2015

ALAMEDA COUNTY HOME VISITING

EVALUATION PLANNING PHASE II

Report Prepared by: ASR Applied Survey Research On behalf of: First 5 Alameda County and Alameda County Public Health Department Celebrating Healthy People in Healthy Communities

TABLE OF CONTENTS

ALAMEDA COUNTY HOME VISITING PHASE II EVALUATION PLANNING

PROJECT BACKGROUND

In July 2014, the Maternal Paternal Child and Adolescent Health (MPCAH) division of the Alameda County Public Health Department (ACPHD) and First 5 Alameda County (F5AC) again commissioned ASR to build on the review of 2011 to focus more narrowly on the development of an evaluation framework that would guide evaluation planning and design. The framework is intended to increase cohesion within the Home Visiting and Family Support System of Care in Alameda County, unifying programs under a Common Outcomes Framework. The Framework, a primary product of the first phase of evaluation planning, is shown below.

TABLE 1. COMMON OUTCOMES FRAMEWORK

	Desired Outcome	Indicators
Child Level	Physical and social-emotional health	Child has medical home
		Child has medical, dental, vision insurance
		Immunizations are up-to-date
		Well child visits up-to-date
	School readiness	Child receives early developmental screening
Parent-Child Level	Physical and social-emotional health	Mothers breastfeed for >6 months
		Improved parenting skills, attitudes, behaviors
		Improved parent-child relationships
		Decreased abuse and neglect
	School readiness	Increased parent support for child learning and development
Parent Level	Physical and social-emotional health	Mother has medical home
		Mother has medical, dental, vision insurance
		Increased knowledge of child development
		Decrease in maternal depression
		Increased social support
		Male engagement
	Self-sufficiency	Increase parents' self-efficacy
		Increased access to community resources
Family Level	Physical and socio-emotional health	Home health and safety (e.g., safe sleep, car seat, guns, mold, pests, etc.) increases
		Family resilience increases
	Self-sufficiency	Housing needs are met
		Transportation needs are met
		Increased food security
		Increased economic self-sufficiency

Phase II of Evaluation Planning

As the evaluation planning efforts turned towards implementation, it became clear that it was necessary to create an inventory of programs' current measurement instruments, measures, and procedures. This inventory was the primary objective of Phase II of evaluation planning. Specifically, the intent of Phase II was to identify programs' current activities that already contribute to, or inform, the common outcomes, as well as data collected related to unique individual program impacts. The resulting inventory provides an overarching summary of, and recommendations for, how programs in the system can contribute towards a collective countywide story while honoring and preserving current measurement methods and procedures as much as possible. These results provide a starting point for concrete steps to shift individual program efforts towards more systematic and collectively shared best practices.

The System of Care includes the following programs in this phase of work:

- Alameda County Public Health Department's (ACPHD) Field Nursing Unit
- Asthma Start
- Black Infant Health (BIH)
- Brighter Beginnings
- Fatherhood Initiative
- Maternal Access & Linkages for Desired Reproductive Health (MADRE)
- Nurse Family Partnership (NFP)
- Special Start at Alameda County Public Health Department (ACPHD)
- Special Start at UCSF Benioff Children's Hospital Oakland (CHO)
- Tiburcio Vasquez Health Center
- Women's Health Promotion, Family Health Promotion (WHP/FHP)
- Your Family Counts/Healthy Families America (HFA)

How this Report is Organized

There are four primary sections to this report:

- **Section 1** documents the process undertaken in this phase of evaluation planning and describes the approach and methodology.
- **Section 2** reviews each of the indicators in the Common Outcomes Framework and describes how each is currently measured by programs.
- **Section 3** reviews each of the programs in the Home Visiting collaborative and examines each program's data collection capacity and procedures, particularly with respect to Common Outcomes indicators.
- **Section 4** reviews each of the databases that are currently employed across the Home Visiting collaborative and provides observations on data completeness, ease of use, and potential for augmentation to accommodate measures under the Common Outcomes Framework.
- **Concluding Observations and Next Steps** includes observations and recommendations based on the findings presented, and next steps for implementing the Evaluation Plan driven by the Common Outcomes Framework.

SECTION I: METHODOLOGY

METHODS

The primary purpose of the Phase II process was to develop an inventory of data collection efforts across the suite of home visiting programs in the collaborative. This inventory is available electronically (it proved too complex to include in print). Although the inventory was initiated during the first phase of this effort, it became clear at the close of Phase I that a complete inventory would be a necessary first step in shifting towards the adoption of a Common Outcomes Framework across all the programs in the collaborative. With support from First 5 and Alameda County Public Health, a formal request was made to all home visiting program directors to prepare for, and engage in, the Phase II process.

DATA SOURCES

Three central sources of information were relied upon to understand the breadth and depth of data collection activities that the programs are engaged in, relative to the Common Outcomes Framework. These included a review of the program forms (i.e., data collection instruments, forms, surveys, assessment tools); interviews with home visiting program staff; and a review of database content.

Program Forms

In advance of the interviews with program staff, all program directors were sent a brief introduction to this Phase II process, along with a request to send to ASR electronic copies of all paper forms that had not yet been submitted as a part of Phase I of the evaluation planning process. Examples of forms provided include registration forms, intake and follow-up forms, assessments, program satisfaction questionnaires, and program exit forms.

With support from First 5 and Alameda County Public Health, ASR received forms that helped to better understand programs' data collection capacity as well as content.

Interviews with Program Staff

In addition to sending forms, program directors were also asked to prepare for interviews by engaging in a discussion with their staff around three primary questions:

1. What activities does your program engage in to address the indicators and outcomes in the Common Outcomes Framework?
    - *For example*, what specific parts of your intervention address physical and social-emotional child health? Does your program address a child's needs for a medical home? Child's needs for medical, dental, and/or vision insurance, etc.?
2. Which of the indicators identified in the Common Outcomes Framework does your program currently measure, and *how* are they measured by your program? Please be as specific as possible, including a description of how the client is engaged by staff to obtain the information requested, and how the specific question is asked on a form or interview, and how the information received are recorded and stored.
    - *For example,* your program may assist families with enrolling children in medical insurance. How is the need for medical insurance initially assessed? When? Is the child's insurance status recorded on a form? Is it a Y/N question, or is the specific type of insurance identified? Etc.
3. What role does data play in the daily work of your program? How have data been useful in supporting your efforts? What do you find most challenging about data collection? Are there data collection procedures your program has developed that have been successful?

ASR, in turn, prepared for interviews by reviewing the forms and responses to the above questions that were received. Over the month of March, ASR conducted six in-person and seven telephone interviews with program managers. Interviews ranged between one to one and one-half hours in duration.

Databases

Across the Home Visiting collaborative, a number of different databases and spreadsheets for data collection are used. Program directors were asked to send these to ASR for review. In addition, access to two central databases – ECChange and ChallengerSoft was granted to ASR for additional review and assessment.

SECTION II: FINDINGS BY INDICATOR

This section describes findings from the forms, data review, and interviews, with focus on each of the indicators identified in the Common Outcomes Framework.

THE INDICATORS

This section reviews each indicator and describes whether and how programs currently measure it. The table below presents the Common Outcomes Framework and identifies the number of programs that are either currently measuring each indicator in some way, or that have plans to measure it in the future.

TABLE 2. NUMBER OF PROGRAMS MEASURING COMMON OUTCOMES INDICATORS

	Desired Outcome	Indicators	Number of programs currently or planning on measuring (of 12)
Child Level	Physical and social-emotional health	Child has medical home	11
		Child has medical, dental, vision insurance	11
		Immunizations are up-to-date	11
		Well child visits up-to-date	10
	School readiness	Child receives early developmental screening	10
Parent-Child Level	Physical and social-emotional health	Mothers breastfeed for >6 months	10
		Improved parenting skills, attitudes, behaviors	6
		Improved parent-child relationships	8
		Decreased abuse and neglect	9
	School readiness	Increased parent support for child learning and development	7
Parent Level	Physical and social-emotional health	Mother has medical home	10
		Mother has medical, dental, vision insurance	11
		Increased knowledge of child development	5
		Decrease in maternal depression	10
		Increased social support	10
		Male engagement	6
	Self-sufficiency	Increase parents' self-efficacy	7
		Increased access to community resources	11
Family Level	Physical and socio-emotional health	Home health and safety (e.g., safe sleep, car seat, guns, mold, pests, etc.) increases	8
		Family resilience increases	6
	Self-sufficiency	Housing needs are met	10
		Transportation needs are met	7
		Increased food security	8
		Increased economic self-sufficiency	11

Child-Level Indicators:

TABLE 3. CHILD-LEVEL INDICATORS

	Desired Outcome	Indicators	Number of programs currently or planning on measuring
Child Level	Physical and social-emotional health	Child has medical home	11
		Child has medical, dental, vision insurance	11
		Immunizations are up-to-date	11
		Well child visits up-to-date	10
	School readiness	Child receives early developmental screening	10

Child has a medical home

All programs, with the exception of the Fatherhood Initiative, collect data for this indicator. Most programs collect information on either the name of the primary care provider and/or simply identify whether a child has a medical home with a "Y/N" question on an intake-type of form. Examples of relevant questions are shown in Table 4, along with possible ways of coding the data.

- Recommendation: Identify a single, consistent way this information is collected, and one that captures the concept of "medical home," which would include consistency and regularity of care. Some programs will need to augment the forms currently used in order to come into line with how other programs are measuring this, or all programs could continue to collect this information in the same way they currently do, but the following responses to the various ways in which this item is collected will identify medical home:

TABLE 4. MEDICAL HOME MEASURES

Medical Home Item	Child HAS Medical Home	NO Medical Home
Infant/child has medical home	Yes	No
Does your child have a regular doctor?	Yes	No
Do you have a doctor or health care provider for your baby?	Yes	No
Primary care provider/pediatrician's name:	Name is given	No name given
LSP: Child Well Care	>=4	<4

Child has medical, dental, vision insurance

All programs (again, with the exception of the Fatherhood Initiative) ask about the type of medical insurance the child is covered by. Most programs use the Home Visit Summary Form (HVSF) to record this information, while others use the Life Skills Progression (LSP), and still others use their own forms (e.g., Nurse Family Partnership (NFP) measures this on the Infant Health Assessment Form, MADRE measures this using intake and closure forms, etc.). Some programs also collect data on dental insurance, but very few collect data on vision coverage.

- Recommendation: Include dental and vision insurance coverage in forms.

Immunizations up-to-date

All programs collect data on this indicator, with the exception of the Fatherhood Initiative. While all programs ask if immunizations are up-to-date, the frequency of assessment and the level of verification varies. The Universal Encounter Form, which is completed for each home visit, includes a question about whether or not immunizations are up-to-date. However, one of the response options is *Not assessed*, so the frequency with which this information is collected can vary. The Home Visit Summary Form is administered every 6 months based on the calendar year (according to First 5 protocol), while NFP and

Healthy Families America (HFA) ask when the child is 2 months old, 6 months old, and every 6 months thereafter. Most programs rely on parent self-report, but some programs have more detailed methods of verifying and tracking immunizations. For example, Special Start and HFA have forms for documenting immunizations received, and Brighter Beginnings must verify (through the state registry) immunizations for Early Head Start (EHS) clients. Some programs also ask why a child is not up-to-date on immunizations.

- RECOMMENDATION: Determine whether greater consistency is needed for measurement, both in terms of verification and frequency. Is parent report sufficient or is verification via the state immunization registry and/or health care provider necessary across programs? Moreover, how frequently should programs follow up on this item?

WELL-CHILD VISITS UP-TO-DATE

Like immunizations, programs measure this in a variety of ways. Some use the HVSF, some use the LSP, and others use their own program forms to collect this information. Some programs use parent's self-report, while others verify by obtaining records or contacting health care providers.

- RECOMMENDATION: As with immunizations, a decision needs to be made as to consistency in how data for this indicator are gathered. Is parent report sufficient or are records needed for verification? And how frequently should this information be updated and re-collected?

CHILD RECEIVES DEVELOPMENTAL SCREENING

Most programs collect data on whether or not the child has received a developmental screening (Y/N), and nearly all programs administer the Ages and Stages Questionnaire (ASQ) and/or Ages and Stages Questionnaire: Social-Emotional (ASQ: SE). All programs who administer the ASQ enter the score in an electronic database. For example, the HVSF includes *Developmental Assessment* (Y/N), and the Universal Encounter Form includes Developmental: *ASQ Completed* (Y/N) and *Other tools completed* (Y/N),

Regarding individual programs, State BIH does not require the ASQ, but the county encourages it and some staff have been trained and are administering it. Women's Health Promotion/Family Health Promotion (WHP/FHP) does not have a specific question that asks if a developmental screening has been completed, but case managers do administer the ASQ to all children <60 months. HFA will administer the ASQ and possibly ASQ: SE at least once by the time the child is 6 months and at least once again before 12 months. NFP administers the ASQ and ASQ: SE when the baby is 2 months old and every 2 months thereafter. Finally, Special Start case managers often do not use the ASQ because of their high need population.

- RECOMMENDATION: Measurement of this indicator could be improved by specifying the time frame-for example: *Child has had a developmental screening in the past 6 (or 12) months.* This timeframe could be based on the Developmental Screening Guidelines adopted by the Steering Committee, which specifies that children under 30 months should be screened every six months and children over 36 months should be screened at least once per year.

PARENT-CHILD-LEVEL INDICATORS:

	Desired Outcome	Indicators	Number of programs currently or planning on measuring
Parent-Child Level	Physical and social-emotional health	Mothers breastfeed for >6 months	10
		Improved parenting skills, attitudes, behaviors	6
		Improved parent-child relationships	8
		Decreased abuse and neglect	9
	School readiness	Increased parent support for child learning and development	7

MOTHERS BREASTFEED FOR > 6 MONTHS

While most programs collect data about breastfeeding (the exceptions are Fatherhood Initiative and Asthma Start), there is variation in the exact information collected. The Home Visit Summary Form and Universal Encounter Form both have questions about breastfeeding. The HVSF includes *Estimated Time Breastfed* and *Type of Feeding* (for which one of the options is Exclusively Breastfed). *Type of Feeding* presumably refers to current type of feeding (at the time of the encounter), although this is not clear. The Universal Encounter Form also includes *Type of Feeding* (with Exclusively Breastfed as an option). The WHP/FHP program only asks whether the mother was breastfeeding at 6 months (Y/N). The two Special Start programs are unique because many of the babies in the program are unable to breastfeed, or have difficulty. For that reason, the focus is on increasing the amount of breastfeeding (in proportion to formula), in addition to extending the duration of breastfeeding.

- RECOMMENDATION: There should be greater consistency in how this is measured across programs and greater clarity around whether this indicator refers to any breastfeeding at all for at least the first 6 months, or exclusive breastfeeding only. If measuring exclusive breastfeeding is the goal, an example of a question to implement comes from the Adolescent Family Life Program (AFLP—through Brighter Beginnings and Tiburcio Vasquez Health Center): *For baby less than one year of age, how long was breastfeeding the exclusive milk source?* Additionally, the response options should reflect the level of detail at which the data will be used/analysed. If the only duration of interest is simply whether or not it was 6 months or more, then the options could be: *Still breastfeeding, Never breastfed exclusively, Less than 6 months, 6 months or more*. Other durations (e.g. *<2 weeks, 2-4 months, >1 year)* should only be included if that specificity is needed for examining program impact or case management.

PARENTING INDICATORS

The set of indicators referred to in this category includes:

- Improved parenting skills, attitudes, behaviors
- Improved parent-child relationships
- Increased parent support for child learning and development

For many programs, these indicators are addressed through programming, but they are not necessarily measured. If measured, it is usually with a couple of questions at most, rather than with any specific tool. For example, BIH collects the following information: "*Describe how you play with your baby"* and *"Describe how you comfort your baby when he or she cries*." Brighter Beginnings asks: "*What do you do when your baby or child: Cries a lo*t? *Has a tantrum or is not behaving well?".* The Home Visit Summary Form, used by several programs, includes a question about whether or not the parent read, sang songs, or told stories to the child 3 or more times per week. The LSP, which is also used by several programs,

includes items measuring the parent-child relationship in the following categories: *Discipline*, *Nurturing*, and *Support of Development*. Many times parenting information is captured in case notes (narrative, open-ended), but not structured questions. Brighter Beginnings and WHP/FHP are planning to implement the Protective Factors Survey, which would address some of the parenting outcomes. HFA has plans to use the H.O.M.E Inventory.

- RECOMMENDATIONS:
  Improved parent-child relationships: For greater consistency, implement the *Nurturing and Attachment* scale from the Protective Factors Survey (PFS) across programs to assess parent-child relationships.
  Increased parent support for child learning and development:
  While the question about reading/singing/stories on the HVSF is a measure of parent support for child learning and development, in order to see change over time it would be better to ask the number of times per week parents read/sing/tell stories (instead of whether or not they do it 3 or more times per week). The question would also need to be added to forms for programs that do not use the HVSF.
  Improved parenting skills, attitudes, behaviors: Because this indicator consists of three different constructs, adequately measuring it would require the addition of a number new of items and/or tools. It is also important to note that this outcome overlaps to some extent with some of the other parenting-related outcomes. For example, parent support for child learning and development and parent-child relationships reflect parenting skills, attitudes and behaviors. For these reasons, it is recommended that this indicator be considered for removal from the Common Outcomes Framework and that observations of program impact instead be focused on parent-child relationships, knowledge of child development, and behaviors (e.g., reading, singing, etc.), as captured by other indicators.
  Alternatively, this indicator might be reduced to focus on "parenting attitudes" and additional measures incorporated to collect data on this indicator. (See below in the recommendations section for the next indicator.)

DECREASED ABUSE AND NEGLECT

There are several types of data collected that address child abuse and neglect. One category of data includes involvement with child protective services (CPS). For example, the HVSF includes the following items:

- CPS open case at referral (Y/N)
- CPS open case during reporting period (Y/N)
- Currently in Foster Care (Y/N)
- Placed in Foster Care (Y/N)

The Stressors tab in ECChange asks:

- CPS Involved (Y/N/U; History of/Current/Police Hold)
- Neglect risk (Y/N)

The Comprehensive Baseline Assessment (used by Brighter Beginnings and TVHC) asks: *Has your child ever experienced any of the following (ever/last 6 months): physical abuse, sexual abuse, emotional abuse?* (Y/N/Suspected) and *Reported to CPS/Police* (Y/N).

The items described above are based on parent self-report. Similar to the immunization data, information on child welfare involvement may be obtained by matching case records, provided that releases of information are in place. This method may be less intrusive to the client, but would require greater investments in time and resources to increase each program's capacity for data extraction, merging, and analysis.

A second category of data collected under this indicator focuses on injuries, such as the following items on the HVSF:

- Intentional Injuries (Y/N/U)
- Unintentional Injuries (Y/N/U)
- Intentional Injury Type
- Unintentional Injury Type
- Type of Visit (ER/Hospitalization)

Two LSP items (*Safety, Child Sick Care*) obtain information about emergency room visits for all causes.

- RECOMMENDATIONS: Collect data on this indicator consistently across programs, identifying at minimum, whether the child has had CPS involvement (Y/N), and whether the case is currently open.

  Additional methods for measuring the risk of child maltreatment would involve incorporating an additional tool, such as the Adult Adolescent Parenting Inventory (AAPI-2) or the Parenting Stress Index Short Form (PSI-SF), as discussed in the Phase 1 report. In that report, it was noted that measuring child maltreatment by relying on substantiated CPS reports alone would capture events that have actually occurred; however, most child maltreatment is never reported to CPS, few cases if reported, are investigated, and an even smaller subset of cases are ultimately substantiated, leading to an underestimation of abusive and neglectful behaviour. As such, the recommendation was made to include additional measures to gauge maltreatment risk. This might be accomplished by measuring change in a "parenting attitudes" indicator using the AAPI-2 or PSI-SF.

  Alternatively, measuring risk for abuse might be accomplished by implementing across all programs, the series of questions on the HVSF regarding child injuries. In addition, the Protective Factors Survey (PFS) includes the item: *When I discipline my child, I lose control*, which could also be implemented to gauge risk of child maltreatment.

PARENT-LEVEL INDICATORS:

	Desired Outcome	Indicators	Number of programs currently or planning on measuring
Parent Level	Physical and social-emotional health	Mother has medical home	10
		Mother has medical, dental, vision insurance	11
		Increased knowledge of child development	5
		Decrease in maternal depression	10
		Increased social support	10
		Male engagement	6
	Self-sufficiency	Increase parents' self-efficacy	7
		Increased access to community resources	11

MOTHER HAS A MEDICAL HOME

This item is usually collected by a "Y/N" question or by asking mothers for the name of their primary care provider, although the LSP includes a measure of *Parent Sick Care*, which identifies whether the parent has a stable medical home and whether appropriate health care is sought consistently.

- RECOMMENDATION: Measurement of this indicator could be improved by asking a question that reflects a more comprehensive concept of a medical home (e.g., regular care, familiarity with the provider, etc.), and one that is consistent with how "medical home" is defined for the child.

MOTHER HAS MEDICAL, DENTAL, VISION INSURANCE

Most programs collect information on the type of medical insurance the mother is covered under. Similar to data collected on insurance coverage for children, some programs collect data on dental insurance, but very few collect data on vision coverage.

- RECOMMENDATION: Include mother's dental and vision insurance coverage in forms.

INCREASED KNOWLEDGE OF CHILD DEVELOPMENT

For many programs, child development is addressed in programming, but is not measured. If measured, it is typically by asking a few questions to gauge knowledge of child development, rather than by using a measurement tool. For example, BIH asks, "*Have you ever heard or read about what can happen if a baby is shaken, known as 'shaken baby syndrome'*"? The *Support of Development* item on the LSP includes a measure of knowledge of child development. Sometimes this is captured in case notes (narrative, open-ended), but not via structured questions. A few programs indicated that they are planning to use the Protective Factors Survey, which would address some of these issues.

- RECOMMENDATIONS: Implement *Child Development/Knowledge of Parenting* items on the Protective Factors Survey across programs:
  - *There are times when I don't know what to do as a parent.*
  - *I know how to help my child learn.*
  - *My child misbehaves just to upset me.*
  - *I praise my child when he/she behaves well.*
  - *When I discipline my child, I lose control.*

Decrease in maternal depression

Nearly all programs administer the Edinburgh Postnatal Depression Screening (EPDS), although the frequency of administration varies. Some administer the instrument every 6 months, others administer at intake or 6-8 weeks after birth (depending on time of entry in program) and later as needed.

The Home Visit Summary Form also has a question about whether or not the client was screened for depression, and whether or not the depression screen was positive.

- Recommendation: While a change in the EPDS score can be used for this indicator, it will be necessary to think about how exactly a decrease will be defined, especially if it is not high at intake for many people. The denominator will likely need to be those above the clinical threshold at baseline. In addition, some attention must be paid upon analysis of the data collected as to whether the initial administration was pre- or post-natally in order to appropriately interpret results. An additional consideration is the extent to which home visiting programs are expected to have an impact on decreasing maternal depression, which is influenced by the intensity of mental health services provided through the home visiting program. If these services are not sufficient to decrease depression, it would be more appropriate for this outcome to be a measure of whether the mother was screened for maternal depression (e.g., was the EPDS administered?).

Increased social support

While social support is measured by several programs, there is considerable variation in the ways in which it is measured and the frequency with which it is measured. For example, social support is somewhat addressed in the Stressors tab on ECChange, with a Y/N indication of social isolation; the LSP gauges relationships with family and friends.

BIH asks a series of questions around instrumental and emotional support, and support from the baby's father. WHP/FHP gauges social support from specific people in clients' lives (e.g., baby's father, client's mother, grandparent, siblings, counsellor, etc.). Brighter Beginnings and TVHC ask about participation in support programs as well as individuals and institutions (i.e., church/religious groups) supporting the client.

- Recommendation: Greater consistency is needed in how "social support" is defined, including who provides the support (specific family members, friends, neighbors, etc.) and the types of support provided (emotional, financial, concrete). Also, the measure of social support will need to be quantified in order to observe changes. A dichotomous measure (such as on the Stressors tab) is not likely to be sensitive enough to detect change.

  Use the Protective Factors Survey, specifically the Social Support Scale, which measures perceived informal support from family, friends, and neighbors who provide for emotional needs:
  - *I have others who will listen when I need to talk about my problems.*
  - *When I am lonely there are several people I can talk to.*
  - *If there is a crisis, I have others I can talk to.*

MALE ENGAGEMENT

Although many programs do not specifically ask about this, some questions asked of some programs include the type of father's involvement (financial and/or emotional – measured by BIH and HFA) and father's attendance at well-baby appointments (measured by WHP/FHP). The LSP gauges the quality of the relationship the mother has with her "Boyfriend, FOB, or Spouse".

- RECOMMENDATION: There remains a need to more clearly define what "male engagement" refers to, including what is meant by *engagement* and which male(s) should be the focus of the engagement (e.g., the father of the baby, mother's current partner, another father figure such as the mother's brother or a grandfather, etc.). Existing questions provide some guidance, such as specific examples of types of male engagement. Consideration should also be given to whether this item should focus on males only or broadened to include other child-rearing partners (i.e., same-sex partners).

INCREASED PARENTS' SELF-EFFICACY

For many programs, this is addressed in programming, but not measured. If measured, it is usually with a couple of questions and not by implementing any specific tool. For example, Special Start's Exit Survey asks parents to indicate the extent to which they agree with the following statements: (1) *I am confident about caring for my baby/child's health and medical needs*; and (2) *I know how to get the services my baby/child needs.* The LSP includes a *Self-Esteem* item, which captures self-efficacy globally (not specifically related to parenting). Sometimes parents' self-efficacy is captured in case notes (narrative, open-ended), but not via structured questions. Brighter Beginnings and WHP/FHP are planning to use the Protective Factors Survey, which includes items related to parenting self-efficacy.

- RECOMMENDATION: Consider implementing one of the following three tools to assess parents' self-efficacy.
  1. The Protective Factors Survey has two items that address parental self-efficacy:
     - *There are many times when I don't know what to do as a parent.*
     - *I know how to help my child learn.*
  2. The Parenting Sense of Competence Scale has 16 items that measure parents' sense of confidence and satisfaction with their parenting. Seven items comprise the efficacy scale; the other six assess satisfaction. A greater number of items (compared to the PFS) means that it is a more robust measure of parenting self-efficacy. An obvious disadvantage is that there are more questions for parents to answer.
  3. The General Self-Efficacy has 10 items about global self-efficacy. It does not assess self-efficacy specifically related to parenting. For this reason, it is important to determine if home visiting programs are expected to have an impact on global self-efficacy, or only parenting-specific self-efficacy.

INCREASED ACCESS TO COMMUNITY RESOURCES

All programs track referrals, most using the Referral tab in ECChange. However, there appears to be some variation in how frequently and how diligently the results or status of referrals are entered.

- RECOMMENDATION: For programs that use ECChange, clear guidelines should be in place regarding the frequency and timing with which the status of referrals is updated. In addition, consider implementing the three Concrete Support subscale items from the Protective Factors Survey:
  - *I would have no idea where to turn if my family needed food or housing.*
  - *I wouldn't know where to go for help if I had trouble making ends meet.*
  - *If I needed help finding a job, I wouldn't know where to go for help.*

FAMILY-LEVEL INDICATORS:

	Desired Outcome	Indicators	Number of programs currently or planning on measuring
Family Level	Physical and socio-emotional health	Home health and safety (e.g., safe sleep, car seat, guns, mold, pests, etc.) increases	8
		Family resilience increases	6
	Self-sufficiency	Housing needs are met	10
		Transportation needs are met	7
		Increased food security	8
		Increased economic self-sufficiency	11

HOME HEALTH AND SAFETY INCREASES

Many programs collect information on home health and safety with a few questions (e.g., gauging presence/absence of a car seat, safe sleep, etc.). Among the programs that use a checklist (BIH and Fatherhood Initiative), it is administered as more of an educational rather than an assessment tool. The checklist used by these two program applies to infants aged 0-6 months and includes the following categories:

- Safe in the car
- Safe when sleeping
- Safe from choking
- Safe from burns
- Safe in the bath and water
- Comforting your baby

This checklist was adapted from other checklists, including the California Chapter 4 American Academy of Pediatrics Injury and Violence Prevention Program's Keeping Your Child Safe brochure (0-6 months), and there are also brochures for other ages. The LSP includes a *Safety* item, which is based on the child's unintentional injuries, as well as home and car safety.

- RECOMMENDATION: For greatest consistency, a common checklist could be used across programs and used as an assessment tool at intake and at program exit to measure the number of safety measures in place at each point in time. As is currently implemented in some programs, the same checklist could be used as a way to identify needs and educate parents about home safety. The California Chapter 4 American Academy of Pediatrics Injury and Violence Prevention Program's Keeping Your Child Safe brochure (available for different ages) can be a starting place.

FAMILY RESILIENCE INCREASES

Although many programs indicate that they address family resilience in their services and programming, very few programs measure their impact on this indicator. The LSP includes some items that somewhat measure this concept, such as in the Relationships with Family and Friends and Relationships with Supportive Services sections, though these do not really capture the construct. BIH collects some information on clients' response to stress and ability to "bounce back". The WHP/FHP program is planning on implementing the Protective Factors Survey, which includes a Family Resilience subscale.

- RECOMMENDATION: Implement the five *Family Resiliency* items in the Protective Factors Survey:
  - *In my family, we talk about problems.*
  - *When we argue, my family listens to "both sides of the story".*

- *In my family, we take time to listen to one another.*
- *My family pulls together when things are stressful.*
- *My family is able to solve our problems.*

Basic Needs Indicators

The set of indicators referred to includes:

- Housing needs are met
- Transportation needs are met
- Increased food security

Although some programs have structured questions about these indicators, many programs indicated that these needs are captured in referrals and case notes. Housing is the most commonly measured of these three indicators, as it is included in the Stressors tab in ECChange as well as on the Life Skills Progression. The LSP also has items about food and transportation needs. Brighter Beginnings and TVHC simply ask whether the client's transportation and food resources are adequate or inadequate.

- Recommendations: Use consistently across programs the Housing and Food Security questions identified by the Steering Committee workgroup:
  - Housing Insecurity (from National Survey of American Families 1999):
    1. *During the last 12 months, was there a time when (you/you and your family) were not able to pay your mortgage, rent or utility bills?*
    2. *During the last 12 months, did you or your children move in with other people even for a little while because you could not afford to pay your mortgage, rent or utility bills?*
  - Food Insecurity (from AAP):
    1. *Within the past 12 months, we worried whether our food would run out before we got money to buy more.*
    2. *Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.*

Increased Economic Self-Sufficiency

All programs already implement or have plans to adopt some type of self-sufficiency measure, though the measures vary. Many programs ask about highest level of education and employment status, such as those using the Education & Employment section of the LSP. The HVSF collects information about employment status and enrollment in public assistance programs. Programs using the ECChange Stressors tab identify whether income is inadequate and whether the client has less than 12 years of education (Y/N/U).

- Recommendation: Determine what constitutes an increase in economic self-sufficiency and ensure all programs collect the appropriate data. Should programs track and be expected to effect changes in clients' employment status? Does "increased economic self-sufficiency" mean an Increase in income? Increase in education? Changes in receipt of public assistance?

  Implementing the *Concrete Support* scale of the Protective Factor Survey also helps gauge changes over time in families' ability to connect with resources.

SECTION III: FINDINGS BY PROGRAM

This section describes findings from the forms and data review and interviews, focusing on each program's data collection activities, largely with respect to those indicators identified in the Common Outcomes Framework.

THE PROGRAMS

Each program's data collection activities are described and recommendations are made around instruments and/or procedures that might facilitate shifting programs toward a more cohesive program evaluation effort under the Common Outcomes Framework.

Approximately half of the programs are currently in some kind of transition: some programs are just beginning, some programs' features are changing, and/or data collection forms and methods are changing.

There is a common concern around how much time it takes to collect data and some frustration about the inability to obtain desired reports from ECChange, and about the inability to link ECChange with other systems (e.g., ETO).

Although many programs assess common indicators at intake/enrollment, the timing of follow-up assessments varies. Many programs administer follow-up assessments at 6-month intervals, but some do them more or less frequently, and for some indicators, follow-up depends on client need. For this reason indicators based on increases or decreases may be difficult to measure. And, for some programs, individualized services for clients means that some indicators may be addressed for some clients but not for others.

ACPHD's Field Nursing Unit

Field nursing provides targeted case management and care coordination services to people of all ages, and caseloads are intermixed (in terms of age). The relevant groups for the purpose of this collaborative are prenatal and postpartum mothers, as well as children ages 0-5. Participants must qualify as low-income and high-risk to receive services. Although pregnant women are considered high risk, postpartum mothers are only considered high risk if there are other medical issues present. Nurses see clients for at least 6 months. Visits are conducted weekly during the first month of engagement, which drops to every two weeks thereafter. Visits may take place at the home, doctor's office, or another community location. Nurses first address needs identified on the referral form and then address other issues as they are identified.

Instruments/Data Sources

Although "Profile" forms are available for nurses to complete, there is no requirement to complete them. Instead, they are used as needed to obtain data that must be entered in ECChange. The Edinburgh and ASQ are also administered.

Databases

In ECChange, the program uses the following tabs: Demographics, Home Visit Summary Form (only clients ages 0-5), Stressors, Referrals, and Case Notes. Edinburgh and ASQ scores are also entered into ECChange.

Challenges

There have been some issues with ECChange, including a mismatch between data nurses entered and data that come out in reports. A committee is investigating this issue. The program managers also feel that it is difficult to pull data/reports from ECChange. The program struggles with consistency in data recording across program staff and is often affected by a database that functions slowly or does not properly save data.

Recommendation

Because there are no standardized paper forms that case managers must use to collect data, it is important to ensure that there is consistency in the way data are collected for data entry into ECChange, particularly for the Home Visit Summary Form, where many common indicators are collected.

Asthma Start

Asthma Start provides asthma education, risk assessments, and linkages to resources to prevent subsequent asthma episodes. The program works with families with children aged 2-10 years old; most are in elementary school. Case managers usually make a total of 2-3 home visits over the course of three months (about one visit per month). If there are major issues, home visits may continue for up to one year.

Instruments/Data Sources

Forms used by Asthma Start include:

- The Asthma Start Registration Form is administered during the first telephone call, but entered in ECChange after the first visit.
- The Asthma Start Initial Interview Form is administered at the first visit.
- The Asthma Start Assessment is administered at the first visit and last visit.
- The Targeted Case Management Assessment and Care Plan is completed at the first visit and then updated at each visit and upon program exit.
- The Asthma at Home Form consists of a list of asthma triggers and is done at each visit.

Databases

Case managers take notes on paper, then transfer most (but not all) information to ECChange or an ACCESS database. The ACCESS database includes data about symptoms, hospitalizations, home triggers, demographics, and case closure information. Data entered into ECChange includes the Summary tab (contact information), Referral tab, Demographics tab, and the Assessment tab. The Assessment tab includes identified problems and the case plan (in an open-ended text box). Asthma Start does not complete the Stressors tab. The Targeted Case Management and Assessment Care Plan are only on paper.

Challenges

One challenge that the program faces is that data collection needs change frequently, and data collection systems are often not flexible enough to quickly adapt to these changes. In addition, the program struggles with consistency in data recording across program staff.

Recommendation

Additional training for program staff in data collection and entry will improve consistency across staff.

It should be noted that although this program conducts home visits, there are several reasons Asthma Start may not be expected to make major contributions to the common indicators. First, the duration and intensity of the program is less than most of the other programs in this collaborative, mainly because of the primary focus on asthma. Other needs are only addressed through referrals. For a similar reason, only a few of the common indicators are addressed by this program. Additionally, many of the participants are not in the 0-5 age range.

Black Infant Health (BIH)

Black Infant Health (BIH) is a state-wide program, and all curricular materials and assessments are provided by the state. The program serves pregnant women, and mothers can remain enrolled until the child is 12 months old. A recent requirement is that women must enroll by 26 weeks or earlier in pregnancy. Most women stay until they have completed the 10 postpartum sessions, and often switch to another Alameda County Public Health Department program (e.g., Women's Health Promotion). BIH consists of 10 prenatal and 10 postpartum group sessions, as well as individual case management (home visits and phone calls). The curriculum will change in July 2015.

Instruments/Data Sources

Assessments cannot be done at group sessions, so they must be completed during individual sessions. There are up to 3 prenatal assessments and up to 3 postpartum assessments. Assessments are completed approximately every three months. There is a timeline for when assessments should be completed that is based on how far along in pregnancy a woman is when she enters the program. There is also a form to track referrals, including whether or not the referral was completed. There are also forms to documents for case management, including: (1) Client logs for individual client interactions and group sessions; (2) Case Conference form; (2) Individual Client Plan; and a (4) Life Plan forms. Other forms include a Safety Checklist (to use as an educational tool), Pregnancy Outcome form, Postpartum Client Satisfaction survey, and Case Closure form. The EPDS is administered 6-8 weeks after the client gives birth. Assessments will change (along with the curriculum) in July 2015.

Databases

The program currently uses MIS, but will be switching to ETO in July. The only data they enter in ECChange are demographics so that other programs can see the client is being served by BIH.

Challenges

Although not necessarily a challenge, it is important to note that BIH is a state program, and all assessments are provided by the state. Although it is possible for them to do additional assessments, it may not be realistic for case managers to collect and enter additional data.

Recommendation

As with other programs with external requirements (e.g., HFA, NFP, WHP/FHP), it will be necessary to determine how forms and assessments align with the common indicators. The transition to a new curriculum in summer of 2015 presents an opportunity to ensure such alignment. It should also be noted that while the primary goal of BIH is to have good birth outcomes, this is not reflected in the common indicators.

Brighter Beginnings

Brighter Beginnings provides services for pregnant or parenting teens, and consists of two programs: (1) Early Head Start (EHS), in which the client is the child (up to 3 years old); and (2) Teen Family Services (TFS), in which the client is the mother. Teen Family Services is further divided into Cal-Learn and AFLP. For both programs, the goal is to provide at least two home visits each month.

Instruments/Data Sources

One of the largest sources of data is the Comprehensive Baseline Assessment (CBA), which is administered during the first and second client visit, and again every six months thereafter. The LSP is also administered every 6 months and it is intended to be completed with the client. Brighter Beginnings also has plans to begin using the Protective Factors Survey, likely beginning in the second half of 2015. For RBA reporting, each staff reports outcomes for their caseload.

Databases

Databases used by this program include ETO, ECChange (as a required part of contracting with ACPHD), and Lodestar. Cal-Learn and EHS enter CBA and LSP data into ETO. AFLP only enters the LSP into ETO. ETO is used primarily for internal purposes, including: case notes (narrative), case management (Targeted Case Management), and to create reports for ECChange. Brighter Beginnings also uses the Home Visit Summary Form. Only AFLP uses Lodestar. Case managers enter data into these systems on a weekly basis.

Challenges

Challenges include the amount of time it takes for staff to enter the data and the amount of data that needs to be collected. Data often have to be entered twice, mainly because ETO and ECChange cannot "talk" to each other. It is often difficult to keep track of data requirements and timelines. There are also issues with the databases, such functioning slowly or not properly saving data. Finally, clients are often transient, coming in and out of program services, making some cases difficult to track consistently or cohesively.

Recommendations

A procedural issue that could be improved is reporting for RBA outcomes. Currently, each staff must report outcomes for their caseload; it would be more efficient and accurate if the numbers for all participants could be pooled and pulled from one system. Reporting on outcomes could then reflect the overall agency impact. Work with staff to create a link between ETO and ECChange to make data entry and reporting more efficient.

Fatherhood Initiative

The Fatherhood Initiative provides several types of services to fathers, including:

- *Care coordination*: This involves service linkages and referrals and addresses short-term (0-6 months) needs. Staff/client interaction is primarily in the form of quarterly phone check-ins.
- *Case management:* This type of service is meant to address more long- term (0-2 years) issues, and consists of visits 1-2 times per month.
- *Boot Camp for New Dads:* This program is for any father with a child who is less than two or expecting a baby in Alameda County, with a focus on low-income families. It consists of a 3.5 hour workshop which uses a best practice curriculum.
- *Support groups:* These groups are open to all men and are based on peer involvement facilitated by program staff.

The extent to which the child's needs are addressed depends on the father's situation. The program has plans to implement Touchpoints.

Instruments/Data Sources

Data collection at intake (with the first 30 days) includes the F5 Referral Form (completed before intake), the Case Conference Form, and the Life Plan. The Client Visitation Form is also used (when/why). There is no standardized process for case closure, but they do use the BIH case closure form. A pre/post survey is used in the Boot Camp for New Dads workshop and aligns with the curriculum. The program also completes quarterly RBA reports.

Databases

Currently, staff enter some Fatherhood Initiative data into ChallengerSoft. The program expects to be using ECChange by late 2015/early 2016. The program manager said it would be helpful to have data dashboards so he can see real-time progress on indicators.

Challenges

The primary challenge is that the Fatherhood Initiative does not currently enter individual-level data into any database and the data they do collect are qualitative and used for case management purposes (on the Case Conference Form and Life Plan Form). As such, any data analysis must be done manually and they must rely on aggregate-level data from other sources. Moreover, with the exception of the pre/post Boot Camp survey, there are no data collected that would help quantify outcomes or impact. This is expected to change when the program transitions to entering data in ECChange.

Recommendation

Further work is needed to identify which of the common indicators are relevant for this program, particularly since interaction with the child varies with each client. Particularly as the program transitions to entering data into ECChange, there is an opportunity to build some alignment between relevant data entry elements in ECChange and developing new forms for the program to begin collecting some quantitative data.

Maternal Access & Linkages for Desired Reproductive Health (MADRE)

The overall goal of MADRE (Maternal Access & Linkages for Desired Reproductive Health) is to help mothers be as healthy as possible so their pregnancy has the best possible outcome. Case managers conduct at least two home visits each month. Women are usually followed for one year, and can be followed for an additional year if the woman becomes pregnant or the baby has medical issues.

Instruments/Data Sources

Forms administered at intake include:

- MADRE Client Information Form
- Antepartum
- Client's Medical History
- Client's Current Pregnancy (if pregnant, or if they become pregnant during program)
- History of Fetal/Infant Loss
- Client's Reproductive History
- The EPDS is administered at intake, and 6 months and 12 months after intake

If the mother has a baby while enrolled, the following forms are used: Ante/Postpartum Assessment and Pregnancy Outcome Form. For referrals, case managers use the Referral Tracking Sheet and/or ECChange. There is also a Case Closure Form, which is completed at program exit

Databases

MADRE began using ECChange in 2014 and is still becoming comfortable with it. In ECChange, MADRE uses the Stressors, Demographics, and Summary tabs. Although staff use the Referrals tab somewhat, they primarily use the Activity/Contacts tab. Most of the program's paper forms remain in the paper chart and are not entered into an electronic database.

Challenges

The primary challenge is helping program staff to become more comfortable using ECChange so that data entry and analysis is more accurate and efficient. The program manager reports that it is time consuming for staff to enter so many details in ECChange.

Recommendation

Staff for this program are still getting comfortable with ECChange and could benefit from additional training. Additionally, many forms are still only on paper, and having more data in an electronic database would facilitate analysis and reporting. MADRE has plans to begin using the Home Visit Summary Form, which will contribute to this transition.

Nurse Family Partnership (NFP)

Nurse Family Partnership (NFP) is a national program that began in Alameda County in 2012. In order to participate, women must be first-time mothers and less than 28 weeks pregnant. Consent is obtained at the first visit, and intake is conducted at the second visit. Nurses conduct visits every 1-2 weeks during pregnancy, weekly for 4-6 weeks after birth, every 1-2 weeks from 6 weeks to 1 year, and monthly visits from 1-2 years old. Three of the nurses use Targeted Case Management (TCM). NFP uses Partners in Parenting, which is a curriculum provided by national NFP. The curriculum has "facilitators" (talking points) and handouts on a variety of topics. Parents can choose a topic to discuss, or the nurse can suggest a topic based on the parent's needs.

Instruments/Data Sources

Assessments provided by national office. The program does not use the NFP referral tracking form; instead, nurses track referrals in ECChange.

Databases

Data from paper forms are entered into ETO and ECChange. Specifically, case managers enter into ETO any specific NFP forms that are required by national NFP. NFP has access to this database and can pull data from it. The program manager can also pull data (e.g., about service provision). ECChange is only used to record referrals and home visiting encounters, or any client contact. Much of this information about encounters and client contacts is open-ended, and case managers do not use it very much; they primarily use paper charts.

Challenges

The primary challenge is that there are too many charting, data, and reporting requirements, and it is difficult and time-consuming to enter data into multiple systems and report data to multiple entities.

Recommendation

Explore ways to link ECChange and ETO to integrate systems and improve efficiency. And, as with other programs with external requirements (e.g., BIH, HFA, WHP/FHP), it will be necessary to determine how forms and assessments align with the common indicators.

Special Start at Alameda County Public Health Department (ACPHD)

Special Start provides services to infants who have at least two medical risk factors and two psychosocial risk factors, and live in Alameda County. Children can remain in the program until they are three years old. Home visits take place at least once per week for the first two months, and then at least every two weeks after that.

Instruments/Data Sources

Special Start uses several instruments to gather data. A care plan is developed initially and then reviewed and revised every six months. The Life Skills Progression (LSP) is also conducted at intake and then again every six months. The Home Visit Summary Form is completed every six months based on the calendar year. Special Start developed the Infant Feeding Measure to address feeding issues specific to their population. It is administered at intake and then again at six months, and is used for RBA reporting. Finally, there is an exit survey that parents complete that asks about parent self-efficacy and program satisfaction. It is completed anonymously—there are no identifiers. This exit survey is also used for RBA purposes. Finally, an encounter form is completed for every client visit. It is open-ended with some check-offs.

Databases

Special Start uses three databases: ECChange and two ACCESS databases. Although care plans are not in ECChange (only on paper), ECChange has a field to indicate they were completed. LSP results (numbers only) are entered into ECChange, and the Home Visit Summary Form is in ECChange. Special Start has an ACCESS database for data from the Infant Feeding Measure, which uses the same identifiers as ECChange. There are plans to also put the Exit Survey into the ACCESS database in the future.

Challenges

As with many other programs, the biggest data-related challenge is the amount of time case managers spend collecting and entering data. A challenge related specifically to the LSP is that scores sometimes look worse over time because the client becomes more comfortable with the case manager, and thus shares more about their struggles and challenges.

Recommendation

Given the Infant Feeding Measure uses the same identifiers as those in ECChange, it may be helpful to enter the data into ECChange (instead of into a separate ACCESS database). Perhaps it could be included in the Assessments tab in ECChange.

Special Start at Children's Hospital Oakland (CHO)

Special Start provides services to infants who have at least two medical risk factors and two psychosocial risk factors (e.g., low-income, homeless, etc.), and live in Alameda County. Children can remain in the program until they are three years old. Home visits take place at least once per week for the first month, and then at least every two weeks after that. Special Start 1-3 Plus provides 13 visits to high medical risk, low psychosocial risk families to help them get services in place.

Instruments/Data Sources

Case managers try to collect intake data before hospital discharge or during the first visit. This includes the Life Skills Progression (LSP), Service Plan and the Edinburgh Postnatal Depression Scale (EPDS). The LSP is completed again every 6 months, and the Service Plan is done every six months and on program exit. The Home Visit Summary Form is completed every 6 months based on the calendar year. Special Start developed the Infant Feeding Measure to address feeding issues specific to their population. It is administered at intake and then again at six months, and is used for RBA reporting. Special Start (CHO) implements an exit survey that parents complete that asks about parent self-efficacy and program satisfaction. It is completed anonymously—there are no identifiers. This exit survey is also used for RBA purposes. Finally, an encounter form is completed for every client visit. It is open-ended with some check-off boxes where case managers document visits. Although case managers do not routinely administer the ASQ, they screen with the Denver Developmental Screening Test if the child does not already have an identified special need. The Service Plan is completed at intake, every six months, and at program exit. It is currently only done on paper

Databases

Like Special Start ACPHD, Special Start CHO uses ECChange and program-specific ACCESS databases. Although care plans are not in ECChange (only on paper), ECChange has a field to indicate they were completed. LSP results (numbers only) are entered into ECChange, and the Home Visit Summary Form is in ECChange. Special Start has an ACCESS database for data from the Infant Feeding Measure, which uses the same identifiers as ECChange. There are plans to also put the Exit Survey into the ACCESS database in the future.

Challenges

The primary challenge is that staff are overwhelmed by the amount of data collection and entry required, particularly because it must be done for multiple systems, including ECChange, medical records and RBA.

Although not necessarily challenges, it is important to note two indicators that may look different for Special Start participants: breastfeeding and developmental screenings. Regarding breastfeeding, because it may not be possible for the mother to exclusively breastfeed, the goal is often to increase both the amount of breast milk (relative to formula) in addition to the duration of breastfeeding. This kind of specificity is captured on the Infant Feeding Measure, but may make it difficult to align data with the common indicator for breastfeeding. Although the program tried administering the ASQ, it did not work very well with families for two reasons: First, it is a low-level screener; these children are usually already receiving many developmental assessments (not screenings) by a developmental pediatrician. Additionally, administration of the ASQ can be difficult because the parent is so involved.

Recommendations

Find ways to streamline data entry and make the process more efficient, particularly given the multiple systems in which data must be entered.

TIBURCIO VASQUEZ HEALTH CENTER (TVHC)

The Tiburcio Vasquez Health Center provides home visiting services to people who are pregnant or parents of children under five years old. Staff conduct at least two home visits per month, and also communicate with clients through phone calls and texts. Staff use the Growing Great Kids Growing Great Families curriculum, but if the client has urgent needs, those are addressed first. Case managers are also receiving training in Touch Points.

INSTRUMENTS/DATA SOURCES

There are many forms completed at intake. Within the first 45 days of program entry, the following forms are completed: the Comprehensive Baseline Assessment (CBA), Intake packet, Rapid Enrollment Form, Intake Form, Service Matrix Form, Additional Outcomes Form, Stressors tab in ECChange. The LSP, ASQ and Edinburgh are all also administered at intake. The LSP is repeated every 6 months based on intake, and the ASQ is repeated every 6 months based on the child's birthday. The Edinburgh is done at intake, within 30-45 days after the birth of a child, once per year, and more as clinically indicated. The Targeted Case Management Initial/Re-assessment Summary is completed every 3 months to identify needs and develop goal and is only captured paper and not entered into any electronic database, with the exception of referrals, which go into ECChange. The CBA is used for supervision and to make sure other forms are accurate; data from the CBA are not directly entered into any electronic database.

DATABASES

TVHC uses two databases: For data entered into ECChange, case managers collect data on paper and then enter it into ECChange. The administrative assistant enters data into Lodestar.

CHALLENGES

As has been noted for other programs, the primary challenge is that data collection and entry must be done in multiple systems, leading to duplication, and taking away time from service provision. A related challenge is that ECChange is not linked to other databases-specifically, Lodestar.

RECOMMENDATION

Given the different reporting requirements (e.g. ECChange, Lodestar, RBA), it would be helpful to sreamline data collection, entry and storage so that the same piece of data does not have to be entered in multiple places.

Women's Health Promotion, Family Health Promotion (WHP/FHP)

WHP/FHP is funded by a federal Healthy Start grant, which is fairly open-ended regarding program activities. Both programs serve low/moderate risk women and provide care coordination. There are three types of clients: (1) Interconceptional; (2) Prenatal; and (3) Pediatric. WHP serves women who are pregnant or Interconceptional, and the client remains enrolled until the baby is approximately 3 months old. The client can then transfer to another program, such as FHP. Staff provide services at "hubs" (clinics where clients go for prenatal care), and home visiting as needed.

FHP serves interconceptional women and children under 2. It is primarily group based, and there are monthly phone calls and home visits as needed. WHP/FHP is in the process of transitioning to a new program structure.

Instruments/Data Sources

Some forms are used for all three types of clients, while others are specific to one type of client. The program is currently not set up to collect data for children over 24 months of age, and there is a need to determine what data collection should look like for this age group. As noted above, WHP/FHP is in the process of transitioning to a new program structure, which will require new program forms. Although some forms will stay the same, some new forms (such as their "Universal Intake Form") will be informed by this evaluation planning process. The goal is to have all forms in ChallengerSoft by summer 2015.

Databases

WHP/FHP uses ECChange only to enter referrals. Participants are only entered into ChallengerSoft once they enter the program. Since ChallengerSoft is already mapped out to align with federal Healthy Start reports, and ECChange does not meet needs for federal reporting requirements, there are no plans to use ECChange for data other than referrals.

Challenges

One challenge is adapting the database (ChallengerSoft) to changing data collection needs. It is a time-consuming and technical process, and program managers would benefit from more technical support, similar to the support that other programs receive for ECChange. Additionally, the focus of the Healthy Start grant is on more traditional perinatal outcomes, such as infant mortality, birth weight, medical home, breastfeeding and substance use during pregnancy. Although the grant encourages addressing outcomes such as mothers' self-efficacy and resilience, these types of outcomes are not reflected in mandated reporting.

Recommendation

Since this program uses ChallengerSoft instead of ECChange, they do not complete the Home Visit Summary Form, on which many of the common indicators are addressed, and is the closest instrument to a "universal" form that is currently in place across the collaborative. For this reason, it will be necessary to identify which questions on their assessments align with Home Visit Summary Form questions. (This will also be the case for BIH, NFP, and HFA). Because this program is in transition, there is an opportunity for this evaluation planning process to inform the new forms that are instituted to ensure such alignment.

Your Family Counts/Healthy Families America

Healthy Families America (HFA) is a national program that is new in Alameda County. The program is just getting started, and will not have clients until at least summer 2015. Participants will begin during pregnancy and can stay in the program until their child is 24 months. Staff will conduct 2-4 visits per month (more if the mother is high risk) during the prenatal period, weekly when the baby is 0-6 months, and every other month when the baby is 7-24 months. Families can disengage for up to 3 months then return to the program. Specific outreach is conducted during the disengaged period. HFA uses a trauma-informed model.

Instruments/Data Sources

Many forms are used to collect data, including:

- Participant Intake Form
- Pregnancy Information Form
- Maternal and Health Demographics Form
- Family Member Information Form
- Household Profile Form
- Referral Tracking Form
- Child Birth Information Form
- Child Health Form
- Child Immunization Log (completed after each immunization dose)
- Discharge Form
- Child Protective Services Form
- Relationship Assessment Tool Form
- Edinburgh Postnatal Depression Scale (6-8 weeks postpartum and later if needed)
- ASQ-3
- ASQ: SE
- H.O.M.E Inventory
- Participant

In addition to forms used to collect data, the Kempe assessment is used to screen for eligibility and to set goals. This tool assesses risks that contribute to child abuse and neglect. It uses a structured interview format and requires training to administer. Several forms are used for case management, including: (1) Participant Contacts; (2) Home Visit Log; (3) Activities and Topics Covered During the Home Visit.

Databases

The program will definitely use ETO, and ECChange will be used to bill for Targeted Case Management (TCM).

Challenges

Because this program is just beginning, challenges around forms, processes, and data collection have not yet been identified.

Recommendation

As with other programs with external requirements (e.g., BIH, NFP, WHP/FHP), it will be necessary to determine how forms and assessments align with the common indicators.

SECTION IV: DATABASE OBSERVATIONS

DATABASES

Programs participating in the Alameda Home Visiting Collaborative utilize several database platforms including ECChange, ChallengerSoft, ETO, MIS, and MS Access/Excel. Access to ECChange, ChallengerSoft, and Asthma Start's internal Excel databases was granted for this phase of the evaluation.[1]

Data were obtained from the last two calendar years from ChallengerSoft (January 2013- December 2014) and from the last 18 months from ECChange and Asthma Start (July 2013-December 2014). The primary focus of investigation was on the aspects of these data systems that can inform performance on the set of common indicators agreed upon by the Alameda County Home Visiting Collaborative. Asthma Start internal databases were not included because they did not contain items associated with the Common Outcomes Framework.

ECCHANGE

Devised by First 5 Alameda and the most common data entry platform used by the collaborative, ECChange contains 10 data entry tabs:

- Summary
- Consent
- Activity (Universal Encounter Form)
- Demographics
- Stressors (Social Stressors/Areas of Concern)
- Family
- Household
- Referrals
- ECC (Home Visit Summary Report Form)
- Assessments (LSP, Edinburgh Depression Scale, ASQ, ASQ-SE, 4P's Plus Screen for Substance Use in Pregnancy, Devereux Early Childhood Assessment, and Drug Use Questionnaire).

ECChange appears to be fairly easy to use for data entry, however limited reporting capability for users is a known issue. It is also the case that not all programs use all the ECChange tabs or administer all assessments, nor does every item of data collected contribute knowledge about how clients in Alameda are faring vis a vis the set of common indicators. Thus, this section begins with an overview of how many clients were active during the period of July 2013 to December 2014 and how many completed a selection of forms that collect data associated with the common indicators (Universal Encounter, Home Visit Summary, Social Stressors/Concerns, and at least one assessment). The discussion then narrows to focus on the individual items that are associated with the common indicators.

Completion Rates

The total number of unique clients served between July 2013 and December 2014 was 4,375, of which 88 received support from more than one agency or program. **Error! Not a valid bookmark self-reference.** displays the number of clients who received services by agency and program. The remaining columns in the table show completion rates as the percentage of clients who had some data entered on the form/tab out of the total number of clients served.

For example, of the 633 Asthma clients with data in ECChange, 89% had a Universal Encounter form, 0% a Home Visit Summary Form, 0% a Social Stressors form, and 17% had at least one assessment completed.

TABLE 5. PERCENT OF UNIQUE CLIENTS WITH INFORMATION ENTERED IN EACH ECCHANGE TAB BY AGENCY AND PROGRAM

Agency	Total number of unique clients	ECChange Tab			
		Universal Encounter	HVSF	Stressors	Any assessment
All (unique count)	**4,375**	**78%**	**29%**	**32%**	**17%**
Asthma	633	89%	0%	0%	0%
Brighter Beginnings	285	*N/A*	61%	60%	41%
AFLP	*15*		*80%*	*80%*	*60%*
ECC 1-3	*2*		*100%*	*50%*	*50%*
ECC Teen	*264*		*59%*	*59%*	*40%*
ECC Teen 25	*2*		*50%*	*100%*	*100%*
MCAH	*2*		*100%*	*0%*	*0%*
CHO: Special Start	346	*N/A*	97%	68%	37%
HFA	304	78%	70%	35%	17%
ECC YFC	*210*	*80%*	*73%*	*40%*	*20%*
ECC YFC Prenatal	*94*	*72%*	*63%*	*24%*	*11%*
MADRE	43	98%	0%	98%	5%
MCAH	1652	73%	2%	12%	4%
NFP	222	83%	0%	69%	21%
Nursing*	108	71%	1%	0%	1%
Special Start/1-3+ and Postpartum	478	12%	5%	56%	42%
Sudden Infant Death Syndrome	17	0%	0%	0%	6%
TVHC	375	*N/A*	59%	55%	38%
AFLP	*4*		*25%*	*25%*	*0%*
CAL LEARN	*78*		*3%*	*46%*	*5%*
ECC Teen	*150*		*76%*	*57%*	*48%*
ECC Teen 25	*133*		*79%*	*57%*	*48%*
MCAH	*10*		*10%*	*80%*	*30%*

Notes: Number of clients served is a unique count. Because 88 clients were served by more than one program, numbers within this column add up to more than 4,397.

*Some programs did not start using all tabs in ECChange at the same time, therefore some program percentages underestimate completion rates (e.g., Nursing began using HVSF forms later than Universal Encounter Forms). Some programs use encounter forms other than the Universal Encounter Form.

Universal Encounter Items

Although there are five different encounter forms entered into ECChange (Universal, CHO, ECC, Telephone, and Special Provider Team Encounter forms), only *Universal* Encounter Forms contained data relevant to the set of common indicators. The 5,532 forms collected from 1,273 clients contained data on child immunizations, type of feeding (breastfed, formula, milk, combination, or other), and completion of ASQ or other developmental screening (see Table 6 below).

TABLE 6. RESPONSE RATE FOR UNIVERSAL ENCOUNTER FORM ITEMS LINKED TO COMMON INDICATORS

Universal Encounter Items	Percent of all forms with information entered	Percent Of Clients With Information Entered At Least Once
1. Immunizations up to date	43%	55%
2. Nutrition/Diet: Type of feeding	32%	41%
3. Developmental Screening completed	4%	4%

N=5,532 Universal Encounter Forms from 1,273 unique clients. Percentages do not include Nursing cases as they were not associated with MCAH.

Response rates were quite low for Universal Encounter items. It appears that the developmental screening item was only completed when affirmative – that is, the data contained only 'yes' responses indicating only that the screening was completed. Thus the quality of this data point is difficult to determine as this pattern of responding does not allow for distinctions among 'no', 'unknown', or skip responses. That is, it is unclear whether a screening was not completed for a particular reason, or if the data are simply missing due to data entry error or other oversight.

Likewise, there were no 'unknown' responses to the feeding question, thus it is unclear how many of the 13,405 missing values across all submitted forms were due to not knowing the answer or not asking the question. A high number of missing values across all the items on the form suggests partial or piecemeal collection of the items at each administration. Some clients had data entered for each item at each encounter while other clients had data entered sporadically for each item. It is recommended that a more systematic administration of the items with responses marked for every question be adopted and that program staff receive additional training on data collection and data entry protocols to shore up within and across-program differences in how data are being collected and entered.

Home Visit Summary Form Items

A total of 1,420 clients had 2,074 HVSF completed between July 2013 and December. A total of 22 items on the Home Visit Summary Form were associated with the common indicators. Overall, the number of valid responses for these items was robust. For example, 100% of the HVSF had a 'yes' or 'no' response to whether the child had a primary pediatric provider. Notable exceptions in Table 7 were *child dental appointments* (50%), *type of feeding* (59%), and *estimated time breastfed* (60%). A valid response rate for *positive depression screen* was difficult to determine as answers were given irrespective of whether the *screened for depression* item was answered as 'yes'.

TABLE 7. RESPONSE RATE FOR HOME VISIT SUMMARY FORM ITEMS LINKED TO COMMON INDICATORS

Home Visiting Summary Items	Percent of forms with information entered
1. Has primary pediatric provider	100%
2. Child has health insurance	94%
3. Number of foster care placements (of those placed in foster care)	93%
4. CPS case open at referral	91%
5. Type of infant health insurance	90%
6. Mother/prim caregiver has health insurance	89%
7. Placed in foster care	89%
8. Screened for depression	88%
9. Employment status mother	88%
10. Enrolled in CAL Learn	88%
11. Enrolled in CAL Works	87%
12. Family received books	84%
13. Developmental assessment	82%
14. Breast feeding at first visit	79%
15. Infant immunizations up to date	77%
16. Employment status father	73%
17. Number of intentional injuries	72%
18. Read, sung or told stories 3 or more times a week	66%
19. Depression screen positive	62%
20. Estimated time breastfed	60%
21. Type of feeding	59%
22. Had dental exam at 1 year or greater	50%

N= 2,074 Home Visit Summary Forms from 1,420 clients. Answering 'unknown' to any item was coded as missing (i.e., not valid).

Social Stressors/Areas of Concern Items

A third of all ECChange clients had some data entered in the social stressors tab, and a vast majority of those clients had unknown or blank entries for the 11 items associated with the common indicators on this form. A total of 1,571 Social Stressors/Areas of Concern Forms were entered into ECChange during the time frame of analyses. As shown in Table 8, item completion rates were low for all items. For example, 64% of all entered forms contained a 'yes' or 'no' response to whether the family had inadequate income, down to 1% of forms with any response to whether there was CPS involvement.

TABLE 8. RESPONSE RATES FOR ITEMS ON THE SOCIAL STRESSOR/AREA OF CONCERN FORM THAT ARE LINKED TO COMMON INDICATORS

Social Stressor/Area of Concern Item	Percent of forms with information entered
1. Inadequate income	64%
2. Depression	27%
3. Housing unstable	25%
4. CPS involved	21%
5. Social isolation	20%
6. Difficult Mother-infant interaction	17%
7. Partner unemployed	14%
8. History of depression	10%
9. Current depression	5%
10. History of CPS involvement	2%
11. Current CPS involvement	1%

N=1,571 Social Stressors/Areas of Concern Forms.

Assessment Items

Assessments were entered into ECChange at a fairly low rate. About a third of all clients had at least one completed assessment with the exception of those served by ACPHN (only 3% had an assessment entered, see Table 9). Life Skills Progression (LSP) was the most frequently administered (n=1,512) followed by the ASQ (n=741).

TABLE 9. COUNT OF ASSESSMENTS IN ECCHANGE BY AGENCY AND TYPE

Agency/Program	Number of Forms Completed					
	4Ps Plus Screen	Edinburgh	Life Skills Progression	Ages and Stages	Ages and Stages-SE	Total
ACPHD	14	214	518	497	45	1,292
ECC YFC/Prenatal(HFA)	*3*	*50*	*71*	*42*	*0*	*170*
MADRE	*0*	*2*	*0*	*0*	*0*	*2*
MCAH	*0*	*1*	*3*	*1*	*0*	*5*
NFP	*0*	*42*	*0*	*59*	*17*	*118*
Special Start	*11*	*117*	*442*	*395*	*28*	*993*
ACPHN	0	69	1	40	0	110
Brighter Beginnings	0	164	258	93	81	597
CHO Special Start	0	34	356	0	0	391
TVHC	0	114	379	111	89	693
Total	14	595	1,512	741	215	3,193

Scores calculated for assessments were typically complete. For example, of the 595 Edinburgh assessments, a minimum of two and maximum of 2.5 percent of responses were missing. The majority of missing responses came from 17 cases that had virtually no assessment data entered. Similarly, the ASQ rate of missing responses was low (5%). Thus, in general, assessment data were entered in full, however there was a small percentage of entries that contained no valid data.

Summary

Overall, ECChange holds great potential to deliver a comprehensive snapshot of client demographics. ECChange provides a solid framework for collecting data that will begin to tell the story of how home visiting clients in Alameda County are faring. A number of the highlighted items have good response rates, particularly from the Home Visit Summary Form. However, the data currently collected fall short of fully representing the common indicators.

There are a number of programs that do not use all the forms, use them inconsistently, and/or only partially complete them. For example, Alameda County Public Health Nursing programs enter little beyond Universal Encounter Forms. Given that other forms contain important data points for evaluation, it would be desirable to pull in other data sources if they exist or begin to incorporate more data collection opportunities for clients served by ACPHN programs. There also seems to be precedent of only entering affirmative responses for some items. This is problematic for evaluation since blank responses could be negative, unknown, or skipped items.

In summary, efforts to clean up data entry procedures and broaden implementation of data collection will improve the quality of the data deposited and taken out of ECChange for the purpose of evaluation. Adding a tab with reporting capability in ECChange that could produce demographic

counts and program outcomes to agencies and programs directly would increase utilization and help to fully optimize the system.

CHALLENGERSOFT

Women's Health Promotion and Family Health Promotion (WHP/FHP) programs use ChallengerSoft to enter data collected from participants and produce data reports. These programs have integrated systems such that it is not possible to obtain separate data reports by agency. Therefore, the analyses of ChallengerSoft pertain to both programs. These programs are also in the process of making changes to their forms, which limits the number of relevant data points to report.

With some training in ChallengerSoft, data reports were obtained with relative ease. The ability to access data reports without much programming is a huge benefit to using this system. However, the platform seems to require a significant amount of memory and/or internet bandwidth to function at peak capability. There were also some programing inconsistencies. For example, the Ages and Stages Questionnaire was an option listed when reporting form counts, but it was not an option listed when reporting individual questions and frequencies of ASQ item response options.

The data investigated were specific to the Alameda Home Visiting collaborative's common indicators and were entered between January 2013 and December 2014. These data included the following forms:

- Client Psychosocial Assessment
- Edinburgh
- Referrals
- Well-Baby Visit
- Six and 12 Month Follow-Up for adult and child

The search uncovered a total of 500 cases with at least one of these forms completed (with a mean of 5 forms per client; minimum=1, maximum=38).

The number of forms completed for each client ranged from a high of 42% for Referral, Well Baby, and Six-Month follow-Up forms to a low of 14% for 12-Month Follow-Up forms[1] (see Table 10 on the following page). Comparisons of the number of clients with a form completed and the number of forms entered in the system provide an estimate of how many clients had more than one form completed (e.g., clients had an average of 4.4 referral forms completed during this time period).

[1] These percentages take into account all clients, regardless of how long they were active in the program.

TABLE 10. CHALLENGERSOFT FORM COUNTS AND COMPLETION RATES

Assessment name and items	Number of clients with form completed	Client completion rate	Total number of forms completed and item completion rates
Client Psychosocial Assessment	153	31%	153
Social support			*99%*
Edinburgh Depression Scale	186	37%	193
All questions			*98%*
Referral	210	42%	915
Referral type			*97%*
Healthcare provider			*16%*
Client barriers			*40%*
Referral result			*95%*
Well Baby Visit	142	42%	397
Provider			*90%*
Father Attended			*90%*
Immunization Status at Age of Well Baby Visit			*97%*
Primary Payment Source			*99%*
6 month follow-up (Adult)	134	42%	137
Medical home			*93%*
Primary payment source			*90%*
6 month follow-up (Pediatric)	131	26%	134
Medical home			*100%*
Primary payment source			*99%*
Breastfeeding			*96%*
Abuse/neglect report			*99%*
12 month follow-up (Adult)	80	16%	83
Medical home			94%
Primary payment source			100%
12 month follow-up (Pediatric)	71	14%	73
Medical home			*97%*
Primary payment source			*96%*
Breastfeeding			*100%*
Abuse/neglect report			*97%*

Note: Completion rate = the number of clients with the form completed over the total number of active clients (n=500).

As noted in the far right column of Table 10, missing data was infrequent, with item completion rates over 95% for a majority of items. Higher counts of forms than clients for follow-up forms (e.g., 137 six month assessments for 134 clients) suggests duplicate entries.

Overall, data derived from ChallengerSoft were fairly clean with relatively few missing values. Thus, WHP and FHP appear to be doing a good job of collecting and entering their data to facilitate program evaluation efforts. Given that the reporting features are only as good at the data that are entered, perhaps some time should be dedicated to identifying duplicates, cleaning out entries that don't belong, and identifying gaps in the protocol if assessments are administered incorrectly.

CONCLUDING RECOMMENDATIONS AND NEXT STEPS

Across programs, some common themes emerged around data collection procedures and while some programs are in some kind of transition or other, this moment presents an opportunity to create intentional alignment between programs under the Common Outcomes Framework for evaluating overall impact of the collaborative effort.

This section summarizes some global observations and in general, our recommendations focus on streamlining data collection efforts and aligning ECChange and other database content to reduce duplication and to ensure data collected will enable program evaluation under the Common Outcomes Framework.

PROGRAM FORMS, DATA COLLECTION

- Take advantage of programs in transition to influence the direction of data collection, taking care to build in alignment of data collection efforts with the Common Outcomes Framework.
- Review program forms that have not been updated recently to reduce redundancy (e.g., questions about maternal depression in addition to administering the Edinburgh).
- Ensure there is clarity about whom data are collected from and who is considered the program participant (e.g., the mother, the focal child 0-5 years old).
- Ensure that missing data can be distinguished from a "no" response. For example, if a child is considered to have a medical home if their pediatrician's name is given, the difference between missing data on this item (e.g., this item was skipped on a form or the respondent does not know the pediatrician's name) and identifying that the child has no medical home must be clearly distinguishable.
- Although several programs use the Life Skills Progression (LSP), and the instrument captures information about many of the indicators, using it to measure any of the common outcomes would require adoption by all programs in the collaborative so that there is consistency in how constructs are defined and assessed. Given the extensive nature of the LSP, expanded use of the LSP is not recommended as a strategy for measuring Common Outcomes. However, data collected during the process of the LSP can be used. For example, "Parent Self Care" includes whether or not the parent has a medical home.
- Incorporate the Protective Factors Survey into data collection efforts across programs to measure common indicators including family resiliency, social support, parent-child relationships, and knowledge of child development.
- Explore the possibility of including more quantitative and less qualitative data in the Universal Encounter Form to enhance the utility value of those data.
- Make RBA reporting, including the process for collecting this data, more integrated with the Common Outcomes Framework, perhaps using the draft Dashboard templates from the Phase I report for reporting outcomes (included in Appendix A).
- Change the question about reading/singing/stories on the HVSF to ask for the number of times per week parents read/sing/tell stories (instead of whether or not they do it 3 or more times per week). The question would also need to be added to forms for programs that do not use the HVSF.
- The Home Visit Summary Form (HVSF) is a strong first step in establishing a common data source across programs, and the closest instrument to a "universal" form that the collaborative is currently implementing. In order to optimize the usefulness of this instrument:
    - Consider shifting the administration of the Home Visit Summary Form so that it is completed at intake and every 6 months thereafter (instead of every 6 months based on the calendar year). This would set all cases on a similar timeline, facilitating data analysis and interpretation.

  - Consider augmenting and expanding administration of this form so that the form covers more of the common indicators and all programs administer and enter this information into ECChange.
  - Emphasize to programs the importance of completing all items on the HVSF so as to minimize missing data.
- Ensure that systems and procedures are in place across programs to log referrals offered to clients and to systematically and routinely follow up on and document the outcomes of those referrals.
- Consider administering a Universal Intake Form across programs, such as the draft proposed in Phase I (revised and included in Appendix B), and integrating with ECChange. As noted above, this could be a modified version of the Home Visit Summary Form.
- It should be noted that although many of the programs in the collaborative serve pregnant women, and collect data about prenatal and birth outcomes, these types of outcomes are not represented in the Common Outcomes Framework. For example, many program collect data on receipt of prenatal care, birth weight and premature birth. While we are not recommending any additions to the already ambitious list of outcomes, given the number of programs that focus primarily on pregnant women (and much less, if at all, on children), it should be noted that these programs will have little to no impact on some of the outcomes in the Framework.
- Once indicators, outcomes, and measures have been finalized, efforts should turn to ensuring methods are consistent across programs to track processes and procedures to ensure quality program implementation.

Database Issues

- Better integrate ECChange with other systems (such as ETO) to reduce duplicate data entry and to facilitate data reporting.
- Address the difficulties associated with ECChange reporting functionality.
- Explore the possibility of adding elements to ECChange to include all common indicators to provide one single place that data need to be entered into, and where reports are produced that can inform as to client outcomes and program impacts.
- Expand ECChange so that all programs enter the same data (i.e., Universal Intake) into this database.

Next Steps

In summary, next steps in unifying the programs in the Alameda County Home Visiting Collaborative under a Common Outcomes Framework are offered here:

- A table is offered in Appendix C that identifies the specific proposed item that will measure each proposed indicator. In some cases, more than one item will be used to measure the indicator, and in other cases, entire assessment instruments are identified to measure a single indicator. In order to move forward toward implementation, some decisions need to be made around outstanding tools and measurement issues in order to finalize the Common Outcomes Framework and Evaluation Plan, including:
    - Whether or not up-to-date immunizations and well-child visits can be based on parent self-report, or if verification is needed.
    - If the outcome "Child receives early developmental screening" has a timeframe.
    - Whether the breastfeeding outcome includes only exclusive breastfeeding or any breastfeeding
    - Identify level of impact home visiting is expected to have on maternal depression, and whether the outcome should consist of screening received rather than decreased depression.
    - How to define "male engagement" and how to measure it
    - How to define "economic self-sufficiency"
    - Whether and how to administer the same tools across programs:
        - Protective Factors Survey
        - Parent Sense of Competency or General Self-Efficacy Scale to measure parents' self-efficacy
        - Home health and safety checklist (Consider selecting items from the California Chapter 4 American Academy of Pediatrics Injury and Violence Prevention Program's Keeping Your Child Safe brochure)
        - Universal Intake Form (individual items on this form also need to be reviewed and considered vis a vis current tools in use)
    - Whether to include an additional method of measuring child abuse/neglect by implementing the Adult Adolescent Parenting Inventory (AAPI-2) or the Parenting Stress Index (PSI) as indirect measures of child maltreatment via parenting attitudes.
    - Consider dropping the indicator: "Improved parenting skills, attitudes, and behaviors" or changing the indicator to focus on a single construct: "Improved parenting attitudes". In this case, the AAPI-2 or PSI might be employed as measures of parenting attitudes, rather than as indirect measures of child maltreatment.
- Explore how to augment ECChange to:
    - Incorporate items on the Universal Intake Form (see Appendix B)
    - Incorporate the Protective Factors Survey
    - Reflect changes recommended for the HVSF reading/singing item
    - Become the data entry portal across all programs in the collaborative
    - Improve reporting functions to produce more user-friendly reports, or if reporting functions exist, provide additional training to program managers about reporting options in ECChange.
- Begin engaging in discussions with program directors about:
    - Ensuring their data collection activities include coverage of all common indicators, as appropriate to their programs, which may include adopting new and/or augmenting current data collection tools and procedures
    - Moving towards data entry in ECChange

- Change data collection cycle (e.g., Home Visit Summary Form) from calendar-base intervals, based on client entry dates

APPENDIX A: REPORTING DASHBOARD TEMPLATE

NOTE: All data in the dashboard below are mock data—NOT actual data. This mockup serves as only one possible example of a data dashboard.

Alameda County Home Visiting Program Consortium

OUTCOMES DASHBOARD, 2014[2]

SCREENINGS

Item	Category of response	At Intake	At Exit
Depression Screening of Client *(Edinburgh)*	Clients who are screened at least once	100%	
	Of these, % scoring in the at clinical levels of risk for depression	15%	10%
Early Developmental Screening of Child *(ASQ-3, ASQ-SE)*	Children who are screened at least once on ASQ-3	100%	
	Of these, % who require further evaluation	20%	10%
	% who require monitoring	30%	25%
	% who are rescreened	35%	25%
	Children who are screened at least once on ASQ-SE	40%	
	Of these, % who require further evaluation	20%	10%
	% who require monitoring	30%	25%
	% who are rescreened	35%	30%

IMPACT PERFORMANCE MEASURES

Item	Category of response	At Intake	At Exit
Client has Insurance *(Universal intake/exit form)*	Medical	85%	100%
	Vision	70%	100%
	Dental	65%	100%
Baby has Insurance *(Universal intake/exit form)*	Medical	85%	100%
	Vision	70%	100%
	Dental	65%	100%
Medical Home *(Universal intake/exit form)*	Client	80%	100%
	Child(ren)	86%	100%
Longer Breastfeeding Duration *(Universal exit form)*	Initiated, but for less than 3 months	---	30%
	For 3-5 months	---	40%
	For at least 6 months	---	30%
Access to Basic Resources *(Universal intake/exit form)*	Transportation	70%	80%
	Food	85%	100%
	Stable housing	85%	95%
Access to Community Resources	Number of resources accessed	4	8

[2] Number of clients served in 2014=#. Number of children served in 2014=#. Number of clients who completed services in 2014=#.

(Universal intake/exit form)			
Prevention of Child Abuse/Neglect *(AAPI-2)*	Average score/ child abuse/neglect risk level	12	9
Homes are Safe for Children *(PEHA checklist)*	Average number of concerns in areas of:		
	Indoor pollutants	7	5
	Home Environment	5	2
	Sleep Environment	4	0
	Home Safety	6	1
Partners are Engaged	Clients who have a partner involved	40%	55%
	male partners involved	5	10
	female partners involved	2	5
Family Protective Factors *(Protective Factors Survey)*	Percent who score high in resiliency for the following subscales and items:		
	Family Functioning/Resiliency Subscale (5 items)	30%	50%
	Social Support Subscale (3)	40%	60%
	Concrete Support Subscale (3)	35%	65%
	Nurturing and Attachment Subscale (4)	65%	75%
	Child Development/Knowledge of Parenting Items (no subscale):		
	I am confident in my role as parent	50%	80%
	I know how to help my child learn	60%	75%
	*I believe that my child (does not) misbehave to upset me**	55%	75%
	I often praise my child for good behavior	80%	90%
	*I (do not) lose control when disciplining**	65%	90%

CLIENT PROFILE (CONTINUED)		
Item	**Category of response**	**At entry**
Educational Attainment	8th grade or less	
	Some high school, but did not graduate	
	High school (or GED)	
	Some college (did not graduate), vocational training, or community college	
	Four–year college or university degree or	
Pregnancy Status When Enrolled	Prior to 28 weeks GA	
	28 weeks until birth	
	Postnatal	
Adverse Childhood Experiences Score (ACEs)	Received a high score (4 or more)	
Housing	House/apartment	
	Public housing	
	Hotel/motel	
	Shelter	
	Homeless	
	Maternity home	
	Foster/Group/Transitional home	
	Other	
Number of Children in the Family	0 (first time mothers)	
	1	
	2	
	3 or more	
Client Insurance Coverage	Medical	85%
	Vision	70%
	Dental	65%
Child Insurance Coverage	Medical	85%
	Vision	70%
	Dental	65%
Medical Home	Client	80%
	Child(ren)	86%
Breastfeeding Duration	Initiated, but for less than 3 months	---
	For 3-5 months	---
	For at least 6 months	---
Basic Resources	Access to transportation	70%
	Obtain enough food consistently	85%
	Have stable housing	85%

Alameda County Home Visiting Program Consortium

OUTCOMES DASHBOARD, 2014[3]

SCREENINGS

Item	Category of response	At exit
Depression Screening of Client *(Edinburgh)*	Clients who are screened at least once	100%
	Of these, *% scoring in the at-risk zone for depression at least once*	15%
Early Developmental Screening of Child *(ASQ-3, ASQ-SE)*	Children who are screened at least once on ASQ-3	100%
	Of these, *% who require further evaluation*	20%
	% who require monitoring	30%
	% who are rescreened	35%
	Children who are screened at least once on ASQ-SE	40%
	Of these, *% who require further evaluation*	20%
	% who require monitoring	30%
	% who are rescreened	35%

IMPACT PERFORMANCE MEASURES

Item	Category of response	At Intake	At Exit
Client has Insurance *(Universal intake/exit form)*	Medical	85%	100%
	Vision	70%	100%
	Dental	65%	100%
Baby has Insurance *(Universal intake/exit form)*	Medical	85%	100%
	Vision	70%	100%
	Dental	65%	100%
Medical Home *(Universal intake/exit form)*	Client	80%	100%
	Child(ren)	86%	100%
Longer Breastfeeding Duration *(Universal exit form)*	Initiated, but for less than 3 months	---	30%
	For 3-5 months	---	40%
	For at least 6 months	---	30%
Access to Basic Resources *(Universal intake/exit form)*	Transportation	70%	80%
	Food	85%	100%
	Stable housing	85%	95%
Access to Community Resources *(Universal intake/exit form)*	Number of resources accessed	4	8
Prevention of Child Abuse/Neglect *(AAPI-2)*	Average score/ child abuse/neglect risk level	12	9
Homes are Safe for Children *(PEHA checklist)*	Average number of concerns in areas of:		
	Indoor pollutants	7	5
	Home Environment	5	2
	Sleep Environment	4	0
	Home Safety	6	1

[3] Number of clients served in 2014=#. Number of children served in 2014=#. Number of clients who completed services in 2014=#.

Partners are Engaged	Clients who have a partner involved	40%	55%
	male partners involved	5	10
	female partners involved	2	5
Family Protective Factors *(Protective Factors Survey)*	Percent who score high in resiliency for the following subscales and items:		
	Family Functioning/Resiliency Subscale (5 items)	30%	50%
	Social Support Subscale (3)	40%	60%
	Concrete Support Subscale (3)	35%	65%
	Nurturing and Attachment Subscale (4)	65%	75%
	Child Development/Knowledge of Parenting Items (no subscale):		
	I am confident in my role as parent	50%	80%
	I know how to help my child learn	60%	75%
	*I believe that my child (does not) misbehave to upset me**	55%	75%
	I often praise my child for good behavior	80%	90%
	*I (do not) lose control when disciplining**	65%	90%

*The original items of "I believe that my child misbehaves to upset me" and "I lose control when disciplining" were reverse-coded for this table. Thus, percentages reported for these items reflect clients who strongly agreed with the statements in the table above.

APPENDIX B: UNIVERSAL INTAKE FORM

ALAMEDA COUNTY HOME VISITING UNIVERSAL INTAKE FORM

Today's date:			Gender:
First Name	Last Name		M.I.
Street Address:			
City:		State:	Zip Code:
Home Phone Number:		Mobile Phone Number:	
Birth Date:		Baby's Due Date or Birth Date of Index Child:	

Source of referral to this home visiting program:_____

What is your marital status?

- ○ Single (never married)
- ○ Married
- ○ Divorced/Separated
- ○ Widowed
- ○ Cohabiting - Living with someone like you were married, but not legally married

Partner involvement/engagement items?

I have an adult partner who provides parenting and/or financial support to me and my child.

- ○ Parenting support
- ○ Financial support
- ○ Both
- ○ Neither

How much school have you completed?

- ○ 8th grade or less
- ○ Some high school, but I did not graduate
- ○ High school (or I got a GED)
- ○ Some college, vocational training, or community college, but I did not graduate from a 4-year college
- ○ College graduate (from a four-year college or university) or more

Are you in school right now? YES NO

What race do you most identify with? (Select all that apply)

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Hispanic or Latino or of Spanish origin
- ○ Native Hawaiian or other Pacific Islander
- ○ White/Caucasian
- ○ Other race or origin: _____

What is your primary language?

- ○ English
- ○ Spanish
- ○ Other:

What is your total household annual income: (check one)

- ○ I have no income
- ○ Less than or equal to $6,000
- ○ $6,001- $12,000
- ○ $12,001- $20,000
- ○ $20,001- $30,000
- ○ $30,001-$40,000
- ○ Over $40,000
- ○ Unknown or refused

What is the source of your household income? (Check all that apply.)

- ○ A job
- ○ Unemployment insurance
- ○ Baby's father/partner
- ○ Other family members
- ○ Friends
- ○ TANF
- ○ SSI/disability
- ○ County/court support
- ○ General relief/assistance
- ○ Cal Works/Cal Learn
- ○ Alimony
- ○ Child support
- ○ Rent from tenants
- ○ Other (Please tell us):_____
- ○ I have no income

Enrolled in CalWorks?

- ○ Yes
- ○ No
- ○ Unknown

Enrolled in CAL Learn?

- ○ Yes
- ○ No
- ○ Unknown

Which household benefits do you currently receive?: (check all that apply)

- ○ WIC
- ○ CalFresh (Food Stamps)
- ○ Utility assistance
- ○ Child care subsidies
- ○ Other:

Current Employment status (mother):

- ○ Employed- full time
- ○ Employed- less than full time
- ○ Not employed
- ○ Employed, on maternity leave
- ○ Unknown

Current Employment status (father):

- ○ Employed- full time
- ○ Employed- less than full time
- ○ Not employed
- ○ Employed, on paternity leave
- ○ Unknown

Are you struggling with any of these issues right now? (**Provide and log referrals to community resources to address identified issues. Use log to track client access of resources.**)

- ○ Homelessness
- ○ Money problems
- ○ Having enough food for the family
- ○ Separation or divorce
- ○ Serious/chronic health problem
- ○ Recent death or serious illness/injury of a loved one
- ○ Legal problems
- ○ Substance abuse
- ○ Transportation problems
- ○ Lack of childcare
- ○ None
- ○ Other (please share with us):_____

How many times have you moved in the last 12 months? _____times

During the last 12 months, was there a time when (you/you and your family) were not able to pay your mortgage, rent or utility bills? YES NO

During the last 12 months, did you or your children move in with other people even for a little while because you could not afford to pay your mortgage, rent or utility bills? YES NO

Is your income adequate to meet your food, housing, and other needs?

- ○ Yes
- ○ No
- ○ Unknown

Within the past 12 months, we worried whether our food would run out before we got money to buy more.

- ○ Never true
- ○ Sometimes true
- ○ Often true

Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.

- ○ Never true
- ○ Sometimes true
- ○ Often true

Do you have health insurance?: YES NO Unknown

What type of health plan do you have ?

- ○ Medi-Cal
- ○ Medicare
- ○ Private insurance
- ○ Uninsured
- ○ Unknown
- ○ Other (please tell us:_____)

Do you have vision insurance?: YES NO Unknown
Do you have dental insurance?: YES NO Unknown

Is your child covered by health insurance?: YES NO Unknown

What type of health plan does your child currently have?

- ○ Medi-Cal
- ○ Private insurance
- ○ Uninsured
- ○ Unknown
- ○ Other (please tell us:_____)

Is your child covered by vision insurance?: YES NO Unknown
Is your child covered by dental insurance?: YES NO Unknown

Do you have a primary care provider? YES NO Unknown

Does your child have a primary pediatric physician/provider? YES NO Unknown

Has your baby/child had a well-baby/well-child check-up? (Please select all that apply)

- ○ No
- ○ Yes, at 2 to 5 days old
- ○ Yes, at 1 month old
- ○ Yes, at 2 months
- ○ Yes, at 4 months
- ○ Yes, at 6 months
- ○ Yes, at 9 months
- ○ Yes, at 12 months
- ○ Yes, at 15 months
- ○ Yes, at 18 months
- ○ Yes, at 2 years old
- ○ Yes, at 2.5 years old
- ○ Yes, at 3 years old
- ○ Yes, at 4 years old

Are your child's immunizations up to date?

- ○ Yes
- ○ No
- ○ Unknown
- ○ Personal belief exemption

Are you currently breastfeeding your baby?

- ○ Yes
- ○ No
- ○ Unknown

About how long did you breastfeed your baby?

- ○ Never
- ○ Less than 2 weeks
- ○ 2 to 3 weeks
- ○ 1 to less than 2 months
- ○ 2 to less than 4 months
- ○ 4 to less than 6 months

- 6 to months to 1 year
- More than one year
- Still breastfeeding

What are you feeding your baby now?

- Exclusively breastfeeding
- Combination breast milk and formula
- Formula only
- Expressed breast milk only
- Milk
- Other

Do you have any concerns about your baby's health or development? YES NO

Has your baby received an assessment of his or her development?

- Yes
- No
- Unknown

In a typical week, how often do you read, sing, or tell stories to your child for at least 5 minutes?
_____days per week

Generalized Self-Efficacy Scale:	Not at all true	Hardly true	Moderately true	Exactly true
I can always manage to solve difficult problems if I try hard enough.				
If someone opposes me, I can find the means and ways to get what I want.				
It is easy for me to stick to my aims and accomplish my goals.				
I am confident that I could deal efficiently with unexpected events.				
Thanks to my resourcefulness, I know how to handle unforeseen situations.				
I can solve most problems if I invest the necessary effort.				
I can remain calm when facing difficulties because I can rely on my coping abilities.				
When I am confronted with a problem, I can usually find several solutions.				
If I am in trouble, I can usually think of a solution.				
I can usually handle whatever comes my way.				

APPENDIX C: INDICATOR AND MEASUREMENT ITEM TABLE

Indicator	Data Source	Item(s)
Child has medical home	Universal Intake Form	Does your child have a primary pediatric provider? (Y/N)
Child has medical, dental, vision insurance	Universal Intake Form	Is your child covered by health insurance? (Y/N)
		What type of health plan does your child currently have? (Medi-Cal, Private, Uninsured, DK)
		Is your child covered by vision insurance? (Y/N)
		Is your child covered by dental insurance? (Y/N)
Immunizations are up-to-date	Universal Intake Form	Are your child's immunizations up to date? (Y/N/DK/Personal belief exemption)
Well child visits up-to-date	Universal Intake Form	Has your baby/child had a well-baby/well-child check-up? (check all that apply: options follow American Pediatric Assoc recommendations)
Child receives early developmental screening	Universal Intake Form	Do you have any concerns about your baby's health or development (Y/N)
		Has your baby received an assessment of his or her development? (Y/N)
	ASQ/ASQ-SE	Assessment produces a score indicating need for further assessment or not
Mothers breastfeed for >6 months	Universal Intake Form	Are you currently breastfeeding your baby? (Y/N)
		About how long did you breastfeed your baby? (categorical: never to more than one year, and still breastfeeding)
Improved parenting skills, attitudes, behaviors	Protective Factors Survey	There are many times when I don't know what to do as a parent (7-point scale of dis/agreement)
Improved parent-child relationships	Protective Factors Survey	I am happy being with my child
		My child and I are very close to each other
		I am able to soothe my child when s/he is upset
		I spend time with my child doing what s/he likes to do.
Decreased abuse and neglect	Protective Factors Survey	When I discipline my child, I lose control
	CMS/CWS	Child maltreatment – open case, substantiated, unsubstantiated, removals, reunification, etc.
	HVSF	Intentional Injuries (Y/N/U) ; Intentional Injury Type
		Unintentional Injuries (Y/N/U); Unintentional Injury Type
		Type of Visit (ER/Hospitalization)
Increased knowledge of child development	Protective Factors Survey	I praise my child when s/he behaves well
		My child misbehaves just to upset me

Indicator	Data Source	Item(s)
Increased parent support for child learning and development	Protective Factors Survey	I know how to help my child learn
	Universal Intake Form	In a typical week, often do you read, sing, or tell stories to your child for at least 5 minutes? (_____days per week)
Mother has medical home	Universal Intake Form	Do you have a primary care provider? (Y/N)
Mother has medical, dental, vision insurance	Universal Intake Form	Do you have health insurance? (Y/N)
		What type of health plan does your child currently have? (Medi-Cal, Medicare, Priv, Uninsured, DK)
		Do you have vision insurance? (Y/N)
		Do you have dental insurance? (Y/N)
Decrease in maternal depression	Edinburgh	Total score indicating clinical need
Increased social support	Protective Factors Survey	I have others who will listen when I need to talk about my problems
		When I am lonely, there are several people I can talk to
		If there is a crisis, I have others I can talk to
Male engagement	TBD	TBD – add items to the Universal Intake Form?
Increased parents' self-efficacy	GSE, PSOC, or PFS	GSE: 10 items on a 4-point scale. Responses summed to yield composite score with range 10-40. (Not specific to parenting – general self-efficacy) PSOC: 7-item Efficacy Scale specific to parenting PFS: There are many times when I don't know what to do as a parent. I know how to help my child learn.
Increased access to community resources	Protective Factors Survey	I would have no idea where to turn if my family needed food or housing
		I wouldn't know where to go for help if I had trouble making ends meet
		If I needed help finding a job, I wouldn't know where to go
Home health and safety (e.g., safe sleep, car seat, guns, mold, etc.) increase	TBD checklist	TBD – Need to decide on the list of safety issues to implement. (Pediatric Environmental Home Assessment is quite extensive)
Increase in family resiliency	Protective Factors Survey	In my family, we talk about problems
		When we argue, my family listens to both sides of the story

Indicator	Data Source	Item(s)
		In my family, we take time to listen to each other
		My family pulls together when things are stressful
		My family is able to solve our problems
Housing needs are met	NSAF questions on UI	During the last 12 months, was there a time when (you/you and your family) were not able to pay your mortgage, rent or utility bills? (Y/N)
		During the last 12 months, did you or your children move in with other people even for a little while because you could not afford to pay your mortgage, rent or utility bills? (Y/N)
	Universal Intake Form	Are you struggling with any of these issues right now? (Homelessness is among a checklist of issues)
		How many times have you moved in the last 12 months (____months)
Transportation needs are met	Universal Intake Form	Are you struggling with any of these issues right now? (Transportation problems is among a checklist of issues)
Increased food security	AAP questions on UI	Within the past 12 months, we worried whether our food would run out before we got money to buy more (Never true, Sometimes, Often true)
		Within the past 12 months, the food we bought just didn't last and we didn't have money to get more (Never true, Sometimes, Often true)
Increased economic self-sufficiency	Universal Intake Form	How much school have you completed (choices: 8th grade or less to college grad or more)
		Are you in school right now? (Y/N)
		Total household income
		What is the source of your household income?
		Enrolled in CalWorks? Enrolled in Cal Learn?
		Which household benefits do you currently receive? (WIC, CalFresh, utility aid, child care subsidy, other)
		Current employment status; Are you struggling with any of these issues right now? (Money problems is among a checklist of issues)
		Is your income adequate to meet your food, housing, and other needs?