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Another road to safety: Program replication guide

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Another road to safety: Program replication guide

Abstract

The "Another Road to Safety" Program (ARS) offers another type of intervention for parents who have maltreated their children and another chance for families to remain together. For the past two years, Alameda County public and community based agencies have come together to provide early intervention services to prevent the reoccurrence of child maltreatment. ARS uses a differential response intervention model that separates parents reported to the child maltreatment hotline into four levels of risk for child safety and risk of future maltreatment: low, moderate, high, and very high. Clients are then referred to services based on their risk level: low risk parents are referred to community resources, moderate to high risk families are referred to voluntary services from ARS, and very high risk clients are retained for services by the county department of social services. ARS clients receive up to nine months of intensive home visiting, with a host of concrete services such as basic needs funding and childcare referrals. The ultimate goal of ARS is to promote family safety and stability to ensure positive child development. This report details the program's history and service model. Graphics highlight program elements such as logic models. Programs and procedures are reviewed. The role of the paraprofessional home visitor is considered in depth. The report concludes with a discussion of lessons learned and potential for program replication in other counties.

Keywords

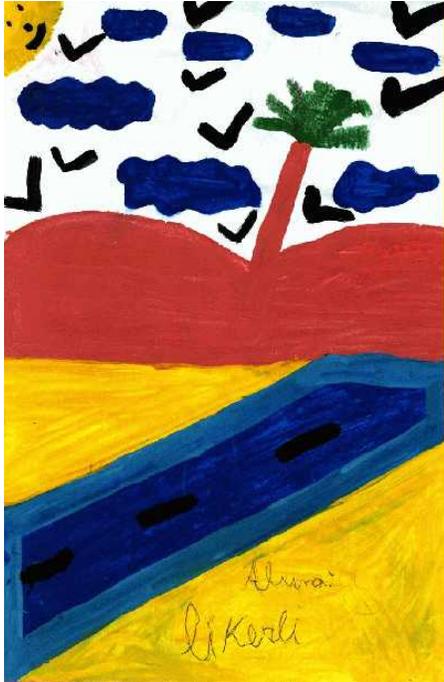
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Association Constellation
Children's Art

Another Road to Safety: Program Replication Guide

An Alternative Response Collaboration in Alameda County, California

Alameda County Social Services
First 5 Alameda County Every Child Counts
La Familia Counseling Services
Family Support Services of the Bay Area

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Executive Summary

Another Road to Safety Program Replication Guide

The “Another Road to Safety” Program (ARS) offers another type of intervention for parents who have maltreated their children and another chance for families to remain together. For the past two years, Alameda County public and community based agencies have come together to provide early intervention services to prevent the reoccurrence of child maltreatment. ARS uses a differential response intervention model that separates parents reported to the child maltreatment hotline into four levels of risk for child safety and risk of future maltreatment: low, moderate, high, and very high. Clients are then referred to services based on their risk level: low risk parents are referred to community resources, moderate to high risk families are referred to voluntary services from ARS, and very high risk clients are retained for services by the county department of social services. ARS clients receive up to nine months of intensive home visiting, with a host of concrete services such as basic needs funding and childcare referrals. The ultimate goal of ARS is to promote family safety and stability to ensure positive child development.

This report details the program’s history and service model. Graphics highlight program elements such as logic models. Programs and procedures are reviewed. The role of the paraprofessional home visitor is considered in depth. The report concludes with a discussion of lessons learned and potential for program replication in other counties.

Early data on ARS indicate that the program is successfully meeting its goals of reducing child maltreatment re-reporting. Certain themes have emerged from the pilot phase of the program:

- Community is a cornerstone of ARS, as home visitors connect clients with community resources and reduce their isolation. Efforts to promote connectivity among community organizations have been and will continue to be important as ARS is implemented countywide.
- Families are eager for the types of help ARS provides--the program has a high acceptance rate. Client needs center around knowledge of parenting and child development and resources to meet basic needs and achieve economic self-sufficiency.
- Relationships on many programmatic levels—client and home visitor, ARS staff, and the four partnering ARS agencies—are key for successful collaboration. With involvement by four institutional partners, working together has meant learning from each other and understanding the different organizational cultures.

The ARS model holds promise for replication in other sites. While the feel of the program will differ depending on the persons involved, there are procedural elements that can be lifted and adapted to the development of new programs. First, partners must share a vision of supporting families. The six guiding principles of ARS can provide this united vision. Second, investing in an in-depth planning process to solicit community perspectives and evaluate the choices for lead community agency can provide a solid foundation for a new program. Through such an effort, staff can learn about the needs of families in a particular community and the resources that are available. Third, certain administrative functions are crucial and must be assumed by one of the agency partners. These functions include “holding” the program vision, providing technical assistance and training to staff, and managing data collection.

ARS is an innovative inter-agency collaboration that builds on community and family strengths using a differential response program model. As differential response is the model to which the California child welfare system is gravitating, it is hoped by the staff of ARS that information about the program can be of use to other counties as they implement this new service strategy.

Preface

This guide is intended for an audience of child welfare administrators, First 5 Commission staff, and community-based organization staff with an interest in implementing a differential response child welfare intervention model. Alameda County since May 2002 has been conducting a pilot program of differential response services called Another Road to Safety (ARS). In reflecting back on the two years of the ARS program, staff at all levels from the organizations involved shared their thoughts on the program's successes and lessons learned. At this moment in time, as California begins to implement a historic redesign of its child welfare system, it is hoped that Alameda County's experiences can be a useful source of learning.

History

A number of factors converged on the state and county levels in the creation of the Another Road to Safety Program. In 1998, indication of increased concern for the welfare of children came from the state government in the form of augmented investment in child welfare services and from the voters of California in the passage of Proposition 10. The California state legislature granted additional state funding to child welfare services in response to a policy paper issued by the County Welfare Directors Association (CWDA).¹ This policy paper described the need for increased financial support in order to provide workload relief for child protective services departments struggling with new state mandates and increasingly complex cases. California voters were similarly moved to devote more resources to children through the passage of Proposition 10. This initiative created a new funding stream through tobacco taxation and dedicated this revenue to enhancing services for children under five and their families. Each county receives funding proportional to its birthrate. County "Prop 10" or "First 5" Commissions design their own strategic plans and allocate funds and/or run programs accordingly.

Concern for children was mirrored on the local level by the residents of Alameda County in 1998, who demanded that the Board of Supervisors make improvements in child welfare services. Issues raised by residents included poor communication between those involved in child welfare; lack of prevention/early-intervention services; and poor quality of services provided to minority children and families. The Board of Supervisors responded by inviting the Child Welfare League of America to evaluate the current child protective services system and to make recommendations for its improvement.

Child Welfare League of America found that the prevention and early intervention end of the continuum of services in Alameda County was lacking. Consequently, many children did not receive services that would prevent future harm and subsequent contact with the child protective services system. In 1997, there were approximately 19,100 reports of child abuse and neglect in Alameda County. A high percentage of calls (60%) were screened out at the hotline and never resulted in services. In 1993-1994, researchers at the Center for Social Services Research at UC Berkeley conducted a study² examining random samples of Alameda County cases screened out at the hotline, cases closed after investigation, and investigated cases referred to the court unit. They found 62% of screened out files had prior reports, as many as 21 times before. Of cases closed after investigation, 71% were found to have had prior or subsequent reports of

¹ County Welfare Director's Association (CWDA) *"Protecting Children, Restoring Families: It Takes Time"* (1998). Available online at <http://www.cwda.org/publications.cfm>

² Gilbert, N., Karski, R.L., Frame, L. (July 1997). The Emergency Response System: Screening and Assessments of Child Abuse Reports, p.xiii

abuse or neglect. CWLA concluded, based on these findings and their own investigation, that without intervention families continue to be reported until such time that their case becomes part of the child welfare system. To ensure better outcomes for families and children, CWLA recommended the development of a “first responder” community-based system of child maltreatment prevention and early intervention that addresses problems in families when first identified to prevent further child welfare involvement.

Alameda County Social Services Agency (SSA) Department of Children and Family Services (DCFS) explored strategies to create new prevention and early intervention services. With support from CWLA, SSA launched an agency-wide effort called the Practice Improvement Project (PIP). One subset of the PIP effort involved setting up a workgroup to focus on the development of front-end prevention services for low to moderate risk families. This workgroup met over a series of nine months to develop policy recommendations. Their research turned up an appealing preventative model in Washington State called Alternative (or Differential) Response.³ In this program, the telephone intake unit assesses each allegation using a standardized assessment tool for the child’s safety and risk of future maltreatment. The telephone intake unit then diverts low to moderate risk allegations to community-based organizations (CBO). A local CBO contacts the family to offer voluntary services. For Alameda County, Differential Response held the promise of helping at-risk families before they reached a crisis point. By engaging community providers, the services were also likely to be perceived as less stigmatizing and more culturally sensitive. Having found their model, SSA now looked for resources and partners to bring this vision to reality.

Elsewhere in the county, the Alameda County First 5 Commission became the first in the state to approve its strategic plan, thus launching the work of Every Child Counts (ECC). Armed with a mandate from the people of California to improve the health and well-being of children 0-5 and their families, Every Child Counts developed “interlocking programs in the three environments where children’s lives are most directly and significantly impacted: at home, in child care, and in the community.” Central to the Prop 10 mandate is systems change. The goal is to transform the organizations that serve families, not to supplant them through the creation of new bureaucracies. ECC formed partnerships with each of the major systems in the county (such as public health) as well as community based organizations. The role of ECC within the county is to provide vision, technical assistance, training, and funding for new initiatives and improvements to ongoing services. Through these efforts, ECC promotes a best practices service model that is relationship-based, family-centered, and builds on family strengths.

SSA and ECC had complementary goals and strategies that lent themselves to partnership. At the same time, both organizations also had to make certain compromises in order to jointly create a program that fit within their organizational framework and culture. From the beginning, the two agencies were entwined through the involvement of the SSA Director (initially Rodger Lum, later Chet Hewitt) on the Alameda County First 5 Commission. The CWLA report created a context for partnership. The population of children identified at the child welfare hotline as potentially at-risk but not at immediate risk to meet agency threshold for investigation and services was an intersection of responsibility for both agencies. ECC brought to the table its prevention dollars and concern for the holistic well-being of young children and families; SSA brought its wealth of experience with child welfare and its access to the children and families. Both organizations were interested in creating a family support home visiting program built on family

³ The Washington State Legislature passed a bill in 1997 providing funding and requiring alternative response services for low- to moderate-risk cases through public health agencies and community support services.

strengths. The CWLA report was a roadmap of where to begin and the direction to go in for improving service delivery to maltreated or potentially maltreated children.

Thus was launched a one year planning process in which the two organizations jointly designed a differential response program. Management of both organizations agreed on the basic structure of the Washington model, but needed to work out the crucial details. The first hurdle was how to handle the population served. ECC could only spend its funds on children under five and pregnant mothers. It was agreed that ECC would put up \$1 million in funding to cover its populations and SSA would seek out \$1 million in federal grant money to expand services for children up to the age of eighteen. Additional funding would be leveraged from Medicaid Targeted Case Management funds and Alameda County's Negotiated Agreement with the California Health and Human Services Agency⁴. With the leverage that Alameda County was already the site of another waiver demonstration project, Project DESTINY⁵, Alameda County Social Service Agency successfully petitioned to use flexible funding for a proportion of ARS clients who meet Title IV-E eligibility requirements. SSA secured a grant from the Administration for Children, Youth, and Families; however, the funding from this grant was insufficient to increase the population served. The program as implemented was limited to families meeting the criteria of ECC's mandated population: namely, with a child under five or a pregnant mother. Accountability and program evaluation were part of the program design process from the beginning. ECC's Evaluation and Technology Director disseminated information to the planning group on current research regarding data collection and outcome indicators for similar programs. In a collaborative process, the group agreed upon indicators for evaluating client success. Building accountability into the program through monitoring client outcomes was kept as a central concern during program planning⁶. Length of services was a point of contention for the two agencies. Most ECC programs were of an extended duration, up to five years in some cases⁷. SSA, on the other hand, provided services generally of shorter duration but with great intensity. Nine months was chosen for the length of service, with case-by-case extensions for an additional three months when warranted. The choice of whether to staff the program with professionals or paraprofessionals was a decision with a range of implications including quality of service delivery and cultural competence. The ARS planning team chose a model with paraprofessionals because having a background match between the helper and the client was seen as crucial for achieving acceptance by families. The paraprofessional model made proper clinical supervision, employee selection, and training especially crucial to the program's success. Providing services through paraprofessionals also complicated other aspects of the model; for example, unionized social workers protested the use of the Structured Decision Making Tool (SDM) by staff without MSWs. Earlier in the planning process, SSA had already chosen the SDM, designed by the Child Research Center, as the standardized risk and safety tool which screeners and direct line staff would use to assess which clients were low to moderate risk and thus eligible for ARS services. SSA management negotiated permission for the SDM use during a meet and confer with union officials.

The implementation plan for ARS involved a two-site pilot phase before countywide expansion. In 1999, when planning for ARS began, the Eastmont neighborhood of Oakland and the Harder-Tennyson neighborhood of Hayward had among the highest rates of child maltreatment referrals, with 624 and 818 referrals respectively, out of a countywide total of 7,300. Accordingly, they were chosen as pilot sites. The

⁴State waivers, through AB1741 which was later extended as AB2026, allow the county to use Title IV-E funding to contract case management services

⁵ Project DESTINY provides wrap-around services for children in high level group homes

⁶ See accountability matrix, Figure 5

⁷ ECC's Family Support Division funds intensive services to pregnant and parenting teens and infants who have been hospitalized in neonatal intensive care.

ARS planning team invested time in studying these communities to form an understanding of their strengths and problems. One source of information was “No Investigation Needed, Close File” (NINCFs, a.k.a. blue sheets) data drawn from the California child welfare database CMS/CWS. NINCF data offered zip-code specific demographic information on families referred for child welfare services. To assess client interest in voluntary ARS services, SSA and ECC staff conducted in-home surveys with clients who met eligibility criteria. Despite the fact that the staff showed up at homes without prior announcement and identified the family's prior CPS report as criteria for the study, the refusal rate was a remarkably low 0.036%. Families surveyed expressed a strong interest in voluntary, in-home services. Parents who attended community forums held in each neighborhood expressed similar interest in ARS program services. Another way that the planning committee learned about the communities was by hiring high school students to walk the streets and develop asset maps. This effort produced geo-coded maps of community resources. The planning committee also explored the capacity of community based organizations to find an appropriate lead agency and to identify auxiliary support services. All of the information gathered in the research phase coalesced to inform the planning committee's efforts during the Request for Qualifications (RFQ) and agency selection planning phases.

Service delivery by CBOs rather than the DCFS staff was seen as crucial by the planning committee to achieve greater community and client buy-in. DCFS needed to increase community partnerships and improve its public image. Building community capacity to protect vulnerable, at-risk children is at the heart of the ARS effort. This goal is in alignment with ECC's efforts to create systems change and SSA's strategy to decentralize its services and bring them to a community level. In the RFQ, the planning committee stated that it was looking for partners that had a record of collaborative work with public and community agencies. The right agencies moreover would be ones willing to take a risk on a new partnership and be committed to the same standards of outcome based accountability, culturally appropriate services, multidisciplinary approaches, and family strengths-based approaches as ECC and SSA. Representatives from SSA and ECC jointly reviewed applications. For South Hayward, La Familia Counseling Service was the clear choice. Since 1975, the agency had been providing culturally and linguistically appropriate mental health services to the Latino community of Hayward. The agency's participation in the South Hayward Neighborhood Collaborative, an association of nonprofit agencies committed to linking community resources through capacity building and services integration, assured that ARS clients would have access to a range of resources and services. East Oakland did not produce an obvious candidate. Rather, two agencies applied separately that each had appealing strengths. Ujima House, the East Bay division of the Haight Ashbury Free Clinic, delivered health, social, and educational services in East Oakland, yet it lacked sufficient administrative structures, such as supervision capacity. FamiliesFirst, Inc., a foster family agency with branches throughout Northern California, appeared to provide the necessary complement of administrative and clinical oversight. SSA and ECC chose to jointly award funding to both agencies if they could create a “marriage” with shared responsibility for the program. The two agency directors at the time were confident that such a merger could be successful. A \$20,000 planning grant for each neighborhood was awarded to the agencies.

During the ARS implementation process in East Oakland, major problems between the two CBOs started to arise out of communication problems and clashes over authority. The two agency leaders who had shared a vision of ARS both resigned within a few months of each other. At this point, implementation of ARS in East Oakland began to unwind as the differences in culture between the two organizations became more apparent. After attempts to resolve the differences proved untenable, all parties agreed to dissolve the relationship. Family Support Services of the Bay Area (FSSBA) was invited to step in and take over the

ARS program in the East Oakland Neighborhood. FSSBA is based in Oakland and has extensive child welfare experience, including "Family Reclaim," a program with similarities to ARS.⁸

The Program Model

Six guiding principles imbue the work of Another Road to Safety:

- Child safety as a priority
- Family outreach when child is safe
- Respect for and partnering with parents
- Strengthen and preserve families
- Community & culturally based services
- Standardized & uniform decision making

Clients are referred to the ARS program if DCFS hotline screeners determine that they meet the three eligibility criteria:

- First, level of risk is initially assessed as low to moderate so that it is deemed "No Investigation Necessary, Close File" (NINCF)
- Second, the family lives within one of the targeted zip codes in South Hayward or East Oakland
- Third, the family has a child under the age of five and/or a pregnant mother

After the ERU Supervisors have reviewed and approved those referrals from the DCFS hotline screeners that meet both criteria, the "blue sheets" are faxed to the appropriate CBO. The CBO then has seven days to reach the family by phone or certified mail to set up an in-home meeting. The clinical supervisor and a Family Advocate/Social Worker from each CBO makes the initial contact, explaining that a CPS report was made on the family for abuse or neglect. Since no case was opened on the referrals, many times the CPS report comes as a complete shock to the family. The Clinical Supervisor goes on to describe ARS services and explain that participation is voluntary. However, if families refuse services, ARS staff will notify CPS, which may choose to open a case. If the Clinical Supervisor has been unable to reach a family by phone or letter, she will show up at their door with a home visitor. The home visitor paraprofessionals are called "Family Advocates" at ARS-La Familia and "Social Workers" at ARS-FSSBA. At this first in-home meeting, ARS staff again describes the program, obtains consents for program assessment and information sharing, and conducts the California Safety Assessment and the California Family Risk Assessment of the Structured Decision Making (SDM) tool. There are often discrepancies between the assessments levels determined by the hotline screener and the ARS Clinical Supervisors. While only cases assessed as low, moderate, or high are referred to ARS, the ARS Clinical Supervisor may observe factors that indicate a higher risk level. Based on the score, the Clinical Supervisor will refer low risk families to community resources; moderate to high risk families will be retained for ARS services; and very high risk families will be assessed case-by-case to determine whether a safety plan can be put in place so that it can be retained for ARS services. While ARS was originally designed to serve low to moderate risk families, over the past two years ARS staff have developed their skills to the point that they are able to serve some higher risk clients. During the next working day, ARS staff will enroll eligible families in ARS services. This process is visually represented in Figure 1.

⁸ Family Reclaim serves families who have open cases with Alameda County Social Services Agency and whose children are at imminent risk of removal due to abuse or neglect. The program employs paraprofessional home visitors to provide services aimed at keeping the child in the home. While the program's strategies and goals are the same, the programs differ in the status of the populations they served, tenets, caseloads, frequency of visits, and resources.

Having a CPS referral as the gateway of entry for ARS services has certain implications for the program. Other child-focused providers in the community cannot make referrals to ARS. It might be possible to reach at-risk families earlier in the abuse cycle if teachers and doctors could refer families about whom they had concerns. The CPS referral also affects the client's initial views of the ARS programs. When contacted and told about the CPS referral, a small portion of families flatly refuses services. The clinical supervisor and home visitor try to push past the no to at least get client agreement for one in-home visit. Many families have strong emotional reactions of anger, fear, and anxiety. Home visitors report a pattern of some African American families reacting with suspicion due to community or family history with CPS and some Latino clients exhibiting fear regarding potential ramifications if they have illegal status. It can also be a huge relief for families to finally get help with the issues they face. The home visitor and the clinical supervisor explain the affiliation between ARS and CPS and emphasize that ARS is truly an alternative that can help to deal with family problems. Ultimately, it is the manner of the home visitor that has the greatest determination on whether families engage in ARS services. Right away, the home visitor begins the process of partnering with families to understand and support them. Once the home visitor and the family begin to form a relationship, the CPS referral generally ceases to be an issue.

After the initial visit, the home visitor makes weekly home visits of an average duration of one and a half hours. Each home visitor carries a caseload of no more than thirteen, and on average only nine. This allows the staff member to devote time to creating a relationship. Within thirty days of case assignment, each home visitor conducts a variety of assessments to guide the development of the "Family Care Plan." The Family Assessment covers indicators of family strengths and concerns and determines the family's ability to parent, protect children from abuse and neglect, and provide for children's special needs. Developmental and health assessments are conducted on all children in the household. The Ages and Stages Questionnaires (ASQ) are used to screen children's developmental levels and areas of concerns. If there are concerns in the socio-emotional domain, home visitors may conduct the Ages & Stages Questionnaires: Social-Emotional (ASQ: SE). Other assessments are conducted as needed, such as screens for depression (e.g., Edinburgh Depression Scale) and substance abuse (e.g., 4Ps Plus Screen for Risk of Alcohol or Drug Abuse, Drug Alcohol Screening Tool). Jointly, the family and the home visitor develop a "Family Care Plan" which outlines goals and steps to achieve them. These same goals are contained in ECC's accountability matrix and are the basis for program evaluation. Goals fall under one of the following categories:

- Child Safety
- Child Growth and Development
- Parenting
- School Readiness
- Health and Wellness
- Building Family Strengths
- Self-Sufficiency
- Relationships
- Nutrition

With the Family Care Plan to guide the intervention strategy with each family, home visitors have an array of services they can provide for families. After conducting the appropriate screenings, the home visitors get a sense of each family's individualized service needs. Drawing upon their connections with local CBOs, the home visitors can make referrals for childcare, housing, employment services, substance abuse rehabilitation programs, respite care, nutrition, domestic violence, and other needs. Both ARS-La Familia and ARS-FSSBA benefit from being housed within larger service agencies. La Familia, the agency that

operates ARS in Hayward, can provide family and individual counseling of a linguistically and culturally appropriate nature to Latino and non-Latino families. The lead agency of ARS in Oakland, FSSBA, can provide respite services. In Hayward, La Familia's participation in the South Hayward Neighborhood Collaborative has created strong relationships between the agency and other community providers that is a boon when making client referrals. When clients have needs that cannot be met through a referral, home visitors have access to a basic needs fund. Basic needs funds are used to support child well-being and parenting. Funds for example may be used for food, needed household items, diapers, or even partial rent payments. The concept behind the basic needs fund is to prevent the crisis of an urgent and unaddressed need and the stress it induces. By providing service referrals and basic needs funds, home visitors help families improve their economic and material conditions to address symptoms of the poverty at the root of many families' challenges to providing a safe and healthy environment for their children.

Beyond the concrete forms of help such as referrals and basic needs funds, the home visitor develops a therapeutic relationship that is the intervention tool with the family. Home visitors provide supportive and educational services to improve parenting. They model healthy relationships and build trust with their clients by becoming a consistent and support presence in their client's lives. Trust is a crucial ingredient in the therapeutic relationship; without it, clients would be unlikely to engage with anyone connected to Child Protective Services because of the agency's reputation and the threat of potential child removal. Through interactions with the children, home visitors show parents ways to promote positive child development and to enjoy spending time with their children. Home visitors use "teachable moments" to help parents better understand their child. This leads to improved parenting skills because lessons are concrete, not theoretical. As the trust builds, parents often disclose information about their own childhood experiences of abuse and neglect. The home visitor uses these opportunities to help the parents heal from past trauma and create positive changes in their parenting styles.

ARS also creates opportunities for families to have fun with their children. One example is the ARS South Hayward Lawrence Hall of Science program. ECC provided the UC Berkeley Lawrence Hall of Science, a center for experiential learning, with a grant to provide free activities for ARS-La Familia families. Lawrence Hall of Science uses space in Hayward donated by Eden Youth and Family Services (a member of the Hayward Collaborative) to hold quarterly, four week sessions. The Lawrence Hall of Science staff creates fun learning opportunities, such as making and playing with bubbles. Parents and children can relax with other families and enjoy their time together.

Figure 2, the Logic Model for direct service provision, details the connection between the processes and services provided by the home visitors with the proximal and distal goals for the families. By helping families meet realistic short-term goals, the home visitors hope to plant the seeds for deeper, more systemic changes in family functioning. Nine months is a relatively short period, so the goal is to use this period to incubate changes in parenting and life skills that will transform the patterns of abuse and neglect.

Overarching the direct service goals are the management and policy goals. Chief among these is systems change. ARS represents a new way of engaging with families that is more tailored to family needs, less adversarial, and less stigmatizing. It holds the hope of creating better outcomes for families by preventing the need for child removal and traditional child welfare services. Figure 3, the logic model for program management and policy decisions, demonstrates the connection between macro decision-making for ARS and the short and long term goals of the program. The success of ARS for its clients has a ripple effect back to the systems that serve at-risk families. It can by promote a more positive image of child welfare

services in communities with historically mistrustful views of the system. ARS can also relieve pressure on overtaxed child welfare by preventing the need for interventions.

ARS brings together two communities, four agencies, and dozens of families willing to take a risk on a new mode of child welfare intervention. Each player brings its own set of tangible and intangible contributions. For example, families contribute their time to home visits and also their willingness to learn new ways of parenting. ECC not only offers funding for the program but also holds a vision of new ways to partner with communities, families, and agencies. Figure 4 gives a more complete accounting of the contributions of communities, families, and agencies to the success of ARS.

The Agent of Change

Because ARS is a tailored program, much discretion is left to the individual home visitor, with the advice and support of the clinical supervisor. The home visitor has a role that is subtle and nuanced. It is a job that requires the right kind of person with the right kind of training. The ARS model is intended to be flexible and adaptable to the needs of each family. A home visitor must therefore hold the program vision while being able to focus on the particular needs of each family with whom they engage. Training and experience allows the home visitor to internalize the program model so that he or she can be fully present with families, not just check services provided off a list. Support provided to the home visitor helps them deal with the challenges entailed by their job.

Home visitors at ARS-La Familia were hired from among the best paraprofessionals involved in the South Hayward Collaborative. Several of the organizations that make up the collaborative employ paraprofessionals, all of whom are called Family Advocates. In the future, home visitors may or may not be hired from the collaborative. An advantage of initially hiring from the collaborative was that the staff already had experience working together.

ARS Program Directors and Clinical Supervisors face a tough job when they hire a home visitor. ARS administrators must hold the service delivery model: the six guiding principles, training and skills development, and reflective supervision. They are looking for a unique make-up of personal attributes plus the ability to absorb training in preparation for the home visitor role. One set of abilities they look for are those necessary for people in the helping professions, such as:

- Ability to meet clients where they are
- Willingness to participate in reflective supervision
- Ability to work on a team
- Openness to learning
- Ability to utilize supervision by bringing their observations and taking directives
- Ability to receive feedback and respond appropriately
- Ability to use self as a tool
- Not taking the work so personally as to develop burnout when there are lapses or non-compliance
- Hope for the families—not letting cynicism get in the way of a vision for families
- Understand own selves
- Be available and responsive to clients
- Flexibility

Other desirable qualities are unique to the demands of the ARS model, namely:

- Live in compatible communities—same language and culture
- Love, knowledge, and respect for the community
- Alert and politically aware of the oppressed conditions of the neighborhoods
- A sense of hope and in the ability to change one's own life
- Ability to connect with families and build trust in short timeframe
- Enough experience so that the idea of a community program and being with real folks isn't daunting
- Not so much experience in social services that it prevents a paradigm shift on how to engage client in child abuse and neglect prevention and intervention
- A level of expectation for the client and for themselves—the understanding that the home visitor can not do the work of changing the clients' lives for them
- Not afraid to make a mistake, values questioning, able to observe
- Belief and commitment to prevention and early intervention
- Biculturalism and bilingualism

Because the model relies on paraprofessionals, certain issues such as setting boundaries come up for staff with perhaps greater frequency than professionals. The lines can be more blurred between friendship and professional relationships because of the similar backgrounds of home visitors and clients. Clinical supervision is essential for guiding the therapeutic relationship, for helping home visitors unload what they carry around of the client's problems. Supervision and training also help mold the natural helping behaviors of the home visitors into therapeutic interventions.

SSA and ECC teamed to create a training curriculum for the home visitors. After each ARS branch was staffed, SSA and ECC staff held a series of trainings. These trainings broadly centered on each organization's expertise: child welfare and children 0-5 and their families. Skills-building training topics included the following:

- Child Development
- Relationship-based early intervention work
- Substance Abuse
- Domestic Violence
- Family Violence
- Child Abuse & Neglect (dynamics of abuse, identifying safety and risk factors)
- Observing family functioning
- Need to keep topic vs. statement focused
- Self-care for the Home Visit
- What to expect from reflective supervision (how to deal with a parallel process--to understand what they are feeling and what the family is feeling and how to deal with it in supervision)
- Identifying and using community resources
- Working with diverse populations (cultural competence)
- How to engage and work with fathers

In addition, ARS managers provided internal training on agency policies and procedures including: case presentations, case notes, and treatment plans.

Once home visitors were selected and trained, they became part of a service team. Interventions are not done alone. Each home visitor receives weekly individual and group reflective supervision. Case consultation is provided by ECC's "Specialty Provider Teams" and by SSA's "Service Team" on a bi-weekly

basis, or more as needed. Home visitors and clinical supervisors meet with the teams to discuss cases. The Specialty Provider Team consists of professionals with expertise in substance abuse, early child development, mental health, and lactation. They provide information and insights related to family and child well-being. Home Visitors may request a special case consult when the clinical supervisor is in agreement that extra consultation is warranted. The Service Team is made up of two DCFS liaisons that oversee the assignment of ARS cases from the CPS hotline. These DCFS staff members have expertise in child welfare and provide information on legal requirements, safety and risk factors, the dynamics of abuse, and intervention techniques. All aspects of the administrative structure of the ARS programs conspire to create a "holding environment" to support the relationship between home visitors and clients. The relationship is the therapeutic tool for creating change in families. To make that relationship the best possible, home visitors need thoughtful consultation, training, and emotional support.

Home visitors continue to develop their skills through frequent trainings conducted by ECC and SSA. Internally, the staff gathers information on resources and services available in the communities for clients. The goal is continuous program improvement, especially during the pilot phase as lessons are learned and applied.

Policies and Procedures

ARS has a complicated organizational structure, with cross-agency involvement on the managerial and service delivery levels. The management plan accounts for this through a "Three Tiered Collaborative Structure." Staff involved with ARS from SSA, ECC, and the two community-based organizations are designated to attend specific meetings and then share information from those meetings within their agency. As previously mentioned, the Service Team is composed of direct service staff: home visitors, clinical supervisors, and DCFS liaisons. This meeting addresses day-to-day service delivery issues and case-specific interventions. The next tier is the Operations Group, composed of administrative staff: the DCFS and ECC program specialists, ARS program managers, Clinical Supervisors and the DCFS liaisons. Issues covered in Operations Team meetings involve day-to-day operations issues, such as policies, procedures, forms, data collection, information sharing, and problem solving. The Oversight Committee completes the structure and is composed of upper management: the DCFS Division Director, the Director of ECC's Family Support Division, ECC and DCFS Program Specialists, and the Executive Directors of FSSBA and La Familia. This group is charged with looking at strategic, governance, fiscal, and systems change issues. Information is shared between teams to facilitate decision making by certain "bridge" members who attend two meetings. The teams meet according to the following schedule: Service Team meets semi-monthly; Operations Group meets monthly; and Oversight Team meets four times a year.

Certain programmatic decisions require the approval of SSA and/or ECC management. One of these is the use of basic needs funds beyond the \$350 maximum family allotment. Another is extending cases beyond the nine-month timeline. Decisions to make exceptions for particular cases are first brought by the home visitor to the clinical supervisor. If the supervisor thinks an exception is warranted, she or he brings the issue before the Service Team. For situations in which there is an impasse, the final decision is made by the DCFS Division Director and ECC's Family Support Services Director.

Sharing client information across agencies has required putting into place confidentiality agreements and waivers. As a consequence of the Negotiated Agreement with the California Health and Human Services Agency, which has programmatic as well as financial ramifications, the ARS CBOs are legally considered extensions of SSA.

Therefore, SSA is able to refer hotline allegations to the ARS CBOs without breaching client confidentiality. Alameda County Counsel went through a protracted process to approve confidentiality consent forms that protected the information of both families and agencies. All ARS staff signs a confidentiality oath. At the first face-to-face contact, the clinical supervisor asks parents for their informed consent to participate in ARS services. They are also asked for consent to share information among the ECC agencies that serve them. Families may participate in ARS services whether or not they consent for their information to be shared (they, of course, cannot elect to withhold their information from SSA). Unless mandated to do so, ARS will not share client information with criminal justice, family courts, INS, IRS, child support systems, DMV, private corporations, marketing firms, and collection and credit agencies. ARS treats client data with a great deal of integrity and is careful about what data is collected, how it is stored, and how information is shared.

Home visitors keep their client records on ECChange. ECChange was created by ECC to monitor and collect data on services provided by their contracting agencies. ARS staff was trained at each agency site in the use of ECChange and can contact a help desk if any problems come up. Case files are created for each child in the family and include electronic copies of assessments and the Family Care Plan. ECChange has dual roles as a case management and an accountability/evaluation tool. There are case management and administrative views of ECChange. In the case management view, home visitors can do the following: enter disposition information (SDM scores and case disposition), record encounters, complete assessments, document the family care plan, and complete the semi-annual summary forms. From their ECChange view, administrators may review case documents for quality assurance and approve requests for case closures. Security and mobility are two major advantages of the system. Home visitors access the system via a secure internet server that utilizes the most up-to-date security technology and meets federal health privacy regulations. Each home visitor is issued a laptop by ECC to allow access in the field to ECChange for charting cases. The laptop need not be connected to the internet to allow for record keeping; home visitors may electronically "pull" cases by downloading them to the computer hard drive and then "return" them by uploading to the internet. All data are linked so that providers can see whether their clients are receiving other ECC services to allow for service coordination.

Centralizing data collection on ECChange creates a pool of data for program monitoring and evaluation. Data in aggregate form can be pulled from ECChange; for example, the racial, ethnic, and socio-economic breakdown of families receiving services. This is an important tool for creating annual reports and tracking service utilization. ARS can also monitor its success in meeting the outcomes of ECC's Accountability Matrix. The Accountability Matrix connects desired outcomes for children and families to a set of indicators, strategies, and performance measures (see Figure 5). ARS services fit into a comprehensive strategy to improve systems of care for children in Alameda County. Monitoring ECChange ARS data against the Accountability Matrix allows for qualitative and quantitative program evaluation.

Lessons Learned

ARS is showing early signs of success. During the period 8/2002-9/2004, ARS successfully contacted and received consents for 286 referred families (90% of all referrals). After conducting assessments, 40 cases were returned to CPS; 92 cases moved or were lost to follow-up; 4 cases were referred to community resources; 4 cases were placed on hold pending risk decisions; and 146 cases were retained for ARS services. As of 9/2004, 32 families were being case managed by the ARS CBOs while 114 families had

their cases closed. Of these 146 cases, 90% had no subsequent interaction with Child Protective Services.⁹

In its organizational development, ARS is now facing transition from pilot to full countywide implementation. Expansion of ARS is at the heart of DCFS's strategic plan. The differential response model is in alignment with the current California Child Welfare System reform. ARS is greatly needed in other Alameda County neighborhoods with high rates of calls to the child protective services hotline. Implementation in new sites will entail the same careful process of choosing neighborhoods based on need, researching community based organizations and community assets, and involving the community in the planning process. Expanding ARS will also require building infrastructure for those neighborhoods that lack a strong network of service providers. ARS as a model is reliant on client referrals to community resources. The South Hayward Collaborative, as a network of linked service providers, has offered a great deal of resources to ARS-La Familia. ARS-FSSBA has experienced greater challenges in acquiring services for their clients due to the lack of a forum in which agencies in the area can share information. Systems change must be part of the agenda if there are insufficient or poorly connected resources in a community.

County leadership, from the Board of Supervisors to the Board of ECC, is committed to full implementation of ARS. The challenge is finding sufficient funding in a time of extreme cutbacks in social services. Were funding available, the ultimate vision would be to make ARS truly a preventative model by allowing other community members such as doctors and teachers to refer families about whom they had concerns. ARS is becoming more visible in the community it serves as ARS management works to forge ties with other agencies. ARS clients, community members, and service providers have asked about making referrals of families to the program. A wider portal of entry to the program would allow for more universal access and thereby decrease the stigma of the CPS referral entry. Access to ARS services will be part of the ongoing discussions between ECC and SSA as the organizations look at integrating ARS into the SSA structure and culture.

A wealth of lessons has emerged from the two-year pilot. Clients have been teachers, as the ARS staff comes to better understand the strengths and needs of those they serve. ARS families are inspiring in their resolve to do well by their children despite overwhelming odds of poverty, mental health problems, substance abuse, unstable housing, and intergenerational cycles of abuse. These parents have experienced many challenges in their lives and have managed to survive, indicating a great resiliency. ARS home visitors have found that the parents they serve love their children and want to be good parents, but many simply lack in resources and parenting skills. Families have shown a great eagerness to accept help in improving their parenting. With regards to parenting, they need help understanding basic child development, discipline, limit setting, communication, reading and playing with their kids. They also need help dealing with their basic needs and economic self-sufficiency. Once basic needs are met, families are better able to get beyond their stress to start dealing with unhealthy family dynamics.

Another lesson that has emerged is that relationships are as key to interagency collaboration as to the work of the home visitors. This is true for the connections among ARS staff members, the ARS CBOs and other community agencies, and the four ARS partners. ARS staff members have had to work on becoming a supportive team as a necessary factor for group and individual supervision. A parallel process unfolds as the home visitor engages and builds relationships with families; the home visitor also needs the support and encouragement from relationships with her colleagues. Connections between service providers in the

⁹ Administration for Children, Youth and Families, 2003-2004 Final Report for Another Road to Safety

community ultimately prove to benefit clients. When the home visitors have personal relationships with other community providers, it is easier for them to link clients up with needed services simply by making a phone call. With the ARS agency partners, personal relationships are necessary to bridge organizational differences. Layoffs at SSA and burdening of the staff that remain with extra duties have impeded relationship building. SSA, ECC, and the two CBOs have different approaches to service delivery, yet they must work together to create a united vision. This takes trust and respect for the persons involved. The four partner agencies must also work together to ensure that ARS remains a priority for the Board of Supervisors and other political powers that be.

The dissolution of the original ARS-East Oakland partnership was unfortunate, but it provided a valuable lesson. Again, relationships played a large part in the collapse of the partnership. The “forced marriage” between Ujjima House and Families First relied greatly on a shared vision between the leaders of the two organizations. When those leaders left their respective organizations, that vision had not been sufficiently communicated to the rest of the staff to provide continuity of the dedication to work together. While an arrangement may look good on paper, it is important to ensure that communication and commitment to the necessary processes as well as the program model are in place.

Replication of the ARS model in other counties holds a lot of promise. While in its nature ARS is somewhat chameleon-like because it will look different based on who is involved, there are some consistent pieces. A will to focus on prevention and family support is the first step. This can be a paradigm shift for social service professionals, who are accustomed to dealing with crises. The six guiding principles can be used to create a shared vision among organizational partners. Configuration of partners may look different than in Alameda County; not always will there be a First Five with the will and resources to participate in a large-scale child welfare program. The program vision, funding, and technical support provided by ECC are crucial functions that would have to be assumed by a participating agency. A commitment to the time intensive training and research takes is also necessary on the part of each of the partners. Investing time in an in-depth planning process with communities is also worthwhile. Such a process helps inform the choice of CBOs with a proven track record and public regard. It can also bring attention to the greatest needs of families in a given neighborhood, from chronic unemployment to substance abuse. ARS can potentially be an organizing tool for communities, bringing together community members and service providers to combat child abuse and neglect.

Choosing an ARS model means putting a high priority on community. Alameda County Social Services Agency is implementing a host of initiatives, such as Family-to-Family and the Child Welfare Redesign, that represent a paradigm shift of employing new ways to partner with communities and improve outcomes for families. In their ability to overcome the challenges of differing organizational cultures, the four ARS partnering agencies have managed to create and sustain a service model that offers hope and support to at-risk families.

ARS Family Story

In November 2003, Mother agreed to participate in Another Road to Safety following an unscheduled home visit. The CPS referral was for general neglect. Mother is a 24 year-old, single, African-American woman who has five daughters: one infant, two preschoolers, and two school-aged children. Mother is planning to continue taking classes to become a Medical Assistant, and the 6, 8 and 9 year-olds are attending elementary school.

ARS Home Visitor has observed Mother's home environment to be somewhat chaotic with friends and family visiting her apartment frequently. Mother's 16 year-old sister is currently staying with her, and their Mother (MGM) visits the apartment almost daily. MGM and Mother's sister appear to have a turbulent relationship. Mother admits to being frustrated with their relationship and all of the arguing that takes place in her apartment. Social Worker plans to address the challenge of not having much privacy for Mother to discuss things freely to better maximize the time that ARS will be involved.

In the three months that ARS has been involved with Mother and her daughters, Mother successfully enrolled her six year-old daughter into Kindergarten. Home Visitor was concerned that this six year-old, who was five at the time of enrollment, had never been to a school of any kind. She seems to be enjoying Kindergarten and Mother is interested in enrolling her 2 year-old into Early Head Start. Home Visitor is attempting to support the mother around the importance of education for her daughters and herself. Mother has also expressed wanting to complete her G.E.D. in conjunction with the Medical Assistant classes. Home Visitor is impressed with the style in which Mother nurtures and provides boundaries for her five daughters. Home Visitor has observed her five daughters to be friendly and respectful. Mother and her five daughters were surprised during the holiday season that their family was sponsored by generous employees of ECC. Mother stated recently to ARS Home Visitor that the wonderful donations made it feel like Christmas for herself and her daughters.¹⁰

¹⁰ ARS-FSSBA, Bi-monthly report, 1/01/04-2/29/04

FIGURE 1

“Another Road to Safety” (ARS)

This diagram depicts all cases that are referred to the Alameda County Child Protective Services

Services in blue shaded boxes will be provided by contracting CBOs

Allegations of Child Abuse/Neglect

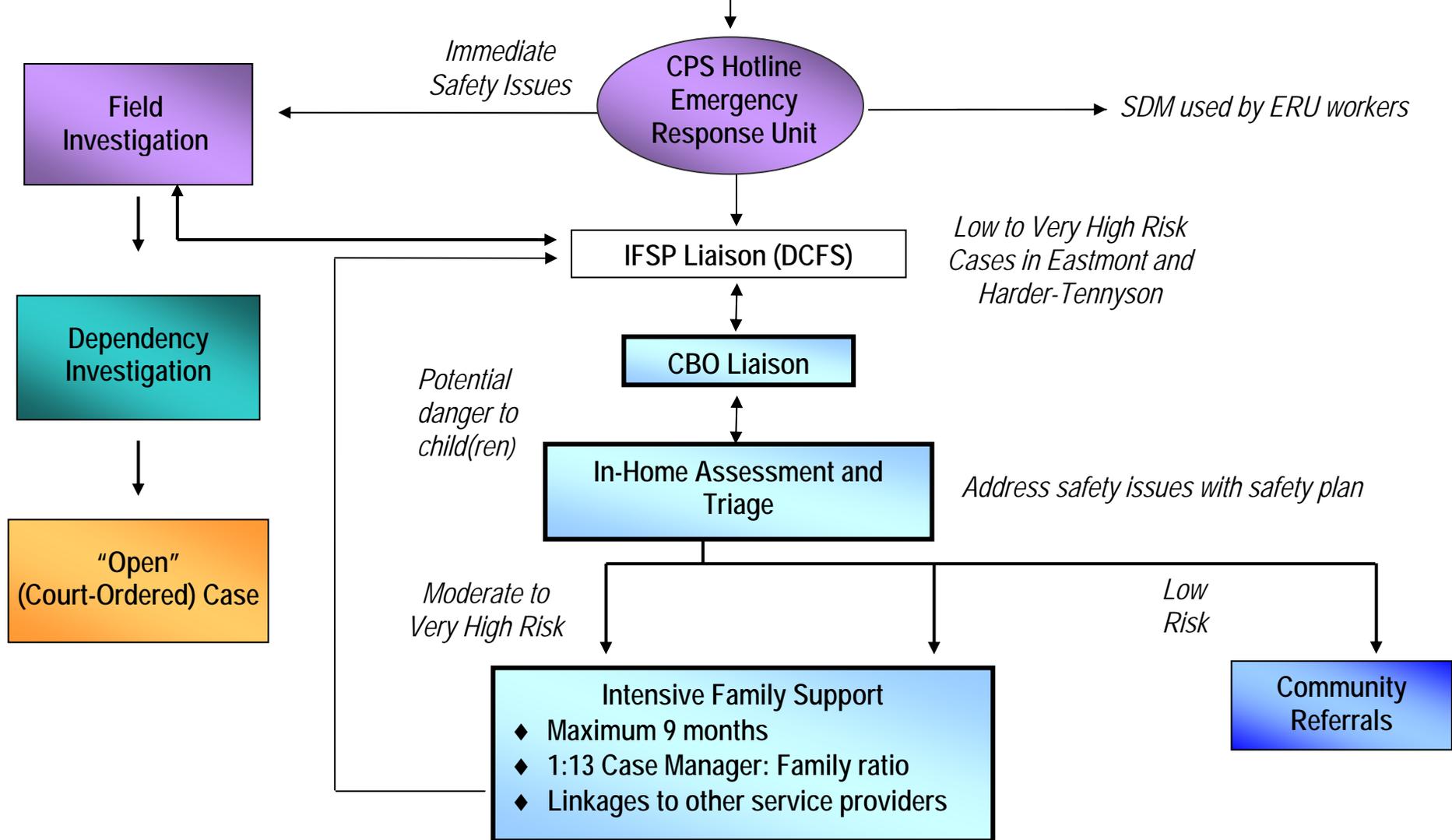


FIGURE 2

Logic Model for Direct Service Provision

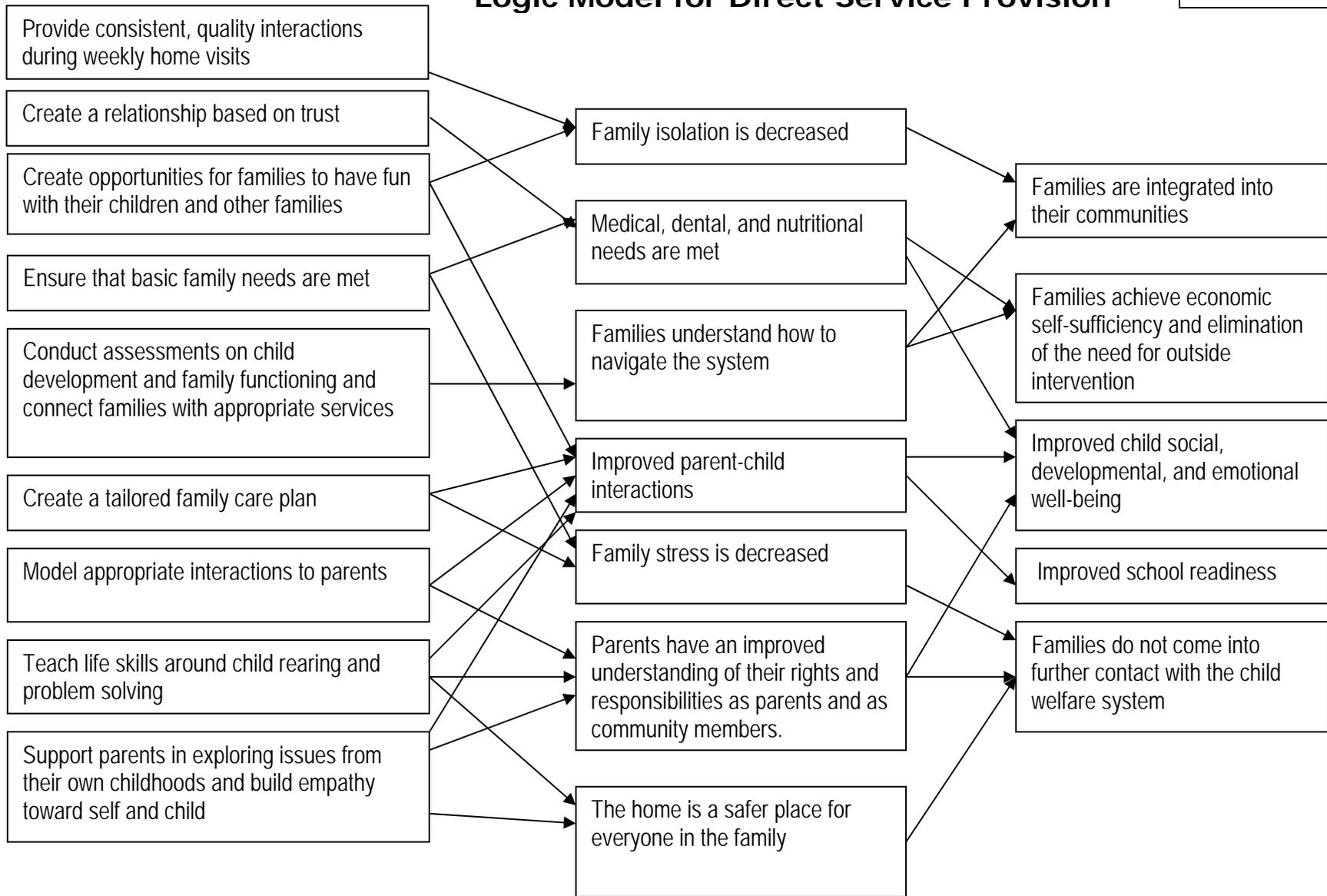
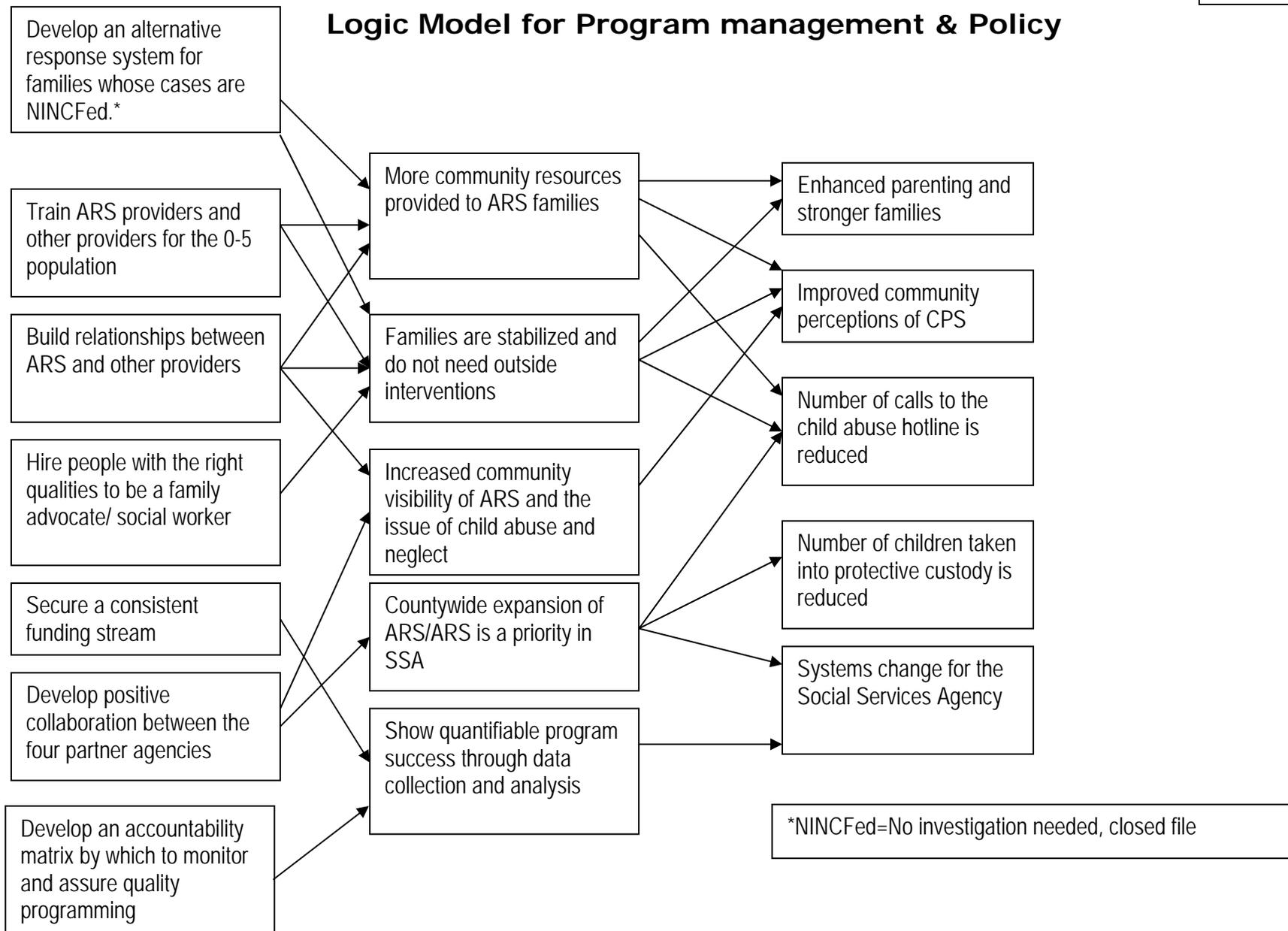


FIGURE 3

Logic Model for Program management & Policy



Contributions to ARS Made by the Community Agencies and Families Decisions

FIGURE 4

Federal focus:

Allow states to petition for flexible Title IV-E dollars to develop prevention and early intervention programs
Offer grants through the Administration for Children and Families for prevention programs
Share promising practices

State focus:

Institute statewide differential response
Partner with communities
Offer preventative services for low to moderate risk families
Create necessary systems changes ,e.g., institute State Waivers, which through the Youth Pilot Program, allow contracted case management services and provide additional training.

Communities (S. Hayward & E. Oakland)

<i>Tangible contributions</i>	<i>Intangible contributions</i>
Availability of and connections between service providers	Civic unity and notions of shared responsibility for children
Incidence of child maltreatment reports as reason for community selection	Community history with CPS
Community infrastructure	Language and culture

Every Child Counts

Tangible contributions

Funding
Administration and oversight
Specialty provider team consultations
Cultural access services
Accountability
ECChange
Training

Intangible contributions

"Holding" the program vision and staff
Offering a different model of how to work with families
Expertise in the needs of the 0-5 community
Being the glue to hold the program together

Families

Tangible contributions

Time
Commitment
Participation in the Family Care Plan and in the relationship-building with the home visitor

Intangible contributions

Willingness to trust
Desire to change
Eagerness to parent better
Interest in giving back by becoming resources families

A. C. Social Services Administration

Tangible contributions

Referrals of families
Federal grant and Title IV-E Waiver
Consults at the bi-weekly Service Team meetings
Training and access to the Standardized Decision Making Tool
Data from the CMS/CWS system

Intangible contributions

Taking a risk
Working with CBOs in a new way
Expertise in child welfare and crisis intervention

**Community-based organizations
FSSBA & La Familia**

<i>Tangible contributions</i>	<i>Intangible contributions</i>
Awareness of and connection to community resources	Understanding of the community's languages and cultures
Relationships with families	Holding a sense of hope for the families
Potentially more cost-effective way of providing services	Reputation within the communities
Organizational infrastructures	

ANOTHER ROAD TO SAFETY OUTCOME INDICATORS

All outcome/indicators will be reported by race/ethnicity, gender, zip code (or other geographic boundary) and age, poverty level and educational level when appropriate.

GOAL 1: SUPPORT OPTIMAL PARENTING, SOCIAL AND EMOTIONAL HEALTH, AND ECONOMIC SELF-SUFFICIENCY OF FAMILIES			
OUTCOME	OUTCOME/INDICATOR	STRATEGIES	PERFORMANCE MEASURE
1B. Reduced incidence of child abuse and neglect in families receiving ARS services	1. <i>Number of families referred from SSA to the CBO for further assessment and possible services</i>	Implement referral of families to CBOs who do not meet SSA screening criteria for investigation	<ul style="list-style-type: none"> ▪ Number of families referred to CBO for assessment ▪ Number and percent of CBO staff trained ▪ Number of families with completed safety and risk assessments ▪ Number of families assessed who: <ul style="list-style-type: none"> ◇ Are referred back to SSA for dependency investigation – very high or high risk ◇ Receive intensive family support services – low to mod risk ◇ Referred to other community resources ▪ Number of adult family members and children receiving ARS services ▪ Number of CBO staff trained to support families' use of culturally sensitive parenting and discipline alternatives ▪ Documentation of training curricula ▪ Documentation of injury prevention and safety education ▪ Number of ARS families referred to CPS ▪ Number of repeat CPS referrals per family
	2. <i>Proportion of referred families who score low-moderate risk on the Structured Decision Making tool (SDM) by the CBO</i>	Train CBO Staff to use the Structured Decision Making tool (SDM) Complete home safety and risk assessment of families referred by SSA to generate risk score Provide intensive family support services for families assessed to be at low-moderate risk	
	3. <i>Number of ARS children with intentional injuries including:</i> <ul style="list-style-type: none"> • <i>Physical abuse</i> • <i>Sexual assault</i> • <i>Homicide</i> 	Train CBO family advocates to support families in use of culturally sensitive parenting and discipline alternatives Provide parent education and support for the use of developmentally appropriate and culturally sensitive parenting and discipline alternatives Include parent support and education for injury prevention and safety in family support strategies	
	4. <i>Number of ARS children/families who have a Child Protective Service Case opened during the reporting period</i>		

GOAL 1: SUPPORT OPTIMAL PARENTING, SOCIAL AND EMOTIONAL HEALTH, AND ECONOMIC SELF-SUFFICIENCY OF FAMILIES

<i>OUTCOME</i>	<i>OUTCOME/INDICATOR</i>	<i>STRATEGIES</i>	<i>PERFORMANCE MEASURE</i>
1B. Reduced child abuse and neglect in families receiving ARS services (continued)	5. <i>Proportion of children receiving ARS services who were placed in foster care</i>		<ul style="list-style-type: none"> ▪ Number of ARS children placed in foster care during the reporting period
	6. <i>The number of ARS primary caregivers screened positive for depression</i>	<p>Train CBO staff to perform depression screening</p> <p>Perform depression screening on primary caretaker when indicated</p>	<ul style="list-style-type: none"> ▪ Number CBO staff trained ▪ Number of primary caregivers screened for depression ▪ Number of primary caregivers screened positive ▪ Number of primary caregivers with positive depression screens who are referred for further assessment/treatment
1C: Enhance economic self-sufficiency among families receiving ARS services	<p>1. <i>Proportion of ARS families with a working member</i></p> <p>2. <i>Proportion of eligible ARS families receiving CalWORKs and CalLEARN assistance</i></p>	<p>Provide referrals to quality child care for those seeking employment</p> <p>Support eligible ARS parent participation in CalWORKs programs</p> <p>Identify and refer CalWORKs parents to parent education classes on job seeking skills</p>	<ul style="list-style-type: none"> ▪ Documentation of child care referrals ▪ Number of children referred to child care ▪ Number of eligible ARS families receiving CalWORKs/CalLEARN ▪ Number of eligible CalWORKs ARS parents referred

GOAL 2: IMPROVE THE DEVELOPMENT, BEHAVIORAL HEALTH AND SCHOOL READINESS OF YOUNG CHILDREN FROM BIRTH TO AGE FIVE

<i>OUTCOME</i>	<i>OUTCOME/INDICATOR</i>	<i>STRATEGIES</i>	<i>PERFORMANCE MEASURE</i>
2C. Improved school readiness	<ol style="list-style-type: none"> 1. <i>Number of eligible children enrolled in Hand-in-Hand</i> 2. <i>Proportion of children receiving ARS services who receive developmental screening</i> 3. <i>Proportion of children receiving ARS services who are reported to be of concern on a developmental screening</i> 	<p>Refer eligible pre-kindergarten children to Hand-in-Hand school readiness programs</p> <p>Train home visitors to perform the Ages & Stages developmental screening</p> <p>Develop appropriate referral sources for children screened who need developmental assessments</p> <p>Refer children for developmental assessments as needed</p>	<ul style="list-style-type: none"> ▪ Number of children referred to Hand-in-Hand school readiness programs ▪ Number of staff trained ▪ Number of children screened for developmental problems ▪ Number of children who are reported to be of concern by domain (gross motor, fine motor, cognitive, language/ communication, emotion and coping, and self-help) on a development assessment in the reporting period ▪ Number of children referred for developmental assessments

GOAL 3: IMPROVE THE OVERALL HEALTH OF YOUNG CHILDREN

<i>OUTCOME</i>	<i>OUTCOME/INDICATOR</i>	<i>STRATEGIES</i>	<i>PERFORMANCE MEASURE</i>
3A. Increased access to early and comprehensive perinatal care to pregnant women and teens	<ol style="list-style-type: none"> 1. <i>Proportion of ARS pregnant primary caretakers who have health insurance</i> 2. <i>Proportion of ARS pregnant primary caretakers who have an identified prenatal provider</i> 	<p>Refer pregnant primary caretakers without health insurance for health insurance</p> <p>Refer pregnant primary caretakers who do not have an identified prenatal provider</p> <p>Offer family planning referrals if requested</p>	<ul style="list-style-type: none"> ▪ The number of women without health insurance ▪ The number of women referred for health insurance (by insurance type) during the reporting period ▪ The number and percent of pregnant primary caretakers without a prenatal provider ▪ The number of pregnant primary caretakers referred to a prenatal provider during the reporting period ▪ Number of families referred for family planning

GOAL 3: IMPROVE THE OVERALL HEALTH OF YOUNG CHILDREN

<p>3B. Increase the proportion of children who receive well child and dental care from a health care provider</p>	<p>1. <i>Proportion of ARS children 2 months and older with health insurance</i></p> <p>2. <i>Proportion of ARS children who have an identified health care provider</i></p> <p>3. <i>Proportion of ARS children with appropriate number of well child visits per age</i></p> <p>4. <i>Proportion of ARS children who are fully immunized</i></p> <p>5. <i>Proportion of ARS children age 3 years and older who received an annual dental exam</i></p>	<p>Ensure children 2 months and older have health insurance</p> <p>Ensure children have an identified primary health care provider</p> <p>Train CBO family advocates to assess appropriate number of well visits by age</p> <p>Train CBO family advocates to assess immunizations</p> <p>Assess families for well-child visits, immunization status and dental exams</p>	<ul style="list-style-type: none"> ▪ The number of children referred for health insurance (by insurance type) during the reporting period ▪ The number and percent of children with a health care provider ▪ The number of children referred to a health care provider during the reporting period ▪ The number of children assessed for appropriate number of well child visits ▪ The number of children assessed for immunization status ▪ The number of children 3 years and older who were assessed for dental exam
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<p>3B. Increase the proportion of children who receive well child and dental care from a health care provider</p>	<p>6. <i>Proportion of ARS children 2 months and older with health insurance</i></p> <p>7. <i>Proportion of ARS children who have an identified primary health care provider</i></p> <p>8. <i>Proportion of ARS children with appropriate number of well child visits per age</i></p> <p>9. <i>Proportion of ARS children who are fully immunized</i></p> <p>10. <i>Proportion of ARS children age 3 years and older who received an annual dental exam</i></p>	<p>Ensure children 2 months and older have health insurance</p> <p>Ensure children have an identified primary health care provider</p> <p>Train CBO family advocates to assess appropriate number of well visits by age</p> <p>Train CBO family advocates to assess immunizations</p> <p>Assess families for well-child visits, immunization status and dental exams</p>	<ul style="list-style-type: none"> ▪ The number of children referred for health insurance ▪ The number and per cent of children with an identified primary health care provider ▪ The number of children referred to a primary health care provider during the reporting period ▪ The number of children assessed for appropriate number of well child visits ▪ The number of children assessed for immunization status ▪ The number of children assessed as up to date for immunizations ▪ The number of children assessed as not up to date by reason ▪ The number of children 3 years and older who were assessed for dental exam
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GOAL 3: IMPROVE THE OVERALL HEALTH OF YOUNG CHILDREN

INDICATOR	INDICATOR DEFINITION)	STRATEGIES	PERFORMANCE MEASURES
<p>3C. Reduce the proportion of children with selected unintentional injuries</p>	<p>1. <i>Proportion of ARS children with selected unintentional fatal and nonfatal unintentional injuries by cause (E-code), including:</i></p> <ul style="list-style-type: none"> ◇ Motor vehicle crashes ◇ Drowning ◇ Burns (scalds and/or flames) ◇ Poisoning ◇ Falls ◇ Choking ◇ Suffocation ◇ Unintentional firearm-related accident 	<p>Provide culturally appropriate home safety and injury prevention education and materials during home visits</p>	<ul style="list-style-type: none"> ▪ Number of children with unintentional injuries by cause ▪ The number of ARS families who received home safety and injury prevention education and materials
<p>3D. Reduce prenatal and early childhood exposure to alcohol, tobacco and other harmful substances</p>	<p>1. <i>Proportion of ARS infants and children exposed to second hand smoke</i></p> <p>2. <i>The number of ARS primary caregivers identified as substance users</i></p>	<p>Train CBO family advocates and provide materials on smoking cessation policy and strategies</p> <p>Refer smoking family members to smoking cessation classes Inform families of dangers of second hand smoke</p> <p>Train CBO family advocates to use the Substance Use Screening Tool</p> <p>Identify primary caretakers who are substance users by self-report or screening</p> <p>Refer substance using primary caretakers to appropriate substance use treatment programs</p>	<ul style="list-style-type: none"> ▪ Number of trainings held ▪ Number and percent of staff trained ▪ Number of smoking family members referred to smoking cessation classes ▪ Number of CBO family advocates trained ▪ Number of primary caregivers who are substance users ▪ Number of primary caregivers referred for substance use treatment

GOAL 3: IMPROVE THE OVERALL HEALTH OF YOUNG CHILDREN

INDICATOR	INDICATOR DEFINITION)	STRATEGIES	PERFORMANCE MEASURES
3F. Reduce post-neonatal and child deaths	1. Number of post-neonatal deaths of ARS children during the reporting period	<ul style="list-style-type: none"> • Provide training for CBO family advocates staff on SIDS • Provide culturally appropriate SIDS prevention during home visits 	<ul style="list-style-type: none"> ▪ Number of CBO family advocates staff trained ▪ Documentation of distribution of culturally appropriate prevention materials
3G. Number of hospitalizations and emergency visits for children receiving ARS services	<p>1. Number of hospitalizations and emergency visits per ARS child during the reporting period for:</p> <p>Asthma, Congenital Syphilis, Failure to Thrive, Grand Mal Status and Epileptic Convulsion, Hypertension, Hypoglycemia, Immunization Related Conditions, Kidney /Urinary Tract Infection, Noninfectious Gastroenteritis, Nutritional Deficiencies, Pelvic Inflammatory disease, Pneumonia Severe ENT conditions, Tuberculosis, Other</p>	<ul style="list-style-type: none"> • Refer children without primary health care providers to a primary health care provider • Refer children without health insurance for health insurance • Provide asthma prevention and treatment education as part of family support to families whose children have asthma 	<ul style="list-style-type: none"> ▪ Number of children with a primary health care provider ▪ Number of children referred ▪ Number of children with health insurance ▪ Number of children diagnosed by their health care provider as having asthma ▪ Number and percent of families with children who have asthma that receive asthma education and prevention