County investments.

Identify and Implement New, Innovative Approaches

We will continue to pursue opportunities with public, private, community, and philanthropic partners for expanding creative and effective models across the county. Most immediately, the emerging partnership of DPSS and First 5 LA's home visitation provider, SHIELDS for Families, Inc., is finding ways to serve a particularly vulnerable population whom we know disproportionately ends up in the child welfare system—families enrolled in CalWORKs. This work could inform practice at the state level as well. Other populations also tend to be overrepresented in the child welfare system, and we will identify additional innovations to address their unique issues and reduce their disproportional involvement.

Timeframe for Implementation

We aim to implement this plan over the next two to three years. While we feel an urgency to move forward, much of our progress will be dictated by the County's contracting process.

Conclusion

Sizable public and private investments have already been made throughout our region to establish networks of family-focused community- and faith-based organizations to meet the needs of the populations Los Angeles County and its partners are committed to serve. We now need to stabilize the pieces already in place, build and expand them, and deliberately weave them together to ensure a strong, coordinated, sustainable network.

This prevention plan is an important step toward achieving our shared vision—that every child is healthy, growing and thriving in a strong family, and supported by a safe and nurturing community. This vision goes hand in hand with our commitment to prevent children and families from coming into contact with the child welfare system, to minimize the duration of any contact that is necessary, and, over time, to limit their involvement with other intensive service systems.

All partners must "own" prevention and recognize their role in helping to achieve it. This includes working together in new ways to create a seamless framework of support for the children and families we jointly serve, identifying the governance structure and funding needed to sustain these efforts long term, and ensuring this plan's success.

We need to be proactive and forward-thinking to successfully produce the outcomes we all want. Each of us must take responsibility for being more resourceful in our approaches to supporting our children and families within their communities, so that their lives are enhanced in ways that are visible, powerful, and lasting.



List of Contributors

Advancement Project
 Antelope Valley Partners for Health
 Best Start El Monte
 California State University, Los Angeles
 California Youth Connection
 Casey Family Programs
 Center for Strategic Public-Private Partnerships
 Children's Data Network
 Children's Bureau
 Children's Institute International, Inc.
 Community Child Welfare Coalition
 First 5 LA
 Friends of the Family
 Inter-Agency Council on Child Abuse and Neglect (ICAN)
 Korean Youth and Community Center (KYCC)
 Los Angeles County Chief Executive Office (CEO)
 Los Angeles County Child Support Services Department (CSSD)
 Los Angeles County Commission for Children and Families
 Los Angeles County Department of Children and Family Services (DCFS)
 Los Angeles County Department of Health Services (DHS)
 Los Angeles County Department of Mental Health (DMH)
 Los Angeles County Department of Parks and Recreation (DPR)
 Los Angeles County Department of Public Health (DPH)
 Los Angeles County Department of Public Social Services (DPSS)
 Los Angeles County Department of Workforce Development, Aging and Community Services (WDACS)
 Los Angeles County Education Coordinating Council
 Los Angeles County Office for the Advancement of Early Care and Education
 Los Angeles County Office of Education (LACOE)
 Los Angeles County Probation Department
 Los Angeles County Public Library
 Los Angeles Unified School District (LAUSD)
 Neighborhood Legal Services of Los Angeles Prototypes
 SHIELDS for Families, Inc.
 South Bay Center for Counseling (SBCC)
 Special Services for Groups
 SPIRITT Family Services
 United American Indian Involvement
 Westside Children's Center

Definitions of Acronyms and Initialisms

AJCC	America's Job Centers of California
CalWORKs	California Work Opportunity and Responsibility to Kids
CDN	Children's Data Network
CSSD	Child Support Services Department
DCFS	Department of Children and Family Services
DMH	Department of Mental Health
DHS	Department of Health Services
DPH	Department of Public Health
DPR	Department of Parks and Recreation
DPSS	Department of Public Social Services
DSE	Division of Special Education
ECE	Early Care and Education
LACOE	Los Angeles County Office of Education
LAUSD	Los Angeles Unified School District
LGBTQ	Lesbian, gay, bisexual, transgender, and questioning
OCP	Office of Child Protection
P3	Performance Partnership Pilot
P&As	Prevention and Aftercare Networks
PEI	Prevention and Early Intervention
PIDP	Prevention Intervention Demonstration Project
SPA	Service Planning Area
WDACS	Workforce Development, Aging and Community Services



Appendix A: Some of Los Angeles County's Prevention History

Los Angeles County has a long record of efforts to enhance child protection and prevent child abuse and neglect. Entities such as the Los Angeles County Commission for Children and Families and the Inter-Agency Council on Child Abuse and Neglect (ICAN), along with the First 5 LA Commission, County departments, academic institutions, partners from the philanthropic community, and others have worked for years to prevent child maltreatment. In 2002, the County Board of Supervisors directed the Children's Planning Council, the Commission for Children and Families, the Department of Children and Family Services, ICAN, and other leaders in child and family services to develop a Countywide prevention plan. A 2005 report titled "Preventing Child Maltreatment: A Comprehensive Plan for a Continuum of Family-Centered Community-Based Prevention and Intervention Services for Children, Youth and Families in Los Angeles County" was issued.¹³ Many entities and organizations were consulted. Scores of recommendations were put forth.

That report—like others—found that the lack of a coordinated, effective strategy for prevention was compromising child safety. It noted the existence of many County and community programs, but also recognized the absence of any structure or mechanism through which these programs were coordinated and held accountable to ensure the effective implementation of prevention strategies in communities or across the county.

In an effort to coordinate the systems and resources affecting the prevention of child maltreatment, the County Board of Supervisors in 2014 established the Office of Child Protection (OCP). The OCP became operational in February 2015, and released its countywide Strategic Plan in October 2016. The OCP Strategic Plan has a focus on prevention, with the stated goal of providing "children and families with the upfront supports and services they need to prevent them from entering the child welfare system and/or limit their involvement with the system once they are known to it."

These and other investments by County and non-County entities over the past five to ten years are now in place across the region. These resources are an integral component to creating an infrastructure of prevention, as well as a wealth of knowledge that can inform the County's commitment to prevention and our prevention plan.

Prevention Initiative Demonstration Project (PIDP)

In 2006, the Los Angeles County Board of Supervisors passed a motion directing the establishment of a comprehensive prevention system. This motion called for promoting family-strengthening efforts in safe and stable communities, and further recommended that:

- The Department of Children and Family Services establish a pilot project designed to show how community-based networks could reduce social isolation, improve economic resources for families, and increase access to existing services, supports, and activities
- The Chief Administrative Office (now the Chief Executive Office), in partnership with others, facilitate community meetings and planning workgroups, develop outcomes and indicators, analyze successful models, and develop recommendations for the County

Responding to the first directive, DCFS established PIDP in 2007. This project built on three integrated or "braided" strategies implemented by networks of PIDP providers in the eight geographic Service Planning Areas (SPAs): (a) building social connections by using community organizing approaches; (b) increasing economic opportunities and development; and (c) increasing access to and utilization of beneficial services, activities, and resources. PIDP continued as a demonstration project for several years and was independently evaluated in 2009 and 2010. Evaluators concluded:

"... PIDP findings show a strong and significant pattern of improvements for families in terms of social support (reported by parents in all eight SPAs), decreased re-referrals (in one of the three areas tested), and more timely permanency (in all of the three areas tested). The fact that results were found across levels of prevention underlines the fact that PIDP accomplished just what it was designed to do in only two years. It pilot-tested locally relevant approaches to strengthening families, and demonstrated the potential for significant improvements in child safety and well-being as a result of well-designed prevention services that braid three core elements to create accessible and welcoming webs of community support, activities, and services for families."



¹³ Prevention Workgroup (2005). "Preventing Child Maltreatment: A Comprehensive Plan for a Continuum of Family-Centered Community-Based Prevention and Intervention Services for Children, Youth and Families in Los Angeles County."

Evaluators also recommended that the County work to encourage cross-departmental efforts to share funding and support for prevention. During the process of creating the current prevention plan, it became clear that a number of departments already support programs that align very well with the goals of this plan. These include both community-based programs funded through County contracts and those operated by County staff who partner informally with community-based service providers.

Although the original DCFS pilot project called for in the Board of Supervisors' 2006 motion was created and successfully implemented (as mentioned on page 7), an entity for coordinating additional prevention resources and efforts beyond the network funded by DCFS was never established.

Inter-Agency Council on Child Abuse and Neglect (ICAN)

The Inter-Agency Council on Child Abuse and Neglect (ICAN) was established in 1977 by the Los Angeles County Board of Supervisors. ICAN serves as the official County agent to coordinate the development of services for the prevention, identification, and treatment of child abuse and neglect. It is the largest county-based child abuse and neglect network in the nation, and is co-chaired by the Los Angeles County Sheriff and the Los Angeles County District Attorney. ICAN staff are housed within the Executive Office of the Department of Children and Family Services (DCFS). ICAN was designated as a local child death review team for the National Center for Fatality Review and Prevention in 1996.

ICAN consists of 32 county, city, state, and federal agencies represented at the department-head and professional/line levels, along with 12 community-based interdisciplinary child abuse councils. In addition, ICAN's nonprofit partner, ICAN Associates, is composed of volunteer business and community members who raise funds and public awareness for programs and issues identified by ICAN. ICAN's activities are carried out through committees of public sector and private sector professionals with expertise in child abuse/neglect. These groups address critical issues affecting the well-being of the most vulnerable children in the County, and include committees on policy, operations, victim services for commercially sexually exploited children (CSEC), cyber-crime prevention, child death review, child and adolescent suicide review, pregnant and parenting teens, child abduction and reunification, the Family and Children's Index, AB 1733/AB 2994 planning and funding recommendations, a safe sleep for infants campaign, the safely surrendered baby law, data/information-sharing, child abuse/domestic violence protocol development, child abuse protocol development, infants at risk due to prenatal substance abuse, and the California Hospital Network.

ICAN provides advice and guidance on public policy development and program implementation to improve the community's collective capacity to meet the needs of abused and at-risk children. ICAN has a unique ability to bring both department-head-level and line-level professional staff together to work collaboratively, holding forums where staff from different agencies share information and learn about the roles each agency plays in the prevention of child abuse/neglect. As a result of these forums, staff from multiple agencies develop a much deeper understanding of the broad system that is required to most effectively combat child abuse and family violence.

ICAN regularly releases three major reports—*The State of Child Abuse in Los Angeles County*, *the Report of the Child Death Review Team*, and the report on *Safely Surrendered and Abandoned Infants*—and also produces five major training events: the NEXUS Conference, the Children's Traumatic Grief and Loss Conference, cyber-crime prevention symposia, child sexual exploitation trainings, and child and adolescent suicide prevention trainings.

ICAN's work has resulted in many positive outcomes, including:

- The successful sponsorship and passage of legislation that has brought millions of dollars into Los Angeles County for child abuse prevention programs, created the Family and Children's Index, allowed for a greater sharing of health information between medical professionals and case workers for children in the child protection and juvenile justice systems, permitted the secure electronic sharing of information by two-person multidisciplinary teams, and enacted drowning prevention ordinances and child product safety measures
- The development of protocols for the countywide response to reports of child abuse and neglect, guidelines for an effective response to domestic abuse and inter-disciplinary protocols for severe non-fatal child injuries; and guidelines for the mentoring of foster youth
- The development of a countywide public awareness campaign for infant safe sleeping

In addition, the ICAN Hospital Network was created to support child abuse screening, reporting, evaluation, and management in all hospitals serving Los Angeles County residents. This privately funded project will build a data-tracking program and connect hospitals to the child protection system and to each other with regard to births and children under age three served by a hospital, emergency department, or inpatient services.



Appendix B: Research on Effective Prevention Strategies

The urgent need to connect parents early on to available resources is highlighted in a recent study from the University of Southern California Suzanne Dworak-Peck School of Social Work's Children's Data Network that examines the cumulative risk of becoming involved with the child welfare system for our youngest children. The study found that 14.6 percent of all babies born in Los Angeles County in 2006 and 2007 were reported to child protective services before age five. Of those reported, allegations of maltreatment were substantiated for only about one-third (5.2 percent of those reported) and only 2.4 percent were removed from their families and placed in out-of-home care.¹⁴ Such high rates of reporting, accompanied by much lower rates of substantiation and removal, suggest that many people may not know where to go when family problems begin to develop, and that communities may not have access to the broad range of supports and services needed.

Calls for help may go unanswered because of pressures on the system, and family problems may not be addressed in a timely way. Too often, a cycle of repeated referrals occurs before DCFS eventually becomes actively involved with these families. By that time, their problems may have already escalated.

As another study finds, the longer these instances of seeking services go unaddressed, the more significant the costs are to the child, the family, and society.¹⁵

"The longer that instability lasts, the harder it is for a family to rise back up. At that point, placing children in foster care may be the only option available to us. But what these families really need is [earlier] intervention . . . when they are beginning to struggle but are still relatively stable, and when the intervention wouldn't involve breaking up families."¹⁶

By intervening with families earlier, we are able to enhance positive child outcomes. Building stronger families prevents child maltreatment.

The Strengthening Families Approach

Based in part on experience in Illinois and elsewhere, along with research conducted by the Center for the Study of Social Policy (CSSP), various jurisdictions around the country have begun implementing the Strengthening Families Approach. Within a community-based context, this approach centers on ways to connect parents to ensure that the five positive attributes that research has linked to a lower incidence of child abuse and neglect—"protective factors"—are present for families.¹⁷ One of these protective factors is connecting parents to services in times of need. These factors have been adopted by many jurisdictions with the goal of preventing child abuse and neglect.

The Five Protective Factors



Parental Resilience: the ability to manage and bounce back from all types of challenges that emerge in every family's life



Social Connections: connections to networks of support essential to parents



Concrete Support in Times of Need: connecting to services to meet basic needs, as well as to address crises that may emerge



Knowledge of Parenting and Child Development: accurate information about child development and appropriate expectations for children's behavior



Social and Emotional Competence of Children: a child's ability to interact positively with others, self-regulate, and communicate effectively

¹⁴ "Cumulative Risk of Child Protective Service Involvement Before Age 5: A Population Based Examination." See *Interactive Cumulative Risk Report*, www.datanetwork.org.

¹⁵ In addition to the individual toll, one recent study by the UC Berkeley Haas School of Business found that for every incident of child abuse, there was a public cost of \$400,533 over the lifetime of the victim. "How Much Does Child Abuse Cost?" chronicleofsocialchange.org, 1/13/17.

¹⁶ McGrath Tierney, M. (2016). "From Family Data to Neighborhood Outcomes." *Stanford Social Innovation Review*, November 29, 2016.

¹⁷ "The Protective Factors Framework," Center for the Study of Social Policy, www.cssp.org.



Research on Best Practices

Ample research exists on services that are particularly effective in improving child outcomes and decreasing child maltreatment. Both home visitation and early care and education services have been shown to significantly decrease instances of child maltreatment, as well as to enhance parents' protective factors.¹⁸

Home Visitation

Home visitation connects to parents at the very earliest stages possible, providing critical support to expecting and new parents. Through parenting information and coaching, as well as connections to key supports and services, home visitation has been proven to increase parenting skills, enhance child health and development, raise high school graduation rates, lessen juvenile justice involvement, and reduce child maltreatment.¹⁹

In Los Angeles, we are fortunate to have a network of at least six federally and locally funded home visiting programs across the county. For the past few years, First 5 LA, the Partnership on Early Childhood Investment, the Department of Public Health, and others have funded and supported the Los Angeles County Perinatal and Early Childhood Home Visitation Consortium in an effort to coordinate this network and develop a shared reporting and accountability system.

Early Care and Education

Evidence also shows that high-quality early care and education (ECE) programs that include support for families can help prevent maltreatment. For example, results from the Chicago Parent Child program, which includes a half-day preschool program for three- and four-year olds along with comprehensive family services, have demonstrated markedly lower rates of substantiated (verified) abuse and neglect.²⁰ Over the last 15 years, the Los Angeles County Office for the Advancement of Early Care and Education, along with the Child Care Planning Committee and the Policy Roundtable for Child Care and Development, have been working on strategically aligning County services with the early childhood education and child development programs that are supported by federal, state, local, and philanthropic resources. Their goal is not to create a new system, but to strategically connect effective programs into a countywide network dedicated to strengthening families, enhancing child development, and preventing child maltreatment.

This work includes an ongoing partnership with First 5 LA, the Child Care Alliance of Los Angeles, Los Angeles Universal Preschool, the Los Angeles County Office of Education's Head Start Division, and others to coordinate a countywide approach to improving ECE quality.



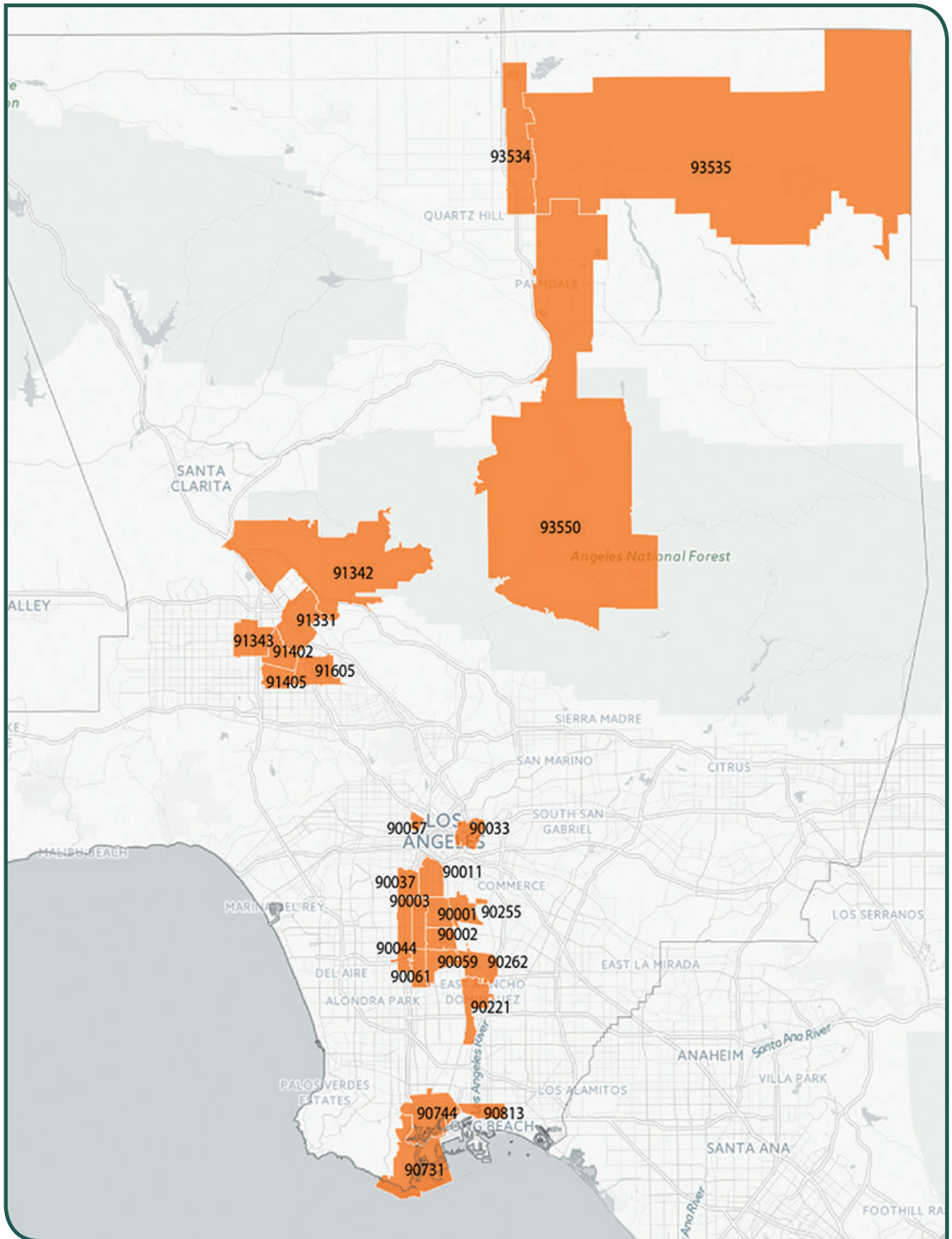
¹⁸ For the effects of home visitation, see "Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect: Fifteen Year Follow-up of a Randomized Control Trial," *Journal of the American Medical Association*, 1997, as cited by the Los Angeles County Board of Supervisors' motion on home visitation, December 20, 2016.

¹⁹ "Home Visiting," Children Now Issue Brief. On high-school graduation rates, see, for example, *Research Spotlight on Success: Healthy Families America Promotes Child Health and Development*. Healthy Families America (2008). www.healthyfamiliesamerica.org.

²⁰ Reynolds, A.J., Mathieson, L.C., & Topitzes, J.W. (2009), "Do Early Childhood Interventions Prevent Child Maltreatment? A Review of Research." *Child Maltreatment*.



Appendix C: Los Angeles County "Hot Spot" ZIP Codes



Top 25 Los Angeles County Prevention Need and Maltreatment ZIP Codes

ZIP Code	Neighborhood	Prevention Need Rank	Maltreatment Rank	Average Rank
90003	South L.A.	2	1	1.5
90044	Athens	5	2	3.5
90002	Watts	6	4	5
91402	Panorama City	4	7	5.5
93550	Palmdale/Lake Los Angeles	1	12	6.5
90059	Watts/Willowbrook	7	10	8.5
90011	South L.A.	18	5	11.5
90037	South L.A.	21	3	12
91405	Van Nuys	8	22	15
90057	Westlake	9	23	16
90001	Florence/South L.A.	20	15	17.5
91331	Arleta/Pacoima	25	11	18
90061	South L.A.	19	18	18.5
90033	Boyle Heights	40	6	23
90221	East Rancho Dominguez	26	21	23.5
91342	Lake View Terrace/Sylmar	29	20	24.5
90731	San Pedro/Terminal Island	37	13	25
91605	North Hollywood	27	24	25.5
93535	Hi Vista	43	9	26
91343	North Hills	45	8	26.5
90255	Huntington Park/Walnut Park	16	41	28.5
90744	Wilmington	46	16	31
93534	Lancaster	49	17	33
90813	Long Beach	3	63	33
90262	Lynwood	33	34	33.5



Appendix D: The Prevention and Aftercare Networks/Best Start Listening Tour

In addition to studying the research on effective approaches and services and documenting our experience with various prevention efforts, we also went straight to the source. To learn more about what works and what can be improved upon, the OCP, the Los Angeles County Commission for Children and Families, and First 5 LA undertook a “listening tour” of Prevention and Aftercare network (P&A) and Best Start providers. These community meetings identified 12 themes that were consistently articulated across these networks:

- **It’s important to focus on the child/family/community levels.** The goal is to build stronger families; children exist within families, and families within communities.
- **The critical strategies connected to “protective factors” are consistently recognized.** Much similarity exists in how the DCFS prevention networks and the Best Start communities approach child well-being, strengthening families and communities through: (1) increasing social connections (decreasing isolation) of parents and families; (2) improving the economic opportunities and conditions of families; and (3) enhancing a family’s ability to access appropriate and responsive supports or services in times of need. Several entities referred to these critical three elements as the “braided strategies.” Some P&A providers add two additional factors: the social/emotional competence of adults, and a family’s increased economic opportunity, stability, and security. There is an overall recognition of the important impact protective factors have on prevention.
- **There is also recognition of the vital yet challenging role of economic stability.** Many conveyed that of all the factors embedded in the three strategies, “economic opportunity and stability” was the most difficult to address and to achieve. Interestingly, the Los Angeles County Department of Social Services (DPSS)—which manages many streams of income support for families—was not often cited as a department with which the networks had a strong connection. Navigating mainstream systems such as Supplemental Security Income (SSI), the Earned Income Tax Credit, CalFresh, and others was also cited as a challenge.
- **P&As and Best Start communities have a critical role in helping parents connect to and navigate systems or networks of support.** All discussed the difficulties parents have in finding their way among networks and separate systems of services; organizations often play an essential role with navigation assistance. One theme expressed was the importance of looking at what is already in communities and finding ways to connect resources so support is more effective and integrated—it’s about connecting to what already exists.
- **Beyond navigation, it’s also about establishing trusted relationships between parents and providers.** In addition to the themes of navigation and access, the importance of trust came up consistently. A relationship with a trusted individual or organization is crucial in a couple of ways. First, parents need a trusting relationship with someone they can have an honest conversation with (“letting their guard down”) about barriers or issues being faced by their families, especially when those issues include immigration status, substance abuse, domestic violence, mental illness, the clearing of criminal records, etc. The second element is a trusted network of services—appropriate, beneficial, and responsive (including culturally) to the needs of the adult or family. This theme is much less about parents’ need for “information and referral” than it is about building trusting relationships, helping parents connect to appropriate services, and keeping tabs to make sure services are provided. Many mentioned needing to actually go with parents—occasionally providing the transportation—to connect to services (sometimes referred to as a “warm hand-off”) and to following up with parents to ensure they are accessing the services and supports needed.
- **Building authentic partnerships with parents is key.** Trusting relationships require authentic partnerships with parents, where they are seen both as equal to and as potential resources for others at the table—community-based organizations and providers, department representatives, etc. Oftentimes the parent voice is not as well incorporated as it should be.
- **Developing trusting relationships takes time.** Given the importance of trust and families’ feeling they are in a trusting environment, this work takes time. Examples of uncovering “deeper” issues in families only after working with them for a period of time surfaced in many conversations. Some entities referenced four to six months for those relationships to be developed.





- **Though they are not the main barrier to enhancing prevention, some specific additional resources are needed.** Overall, issues of helping parents access services and supports centered around the need to develop trusting relationships and trusted navigators, but specific service gaps were also identified in several conversations. Those most often cited were in children's mental health and postpartum depression treatment, as well as resources to enhance economic stability. In addition, many expressed a need for flexible funding to engage parents via informal community events while also supporting logistics like child care, event venue fees, and transportation.
- **County department connections to communities are vitally important . . . and remain inconsistent.** Relationships with the regional/local offices of various County departments affect local networks and communities. Many providers serve several jurisdictions and could compare areas in which those relationships helped or hindered a network's ability to engage parents and families. For prevention, relationships with regional DCFS offices are key, and those depend greatly on the individual regional administrators. Many participants also cited connections to schools as important, but often missing, because access depends on one-on-one relationships with the principal.
- **Connecting networks greatly enhances the array of resources available to families, and should be more intentional.** Family-serving networks are innovative and nimble, and have found effective ways to connect to other supports. Significant differences exist in how networks are structured and operationalized, but what they have in common is providing an environment that engages parents and connects them to resources and services that are funded by a broad variety of entities. Various network meetings, community workgroups, Best Start community partnerships, and other forums bring together parents and needed resources. Some are formal (getting into a program, for example), and many are informal (a plumber who is able to help out a neighbor at a lower price than if the neighbor had to call a business). Many networks are able to set up workgroups when gaps in necessary services and supports are identified, and find ways to connect to others providing them. As important as this is, several entities mentioned that this could be much more intentional (some suggested it be mandated and measured for accountability).
- **Categorical funding and reporting requirements are often challenging.** From a provider perspective, the categorical nature of funding complicates the goal of connecting families to critical services, requiring navigators to piece together multiple requirements and funding streams that can be flexibly used to meet family needs. Providers also pointed to the different reporting requirements for each funding stream as a barrier contributing to a disjointed system. They further noted that funding is generally for direct services, making it difficult to fund community support/trust-building strategies.
- **Though a lot of data exist, there is no standardized, consistent way to measure and report on prevention.** This is critical and needed. Related to the focused strategies and related outcomes ("the protective factors"), participants sent a consistent message that we need to do more to measure prevention in a standardized, consistent way. This would enable us to better measure progress and consistently tell the story of the importance of investing in prevention. Although each P&A provider collects data uniquely, there is no common framework, without which it's hard to demonstrate a direct impact on prevention.





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

Home Visiting Program Outcome Indicators

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

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

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



Executive Summary

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



Home visiting¹ is a form of family support that includes parent coaching and comprehensive resource referrals provided by trained professionals in the home and community environment. It has been proven through research to be effective in reducing child abuse and neglect, improving child development, reducing preterm births, improving maternal and child health, increasing school readiness, reducing reliance on public financial benefits, and reducing crime. It is an invaluable model for improving family outcomes, preventing expensive crisis-based intervention, and triaging families to appropriate and needed services.

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

Acknowledgments

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

What home visiting models do we have here in LA?

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



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



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

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



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

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

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

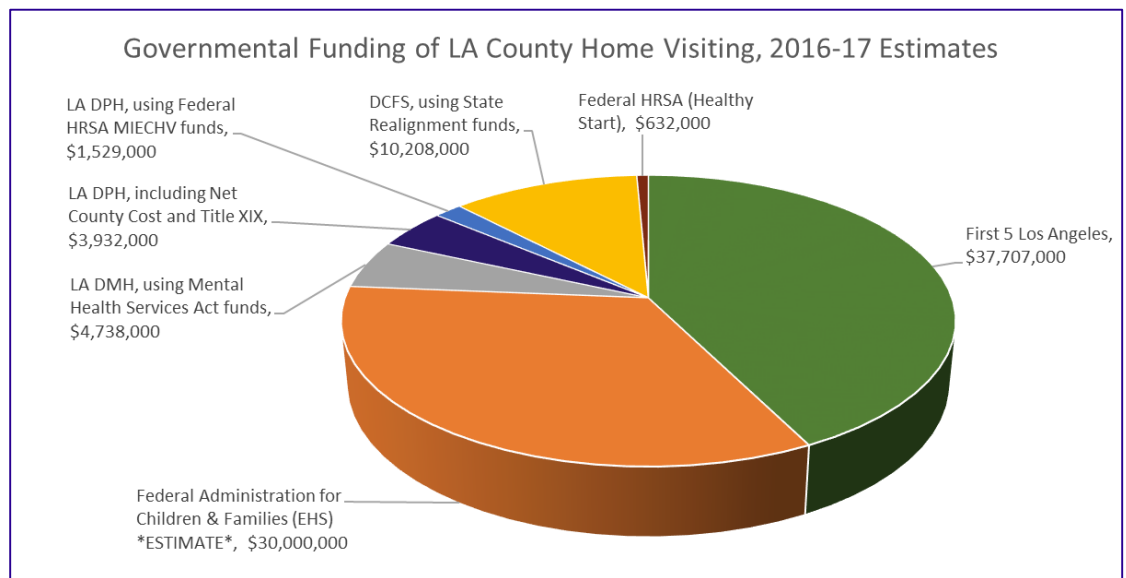
	EHS	NFP	HFA	PAT	WB	PFF	HS
Increases Cognitive & Social Development	✓	✓	✓	✓	✓		
Improves School Performance		✓	✓	✓			
Improves Maternal Health		✓	✓	✓	✓		
Improves Child Health	✓	✓	✓	✓	✓		
Improves Mental Health	✓	✓			✓	✓	
Improves Family Safety & Parenting	✓	✓	✓	✓	✓	✓	
Increases Self-Sufficiency (Decreases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

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

Analysis of current home visiting capacity and gaps revealed that we have a strong base of quality home visiting programs established in Los Angeles. Current publicly-funded² home visiting programs in Los Angeles are funded through the contributions of five local governmental entities, plus numerous contracts awarded by the federal government to local non-profit organizations.

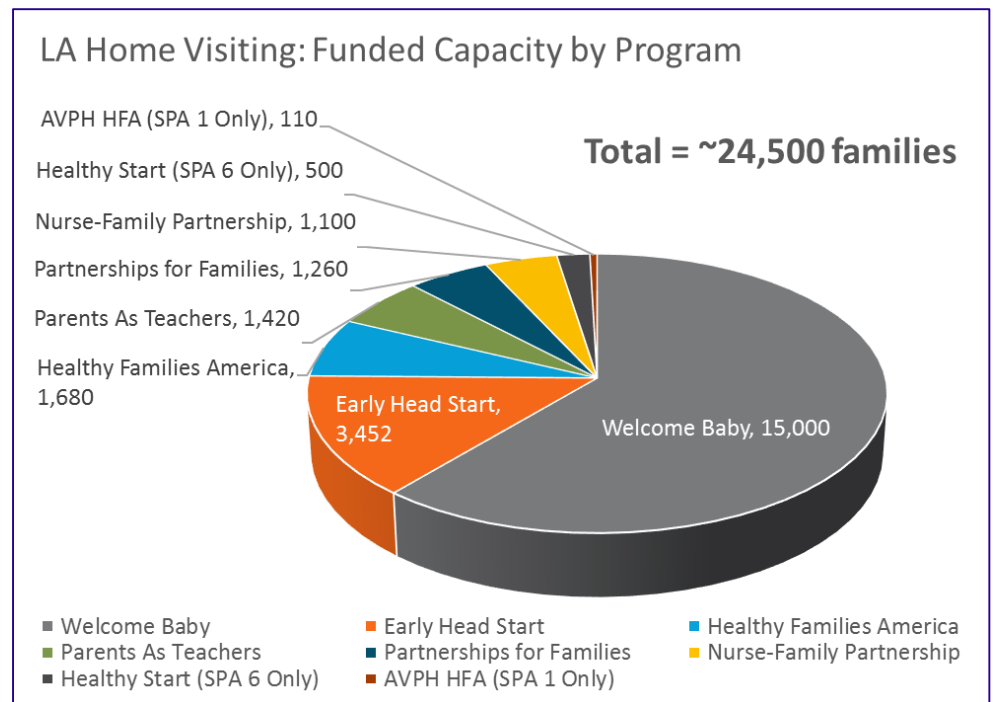
² While the majority of home visiting programs in Los Angeles utilize public funding, it is worth noting that there are additional smaller home visiting programs run by non-profit agencies utilizing philanthropic or grant dollars that are not included in the numbers herein. There are also additional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

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



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

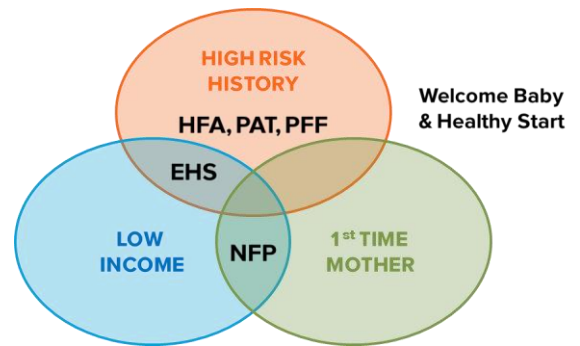
Collectively, these funding streams enable 55 local non-profit organizations to provide home visiting services to LA families, with the collective total capacity to help approximately 24,500 families per year, including approximately 15,000 families from the general population and 9,500 high-risk families,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



What eligibility restrictions currently limit access to home visiting?

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

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



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

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

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

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

Are we currently maximizing our existing funded capacity?

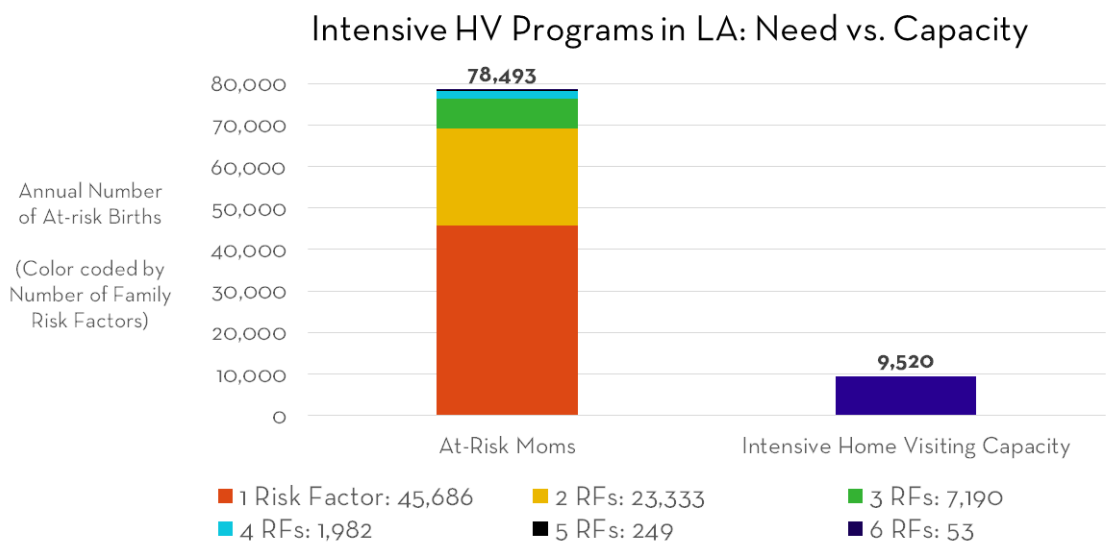
Data, research, and interviews with home visiting providers revealed that we are very close to maximizing our current capacity. EHS, PFF and Antelope Valley HFA are generally operating at capacity, although recent changes in funding allocations may temporarily open up new capacity in some SPAs for PFF.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

How does our current capacity relate to full community need?

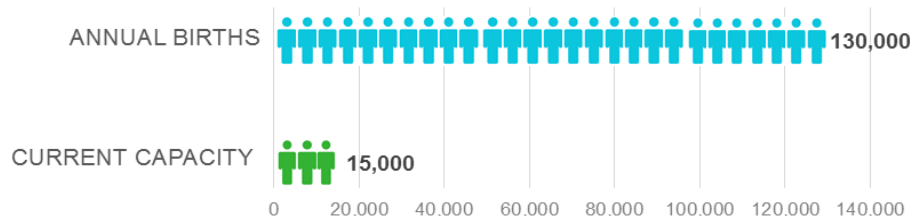
Comparing current home visiting capacity to the full community need for family support reveals a substantial gap in services for both high-risk populations and the general LA population.

The 2014 Department of Public Health LAMB data reveals an estimated 78,500 families giving birth in LA County each year exhibit at least one high-risk factor;³ an estimated 33,000 families exhibited two or more risk factors. Comparing this community need to the 9,500 spots currently available for at-risk families in Los Angeles documented above points to a current rate of

only 12-29% of high-risk families accessing home-based family support in Los Angeles. The graph to the right demonstrates the gap between the need for intensive services in Los Angeles County and the number of families who receive intensive services on an annual basis.

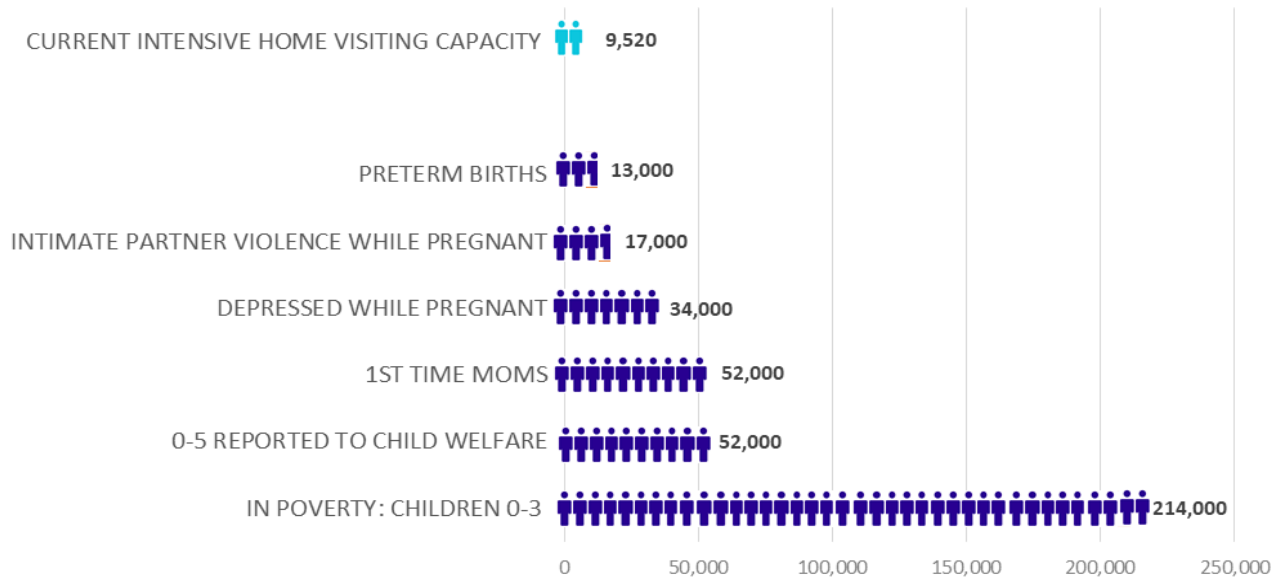


A comparison of the 15,000 families who receive “universal” preventative home visiting services with the 130,000 births annually in LA County reveals a similar need to improve our system of supports by expanding funding. Current funding provides sufficient capacity to serve 12% of the general population.



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

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



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

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

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

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

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