First 5 Alameda County Home Visitation Programs: A Multidisciplinary Approach

Written Testimony
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Background

First 5 Alameda County Every Child Counts (F5AC), funded by revenues from the California 1998 Proposition 10 tobacco tax, works to ensure that every child reaches his or her developmental potential. F5AC focuses on children and families from prenatal to age five years.

Alameda County is the seventh most populous county in California with a population of 1,454,159 (American Community Survey Demographic Estimates, 2005-2007) and one of the most ethnically diverse regions in the United States. It is a county with sprawling urban areas as well as agricultural centers, and is as large as many states with over 821 square miles.

In 2007, 125,450 children aged 0-5 years lived in Alameda County. Young Latino and Asian children are the fastest growing populations accounting for approximately 33% and 25% of all births, respectively (State Department of Finance, Demographic Research Unit, 2007).

Race/Ethnicity	Alameda County Population (1)	Birth Population (2)
African American/Black	13.0%	11.0%
Asian	24.6%	24.5%
Caucasian/White	24.4%	22.0%
Latino	21.4%	42.2%
Native American	0.6%	0.2%
Pacific Islander	0.8%	-
Multiracial	3.6%	-
Other/Unknown	11.7%	0.1%

Sources: American Community Survey 2006 (1); Alameda County Public Health Department Vital Stats, 2007 (2)

Overall, in 2006, an estimated 3,149 (3.0%) of all children ages 0-5 in Alameda County were foreign born, and 2,483 (2.4%) were not U.S. citizens (American Community Survey, 2006). Linguistically, 43.5% of the 5+ population speak a language other than English at home, and 19.1% speak English less than very well. Among these, 19.1%, 45.1% speak Spanish and 42.5% speak Asian and Pacific Islander languages (American Community Survey, 2006).

As evidenced by the data above, Alameda County needed to address a variety of factors in developing programs to meet the needs of a large and diverse county. F5AC began planning for the implementation of a voluntary home visitation strategy in 1999. F5AC explored several best practice home visitation models in existence at that time: Hawaii's Healthy Start, Healthy Families America, The Nurse Family Partnership-Olds Model and Parents as Teachers. F5AC decided **not** to utilize one particular model, but rather embraced the best practice standards that were emerging by creating a set of tenets to infuse into F5AC home visitation programs for the prenatal to five population in Alameda County.

FSS Tenets provides a framework for continuous quality improvements to meet evolving needs in targeted populations

1. **Family-centered:** acknowledges the reciprocal nature of family well-being and child development, and includes support to the family as a whole rather than restricted to child-level services.
2. **Relationship-based services:** Emphasizes that the family-provider relationship is the most important tool for provider and addresses the need for staff to be supported to "reflect" on her/his responses to individual cases
3. **Child development focused:** Expects the service provider to continually observe and use opportunities to help families understand their child's behavior in the context of child development; incorporates a "child find" strategy for early identification and intervention by requiring completed developmental screenings/assessments throughout the period of services
4. **Appropriate caseload ratios:** Maintains a case ratio of 1:20-25 per case manager (and 1:13 for families at risk for child abuse) to support the manageability and intensity of family support services by individual staff
5. **Reflective supervision:** Supports staff to understand the importance of reflection as a tool in their intervention work with families. Supervisor/staff relationships parallel the provider/family relationship
6. **Multi-disciplinary approach:** Emphasizes the use of a variety of professional disciplines to meet family needs

Implementing home visitation models in Alameda County also relied on key operational factors: the ability to access a large number and diverse pool of nurses to serve our diverse community; the cost of using PHNs to provide services; capacity to address language and cultural continuity for parents; the need to utilize existing programs; the desire to avoid investing in unsustainable programs; the capacity to meet diverse and multiple family risk factors.

- **Relying on the nursing supply in Alameda County severely limited the number and diversity of families able to receive home visits:** Of the approximately 21,000 annual births in Alameda County, 7000 were to very low-income mothers qualifying for California's Medicaid and Healthy Families programs; 1,504 were born low birth weight; 1,325 to teen mothers. The number and cost of Public Health Nurses who had both linguistic capacity and reflected the cultural backgrounds of our community could not possibly meet the demand for services.
- **The high risk nature of clients targeted by F5AC required multi-disciplinary approaches to engage difficult-to-reach families:** F5AC families targeted to receive home visitation included pregnant and parenting teens, parents of infants discharged from the neonatal intensive care unit due to severe and long-term health issues at the time of birth, and children at-risk of neglect or abuse due to substance use, mental illness or other unstable family environments. Up to 36% of mothers experienced postpartum depression, 7% of children were exposed to substance use, and 9% of families were involved with Child Protective Services. Each significant risk factor necessitated immediate attention by a multi-disciplinary team of providers who were most able to offer timely support services--which were pre-requisites for maintaining a quality, trusting and continuous relationship between a home visitor and the family.
- **Meeting culturally and linguistically diverse needs of families necessitated an agile and culturally responsive workforce**: Community organizations offered comparative advantages by staffing the programs with home visitors who reflected the face of the county's community. A children's hospital and family services department of Alameda County Public Health provided a mix of nurses and paraprofessional community health workers who effectively addressed long-term health and child development issues of children discharged from the Neonatal Intensive Care Unit. Multi-lingual and bi-cultural specialists helped families navigate community resources and medical specialists critical to the stability and health of the families. Community-based organizations that focused on reaching teen parents worked with schools and Social Services Agency to help young parents remain on track with high school requirements and to assist in obtaining services to which they are entitled to give their children a healthy start. Three community-based organizations demonstrated success in offering alternative response intensive case management to families already known to the Child Abuse Hotline but who did not qualify for immediate investigation by Child Protective Services.

Over the past 9 years, F5AC collected individual client level case management and outcomes data to support a robust accountability framework of continuous program quality assurance and impact measurement. F5AC's home visitation models produced impressive outcomes.

- **Children stayed healthy and up-to-date on preventive care**: Over the last 8 years, F5AC home visiting programs consistently reported 86-99% of children had health insurance; 94-98% were up-to-date with immunizations; 92-97% had an identified primary pediatric provider (medical home); 95-98% had all the appropriate well-child visits for age.
- **Early identification and treatment of maternal depression**: Early identification of mental health issues and referral to appropriate supports and treatment options

provided the necessary foundation for a socially and emotionally secure parent-child relationship. F5AC implemented a county-wide standard to screen every at-risk parent for depression. 20-36% of mothers who received home visits screened positive for maternal depression. Those who screened positive for depression were also more likely to have children who screened "of concern" in at least one developmental domain.

- **Anticipatory guidance and early screening and support for children's development**: Home visitors used their encounters with families to help parents learn what to expect as their baby grows. A county-wide strategy to promote developmental screening of every child helped identify 20-63% of children with developmental concerns.
- **Positive breastfeeding trends**: In addition to promoting bonding between parent and child, 56% of teen parents and 63% of parents of children discharged from the NICU breastfed or used breast milk as the primary source of nutrition for their babies. Of those who breastfed, over 30% did so for more than six months.
- **Low incidence of ER visits and hospitalizations for preventable illnesses and intentional injuries**: Less than 1% of children without chronic medical conditions visited the emergency room while fewer than 4 per 100,000 suffered intentional injuries.
- **Teen parents stayed in school or graduated**: Almost 60% of teens who received home visits remained in school or graduated from high school.

Summary

In implementing home-based early intervention services, First 5 Alameda County had to take into account the particular demographic needs and workforce issues within our community. A key to successful program implementation was staying true to F5AC family support tenets while structural and demographic changes continuously shifted in the county. We were guided by evidence-based practice, but above all else, needed to have the flexibility to use the evidence base tailored to the circumstances of the populations to be served (pregnant and parenting teens, infants discharged from the neonatal intensive care unit, children referred to child protective services, parents in need of family support during the transition to parenthood). Each one of these populations had different needs in reference to dosage, single discipline versus multidisciplinary, and type of professional providing the intervention. What unified our providers in the provision of home-based services was the common language we developed over the years, the ongoing training and support to staff, and continuous monitoring and quality improvement measures put in place to assure we were having an impact on families.