

# Home Visitation Service Availability for High Risk Pregnant Women - **2010**

## Community Level Health Department

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**Purpose:** To assess capacity for providing home visiting services to high risk pregnant women and women with young children

### *Availability/Accessibility of Services*

- Can you give us a background about the services your agency provides and the populations served?
- Of all pregnant women receiving services in your agency, what percentage would you estimate as having multiple risk factors (e.g., substance use, DV, etc)?
  - Who serves the majority of high risk women in your community?
- What is the continuum of services available in this community for pregnant women and mothers with young children who have multiple risk factors?
- What are the most common needs of pregnant women and mothers with young children who come into contact with your agency?
  - Which services are hardest to obtain for pregnant women and mothers with young children?
- Do you use standardized assessment tools to identify the needs of high risk women/families? If so, what assessment tools?
  - Do you use a standardized developmental screening/assessment tool for children who come in for services?
    - If so, what is it?
    - How is it used to provide services if indicated?
  - In your community, are other health care service providers using any developmental screening tools for children? If so, do most providers refer to services based on results?
- What types of supports are available to facilitate participation in your services? (e.g. public transportation, child care, etc. )
- What other barriers to service access do you see in your community? How do you address the barriers?

### *Assessment and Referral Coordination with HV programs/Service Capacity*

- How do you coordinate services for pregnant women or mothers with young children within your own agency?
- Do you specifically coordinate services with home visitation programs? What does the coordination among the programs look like?

- Do you refer to HV services that are not affiliated with the HD for pregnant women and women with young children?
- If so, which HV programs do you most frequently refer to? Why?
- About how many women do you refer to all HV programs in a given month?
- Is there collaboration between HD staff and HV staff? At what levels?
- What are the reasons that you would refer to home visiting within your agency and outside of your agency? When would you refrain from referring?
- How might home visiting programs in your community build capacity to serve multi-risk families?
- What challenges exist for home visiting programs to serve high risk pregnant women and women with children?
- How do you address the needs of diverse populations?

*General*

- What would your community need to improve birth outcomes and reduce childhood exposure to risk factors such as substance use, domestic violence, etc?