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Promotion of Service Integration Among Home Visiting Programs and Community Coalitions Working With Low-Income, Pregnant, and Parenting Women

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This study assessed service integration promoted by home visitors and community coalitions in Baltimore's Comprehensive Family Support Strategy. The study first assessed home visitors' coordination of services for their clients. Two yearly home visitors surveys (n = 32) assessed changes in their perceptions of 11 community resources' availability, service quality, and referrals made to those resources. There were statistically significant increases in the percentage of home visitors who (a) reported availability of seven resources, (b) gave high service quality ratings for six resources, and (c) referred clients to all 11 resources. The study also assessed six community coalitions' actions to promote service integration during 1 year through observation of coalition meetings. Coalitions discussing more service integration exhibited greater increases in home visitors' perceptions of high service quality and referrals. Home visiting practitioners should consider including coalitions as part of their program models in order to better link clients to appropriate community resources.

Keywords: service integration; home visiting; community coalitions

Baltimore City has had high rates of infant mortality, preterm birth, low birth weight, and child abuse and neglect compared with other urban areas (Annie E. Casey Foundation, 2004). Baltimore's Comprehensive Family Support Strategy (BCFSS) was initiated in 1999 to address these problems by improving the health, functioning, and self-reliance of families with children birth to 6.

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An ad hoc Family Support Strategy Team selected six health and well-being indicators to affect (a) low birth weight, (b) preterm birth, (c) infant mortality, (d) child abuse and neglect, (e) child accidents and injuries, and (f) school readiness. The ad hoc Team also specified four core components for the strategy model: (a) home-based services, (b) center-based services, (c) community-based activities, and (d) service linkages. In 1999, BCFSS identified 15 city neighborhoods that scored poorly on child health and well-being indicators and invited them to apply for planning grants. Seven of 10 neighborhoods that applied for planning grants were funded in 2000 to implement services in the core areas and to develop a neighborhood coalition to guide implementation of their local family support strategy.

Community Coalitions: Background and Previous Research

Community coalitions became increasingly prominent across the United States in the early 1990s, largely as an approach to combat substance abuse. Along with the formation of an organization—the Community Anti-Drug Coalitions of America (CADCA)—to facilitate the

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development and functioning of substance abuse coalitions, considerable private and public funding (Kaftarian & Hansen, 1994; Thompson, Spickard, & Dixon, 2001) was allocated to examine coalitions' impact on decreasing substance abuse and improving conditions in the community environment. Although many coalitions today continue to focus on categorical issues such as substance abuse, others are more comprehensive, focusing on multiple issues and/or attempting to address social determinants of health and well-being such as community cohesion or income disparities (Roussos & Fawcett, 2000).

During the past decade, coalition building has gained increased prominence as a strategy for improving community health (Backer, 2003; Roussos & Fawcett, 2000; Wolff, 2001). There is considerable research on coalition development and functioning (Goodman, Wandersman, Chinman, Imm, & Morrissey, 1996; Kessler, Steckler, McLeroy, & Malek, 1998; Mayer et al., 1998) but far less research linking coalition attributes and actions to community-level health outcomes or behavior change (Broussard & Blankenship, 1996; Fawcett et al., 1997; Freudenberg & Golub, 1987; Vincent, Clearie, & Schluchter, 1987).

Coalitions can influence community health outcomes by promoting community and systems changes, such as new programs, policies, or projects (Roussos & Fawcett, 2000). Community and systems changes are proximal outcomes that contribute to long-term community health outcomes. Service integration is one type of community and systems change that coalitions can affect. In the context of health and human services, the Health Resources and Services Administration (1999) defined *service integration* as "an ongoing process of combining resources across . . . systems to support and assure high quality program of care for the child and the family" (p. 3).

Wolff (2001) proposed that the creation of coalitions to promote service integration is a response to health and human service systems' increasing fragmentation. He noted that as these systems have grown in recent decades they have become increasingly complex and difficult to navigate. Moreover, categorical funding has forced clients to use separate agencies to meet their needs (e.g., substance abuse and parenting services). These separate agencies, however, often have rigid organization structures, poor interagency communication, and limited interaction and knowledge about each other's services (Breer, McAuliffe, & Levine, 1996; Glisson & Hemmelgarn, 1998; Hoge & Howenstine, 1997). Thus, community coalitions provide a venue for members of different health and human service agencies to discuss and implement service integration programs and policies.

Roussos and Fawcett (2000) listed four common forms community coalitions take: (a) grassroots and broader advocacy efforts, (b) consortia of health care providers, (c) alliances among service agencies, and (d) partnerships among community members and organizations.

The coalitions established as part of BCFSS and discussed herein fit the last description, as each BCFSS coalition contains representation from community members and multiple organizations working to promote the health and well-being of women who are pregnant and women with young children.

Home Visiting: Background and Previous Research

As indicated earlier, BCFSS neighborhoods implement services in four core areas, one of which is home-based services (e.g., home visiting). In the past decade, federal and state agencies (National Commission to Prevent Infant Mortality, 1989; U.S. Advisory Board on Child Abuse and Neglect, 1990), private foundations (Robert Wood Johnson Foundation, 2002), and professional societies (American Academy of Pediatrics, 1998) have increasingly supported home visiting programs to promote maternal and child health and development. These programs focus on a range of outcomes, including improvement of birth outcomes (Olds et al., 1999), prevention of child abuse and neglect (Duggan et al., 1999), and promotion of school readiness (Baker, Piotrkowski, & Brooks-Gunn, 1999; Wagner & Clayton, 1999). While home visiting goals vary, programs are similar in that they aim to bring services to parents rather than expect families to seek out services.

A growing body of research has examined home visiting programs' implementation (Duggan et al., 2004; Hebbeler & Gerlach-Downie, 2002). *Implementation* refers to the frequency, timing, content, and quality of services provided by the home visiting program. One important aspect of implementation is the timely and appropriate linkage of clients with community resources. Hence, service integration plays a vital role in home visiting programs' ability to function effectively and to meet clients' needs.

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The Current Study

This article describes BCFSS' progress in achieving service integration at the provider and community levels. BCFSS' theory of change (Chen, 1990; Safe and Sound Campaign, 1999; Weiss, 1995) proposes that community-level service integration can create, modify, and/or illuminate policies, procedures, and resources that facilitate home visiting providers' efforts to integrate services for their clients. BCFSS' theory of change also proposes that service integration at the provider and community levels is a process outcome that helps home visiting clients receive needed community resources to promote their family's health and well-being.

The current study's first goal was to assess BCFSS coalitions' promotion of community-level service integration as indicated by service integration activities undertaken by each BCFSS coalition. Our second goal was to assess home visiting providers' capacity to coordinate services with health and social service agencies, as indicated by home visitors' perceptions of community resource availability and quality and experience referring families to each type of community resource. Our third goal was to examine the relationship between provider- and community-level service integration.

METHOD

BCFSS Home Visiting Models

The seven BCFSS neighborhoods use different home visiting models. At the onset of implementation, two neighborhoods had federally funded Healthy Start home visiting programs (National Healthy Start Association, 2004) and were given additional funding to increase the number of families they served. Another neighborhood chose to create a home visiting program using the Healthy Start model. Two neighborhoods implemented the Healthy Families America model (Healthy Families America, 2001), one chose a locally developed model that used nursing students as home visitors, and the last developed its own model in collaboration with a community hospital.

Each BCFSS home visiting program recruits women who are pregnant or women with a child younger than age of 6 months who live in their geographical catchment area. An outreach worker typically makes the first contact with a prospective enrollee. Some women are recruited through community events while current home visiting clients refer other women. When a prospective client is determined to be eligible for a home visiting program and has consented to join, an intake specialist conducts a strengths and needs assessment.

Home visiting is provided for 1 to 3 years, depending on the program. All models call for visits at least every 2 weeks for new families and less frequent visits as families achieve milestones in healthy family functioning. Each program's visit content is guided by individualized

family support plans that specify family goals and ways to achieve them. The home visitor and mother update these goals on a regular basis, typically every 6 months, until a client exits the home visiting program. The home visiting program provides a range of services, either directly or through referrals to community resources. Services include care coordination, parenting support, income and nutritional assistance, job training, and services to address malleable risks of mental health, domestic violence, and substance abuse.

BCFSS Coalitions

Each BCFSS coalition serves as the local governance body for its neighborhood's family support strategy. Coalitions are also responsible for promoting service integration within their neighborhood. On the release of planning grant funding to each neighborhood, BCFSS initiative leadership selected a lead agency for each coalition. Lead agencies needed to (a) be physically located within the neighborhood catchment area, (b) possess the organizational capacity to serve as the administrative and financial fiduciary for the coalition, and (c) have visibility and stature within the neighborhood. Because two of the seven BCFSS neighborhoods shared many stakeholders, one coalition was created to serve these neighborhoods, thus creating a total of six coalitions.

Lead agencies are responsible for recruiting coalition members from five groups: (a) BCFSS-funded service providers; (b) nonfunded service providers specializing in early childhood, health and/or mental health, substance abuse, and job training; (c) public agencies, such as Baltimore City Department of Social Services; (d) community-based organizations; and (e) parents. Coalitions typically meet monthly for about 2 hours. Each meeting normally includes an update on clients served by BCFSS-funded providers, discussion of progress in meeting BCFSS fiscal and programmatic requirements, and planning to address BCFSS goals. Coalitions also sponsor events and activities for their members and other stakeholders working with women in their communities who are pregnant and parenting.

Sample

Home visitors. In fall 2001 and fall 2002, home visitors were asked to complete a program survey that included a section on community resources. In 2001, 44 (88%) of 50 home visitors completed the survey; in 2002, 44 (86%) of 51 home visitors did so. Because we were interested in assessing changes over time, the sample was limited to home visitors who completed surveys both years ($n = 32$). All home visitors were African American women. At the time of the first survey administration, they had worked as home visitors for an average of 20 months; the difference in length of time as a home visitor between home visitors who completed surveys in 2001 and 2002

and home visitors who completed a survey only in 2001 was not statistically significant.

Coalitions. Coalition meetings were observed from July 2001 to June 2002 to document activities that promoted service integration. A total of 53 meetings were held during that period across the six coalitions; all were observed.

Measures

Home visitors' perceptions of community resources. The survey focused on community resources in 11 areas: substance abuse treatment, parenting education, educational resources for adults, job training, emergency, mental health, prenatal care, day care, early childhood, domestic violence, and nutrition and/or health care. These were deemed by BCFSS neighborhood leadership to be the most important referral areas for their home visiting programs. To measure home visitors' perceptions of available community resources, we asked "Is there [type of resource] available for your families—either inside or outside your community? That is, is there [type of resource] that your families are eligible for either inside or outside your community?" Home visitors were given three response choices: yes, no, or unsure.

Home visitors who said that a service was available were asked to rate the quality of services using the following choices: excellent, good, satisfactory, poor, or unsure. Home visitors who said that a service was available were also asked whether they had ever referred clients to the community resource with the question: "Have you ever referred any families to [type of resource]?" Home visitors were given three response choices: yes, no, or unsure.

Coalition observations. We created a structured observation protocol to document service integration activities discussed by each coalition. Included in this protocol was the completion of a detailed qualitative summary for each meeting observation. As part of the qualitative summary, four service integration areas were to be documented if discussed during a coalition meeting: (a) referrals with other organizations (e.g., developing referral agreement between multiple agencies), (b) sharing of resources such as materials and space (e.g., coordinating the use of a van to transport clients), (c) cosponsoring of events (e.g., collectively sponsoring an advocacy event), and (d) undertaking of joint projects (e.g., developing a community newsletter for service providers). We used the measurement approach developed by the Work Group on Health Promotion and Community Development at the University of Kansas (Francisco, Paine, & Fawcett, 1993) as a framework to document service integration. This approach directs researchers to document examples of community changes that emerge from the work of community coalitions.

Procedure

Home visitor surveys. Home visitors completed informed consent procedures approved by the Johns Hopkins University Institutional Review Board and completed the survey independently via group administration.

Coalition observations. The first and fourth authors piloted the observation protocol at three coalition meetings prior to July 2001 to establish its reliability. The fourth author then conducted participant observation at all 53 coalition meetings.

Analysis

Quantitative analyses. We used the McNemar test to determine, for each resource, whether the proportion of home visitors indicating that the resource was available showed a statistically significant increase between 2001 and 2002. For those resources that respondents indicated as being available, we used the McNemar test to indicate whether there was a significant increase in the proportion of home visitors who rated service quality as excellent or good, or in the proportion of home visitors who referred families to those resources. We used a two-tailed alpha level of .05 to define statistical significance.

We created a composite service quality score for each coalition for both years. This score indicated the percentage of community resources rated as excellent or good across home visitors. We also created a composite referral score for each coalition across home visitors, for both years, that indicated the percentage of community resources to which home visitors made referrals.

Qualitative analyses. The first author coded the qualitative summaries from the 53 observation protocols using a deductive analytic approach (Patton, 2002) that applied four predetermined codes to passages of text. Specifically, each observation protocol was coded for examples of the four service integration areas: (a) increased referrals, (b) sharing of resources, (c) cosponsoring of events, and (d) undertaking of joint projects.

► RESULTS

As seen in Table 1, in 2001 between 39% and 84% of home visitors perceived that a particular resource was available for their clients. Six resources were rated as excellent or good by 67% or less home visitors who reported the resource to be available. Only three resources had been used as a referral source by more than one half the home visitors who reported the resource to be available.

Table 1 shows that the percentage of home visitors who reported resource availability increased between 2001 and 2002 for all 11 community resources. For 7 of these, the increase was statistically significant. The percentage of home visitors who rated service quality as

TABLE 1
BCFSS Home Visitors' Knowledge of Attitudes Toward, and Referrals Made to,
Community Resources in 2001 Versus 2002, Among Those Completing Program Surveys Both Years (n = 32)

Resource	<i>Among Home Visitors Who Said Resource Was Available</i>								
	<i>% Said Resource Was Available</i>			<i>% Rated Service Quality Excellent or Good^b</i>			<i>% Ever Referred Clients^a</i>		
	2001	2002	p	2001	2002	p	2001	2002	p
Substance abuse treatment	78	94	.13	60	67	.30	20	63	.00
Parenting education	69	97	.00	86	84	.09	27	90	.00
Educational resources for adults	72	97	.01	78	78	.09	39	97	.00
Job training	72	78	.77	57	64	.33	44	82	.00
Emergency services	59	100	.00	68	84	.00	47	100	.00
Mental health services	41	75	.01	54	71	.00	23	92	.00
Prenatal care	84	100	.07	67	84	.02	56	88	.00
Day care	66	84	.11	76	78	.18	52	89	.00
Early childhood services	56	94	.00	72	81	.00	33	84	.00
Domestic violence services	39	81	.00	58	74	.01	58	78	.00
Nutrition and/or health services	47	72	.02	60	83	.00	40	88	.00

NOTE: BCFSS = Baltimore's Comprehensive Family Support Strategy.

a. Percentages in table reflect responses of home visitors who indicated resource was available. However, to conduct McNemar tests, service quality and referral responses for home visitors who indicated a resource was not available were recoded to < excellent or good and no referral made, respectively. *p* values reported here reflect analyses with recoded responses.

excellent or good increased for 9 resources. For 6, the increase was statistically significant. The percentage of home visitors who referred clients to community resources increased substantially for all resources. All of these increases were statistically significant.

We documented 25 service integration activities across the four service integration areas. As shown in Table 2, we documented activities for five of six BCFSS coalitions. The total number of activities ranged from 3 to 7 among the five coalitions that discussed such activities. Across all coalitions, we observed 10 examples of referrals with other organizations, six examples of sharing resources, three examples of cosponsoring events, and six examples of joint projects.

As shown in Table 2, we found the largest increases in home visitors' favorable perceptions of service quality among the four coalitions with four or more service integration activities. Coalition A discussed the most activities—seven—and also exhibited the greatest increase (41%) in the percentage of resources rated as having excellent or good service quality. Coalition F discussed no activities and exhibited a 4% increase in the percentage of resources rated as having excellent or good service quality. We also found the largest increases in home visitors' referrals to community resources among the four coalitions with four or more service integration activities. Moreover, as seen in Table 2, the two coalitions that discussed fewer than two activities classified as referrals were the same coalitions with the smallest increases in home visitors' referrals.

► DISCUSSION

Summary of Key Findings

Our findings indicated that service integration was improved at the provider level. There were statistically significant increases in the proportion of home visitors who perceived that community resources were available for their clients, felt that service quality was excellent or good, and referred clients to community resources. We also found that service integration was enhanced at the community level through the work of BCFSS coalitions. Across six BCFSS coalitions, 25 service integration activities were observed at coalition meetings during 1 year. Activities were found in all four service integration areas documented by coalition observations: referrals with other organizations, sharing of resources, cosponsoring of events, and undertaking of joint projects. Linking findings between these data sources, we found that coalitions with more service integration activities also showed greater increases in home visitors' perceptions of high service quality and referrals to community resources.

Relationship to Previous Research

Home visiting research. Our finding that more than one half of BCFSS home visitors referred clients to each of 11 types of community resources in 2002 is an important

TABLE 2
Number of Service Integration Activities and Home Visitor Ratings of Community Resources, by Coalition

Coalition	No. of Service Integration Activities Between 2001 and 2002					Home Visitor Ratings of 11 Community Resources			
						% of Resources Rated as Having Excellent or Good Service Quality		% of Resources to Which Referrals Ever Made	
	Referrals	Sharing Resources	Cosponsoring Events	Joint Projects	Total Changes	2001	2002	2001	2002
A	3	1	2	1	7	55	94	29	95
B	2	0	1	3	6	55	84	18	73
C	2	2	0	1	5	18	48	7	65
D	2	1	0	1	4	33	70	15	85
E	1	1	0	1	3	36	42	30	52
F	0	0	0	0	0	66	70	64	91
Across Coalitions	10	5	3	7	25	42	70	25	78

intermediate outcome that reflects a prerequisite to clients' access to, and receipt of, needed services. These findings are tempered, however, by findings from a complementary study we conducted (omitted for blind review) indicating that fewer than 30% of home visiting clients who needed mental health, substance abuse, or domestic violence services received these services. Thus, although our current research found that home visitors self-reported increased referrals of clients to needed resources, many clients did not appear to receive services in resource areas. Client characteristics such as (a) motivation to seek out services to which they were referred and (b) ability to get to services also play a role in receipt of needed services.

Community coalition research. Many studies have documented coalitions' influence on community and systems changes, such as developing new programs, services, and practices (see Roussos & Fawcett, 2000). Our findings add to the growing literature on coalition capacity to produce community and systems changes, as five BCFSS coalitions produced community changes related to service integration in 1 year. Our observations indicated that each BCFSS coalition that produced one service integration community change also produced at least two more community changes within our period of observation. We believe this finding may be attributed to BCFSS coalitions' heightened collective efficacy, perhaps burgeoned by the implementation of each service integration activity. Weick's (1984) concept of "small wins" offers a workable hypothesis for this premise. Specifically, he noted that a group's small, manageable accomplishments, or small wins, may lower its resistance to tackle subsequent tasks. Moreover, breaking a group's work into smaller, more manageable tasks allows the group to view social or health

problems as less intractable. In the case of BCFSS, we proposed that community coalitions, strengthened by each service integration activity they produced, may have started to view the improvement of birth, child safety, and school readiness outcomes as more manageable goals.

Implications for Practitioners

Our study findings yield an important implication for home visiting practitioners. We recommend that home visiting programs consider including community coalitions as part of their program models. Our findings suggest that the first part of BCFSS' theory of change was met. Specifically, community-level service integration activities promoted by BCFSS coalitions appeared to facilitate home visiting programs' efforts to integrate services for their clients.

We believe that community-level service integration activities directly influenced home visitors' perceptions of available resources, service quality, and referrals made. Home visitors may have directly benefited from service integration activities by obtaining information about available resources for their clients by attending joint events sponsored by their neighborhood coalition, such as domestic violence or substance abuse trainings. Home visitors who initially rated these services as satisfactory or poor may have changed their ratings to excellent or good based on their receipt of more detailed information about these resources or interaction with the domestic violence and/or substance abuse trainer(s), perhaps debunking myths and misconceptions about these resources.

We believe that home visitors may have also indirectly benefited from the service integration activities promoted by BCFSS coalitions. For example, home visiting program

managers who attended bimonthly networking meetings may have learned about available services for clients and conveyed that information to the home visitors they supervise. Home visitors, in turn, may have become more aware of and comfortable with the quality of available services and increased the number of referrals to these services.

Home visitation programs such as Healthy Start and Healthy Families America acknowledge the importance of service integration in promoting healthy outcomes for their clients (Healthy Families America, 2001; National Healthy Start Association, 2004). We are unaware of studies that document these programs' effectiveness in promoting service integration, however. Our findings suggest that home visiting programs may benefit from using community coalitions as their mechanism to facilitate home visiting clients' linkages with ancillary services.

Study Limitations

The current study would have been strengthened by the inclusion of comparison communities with home visiting services, but without community coalitions. These comparison communities would have allowed us to determine whether increases in home visitors' perceptions of resource availability, quality, and referrals were greater in BCFSS neighborhoods with coalitions than in neighborhoods without coalitions. A second study limitation is our potential underreporting of service integration activities. We only documented service integration activities discussed at coalition meetings. Other studies (Lewis et al., 1999; Paine-Andrews et al., 2002) have relied on key coalition leadership or all coalition members to document community changes that took place between meetings. We believe that significant service integration activities were always discussed at BCFSS coalition meetings and, thus, documented by our observation protocol; however, it is possible that some smaller service integration activities such as the sharing of organizational resources were not discussed at meetings. A related limitation is that coalition discussion of service integration activities does not provide "verifiable data" that activities actually occurred.

The single group pre- and posttest design used to document home visitors' perceptions of available services, service quality, and referrals also poses threats to internal validity. One possibility is that between survey administrations, more resources actually became available—a potential history bias. Neither we, nor BCFSS neighborhood leadership, identified new resources that became available between survey administrations, however, suggesting that increases in home visitors' perceptions of resource availability and referrals were not because of an increase in the actual number of available resources. Another possibility is that home visitors became more knowledgeable about and made more referrals to available

resources simply because they had become more seasoned home visitors over time. However, respondents had worked as home visitors 20 months, on average, at the first survey administration. Thus, they had ample time to become aware of community resources and make referrals prior to the first survey administration.

A third potential threat to internal validity is testing bias. We found no evidence of this, however. Home visitors who completed only the 2nd year survey were remarkably similar to those who had completed both surveys in their perceptions of available resources, service quality, and referrals. If the first survey had positively influenced these variables, we would have expected more favorable outcomes at the second survey for those who had taken the first survey versus those who had not.

We also conducted statistical analyses to determine whether the 32 home visitors who completed surveys in 2001 and 2002 and the 12 home visitors who completed surveys only in 2001 differed in their baseline ratings of resource availability, service quality, and referrals. Our analyses indicated no statistically significant differences between these two groups on any study variable, indicating that home visitors completing surveys in 2002 were representative of home visitors overall.

Another limitation is our inability to fully test the second part of BCFSS theory of change by measuring potential increases in the number of referrals made by home visitors. Because the management information system for BCFSS was under construction during 2001, we did not have referral records that correspond with our survey baseline. Thus, although home visitors reported making more frequent referrals in 2002 across all 11 resources, we are unable to triangulate these data with actual referral data to determine whether service integration at the community level facilitated actual increases in the number of referrals made at the provider level by home visitors.

Future Directions

We feel there are two important directions for future research emanating from the current study. First, future research should examine whether increased referrals to community resources contribute to favorable health outcomes for home visiting clients. An increasing body of research has examined the impact of other aspects of home visiting program implementation (e.g., intensity of services, duration of services, staff turnover) on client health outcomes (Duggan et al., 2004; Hebbeler & Gerlach-Downie, 2002). Some home visiting programs have case management components to facilitate referrals to needed services. Findings from evaluations of these programs indicated, however, that there were no differences in the number of services received between a home visited and control group (St. Pierre, Layzer, Goodson, & Bernstein, 1997) or that referrals did not lead to improvements in child development or

parenting knowledge, attitudes, and behaviors (Wagner & Clayton, 1999).

Second, future research needs to examine the benefits derived by home visiting programs through their involvement in community initiatives similar to BCFSS. In particular, we recommend research that examines the effects of community coalitions on home visiting programs' ability to coordinate services for their clients. Given the continued proliferation of home visiting programs nationally, we advocate using case-control designs in which communities newly implementing home visiting programs are matched on key demographic variables and subsequently divided into coalition and noncoalition sites. Coalition sites would develop coalitions aimed at promoting service integration that facilitate their clients' receipt of needed community resources. Although limited in their ability to show causality between community and home visiting program service integration, these case-control studies would provide evidence of coalitions' value in promoting home visiting programs' service integration.

Summary

Recent years have seen increasing calls for participatory, or collaborative, approaches to improving community health outcomes (Minkler & Wallerstein, 2003). A key characteristic of a participatory approach is its inclusion of multiple community stakeholders in developing community health improvement strategies. The current study illustrates that home visiting programs benefit from their collaboration with stakeholders who are part of a community coalition. We believe that home visiting programs should explore the creation and use of community coalitions to enhance the likelihood that women who are pregnant and parenting and their young children receive necessary community services. We feel that by collaborating with community coalitions, home visiting programs' ability to meet the needs of their clients will be enhanced, leading to improvements in maternal and child health outcomes.

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