HEALTHY START HEALTHY FAMILIES

YEAR 14 REPORT
JUNE 2008 – MAY 2009

- *Promoting positive parenting*
- *Enhancing child health and development*
- *Preventing child abuse and neglect*

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INTRODUCTION

Healthy Start Healthy Families (HSHF) is an intensive home visitation program serving families in seven of eight wards of the District of Columbia. Since the inception of Healthy Families DC in 1994 and the merge with Healthy Start in 2006, HSHF has provided intensive home visiting services to over 1,500 high-risk families. The comprehensive services offered by the HSHF program are designed to reduce family risk factors and enhance protective factors in order to prevent child abuse and neglect, improve maternal and child health outcomes, and promote optimal child development. Over the past fourteen years, HSHF has demonstrated its ability to maintain high quality standards and consistently achieve positive maternal and child health outcomes despite funding challenges, expansion and infrastructure change in its host organization, and a changing political landscape. The program's ability to achieve positive outcomes with its high-risk families is accomplished through strict adherence to rigorous quality standards and research-based effective practices. HSHF received its first HFA accreditation in November 1999, and was again awarded a four-year credential in May 2005. As the program begins its 15th year of operation, it will once again demonstrate its commitment to excellence and the highest quality services by undergoing the new HFA accreditation process.

Having just completed its fourteenth year of program operation in May 2009, this evaluation report serves as an update from the comprehensive *Healthy Start Healthy Families Years 11-13 Evaluation Report*, which provides more detailed historical information.

Background and History

The HSHF program focuses on two key areas: 1) child abuse and neglect and 2) infant mortality. Child maltreatment continues to be a pervasive problem in the United States as evidenced by 2006 statistics. Nationally, CPS investigated 3.6 million reports of child abuse and neglect, 905,000 of which were confirmed cases of neglect (64%), physical abuse (16%), sexual abuse (9%), and emotional abuse (7%). In a non-CPS study (Finkelhor, 2005), researchers reported that 14% of US children experienced some form of child maltreatment, including sexual abuse, neglect, physical abuse, and emotional abuse. Most vulnerable are the youngest children, particularly infants under 1 year of age. A recent study (2008) released by CDC-P found that 1 in 50 infants in the US are victims of nonfatal child neglect or abuse. Experts indicate that most maltreatment cases are a result of neglect and may in part reflect families without health insurance who cannot adequately care for their children. In the US, approximately 16% of people and 11% of children did not have health insurance during 2005. Infants and children under the age of 4 years are also more likely to die from abuse and neglect. In 2006, more than 1,500 children died, 78% of which were under the age of 4 years. Even more alarming is that the maltreatment is most often perpetrated by the child's own parents. The CDC-P reports that most (83%) child victims were abused by one or both of their parents, with mothers accounting for 40% of perpetrators.

Children who experience child abuse and neglect are at increased risk for a variety of poor health outcomes that not only affect the victims, but also cost billions of dollars to treat. In 2005**,** the Centers for Disease Control and Prevention (CDC-P) recognized child maltreatment as a serious public health problem with extensive short and long-term health consequences. The compelling results of the Adverse Childhood Experiences (ACES) study (2003) demonstrated the link between childhood stressors, such as child maltreatment and exposure to intimate partner violence, and adult risk behavior and health problems. These early stressors negatively effect the brain's architecture as it develops, resulting in a reduction in the size of the brain, a low threshold for stress and higher reactivity to stressors, a vulnerability to infections and chronic health issues, and cognitive deficits. In adulthood, early childhood toxic stress is linked to a variety of health problems, including alcoholism, chronic obstructive pulmonary disease, depression, fetal death, substance abuse, ischemic heart disease, sexually transmitted diseases, smoking, suicide, unintended pregnancy, multiple sexual partners, and risk for intimate partner violence. Additionally, the risk for negative health outcomes increases proportionately to the number of adverse childhood experiences. Programs like HSHF have proven to be highly effective in reducing child abuse and neglect (CDC, 2003) and are therefore critical in efforts to improve health and self-sufficiency outcomes for families.

Historically, the District of Columbia has ranked worst nationally on multiple indicators of child well being and has had one of the highest rates of infant mortality in the country. Although many cases of infant mortality are due to abuse or neglect, socio-economic factors are also potent contributors. Infant mortality is linked to gestational age and factors such as prenatal care, maternal age, maternal education, birth order, maternal smoking, and marital status. Risk increases with lower birthweights (<3500 grams), which are often a result of the socio-economic factors, such as healthcare access. The infant mortality rate in the US during 2006 was 6.7 % per thousand, but was twice as high for blacks (13.3 per thousand) than for whites (5.7 per thousand). In DC during 2006, the infant mortality rate of 11.3 per thousand is double the national rate and slightly higher than the US rate for blacks (Kids Count, 2009). Compounding the issue are the percentages of infants born in DC with low birthweight (14%) and mothers who receive late prenatal care was (29%).

Community-based home visitation programs, such as Healthy Start Healthy Families, play a critical role in addressing these poor child health outcomes. The unique mix of socio-economic, racial and cultural factors in DC places its families and children at much higher risk. Large portions of the city are populated by mostly low-income and economically challenged families. An increase in the number of Hispanic families, mainly in Wards 1 and 2 of the city, has led to the need for bilingual support services for immigrants new to this country. While the number of bilingual support services has grown with the increasing number of Hispanic/Latino families, the demand far outweighs available services. Many of these families are under a huge amount of stress, speak limited or no English, have financial strains, and have low levels of education. These factors contribute to the difficulties these families face in finding adequately paying jobs. In other parts of the city the majority of families are African-American and many struggle with poverty, low education levels and difficulty finding and maintaining adequate housing and employment.

Not only do these factors inhibit parents' ability to properly care for their children, these stressors can lead to an increased risk for child abuse and neglect. In response, the HSHF program provides the most comprehensive preventive services to the District's most vulnerable families, enabling the program to reach more families.

This report describes the program implementation and outcomes achieved in Year 14. Detailed historical and program information is also available in the HSHF Year 10 Longitudinal and Years 11-13 Annual Report.

Mary's Center for Maternal and Child Care, Inc.

Mary's Center for Maternal and Child Care, Inc. was founded in 1988 by Maria Gomez (CEO and President) and a group of health care workers to provide comprehensive, culturally appropriate health, social, and educational services to District residents, particularly the growing immigrant population. Located in Adam's Morgan in Northwest DC, Mary's Center was designated as a Federally Qualified Health Center (FQHC) in 2004, allowing it to expand its services to an additional site on Kennedy St. in Northeast DC. Both sites provide holistic and culturally sensitive bilingual primary health care to men, women and children who reside in DC, including prenatal care, a WIC clinic, home visitation services, support and educational groups, midwifery, family planning, pediatric care, dentistry, a teen clinic and extensive social services. As the host agency, Mary's Center provides HSHF with support through its strong infrastructure, in-kind services and information sharing available with its other programs, and its expertise in advocacy and resource development.

Partners

HSHF's partnerships with child development, behavioral/mental health, education and physical/medical health organizations have continued to enrich the services it is able to provide to its clients. The Mary's Center for Maternal and Child Care, Inc. has established a formal partnership with Children's National Medical Center, which provides health and supplemental services at multiple sites throughout the District. This approach has enabled HSHF to replicate the program at multiple sites, provide services throughout the city, ensure culturally competent programming, and offer community specific wrap-around services available at the different sites.

Children's National Medical Center (or Children's Health Center) is an integrated health care system throughout Washington, DC and includes services from the main hospital and outpatient clinics providing Women Infants and Children (WIC) Supplemental Food Program, the Child Development Clinic, Adolescent Employment Readiness Center, the Child and Adolescent Protection Center, the Eating and Feeding Disorders Clinic, HIV services and mental health services. The Healthy Start/Healthy Families CHC site is located in the Anacostia section of DC.

Funders

During Year 14, the HSHF program maintained its diversified funding streams, including private foundations such as Freddie Mac. Since its inception, the HSHF program has received funding from a variety of private, public, and government agencies. In

contrast, the HS program has been funded solely from federal government dollars. With the merging of the two programs for Years 12 and 13, there has been an even wider range of funding sources and a more efficient use of existing resources and personnel. Additionally, the HSHF program continues to benefit from the health and social services offered by Mary's Center for Maternal and Child Care, its host agency, as well as its partners throughout the city. (***see Appendix A*: *Healthy Start Healthy Families Funding Sources: June 2008-May 2009***).

Advisory Board

The structure and composition of the Advisory Board changed in Years 12 and 13 with the HSHF merger. In previous years the Board was comprised of a diverse mix of professionals from the community and served in an advisory capacity for the program, guiding the program in essential planning and policy implementation. After the merger, the HSHF program decided to use the existing Mary's Center Board of Directors and the DC Home Visiting Council. The VP of Programs maintains ongoing representation on the Board; of which 50% are community partners ***(see Appendix B: List of Advisory Board Members 2008-2009).***

National Accreditation

The HSHF program was built on research-based best practices and has drawn upon these practices as it has grown over the years. All Healthy Families programs must participate in the accreditation process in order to be considered an official Healthy Families site. During this intensive process, sites prepare a lengthy written self-assessment that is submitted to a team of peer reviewers for evaluation prior to a two to three-day site visit. It is through the self-assessment and site visit that the trained reviewers are able to assess the program's adherence to the 12 research-based critical elements, a set of guidelines for best practices in a home visitation program. Accreditation ensures that programs implement evidence-based effective practices and adhere to quality standards on a regular basis over time.

The HSHF program was first accredited in November 1999, when it became the first nationally credentialed Healthy Family America site in the District of Columbia. In May of 2005, HSHF received a four-year re-credential from Healthy Families America. As the program enters its fifteenth year of operation, it will complete the new HFA Accreditation process.

Program Description

The HSHF program represents a merger of two distinct home visiting programs: Healthy Families DC and the Mary's Center Healthy Start programs. They sought to improve outcomes for children and both provided their services using a home visiting strategy. Both separate program models will be described first, followed by a description of the merged model.

Healthy Families America (HFA)- is a nationally recognized voluntary program for the prevention of child maltreatment. It was first implemented by Prevent Child Abuse America (PCA America) in 1992, building on two decades of research in the field of home visitation.

The program connects expectant parents and parents of newborns with health and child development assistance in their homes. Highly trained home visitors, who on average have four years of home visiting experience and three years tenure with their HFA program, provide the services. Nationally, 76% of HFA home visitors have some college experience or college degrees.

The quality of HF services is assured through adherence to best practice guidelines defined through twelve Critical Elements based on 20 years of research. An HFA site accreditation is required every three to four years. The accreditation process involves an in-depth examination of each site's operation, as well as the quality of the home visits. (***See Appendix C- HSHF Critical Elements***). This means that the program has high quality practices across program services, from the amount of participant contact and supervision to the content of home visits and supervision. Other key elements of the model include the intensive, comprehensive, long-term (3-5 years), flexible and culturally competent services. In this way, the program is able to best serve the community and ensure that it is delivering quality program services to promote healthy growth and development in the parents and children it serves.

In HSHF, screening and assessment are the processes through which families are either identified as eligible for HSHF home visitation services or may be referred to other community agencies based on family need and willingness. Most families are referred to the Assessment Coordinator through local clinics and through outreach efforts. Families who may possibly be in the "high risk" category are identified based on their score on this initial screen, and assessment workers make efforts to contact these families. Highly trained Family Assessment Workers conduct individual family interviews, or assessments, with all potential HSHF families to begin to develop an understanding of what stressors and strengths the family currently faces. Through the use of the standardized Parent Survey (formerly the Kempe Family Stress Checklist-FSC), the assessment team is able to identify those families most in need of supportive services and offer them the home visitation portion of the program. Because the program is voluntary, families may decline services if for any reason they do not wish to participate in the program. Further, at any time during their program participation a family may terminate services.

Through the HFA Leveling System (*see* ***Appendix D- HSHF Service Levels***), HSHF ensures that families are seen regularly and frequently, especially early on in their program tenure. During pregnancy, families are seen at least bi-weekly, if not weekly, depending on the family's situation and the trimester in which the family enrolled. All families are seen weekly starting one month before the baby's estimated date of birth. From this point on, the family is seen weekly until a minimum of six months after the birth of the baby. The program has the flexibility to provide the intensity of services based on the needs of the family. Some may continue with weekly home visits for a year or more. However, once families are meeting certain guidelines regarding self-sufficiency, child development knowledge, and understanding of external support, they will progress through the level system to bi-weekly, monthly, and then quarterly home visits. Home visits terminate only after a family has been in the program for three to five years, graduates, ages out, or voluntarily discontinues program services. In Year 12, the HSHF program

added a Level XC to clarify a family's status on creative outreach. As a family is not yet enrolled until the consent form is signed, families referred to an HSHF agency for home visits without a signed consent form carry an Intake status. Once a family is referred from Intake & Assessment and has not been formally enrolled by the FAWs (i.e. no consent form, but the family has agreed to services), the family is assigned to a site and FSW and placed on Level X for immediate creative outreach methods as an Intake status. It should be noted that these families are included in FSW's caseload total and weight. Once contact is made and the consent form is signed, the family is moved to the appropriate level as an Enrolled family with weight and expected home visits calculated appropriately to meet the new level in the next month's data.

Home visits are at the core of the HSHF program, and can be a balancing act of focusing on the parent, child, and parent-child interaction. The principal aim of the home visits is to ensure that children are healthy and ready for school by conducting developmental activities with children and modeling positive parent-child interaction. In addition, FSWs also focus on the parents' needs, goals, stressors, and strengths to empower them to provide the best possible care for their children. In using such empowering, strength-based techniques, parents come to see their FSW as an individual who advocates for their best interests.

Parents as Teachers (PAT), a nationally recognized child development curriculum, which outlines common behaviors children display at varying ages, is used regularly with parents. This is supplemented with the Great Kids curriculum. Additionally, the Ages and Stages Questionnaire (ASQ), a screen administered with all target children of appropriate developmental stages, allows parents the opportunity to increase and solidify their knowledge of developmental milestones and to ensure that they have realistic expectations of child behavior patterns.

Individual Family Support Plans (IFSPs) are completed with each family on an ongoing basis throughout their tenure in the HSHF program. Initially completed within 30 to 45 days of enrollment, IFSPs help the family to focus on short-term goals. FSWs encourage families to choose goals that are realistically obtainable within a three to six month timeframe. Every three to six months, goal plans are reviewed, achievement of goals is assessed, and new goals are formulated.

Additional key features of the HSHF program are the attributes of the program staff and the quality and quantity of supervision and trainings offered. HSHF staff members are chosen based on a variety of factors including personal and professional experience, education, and personality traits that make them qualified to work with an overburdened population.

The program also emphasizes the importance of ongoing supervision and staff training. Supervisors provide a minimum of one-and-a-half to two hours per week of one-on-one supervision to all direct service staff. Supervision, like home visits, is strength-based. Because this type of work with families who often have multiple stressors can be difficult and challenging for staff, HSHF believes that in order to prevent burnout and to

ensure that staff members feel supported, frequent strength-based supervision is a necessity. Further, during both supervision and in-group training sessions, the staff is offered high-quality trainings in areas related to their work. Topics such as domestic violence, cultural competency and/or burnout prevention are fully explored to ensure that staff members feel fully equipped in their roles. Further, supervisors may arrange for individual or group trainings based on specific needs or desires identified during supervision sessions.

Another way in which the HSHF program supports its staff members is through assigning each a limited caseload. Each full-time FSW has a maximum caseload capacity of 25 families. A weighted system is used to determine the amount of time the FSW spends with a family based on their level, and a maximum case weight of 30 is allowed. In this way, FSWs are able to devote time and attention to each family without feeling overwhelmed or rushed.

Healthy Start (HS) is a federally funded program designed to improve maternal and child health by increasing access to and use of health services for women and their families while strengthening local health systems and increasing consumer input into these systems of local care. The underlying assumption is that community-driven strategies are needed to address factors contributing to infant mortality, low birth weight, and other adverse perinatal outcomes in high-risk populations particularly in African-American and other disparate minority groups**.** HS provides services tailored to the needs of high risk pregnant women, infants and mothers in geographically, racially, ethnically, and linguistically diverse communities with exceptionally high rates of infant mortality. This is accomplished through the implementation of innovative community-driven interventions that build upon community resources (outreach, health education, case management, utilization of prenatal/postnatal care) to improve the quality of and access to health care for women and infants at both service and system levels.

At the service level, HS ensures that mothers and infants have ongoing sources of primary and preventive health care and that their basic needs (housing, psychosocial, nutritional and educational support and job skill building) are met. Following risk assessments and screening for perinatal depression and other risk factors, case managers provide linkages with appropriate services and health education for risk reduction and prevention. Mothers and infants are linked to a medical home and followed from entry into prenatal care through 2 years after delivery (interconceptional).

At the system level, HS develops a consortium composed of neighborhood residents, perinatal care clients or consumers, medical and social service providers, as well as faith and business community representatives. Together these key stakeholders address the system barriers in their community, such as fragmentation in service delivery, lack of culturally appropriate health and social services, and barriers to accessing care.

Healthy Start/Healthy Families (HSHF)

The merging of the Healthy Start and Healthy Families home visiting programs at the Mary's Center was designed to capitalize on the strengths of each program model, while

maintaining each model's integrity. Goals of the merger focused on ensuring implementation of best practice standards across all home visits; strengthening outreach and the identification of pregnant women; implementation of a more comprehensive evaluation of what works best in outreach and home visiting; utilization of an interdisciplinary team; and a more sustainable financial infrastructure.

The merged program has one Home Visiting Director to oversee the implementation of the strong outreach and medical components of the Healthy Start model, while incorporating the strong parenting support and child development components of the Healthy Families model. The merge also allows the program to continue to see traditional Healthy Start families beyond the child's second birthday, if necessary, to promote long-term change and improve outcomes.

The screening and assessment process remains the same for the HSHF program. Women are referred to the program by outreach workers and a variety of community clinics including: the Washington Hospital Center; the Washington Free Clinic; Upper Cardozo Health Center; Community of Hope Health Services; WIC at Children's Health Centers-Good Hope Road; Healthy Babies Project; DC Birthing Center; Anacostia Health Center; and Walker-Jones Health Center. All positive screens are referred to the Assessment Team, who completes a comprehensive medical, psycho-social assessment. If the assessment is positive for the HSHF program, then a Family Support Worker (FSW) is assigned to the family and home visiting services are offered as space allows. Families not offered services or who decline services are linked with other community resources.

Several key components of the HF model have been incorporated into the HSHF program, including the HFA Leveling system to ensure that all families receive the intensity of service needed *(see description above)*; the Parent as Teachers (PAT) curriculum for all postnatal participants; and the Individual Family Support Plan (IFSP). The Partners for a Healthy Pregnancy curriculum is used with all prenatal participants.

<u>HSHF Program Enhancements:</u>

Mental Health Component-this enhancement was initially added through a Starting Early Starting Smart (SESS) grant through the Substance Abuse and Mental Health Services Administration (SAMHSA). The component was designed to address barriers that families experience in accessing mental health services. Previous to this grant, not only were the families less likely to seek therapy from an outside source—often due to cultural ideas about seeking mental health support—but there was also a shortage of affordable bilingual mental health services available in the community. This meant that only the most critical mental health issues were given priority, and many people became discouraged with being placed on a waiting list, being seen infrequently, or being seen in a group setting for therapy.

Initially, two part-time Mental Health Providers (MHPs) were employed to provide short-term, home-based therapy to families. One MHP was English-speaking with an extensive background in substance abuse issues, and the other was bilingual. Many

referrals were made to the MHPs and the home-based nature of the services allowed families who may not otherwise have sought out help to participate in therapy. Depression screens completed with families during this time period showed significant reductions in depression in just six months. This result supports the need for easily accessible mental health services such as those provided by these home-based clinicians. In May 2005, one full-time bilingual Mental Health Worker was hired by Mary's Center, and mental health home visitation services continued. Families, especially those who spoke Spanish or lived in a location lacking adequate community-based programs, were more easily linked with counseling services. In the past several reporting periods, the HSHF program has had one Mental Health therapist to provide home-based services and for consultation with staff. As a result of the feedback from this component, a Domestic Violence (DV) Screen has been added to the assessment and a DV group was started in which mothers and children meet in separate groups with mental health staff. Despite the outreach and education around mental health that has been conducted with this component, stigma still exists that inhibits families from seeking or accepting services. As a result, the FSWs continue to provide a critical role in developing readiness and support.

Early Intervention Specialist-Also funded initially through the SESS grant, a full-time Early Intervention Specialist was based within the Mary's Center EIT program for any children who had a positive screen for a developmental delay. FSWs used the ASQ (Ages and Stages Questionnaires) as the main tool to screen for a possible delay, and when a child scored low in a certain area, the Child Development Specialists at Mary's Center were consulted. This coordination of program services meant families were able to link their children with needed intervention services more quickly and efficiently.

Public Health Nurse-As an extension of the maternal health services offered by the Mary's Center, this position was created to address the more intense medical issues that program mothers face. Staffed by a Registered Nurse (RN), prenatal and post-partum home visits are completed, linkages and referrals made when appropriate, and education/information is provided. The PHN is often the first contact with the family and continues to see the family, and provide consultation with staff.

METHODS

Donna D. Klagholz, Ph.D. & Associates, LLC has served as the external evaluator of the HSHF program since its third year of operation. Since then, DDK & Associates has conducted an annual external evaluation of the program, creating a detailed historical record of the HSHF program's evolution and outcomes over the years. The continuity of external evaluator and consistency of methodology and measures for the past twelve years has enhanced quality and increased the credibility of longitudinal outcomes.

The comprehensive evaluation for the HSHF program is a quasi-experimental pre/post-test research design that utilizes both qualitative and quantitative data and methods. Following a Utilization-Focused approach, it includes a formative evaluation of the program's implementation and an outcome evaluation of the program's impact on participants. Over the past fourteen years, HSHF has also developed internal monitoring mechanisms that enable management to evaluate program operations and fidelity, staff training, quality assurance of data integrity, service utilization and participant feedback. The Program Director and Supervisors ensure consistency and quality of data collection and entry. Site Supervisors/Coordinators also review all standardized measures before sending them to the evaluator for scoring and data entry.

During Year 14, Mary's Center began implementation of an electronic medical record (eCW), necessitating that HSHF staff discontinue use of the KIDS2 database that had been used for the past several years, and become trained on eCW electronic forms and data entry, as well as SQL code for reporting on many management and outcomes variables. Over the past ten years, the HSHF has changed databases three times, presenting challenges to both staff and evaluators in reporting and missing data. To ensure data and reporting and accuracy, the HSHF program staff and the evaluators have worked together to extract data from multiple data sources, both paper and electronic, and cross-check it with reports generated by the current database. Further, the eCW client record and reporting system is still under refinement, as it is being tailored to accommodate social service and mental health variables and to link family members to each other, particularly mothers and children.

Theory of Change

The logic model provides a useful framework for conceptualizing the program model and evaluation. It clearly links the key program components and activities to targeted change in the participants and to intermediate and long-term outcomes. ***Appendix E: HSHF Logic Model*** provides a graphic illustration of the theory of change for the HSHF program. Although modified over the past twelve years, the plan was developed at program inception and has been implemented consistently since that time.

Target Population

The HSHF program targets mothers who are either prenatal or within 90 days postnatal, and who reside in the District of Columbia and who are at risk for poor maternal and child outcomes. Families are identified to be at risk for child abuse and neglect based on a standardized screening and assessment process. Families are also assessed for medical risk during the screening and assessment. All HSHF families screened and assessed in Year 14 were identified through the Mary's Center and partner sites throughout the District, as well as through the program's outreach efforts.

Women with a positive screen indicating multiple stressors (i.e., single parent, self-report of depression, or history of abuse) are contacted by the HSHF Assessment Coordinator or Family Assessment Worker (FAW) to schedule a home visit and complete an in-depth assessment. The Parent Survey, formerly the C.H. Kempe Family Stress Checklist (FSC), is designed to assess ten risk domains, including substance abuse, self-

esteem and depression, as well as perceived expectations about childrearing and bonding and attachment. The Family Assessment Worker administers the Parent Survey to eligible individuals. Families who score at or above 25 are considered overburdened and at risk for poor outcomes.

Active Sample

Families are considered to be active during a fiscal year if they have had at least one home visit or completed any of the standardized measures. The HSHF program capacity remained at 300 for Year 14. **Table 1** below the program capacity and the number of active families served. All data analysis for enrollment, retention, and demographics are calculated using the active sample of participants.

Table 1. Program Capacity and Families Served Year 14

Program Year	Program Capacity	# of Families Served	Active Sample
Year 14 *(June 2008-May 2009)*	300	354	278

Procedure

The evaluators have worked with HSHF to develop and implement mechanisms for participant protection, including consent and confidentiality procedures (***see Appendix F: Parental Consent for Participation)***. These procedures have been implemented consistently across all program years. The consent forms are written at an appropriate reading level for the client base and also written in Spanish. Clients were also given consent forms to be used in evaluative studies. This too was written at an appropriate reading level and provided in Spanish ***(see Appendix G: Parental Consent to Participate in Program Evaluation).***

Process/Formative Evaluation

The process evaluation documents the evolution and implementation of the program in order to provide feedback to administrators, to interpret mediating influences on outcomes, and for program replication. All program data and satisfaction surveys are collected by HSHF staff and provided to evaluators in sealed envelopes.

Baseline data is collected within two months of enrollment or infant date of birth with follow-up data collected at 12 months and annually thereafter for most measures. Information is gathered on dosage, duration in the program, and how the program activities were carried out. Additionally, information on the administration, staffing, and organizational linkages is documented. To accomplish this, several techniques for data gathering are utilized (**Table 2),** some of which are drawn from the ethnographic research paradigm. *1) Descriptive/Participant Observation*-observe all program components as they are implemented and the major context areas and activities that impact the project; 2) *Document Analysis*-All relevant documents will be collected and reviewed, such as program curricula, and training schedules. This information will supplement the service utilization data available in the program's database; 3) *Informal Interviews*-During all site visits, phone calls, and meetings, information on program successes, challenges, and

changes will be informally collected from staff; 4) *Staff and Participant surveys*: Program staff and HSHF participants will complete project developed questionnaires that solicit their perceptions of the program's effectiveness; benefits and barriers to participation; recommendations for program refinements; and satisfaction.

Table 2. Process Evaluation Tasks

Process Evaluation Tasks	Data Source/Documentation	Schedule
• HS/HF Home Visit Observation	Home Visit with parent/ Observation summary	Bi-annually (Sept/March)
• Observation of HSHF Group Activities	Board Meetings/Parent Groups Observation summary	Bi-annually (Oct/ March)
• HS/HF Staff and Participant Satisfaction Surveys	Participating families/Program staff Summary reports of staff and participant findings	Annually (July)
• Meetings/Interviews with Project Directors/ Mental Health Specialist	Summary of key services and issues related to program implementation	Bi-annually (Sept/July)
• Collection of Program Documents	Collect/ summarize program documents/ reports/ training records/staff tenure	Ongoing
• Collection of Dosage Data and Demographics	HSHF database, participant files for missing data/service utilization data	Bi-annually (Dec/June)

Outcome Evaluation

The outcome evaluation examines the impact and the effectiveness of the program activities on participants and progress towards meeting stated goals and objectives. Further, this component of the evaluation is used to identify the mediating influences of ethnicity, age, educational level, literacy, and acculturation on outcomes, and measure covariance among outcome indicators, such as parenting knowledge on reducing repeat births. Repeated measures research design and program service statistics will be used to determine program efficacy. Several standardized measures as well as the Individual Family Support Plans (IFSP) will be subjected to this analysis (*see Appendix E-Description of Measures)*.

The Instrument Administration Matrix **(Table 3)** outlines the data collection measures, domain, administration, and data points. The schedule is determined by the date of enrollment for most measures, but by the age of the baby for the ASQ. Therefore, there are not fixed data points, but ongoing data collection as determined by those dates. The program will examine options for measuring parent-child interaction, including the Healthy Families Parenting Inventory (HFPI). Also, the program will explore the use of the ASQ-SE, which will enhance its ability to detect early social-emotional issues in the target children.

Table 3. HSHF Instrument Administration Matrix

Measure	Domain	# Items/ Admin Time	Source	Data Points
Ages & Stages Questionnaire (ASQ)	Child Development	30 items/ 30 min	Parent & child	Baseline (baby 4 months old)/ Every four months
Carolina Parent Support Scale (CPSS)	Maternal Social Support/ Social Isolation	23 items/ 10 min	Parent	Baseline (enrollment)/ Annually
Knowledge of Infant Development Inventory (KIDI)	Parenting/Knowledge of Child Development	36 items/ 20 min	Parent	Baseline (enrollment)/ Annually
Individual Family Support Plan (IFSP)	Specific family goals/objectives	N/A	Parent	Baseline (enrollment)/ Every four months
Public Health Questionnaire (PHQ-9)**	Depressive Symptomology	9 items/ 5 min	Parent	Baseline (enrollment)/ Annually

Use of PHQ-9 began in Jan 2008

Program Goals and Objectives

Derived from the Healthy Families America and Healthy Start program models, the HSHF goals and objectives focus on parenting, maternal and child health, child development and school readiness, family self-sufficiency, and the reduction of child maltreatment.

Goal 1. Systematically Screen and Assess the Program's Target Population

1. 100% of HSHF staff will be trained in the screening process.
2. 80% of all positive screens received by HSHF will be assessed for service needs, excluding families who cannot be located for assessment and those who decline services.
3. All positive assessments will be enrolled as program capacity limitations allow. All other positive assessments will be referred to other services.

Goal 2. Promote Optimal Birth and Child Health Outcomes

1. 90% of families entering the program will enroll prenatally.
2. 90% of families who enrolled in the 1st or 2nd trimester will deliver babies with healthy birth weights.
3. 90% of children will be up to date on their immunizations.
4. 90% of children will be enrolled in a health insurance program.
5. 80% of women will attend their postpartum care appointment

Goal 3. Promote Optimal Child Development and School Readiness

1. 90% of children will be screened for potential developmental delays at regular intervals (Every 6 months in the first year and annually thereafter).
2. 100% of children who screen positive for potential developmental delays will be referred for developmental assessment and early intervention services (parental consent permitting).
3. 90% of families who reach Level 2 will be knowledgeable about public and private school programs in the District and how to become involved in their child's school readiness.

Goal 4. Foster Positive Parenting and Parent-Child Interaction

1. 85% of parents will score at or above normal range for knowledge of child development after 1 year of enrollment and annually thereafter.
2. 85% of parents will demonstrate positive parent-child interaction after 1 year of enrollment and annually thereafter.

Goal 5. Promote and Support Family Self-Sufficiency

1. 75% of families will show progress toward attaining their IFSP goals.
2. 80% of families will have improved self-sufficiency within 12 months of enrollment as measured by improved housing, education, or employment status.
3. 80% of mothers will not have an additional birth within two years of the target child's birth.
4. 95% of mothers will be screened at least once for depression.

Goal 6. Prevent Child Abuse and Neglect

1. 95% of enrolled families will not have substantiated reports of child abuse and neglect with the Child and Family Services Administration.

RESULTS

A. PROCESS EVALUATION

Screening, Assessment and Enrollment

The HSHF program strives to systematically screen and assess the target population at each of the referral sites. Although the responsibility for the screening lies within the referral agencies, HSHF supports this effort through several means, including: 1) regular training and consultation with all referral providers; 2) coordination of screening efforts across referral sites; and 3) on-site hours at the referral sites. The HSHF Assessment Coordinator leads these efforts and ensures that families referred with a positive screen are assessed in a timely fashion, unless families decline services or cannot be reached. Due to staffing limitations, the number of positive screens usually exceeds the program's capacity to perform assessments. However, in Year 12 HSHF increased the number assessment workers, enabling them to significantly increase the percentage positive screens that are assessed. Additionally, there are a number of families (25%; n=267/1049) who are not assessed because they have either declined the assessment, are no longer pregnant, are unable to be contacted, or have moved out of the service area.

Parents with positive screens are assessed by specially trained HSHF Family Assessment Workers (FAW) using the Parent Survey (formerly the Kempe Family Stress Checklist-FSC). The assessment measures risk in ten domains, including self-esteem, depression, and substance abuse, as well as perceived expectations regarding childrearing, bonding and attachment. Therefore, there is no single eligibility requirement, but rather information is collected on a range of possible risk factors. Families must score 25 or higher to be eligible for the program. Since the program is voluntary, if eligible families decline home visitation services or if there is no available space in HSHF for new families, the FAW uses her in-depth knowledge of community resources to connect families to other services available either at Mary's Center or in the community.

Table 4 displays the screening, assessment, and enrollment for the HSHF program since its inception in 1996. As seen in the table, the HSHF program has consistently increased it ability to screen and assess families throughout the District of Columbia. From Year 10 to Year 14, HSHF doubled the number of families screened and tripled the number of families assessed. However, not all eligible families are enrolled in the HSHF program. In Year 14, the program was unable to enroll 23% (n=107) of eligible families due to capacity limitations. An additional 13% (n=59) were not enrolled because they have either declined the enrollment, are no longer pregnant, are unable to be contacted, have moved out of the service area, or due to language capacity.

Table 4. Screening, Assessment and Enrollment: Years 1-14

YEAR*	# Families Screened	Total Positive Screens	Total Assessments Completed	Total Positive Assessments	Total New Enrollments ***
YR 1&2	203	194	167	121	93
YR 3	93	90	88	50	39
YR 4	Not available	Not available	Not available	31	28
YR 5&6	543	458	310	229	176
YR 7	500	476	276	149	154
YR 8	434	402	182	133	103
YR 9	479	438	143	96	111
YR 10	534	496	180	128	116
YR 11	246	234	121	72	148
YR 12	607	550	343	214	216
YR 13	945	810	528	324	168
YR 14	1088	1049	678	460	179
TOTAL	5,672	5,197	3,016	2,007	1,533

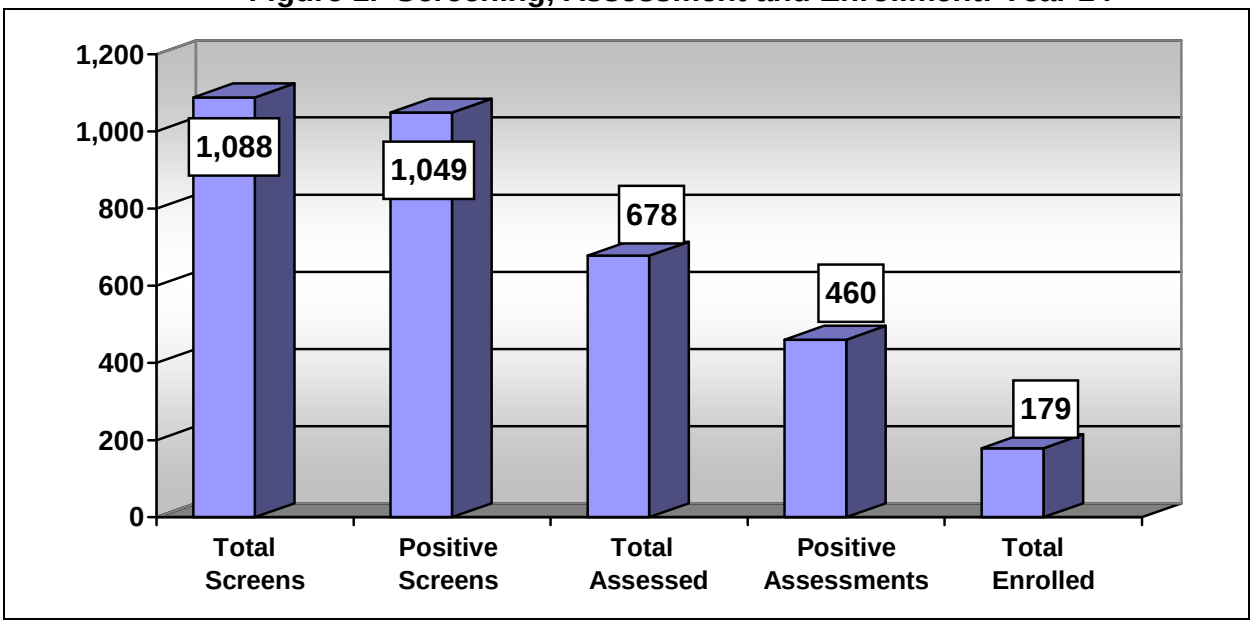
**Represents two years of activity*

*** Not all positive assessments are entered into program database; some negative assessments enrolled; can include Healthy Start participants that enrolled earlier than the merge in Year 12*

Figure 1 below shows the total screening and assessment data for Program Year 14. Almost all screens that were completed resulted in a positive outcome, 96% (n=1049/1088). Of these, two-thirds (65%) were assessed. This percentage is significantly higher than in the due to the increased number of Family Assessment Workers position in the program. Additionally, the HSHF program and Mary's Center have intensified their focus on the assessment process in order to better target services and meet community need.

Of the 678 families that were assessed, more than two-thirds (68%) scored positive for risk and were eligible for the program. However, only about one-third of those families (39%) were able to be enrolled into the program due to capacity limitations. Despite the fact that the program increased its capacity to 300 families in Year 12 with the merge of the HS and HF programs, it is still unable to meet the outstanding need for its services in the District. This becomes more striking when the number of families enrolled (n=179) is compared to the total number of positive screens (n=1,049). Only a small fraction (2%) of families determined to be at-risk were able to receive the intensive home-based services offered by HSHF. This shows a large gap in services for the at-risk population in District of Columbia. However, HSHF makes every attempt to refer families to other services as indicated on their screening and assessment results and as services are available in the District.

Figure 1. Screening, Assessment and Enrollment: Year 14

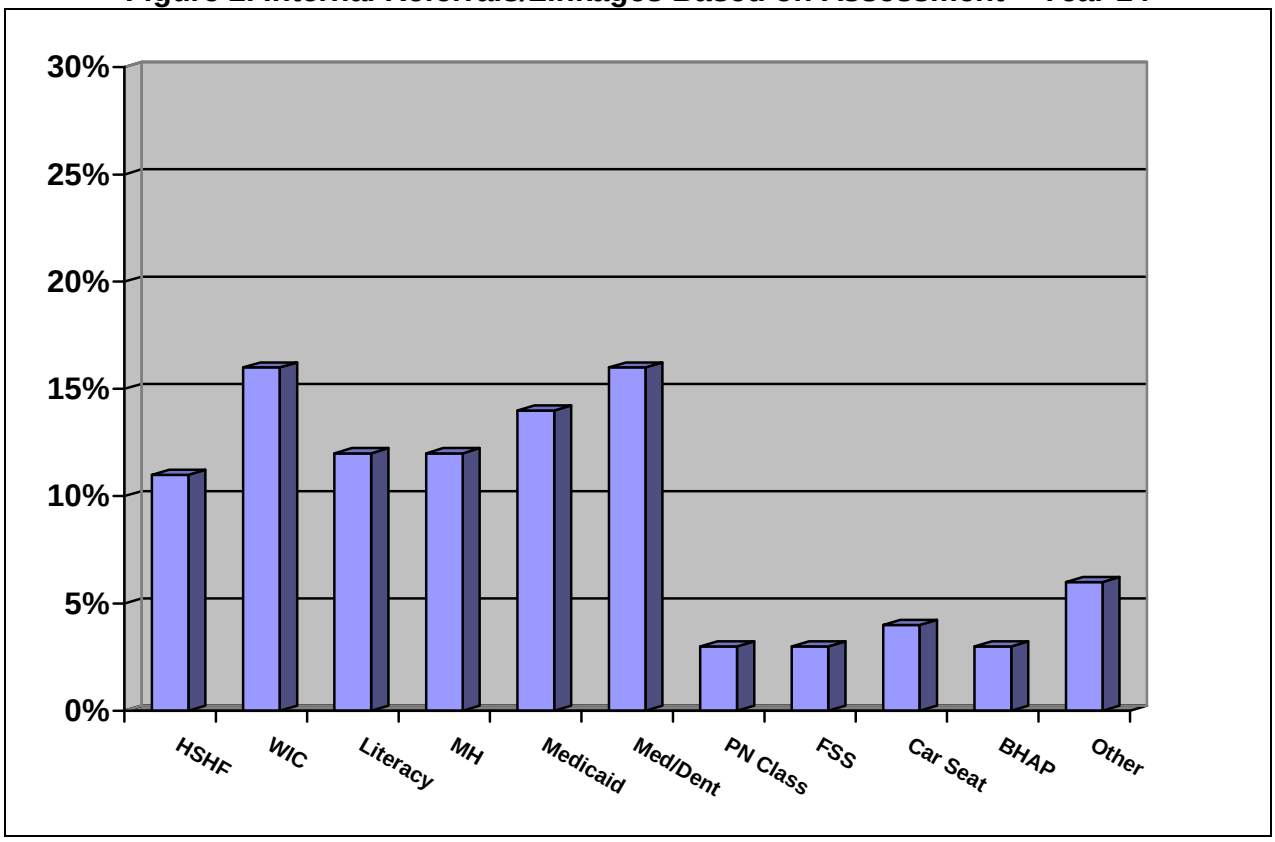


Assessment as a Service

The HSHF program considers the assessment process a valuable service that identifies prevalence of risk factors and unmet needs in the target population. As a result, they are often able to provide linkages to appropriate services, even if the family is not eligible for HSHF. Additionally, the assessment team tracks the types of referrals that are made for families, whether the referral was successful, and barriers to follow-up on referrals. Efforts are made to expedite the assessment, referral and linkages so that families stay connected. The HSHF assessment team follows-up on referrals for assessment within two weeks.

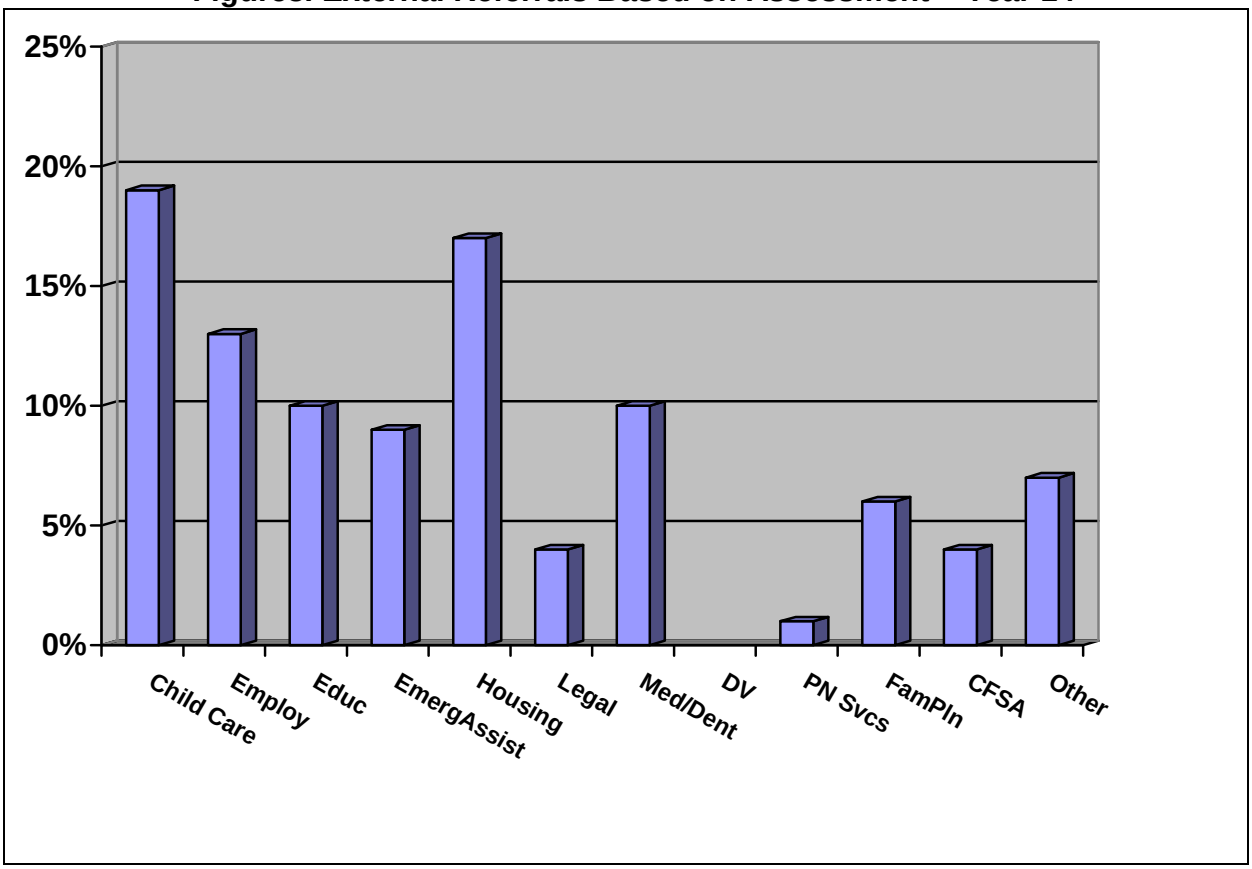
Internal referrals are those referrals and linkages that are made to Mary's Center programs. As seen **Figure 2**, Internal referrals in Year 14 were primarily to WIC (16%), Medical and Dental services (17%), Emergency Medicaid (14%), Family Literacy –Even Start (12%), and to the HSHF program.

Figure 2. Internal Referrals/Linkages Based on Assessment – Year 14



External referrals and linkages are made to outside agencies for services that Mary's Center does not offer or has limited capacity to do so. As seen in **Figure3**, services that increase families' self-sufficiency were the ones that received the most referrals, including: Child Care; Employment Job Training and Placement; Temporary and Permanent Housing; Emergency Assistance for food, clothing and cribs; and Education for both adults and children. In Year 14, referrals focused on child care, housing, and medical/dental services.

Figure3. External Referrals Based on Assessment – Year 14



Attrition/Retention

Attrition and Retention are measured annually on two samples: 1) Using a sample of all families ever enrolled in the Healthy Families DC program (this sample is used for credentialing also) and 2) Using a sample of families enrolled in the program during the current reporting period (any families who enrolled in the program during Years 1, 2, 3, or 4, etc and remained active in the program during the current reporting period, as well as those who were newly enrolled in the reporting period). There are no other exclusionary criteria applied. All families enrolled are included in the analysis. The number of families whose cases have been closed is then divided by the total number of families ever enrolled. It is important to note, however, that factors determining enrollment vary by HFA site and over program years at HSHF and therefore these factors limit comparison values of attrition and retention rates. In Years 1-9, HSHF considered enrollment as the point in which the family accepts services (often at the point of completed positive assessment), other programs consider enrollment beginning at the point of the first home visit. Beginning in Year 12, HSHF considered enrollment as the point when the family signs the consent form. Refusal rates are different and are calculated on the number of families that are eligible for the program based on the assessment, but who refuse services for any reason. Refusal rates are an indication of a program's ability to engage families, while attrition rates represent the program's ability to keep families that they engaged.

As seen in **Table 5** below, HSHF did an excellent job of retaining families over the fourteen years of program implementation. However there has been some variance over the life of the program, which can be attributed to either the expansion or contraction of the program capacity due to funding. As the program expanded in Year 5 and 6, and more families served, attrition rates increased. In Years 7 and 8, the program improved its ability to retain a larger number of enrolled families. In recent years, the capacity has remained steady at 300. As a result, the attrition and retention have remained fairly steady and equivalent.

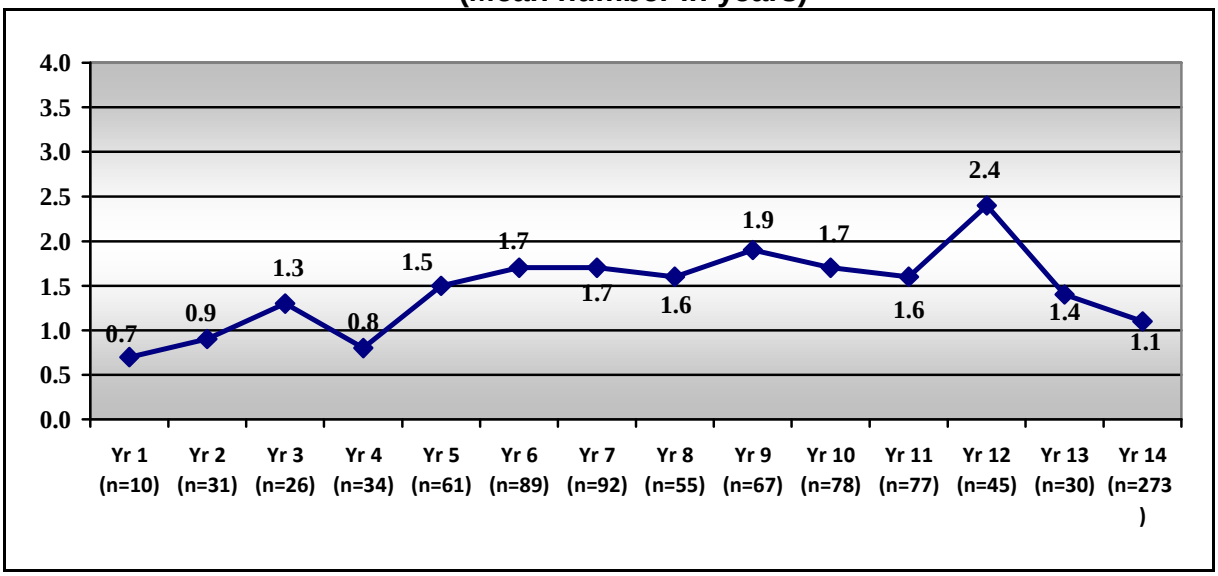
Table 5. HSHF Attrition/Retention Rates

	Carry-over	Enrolled in FY	Open during FY	Closed during FY	Graduated / Age > 5 years	Attrition Rates*	Retention Rates
Years 1-4 ***(3/1/95-6/30/99)***	-	161	161	20	-	12%	88%
Year 5/6** ***(7/1/99- 6/30/01)***	141	176	317	126	21	40%	60%
Year 7 ***(7/1/01- 9/30/02)***	170	154	324	113	13	35%	65%
Year 8 ***(10/1/02-9/30/03)***	198	105	303	102	7	30%	70%
Year 9 ***(10/1/03-9/30/04)***	194	114	308	117	11	38%	62%
Year 10 ***(10/1/04-9/30/05)***	180	122	302	115	-	34%	66%
Year 11 ***(10/1/05-6/30/06)***	187	151	338	64	2	19%	81%
Year 12 ***(7/1/06-6/30/07)***	272	216	488	243	2	47%	53%
Year 13 ***(7/1/07-5/30/08)***	243	146	389	196	7	48%	52%
Year 14 ***(6/1/08-5/30/09)***	200	179	379	193	-	51%	49%
Longitudinal		**1,512**	**-**	**1,263**		**X=35%**	**X=65%**

**does not include graduations or aged out*

Duration of enrollment was examined for those cases that closed during the fiscal year. As seen in **Figure 4,** the there was a peak in duration of enrollment in Year 12, likely due to the merge of the HS and HF programs. However, the mean duration of enrollment for Years 13 and 14 reflect the increased program capacity and percentage of new enrollees during those years.

Figure 4. Duration of Enrollment/Closed Cases for Years 1- 14 (Mean number in years)



When length of enrollment was analyzed by attrition status for only those participants who remained open at the end of the year and those who were closed for reasons other than graduation, *there was a significant difference (t=2.47; df=127; p=.015) in average length of enrollment.* The mean duration of enrollment and range for each group is summarized in **Table 6**. It is not surprising that families who terminated had a shorter length of enrollment (just under a year) and families who remained in the program and who graduated had durations of less than 1 year to over 8 years.

Table 6. Enrollment Mean and Range: Year 14

Enrollment Status at the end of Year 14	Mean Length of Enrollment *(in years)*	Enrollment Range *(in years)*
Open	1.17	.03 - 8.54
Closed	.97	.02 – 5.28
Total Year 14	1.06	.02 – 8.54

Service Levels

In order to provide the highest quality services to families, the HSHF program has always maintained a well-defined level system to ensure that families are able to receive the level of care most appropriate for their needs. The leveling system is derived from the HFA critical elements and is in accordance with the HFA model. As such, families enter the program and remain on the most intensive level of service with weekly home visits for the first six months after the birth of their babies. After this point, a written checklist is reviewed during supervision with the FSW and supervisor to determine if the family continues to require this level of support. If families are showing a strong level of support outside of the program, show an understanding of developmental milestones, follow up on the child's pediatric appointments, and maintain scheduled home visits with their FSW, they may be eligible to move to bi-monthly, monthly, and eventually quarterly home visits. However,

families are not pushed along before they are ready, and must agree that they are ready for less frequent and intensive support.

The HFA leveling system is an integral part of the merged HSHF program. Early enrollment, ideally early in the mother's pregnancy, allows the program to work towards healthy birth outcomes through a focus on early intervention services and prenatal care, including sharing information on health and nutrition during pregnancy. Both the HS and HSHF programs have had the advantage of their strong partnership with Mary's Center and other maternal and child health clinics throughout the city that screen and refer new mothers while they are still pregnant.

In Year 12, as a result of the merger of the HS and HF programs, the HSHF Service Level system was updated and remained the same for Year 14 (***see Appendix D- HSHF Service Levels***). Enrollment was considered to occur on the date that the consent for was signed and they have an enrollment date, not at the time of first home visit or verbal consent. If families were found eligible but they could not be enrolled, usually due to no vacancies, they are placed on Level X. All families are started on Level I/P-I. Although both programs had similar services and a leveling system in place, at the time of the merge, the HF more stringent timelines, procedures and levels were applied to all cases. In order to assign appropriate levels to all the former Healthy Start families, the Training Director met with each team, reviewed each case and assigned a HF service level.

Mental Health Component

A vital program enhancement offered by the HSHF program is the mental health component. These services were piloted through a Starting Early Starting Smart (SESS) grant awarded to the program in 2001, and have been sustained with separate funding since 2006. The goals of the home visiting mental health services are to reduce the symptomology in order to reduce impact on child, and build maternal mental health and reduce infant mental health issues by improving the mother's capacity to parent. Depressed mothers are not able to parent or interact adequately with their child. Additionally, the child may stimulate the mother's memories of her own victimization and abuse, further impeding her ability to parent adequately. In order to identify the participants who may be in need of mental health services, the HSHF routinely screens for depression using the CES-D or PHQ-9, as well as results of the Family Stress Checklist and ongoing observation. In addition to depression, domestic violence is a key focus of the mental health component. Not only is there a significant rise in DV in pregnancy, children often press parents' triggers for violence. The program completes a DV screen at assessment and as determined by the FSW.

The HSHF mental health professional provides mental health assessment and therapy to mothers in the home, as well as support and technical assistance to the Family Support Workers regarding mental health issues. The therapist carries a caseload of approximately 15 active clients who receive weekly or biweekly therapy sessions. Referrals are made to the psychiatrist at Mary's Center as needed. If deemed appropriate and if the client is agreeable, an appointment is made with the psychiatrist, who assesses the client's need for medication and follow-up.

Once the mental health therapist receives a referral from the FSW, she completes a comprehensive mental health assessment and gathers a client history. Based on the assessment, the therapist then develops a plan, which includes what the client wants. Typically, one to three goals are developed around those needs and an intervention for each. The therapist emphasizes the voluntariness of treatment with the mother and schedules a regular meeting time, either weekly or bi-weekly. During treatment, there is ongoing communication between the therapist and the FSW to support the mental health issue, but this varies depending on both the FSW and the client. Clients are seen on an ongoing basis and are transitioned to biweekly then to monthly as symptoms subside and goals are achieved. The therapist places a follow-up call in about 3-6 months after stopping therapy. Recidivism is very low.

During Year 14, the therapist provided counseling services to approximately 20 home visiting clients. Many more mothers screened positively for depression and were referred, but about three-quarters of these women were not yet ready for therapy, as determined by no shows for their appointments or not returning phone calls to make appointments. Upon receipt of the referral, the therapist first talks to the mother by phone about the assessment and then schedules a time for the assessment. Sometimes the home is not private enough to conduct a mental health assessment and so it is often better to conduct the assessment at the Mary's Center office. After the intake and assessment are completed, the therapist typically attempts weekly therapy meetings. However, due to missed appointments and scheduling conflicts, therapy is often conducted on a bi-weekly basis instead.

During the therapy sessions, the individual client issues are addressed. The most common diagnoses in Year 14 were depression, anxiety, and/or PTSD. Many clients have a history of domestic violence (DV), physical abuse as child, sexual abuse, immigration trauma, acculturation issues, and stress related to children who are left behind in their native country. The therapist employs several types of therapy depending on the diagnosis and the client. Although trained as a systemic therapist, she is unable to focus on the entire system and is only able to focus on the client. As a result, the therapist implements a variety of psycho-educational strategies. For example, with trauma, PTSD and DV clients, she uses trauma focused Cognitive Behavioral Therapy (CBT), applying a psycho-educational approach to the clients' systems and how these are affected by the trauma. Therapy focuses on connecting past traumas to their current feelings, thoughts, and actions; cognitive restructuring; and challenging cognitive distortions. Additionally, she teaches relaxation techniques and expression of feelings.

Most clients experience high levels of stress around self-sufficiency issues, such as jobs and housing. Often the clients are abused in their jobs if they are undocumented, but they have no recourse. If they are unemployed and in a DV relationship, it is more difficult for them to leave the violent relationship, since they feel trapped economically. These difficulties are compounded by a lack of problem-solving skills and concomitant anxiety that prevents them from using logical thinking and decision-making. In these cases, the

therapist works closely with the FSW to break down the self-sufficiency tasks into action steps, while she works on the core mental health issues and anxiety.

The therapist meets weekly with psychiatrist to discuss patients and their treatment plan. Periodic meetings are also held with the FSW, resulting in a strong team approach. Initially, the psychiatrist sees patients weekly and then decreases the frequency to every two weeks, and eventually to once a month and shorter sessions to monitor medication. Approximately 5 patients have been referred to the psychiatrist for evaluation and medication management, three of whom see the psychiatrist regularly and are using their medications successfully. In contrast, medication compliance is an issue with several other clients. Once again, the therapist works with the FSW to build readiness with the client before referring them to the psychiatrist or initiating weekly sessions.

Most of the clients during Year 14 were Latino, but several were African-American, and one was Ethiopian. However, fewer African-American clients were referred due to the distance of the Southeast site and Mary's Center, which is approximately 1½ hours of travel each way using public transportation. Additionally, although the therapist is cross-culturally trained, there are multiple barriers to providing service to the African-American population. Since many of the services are offered at Mary's Center, the distance from Southeast and the very strong Latino culture at the Center, prevent these clients from engaging. Additionally, the only psychiatrist available is based at Mary's Center, further challenging those clients who may be in need of medication. In response, the therapist seeks local psychiatrists to fulfill the needs of SE clients for medications and monitoring.

Case Study

The mother is an undocumented immigrant from Ethiopia with two children, one 2 years old and one 7 months old. She has been a victim of domestic violence, but she came to US on her husband's refugee visa and the immigration lawyers have told her she will lose her visa if she leaves her husband. There are strong cultural prohibitions around disclosing domestic violence and talking about husbands, as well as around using medication.

The therapist worked closely with FSW to increase the mother's readiness to acknowledge the domestic violence and talk about it and referred her to the psychiatrist for a medication assessment. The mother initially opened up about her current abuse and her past with her mother with, but eventually discontinued her medication and therapy with the psychiatrist.

The FSW focused first on the more practical steps of developing a 'Safety Plan' with the mother, such as on logistics of finding a shelter and housing. Simultaneously, the MH therapist worked on processing her anxiety around the safety plan and helped her reframe the issue in her head, which would reduce her anxiety and make her feel more in control. After about six months of team effort and weekly check ins with the FSW, the mother left her husband and went to the shelter with her two children. She stayed at the provisional shelter for 3 months (which is the maximum allowable time) but she still did not have a job, so they let her stay another month. The FSW helped her find a more permanent home, but

she is still looking for a job. Additionally, at the shelter, she had a case manager who worked closely with the FSW and was instrumental in finding resources for the children. Critical to the success with this client was the teamwork among the professionals and the FSW, the collaborations, and clear boundaries.

Staffing

The Healthy Start Healthy Families program employs a highly trained and diverse group of individuals representative of the community they serve. The programs demonstrate their commitment to families through hiring from within the community and maintain its high standards through hiring employees with a combination of professional experience and personal qualities relevant to aiding an underrepresented population. Thus, staff members have the unique ability to work together as a team and serve the families in a strength-based manner.

The staffing pattern has remained the same as in Year 13. As seen in **Table 7**, during Year 14, full staffing of the HSHF program included 28 full-time positions, including a Program Director; four Supervisors (2 Project Coordinators and 1 Social Service Manager) who supervised 12 FSWs and 4 FAWs at the three program sites (Mary's Center; Kennedy Street; and CHC/Greater Southeast). The program also employs a Registered Nurse to do prenatal and post-partum home visits; a Mental Health Therapist to conduct screening and therapy in the home; and 2 Outreach Workers to identify pregnant women not linked with prenatal care and women linked with a provider but not linked to insurance or prenatal care). In January 2009, a second public health nurse was added. ***(See Appendix H – HSHF Organizational Chart-Year 14***).

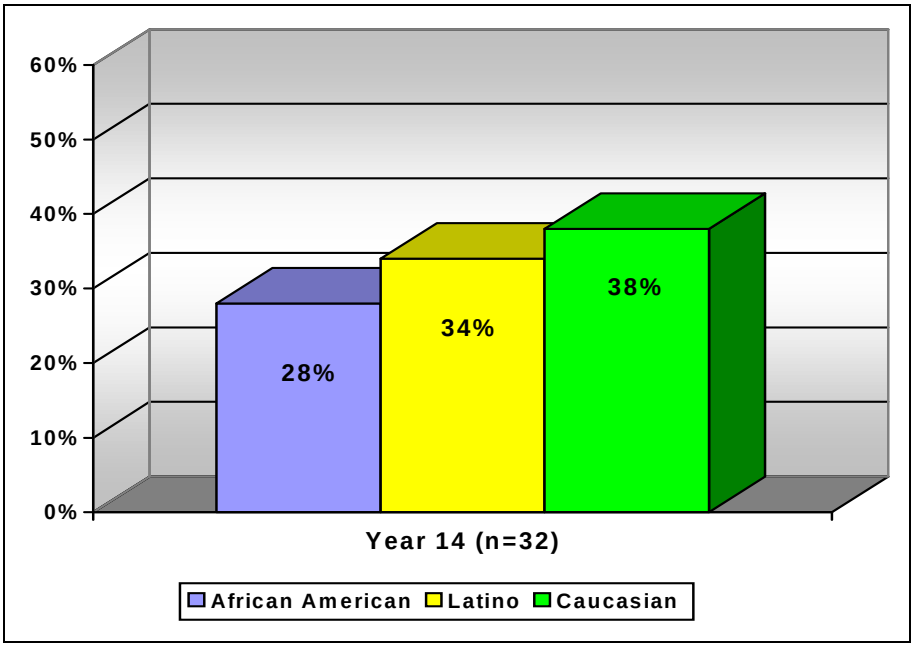
Table 7. Staffing-Year 14

Position	Year 14
HV Program Director	1
Coordinators/Social Service Manager	3
Assessment Coordinator	1
Family Assessment Worker (FAW) I	4
Family Support Worker (FSW)	12
Outreach Worker	2
Mental Health Therapist/HV MH	1
Registered Nurse/HV RN	2
Program Assistant	1
Total Number of Positions	**27**

Staff Characteristics

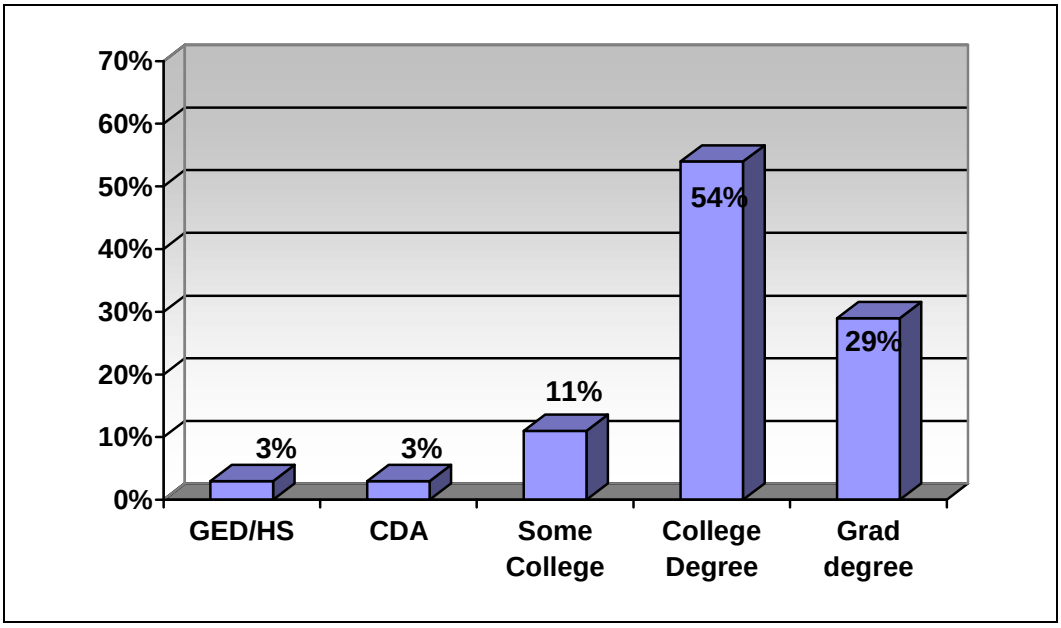
The ability of staff to provide high quality, culturally and linguistically appropriate home visitation services reflects their ethnic status and educational background. Staff ethnicity and language that is representative of the target population enhances their ability to engage and retain families, as well as more accurately understand the cultural issues that may impact their parenting, health, and self-sufficiency. As seen in **Figure 5**, most of the staff identify themselves as Caucasian (38%), while one third are Latina (34%) and the remaining staff identify themselves African American (28%).

Figure 5. Staff Ethnicity Year 14



Staff education levels are shown in **Figure 6** below and indicate the high level of education achieved by most of the program staff. All staff are high school graduates, and most (83%) have a college degree or higher. Additionally, the percentage of college graduates has steadily increased each year, with 54% in Year 14. An increasing percentage of staff members each year had a graduate degree (29%). Only two staff members had a level of education high school degree or CDA. It should also be noted that several staff members (n=3) were enrolled in graduate programs during Year 14.

Figure 6. Staff Education Levels Year 14



Staff Attrition/Retention

The HSHF program has retained many of its staff over the past fourteen years. High levels of staff retention are reflective of a stable program that values its staff and provides opportunities for feedback and growth. Staff retention has also been linked to family retention, particularly retention of the Family Support Workers who engage the families and are involved with them directly on a regular basis. ***(See Appendix I – HSHF Staff Tenure Dates-Years 1-14)***. **Table 9** summarizes the average tenure for the major staff positions: Management; Family Assessment Workers; Family Support Workers; Professional Support Staff (i.e., mental health). The total number of staff may exceed the number of staff positions since multiple may have filled a position, due to turnover or to part-time status.

As seen in the table, there is excellent retention of management, assessment workers and other professional staff. However, it is evident that front line staff positions, including Family Support Workers and Outreach Workers, are experiencing significant turnover.

Table 9. Percentage Staff Retention-Year 14

	Year 14
Management	80% (n=4/5)
Family Assessment Worker (FAW)	100% (n=4/4)
Family Support Worker (FSW)	42% (n=5/12)
Professional Support (PHN; MH)	100% (n=3/3)
Outreach Workers	50% (n=2/4)
TOTAL RETENTION	**88% (n=28/32)**

Staff Development

Healthy Start Healthy Families has provided rigorous, continuous and varied training as part of its commitment to supporting staff and ensuring that employees feel competent and prepared for their work with families. The Program Director is a certified trainer for the "Great Kids" curriculum and is able to provide ongoing technical assistance to program staff on implementation issues. As part of the HFA accreditation process, certain trainings have been identified as required at certain timeframes. For example, certain core trainings, such as those mentioned above, are required prior to FSWs completing any home visits with families. Other trainings are required within six months or one year of hire. Additionally, "wrap-around" trainings are required on an ongoing basis. Beyond these required trainings, the HSHF program provides trainings particular to its service population and staff makeup. For example, supervisors may identify a training area needed based on a particular staff member's interest or need for additional information.

All new staff underwent the required 32-hour *Healthy Families "Core Training*", which covers topics such as the history and philosophy of home visitation, the core strength-based approach of the Healthy Families model, identification of child abuse and neglect, professional boundaries, and limit setting and confidentiality. New staff also received the *Parents as Teachers Curriculum Implementation Training*, and the *Ordinary Miracles Training*, as well as a variety of trainings to orient them to the community, program and agency.

The extensive number and type of trainings offered in Year 14 demonstrate the program's dedication to expanding the knowledge and skills of its staff through providing trainings covering 60 different topics ***(See Appendix J- HSHF FY '09 Staff Trainings)***. HSHF offered **a total of 37 different trainings in Year 14**, some of which were offered more than once. The trainings can be divided into four general topic areas: 1) Professional Development, 2) Family and Child Health Care, 3) Family Mental Health and Well-Being, and 4) Child Development.

- *Professional Development* – HSHF offered **12 trainings** designed to improve staff competency and to enhance their ability to do their jobs well, such as: motivational interviewing; orientations to local community, program and agency; mental health referrals; adoption; computers and databases; community resources and networking; cultural competency; diversity, and traditions; serving LEP families; sensitivity to LGBTIQ community; and how to provide strengths based service.
- *Family and Child Health Care* – There were **10 trainings** that focused on maternal, child and family health care, including topics such as: substance abuse; STDs; nutrition; harmfulness of tobacco; SIDS; Lead education; and HIV testing and counseling.
- *Family Mental Health and Well-Being* – Trainings in this area focus on prevention and early intervention of mental and behavioral health issues, as well as the promotion of child and family safety and well-being. In addition to the HFA Core Training, there were **10 trainings** offered in this area, including: child abuse and neglect reporting; home security;

car seat safety; domestic violence; teens and gangs; options counseling; infant calming techniques; mental health case reviews; and Shaken Baby Syndrome.

- *Child Development* –In addition to the training on the **Parents as Teachers curriculum**, HSHF trains all staff on the Ordinary Miracles method using videotaping of parents interacting with their babies as a teaching tool to develop bonding and parenting skill. There were also three separate trainings on early literacy; parenting skills; and early childhood development.

Staff Satisfaction

As in past years, HSHF staff members were asked to share their experiences with the program by responding to a short series of questions. These anonymous surveys solicit input from staff regarding job satisfaction and work-related stress, their views on program strengths and areas for improvement, as well as perceptions of the nature and quality of support and benefits they have received. A total of 18 FY '09 staff satisfaction surveys were collected and tabulated with results outlined below.

Staff members were asked to identify their roles in the program and how long they had worked for HSHF the time of survey completion. The majority of respondents (83%; n=15) were Direct Service Providers, 41% of whom worked for HSHF for less than one year (n=7) **Tables 10 and 11** show the individual staff positions and tenure of all 18 survey respondents.

Table 10. Survey Respondents' Positions*

Capacity	Frequency (n=18)
Administrative/ Management/Supervisory	17% (n=3)
Family Support Worker (FSW)	56% (n=10)
Family Assessment Worker (FAW)	11% (n=2)
Registered Nurse/Mental Health Therapist	11% (n=2)
Outreach Worker	5% (n=1)

Table 11. Survey Respondents' Program Tenure*

Capacity	Less than one year	One to Two Years	Two or More Years
Administrative/ Management/Supervisory	-	-	(n=2)
Family Support Worker	(n=5)	(n=4)	(n=1)
Family Assessment Worker	-	-	(n=2)
Registered Nurse/MH Therapist	(n=1)	-	(n=1)
Outreach Worker	(n=1)	-	-
Average Tenure (n=17)	41% (n=7)	24% (n=4)	35% (n=6)

** Only 17 staff members responded to this question*

The current survey includes 16 statements to which respondents were asked to indicate "Strongly Agree," "Agree," "Not Sure," "Disagree," or "Strongly Disagree." Three areas consistently have 100% staff agreement (combining "Strongly Agree" and "Agree"), including understanding the goals and objectives of HSHF, *feeling that the program is designed to optimize child development*, and *feeling comfortable working with culturally diverse families*. Several areas that did not have 100% agreement in FY'08 are now showing unanimous agreement, indicating that the program responded to the feedback provided and improved in these areas. These four areas include: *receiving an adequate amount of supervision, recognition that HSHF is strength-based and family centered, participation in training as preparation for program position*, and that *the program uses bilingual materials as appropriate*. Two areas that staff was in 100% agreement FY'08, several current respondents indicated they are not sure about: *understanding the HSHF combined model* and *whether they had training in the 6 months prior to completing the survey*. Since most of the FSW staff is relatively new to the program (<2yrs), it is not surprising that they may not be clear what is being asked about the 'combined model', which refers to the program integration that occurred in 2006. **Table 12** shows the responses to the current year's survey, compared with FY'08 responses. Several areas should be explored further with staff, including: *management's responsiveness to staff needs; the cultural representativeness of the staff;* and that *the program prepares children for school*.

Table 12. Staff Impression of the Effectiveness of the HSHF Program (n=18)

Program Services	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	FY'08 Strongly Agree/ Agree
1. I understand the HSHF combined model*	41% (n=7)	41% (n=7)	18% (n=3)	0	0	100%
2. I understand the goals and objectives of HSHF.	50% (n=9)	50% (n=9)	0	0	0	100%
3. I receive an adequate amount of supervision to help me get my job done in a quality manner.	72% (n=13)	28% (n=5)	0	0	0	86%
4. HSHF is designed to optimize child development through comprehensive support to families.	83% (n=15)	17% (n=3)	0	0	0	100%
5. The program management is responsive to the needs of staff.	28% (n=5)	50% (n=9)	6% (n=1)	11% (n=2)	6% (n=1)	79%
6. HSHF is strength-based and family centered.*	88% (n=15)	12% (n=2)	0	0	0	91%
7. I have participated in training that adequately prepared me for my position.	67% (n=12)	33% (n=6)	0	0	0	86%
8. I have participated in training in the past six months.	67% (n=12)	28% (n=5)	5% (n=1)	0	0	100%
9. The agency and program management represent the target population	39% (n=7)	56% (n=10)	0	6% (n=1)	0	82%
10. The staff is culturally representative of the families served.	44% (n=8)	33% (n=6)	6% (n=1)	17% (n=3)	0	91%

Program Services	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	FY'08 Strongly Agree/ Agree
11.The program uses materials that are culturally appropriate.	28% (n=5)	61% (n=11)	6% (n=1)	6% (n=1)	0	91%
12. The program uses bilingual materials as appropriate.	50% (n=9)	50% (n=9)	0	0	0	85%
13. I feel comfortable working with culturally diverse families.	61% (n=11)	39% (n=7)	0	0	0	100%
14. HSHF helps prepare children for school.*	41% (n=7)	47% (n=8)	12% (n=2)	5% (n=1)	0	81%
15. The enhanced mental health services have significantly helped HSHF families	67% (n=12)	33% (n=6)	14% (n=3)	0	0	86%
16. The enhanced health services have significantly helped HSHF families	28% (n=5)	61% (n=11)	11% (n=2)	0	0	91%

*Only 17 staff members responded to this question.

Job satisfaction was assessed using a similar format. Whereas on the previous survey, there was 100% (FY'08) agreement that *staff members enjoyed their work* (FY '09=83%) and that their *work used their skills* (FY '09=88%), these areas now show ambivalence or disagreement from several respondents. There is currently, however, unanimous agreement in two areas where previous ambivalence was expressed: *finding work worthwhile* and *making a positive impact on program children and fam*ilies. As in past years, varying opinions are expressed with regard to feeling appropriately compensated. Only *one FSW agrees that compensation is adequate*, whereas there is more agreement among administration and nursing staff. **Table 13** shows the breakdown of job satisfaction-related statements with staff responses, as well as FY'08 percentages for comparison.

Table 13. Job Satisfaction of HSHF Staff (n=18)

Job Satisfaction	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	FY'08 Strongly Agree/Agree
I enjoy my work.	56% (n=10)	28% (n=5)	17% (n=3)	0	0	100%
I find my work worthwhile.	56% (n=10)	44% (n=8)	0	0	0	95%
I find the work that I do is hard.	17% (n=3)	39% (n=7)	6% (n=1)	39% (n=7)	0	55%
I find my work boring.	11% (n=2)	0	6% (n=1)	50% (n=9)	33% (n=6)	0%
The work I do uses my skills.	44% (n=8)	44% (n=8)	6% (n=1)	6% (n=1)	0	100%
I am satisfied with my position.	35% (n=7)	50% (n=10)	5% (n=1)	10% (n=2)	0	85%
I am appropriately compensated for my position.	6% (n=1)	17% (n=3)	17% (n=3)	28% (n=5)	33% (n=6)	29%
I feel appreciated by HSHF management for the work I do for the program.	33% (n=6)	50% (n=9)	11% (n=2)	6% (n=1)	0	82%
I have made a positive impact on children/families I work with.*	47% (n=8)	53% (n=9)	0	0	0	95%

*Only 17 staff members responded to this question.

In order to assess staff's perception of the strengths and weaknesses of the program, they were presented with two open-ended questions. When asked what areas of the program are particularly strong for staff, 15 staff members responded, offering a total of 29 comments. Three areas were mentioned more than any other areas: 1) the strength-based approach utilized by the program; 2) the program management/ supervision; and the quality of staff/FSWs. Each was identified by about half of respondents. When compared to the results from the previous survey, these areas have increased significantly in staff perceptions. Staff teamwork continues to be among the most frequently cited areas of strength. One respondent noted, "*Team members feel comfortable sharing tips/techniques/resources, which strengthens our impact with families*." Additionally, program enhancements, such as having outreach workers and access to early intervention at Mary's Center to support the program were recognized as strengths. One respondent expressed that, "*The Assessment/Outreach team has formulated a stronger system to reach participants (more organization; more staff hired)…and they do a great job of connecting with other community organizations."* The organization was also praised for how well it handled the transition period between Supervisors at Kennedy St. **Table 14** shows all current strengths cited by the staff in rank order, along with the frequency with which they appeared.

> *"Management has done a great job hiring home visitors who care deeply about the goals of the program and who work well with families."*

Table 14. Program Strengths Identified by Staff (n=15)

Strength	Frequency
Strength-based approach	7
Supervisor/Management Support	7
Staff Characteristics and Teamwork/Collaboration	6
Training	3
Community program connections/events	2
Accomplishment of participants' goals	1
FSW knowledge and Information provided on Child Development/curriculum	1
FSW-Client relationship	1
Assessment/Outreach team	1
Cultural competency	1
Access to onsite Early Intervention and quick follow-up on referrals	1

.

When asked which areas of the program need improvement, 13 individuals offered a total of 23 responses. Responses covered a wide range of issues. Lack of funds, both for program supplies, resources necessary to perform work effectively, and for salaries was the most frequently identified challenge (n=6). It was suggested that additional funds could be used for planning and facilitating events, seminars, and outreach, as well as providing more confidential spaces for participants to meet with workers. It was also suggested that higher salaries would increase staff tenure, as would more opportunities for advancement. More consistent communication not only between staff members, but across sites, was mentioned by four individuals. Their concerns included consistency in reporting protocols between sites, making sure all team members are on the same page, and having more regular communication between FSW's, FAW's, Outreach Workers, Mental Health staff, supervisors, etc. It was also suggested that positive feedback and equal praise for all sites, as well as appreciation by upper management for the staff's hard work are areas that need improvement. **Table 15** shows the areas for improvement cited by the staff in rank order, along with the frequency of each.

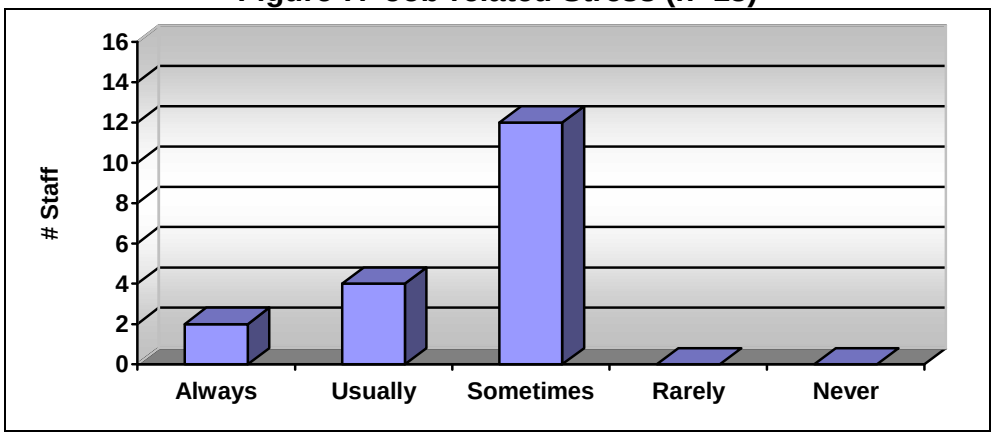
Table 15. Program Areas of Improvement Identified by Staff (n=13)

Needs Improvement	Frequency
Funds for Supplies/Resources/ Confidential Space/Pay increase	5
Consistent communication	4
Appreciation by upper management; equal praise for all sites.	2
Streamline intake process and documentation process to have more time with families	2
Caseloads too big; need more staff	2
Difficulty getting promotion/few growth opportunities	2
FSW safety	1
Coordination of transportation (program car or system of carpools) for FSW's who do not have cars/ Parking for those who need to have cars.	1

Lack of resources to deal with substance abuse; perhaps MH worker who specializes in Substance Abuse	1
Electronic Medical Record (eCW)	1
Include FOB more in program structure	1
More training in therapeutic communication and strength-based approach	1
Make space available in the agency for effective, consistent supervision	1

HSHF staff members were asked to indicate how stressful they feel their job is by checking one of five choices: "Always stressful", "Usually stressful", "Sometimes stressful", Rarely stressful" or "Never stressful." As seen in **Figure 7**, most respondents (67%; n=12), indicated that they perceive their job to be "Sometimes stressful." Four staff members (22%) indicated that they "Usually" feel stressed, and two "Always" do. There are no staff members who "Rarely" or "Never" feel stressed. It appears that the level of stress is slightly higher as compared with the previous FY'08 results, where three staff members felt "Rarely stressful" and no staff reported feeling "Always" stressful. This may be attributable to the fact that most of the respondents are FSWs (56%) and are predominately are new staff (71% employed <2yrs).

Figure 7. Job-related Stress (n=18)



Each staff member was asked to indicate which benefits she has received as a result of participation in work related trainings. The benefits included promotion, wage increase, bonus, certification, or other. Most staff members (n=10), nine of whom were FSWs, reported receiving no benefits. Eight staff members reported receiving various benefits, two of whom reported receiving multiple benefits. **Table 16** shows the breakdown of benefits reported by these 8 staff members. The most frequently mentioned benefit was Certification (n=7). Of these, three also received promotions and wage increases, with one of those also receiving a bonus and "other." Of the two remaining staff members, one received a promotion and one reported a wage increase.

Table 16. Benefits Received by Staff (n=8)

Benefit	Frequency
Certification	(n=5)
Promotion	(n=2)
Wage Increase/Bonus	(n=4)
Other (Continuing Education Credits)	(n=1)

In summary, the overall level of HSHF staff satisfaction FY'09 has increased significantly compared to prior years surrounding the merge of the Healthy Start and Healthy Families program. Clearly, the program management's response to staff feedback and concerns impacted staff perceptions regarding adequate supervision, the program's strength-based approach, participation in training, and appropriate use of bilingual materials. The program's strength-based approach was one of the strongest program aspects identified by staff, and it was unanimously agreed "the program is strength-based and family centered."

Despite some continued ambivalence and disagreement about whether management is responsive to the needs of the staff, there were multiple indicators that management has addressed some serious concerns of staff and strengthened many program components. This is reflected in the unanimous agreement regarding adequate supervision, as well as the number of comments praising management and the organization in terms of doing a great job in hiring well qualified home visitors, the smooth transition to Kennedy St, the expansion of the outreach/assessment team, and access to on-site early intervention and mental health. However, management should continue to explore outstanding areas of concern in supervision and team meetings.

Areas of program improvement identified by survey respondents suggest a wide range of issues that present challenges for the staff. The fiscal limitations of the program and the resultant impact on both salaries and services continue to color the recommendations put forth by the staff to improve the program. These are not only key factors in suggestions for higher salaries and more funding for supplies, but they also have a bearing on such recommendations as hiring more staff, providing FSW transportation, substance abuse resources, increased training, and addressing physical space issues within the agency. Current fiscal limitations within the program and organization reflect the overall downturn in the economy over the past two years, which has significantly impacted both public and private funding sources. Conveying this to staff may be beneficial. On a related topic, several staff noted that communication could be improved, including better communication among team members, inter-site communication, and consistency in reporting protocols and feedback among all sites.

"HSHF is an excellent program. It would be wonderful to be able to extend it to other areas needed, such as Maryland."

Job stress continues to be experienced by most staff members, and at slightly higher levels than last year. Management may want to explore possible strategies and supports for staff to address the level of stress. Despite this and the fact that job benefits were reported by less than half of respondents, the staff unanimously agrees that their work is

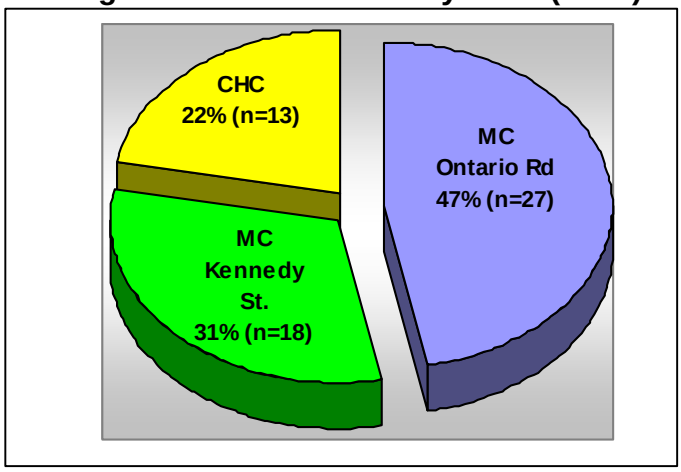
worthwhile, they are making a positive impact on the families with whom they work, and that they enjoy their work.

Participant Satisfaction

The HSHF Program distributed a Participant Satisfaction Survey to all active program participants. The purpose of the survey is to gather input from participants on how program services are benefiting families and any areas where the program could use improvement. **The Survey was completed and returned by 60 participants**. The survey is a short questionnaire focusing on frequency of home visits along with perceptions of services and benefits gained as a result of participation. All surveys were completed anonymously and were in either English or Spanish, depending on the dominant language of the participant.

As seen in **Figure 8**, the surveys were returned from three sites. Most were from the Ontario Road site of Mary's Center. Site information was unavailable for two surveys.

Figure 8. Returned Survey Sites (n=58)



Two-thirds of mothers (66%; n=39) indicated that they were between the ages of 21 and 30 at the time of survey completion. An additional 22% (n=13) were 31 years of age or older, and the smallest percentage (12%; n=7) were between 16 and 20.

Participants were asked how frequently they were visited at home by their FSW. Most (54%; n=32) reported that they were visited once per week.

Table 17. Participant Reports of Home Visit Frequency

Visit Frequency	N (%)
Once a week	32 (54%)
Twice a month	22 (37%)
Once a month	5 (9%)

Almost all respondents (96%; n=54) reported that they received their first home visit before their baby was three months old. Most (60%; n=35) were visited within the week prior to survey completion, with an additional 28% (n=16) reporting a visit within the previous two weeks.

The survey asked participants to respond to a series of statements regarding their perception of the services they received by answering "Yes" or "No." As seen in **Table 18**, not all questions were answered by all respondents; the total number of respondents for each question varied and, if less than 60, is indicated after each statement. The largest number of negative responses were given to Statement #1, regarding satisfaction with the frequency of visits. Six respondents indicated that they were not visited often enough. All respondents, however, agreed with most statements.

Table 18. Perceptions of Program Aspects (n=60)

Statement	Yes	No
1. My FSW visits often enough. (n=57)	90%	10%
2. My FSW gives me information on how to care for my baby.	100%	n/a
3. My FSW is helping me learn about my child's development. (n=59)	100%	n/a
4. My FSW helps with my needs and the needs of my baby and family. (n=58)	100%	n/a
5. My FSW is respectful of my baby, family, and me. (n=58)	100%	n/a
6. My FSW accepts and respects my culture.	100%	n/a
7. My FSW gives me information I can understand.	100%	n/a
8. My FSW helps me be more independent by helping me make my own decisions.	97%	3%
9. My FSW has helped me become a better parent.	98%	2%
10. HSHF has made a positive impact on the life of my baby. (n=59)	100%	n/a

Participants were asked <u>what they liked best about the program</u>. Fifty-four participants responded, offering a total of 71 comments. The comments fell into six general areas: advice and support (n=22); the FSW (n=14); information (n=13); the home visits (n=8); everything (n=11); specific activities, such as the Orientation (n=2) and the Baby Shower (n=1); or services, such as Clothing and Food (n=1). Of the fourteen respondents who cited <u>their FSW</u> as what they liked best about the program. Several merely mentioned that they liked their FSW, while others noted the FSW's attentiveness, caring, and helpfulness. Several appreciated the concern the FSW demonstrated toward their children. Respondents who mentioned that they liked the <u>Information provided</u> by

"I don't feel so alone when [my FSW] visits."

"[My FSW] is very caring with my children; she plays with them and asks how they are doing,"

the program or FSW offered comments focusing on the knowledge they gained regarding their children's development and care and becoming a better parent as a result. The aspects of the Home Visits that some respondents cited included the convenience, as well as the personal attention and happiness they feel during a home visit.

Participants were also asked if there was anything they did not like about Healthy Start Healthy Families. Only three respondents offered comments. One indicated that she had not been happy with her first FSW, but was reassigned and is very happy with her new one. A second respondent mentioned that she would have liked to have transportation to get to her FSW when she needed help with translation of baby-related documents. One participant expressed her dissatisfaction that the program has to know so much personal information about her.

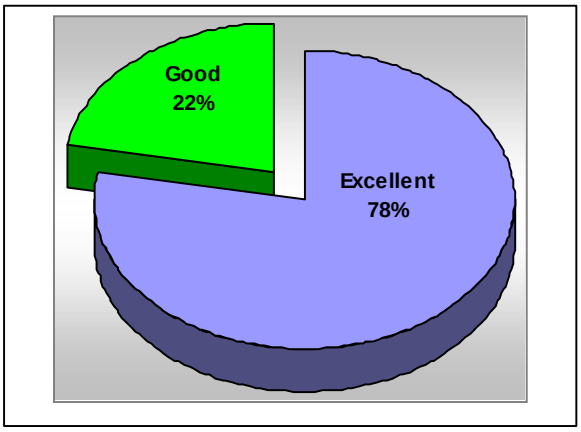
In total, 13 respondents offered suggestions as to how the program could be improved. Most of the suggestions reflected a desire for more services, including group activities and the expansion of services to serve more families. Nine comments focused on expressing a desire to have more from the program: more activities or family events (n=5). One suggested more FSWs for more families, more frequent visits, more locations, and more materials for children, i.e., computers, books. One participant suggested that client intake could be improved by posting more flyers in clinics and doctors' offices. She added that she wished she had known about the program with her first three children. Another seemed to indicate that she would like economic help for single mothers. A final respondent suggested that the program make a packet of information that could be given to parents.

Three final questions on the survey asked participants to rate their FSW, the HSHF program, and whether they would recommend the program to a friend or relative. As seen in **Figure 9**, ***81% of respondents (n=47) rated their FSW as Excellent.***

Figure 9. Participant Ratings of FSW (n=58)

As seen in **Figure 10**, ***all HSHF participants rated the program as either Good*** *(22%; n=13/58)* ***or Excellent*** *(78%; n=45/58)* of respondents.

Figure 10. Participant Ratings of HSHF Program (n=58)



Fifty-seven participants responded to the final question regarding whether they would recommend the program to a friend. ***All (100%) respondents indicated that they would recommend the program to a friend or relative.***

In summary, the HSHF participants are overwhelmingly satisfied with the program and the services they are receiving. They appear genuinely appreciative of the care and concern shown by the FSWs, and value the knowledge they have gained as a result of participation. Results demonstrate a high degree of program fidelity as evidenced in participant reports of the timing of first home visits; the frequency of home visits; content of home visits focusing on child development, parenting efficacy, and self-sufficiency; and the cultural competence and sensitivity of their FSW and the program. Comments also reveal a population that recognizes the strength of the relationships they have developed with their FSWs and see these relationships as key in their children's healthy development and their growth as parents.

Population Demographics

The characteristics that define the program population are important because they act as mediating influences on the program effects. These demographics illuminate the risk, strength, and resiliency factors with which families enter the program and assist in interpreting outcome evaluation results. Both standard population demographics, such as level of education, employment and marital status, and measured risk factor demographics, such as assessments from the Parent Survey (explained in the Risk Factors section below), can contribute to a participant's overall level of risk for child maltreatment and add to the strains on already stressed families.

Residence/Ward Program families reside in every Ward in the city (see **Table 19**). The Wards with the highest percentages of families have been particularly targeted due the high risk factors present in the communities, including poverty, violence, poor birth outcomes, and a lack of access to health care.

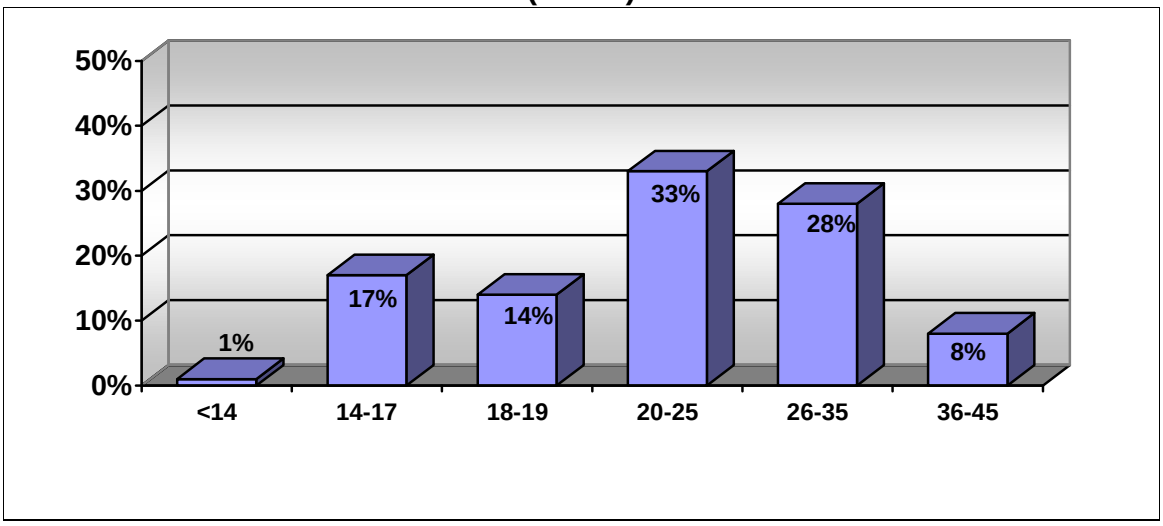
Table 19. Mother's Residence by Ward
(n=216)

Ward	Year 14
1	26%
2	2%
3	2%
4	25%
5	9%
6	3%
7	11%
8	22%

Mother's Age

Mother's age is an important factor in determining risk for poor parenting. Teen and young mothers face particular challenges in terms of completing educational goals, achieving self-sufficiency, single parenting, and a lack of emotional maturity necessary for parenting. As seen in **Figure 11**, the majority of participants in Year 14 were over the age of 20, with most falling within the 20-25 years of age at enrollment. Also evident in the Figure is a decrease in the percentages of teen mothers and a proportionate increase in mothers' ages over the three years. This trend is aligned with an overall decrease in teen births in the District over the past five years (2001-2006). The teenage pregnancy rate decreased 18.9 percent from 2004 to 2005 [1], representing the lowest rate since 1976. However, a small increase in teen pregnancy was measured in 2006 [2], which NCHS has attributed to a reported decrease in contraceptive use. These data are important in helping HSHF to better address the evolving needs of its target population.

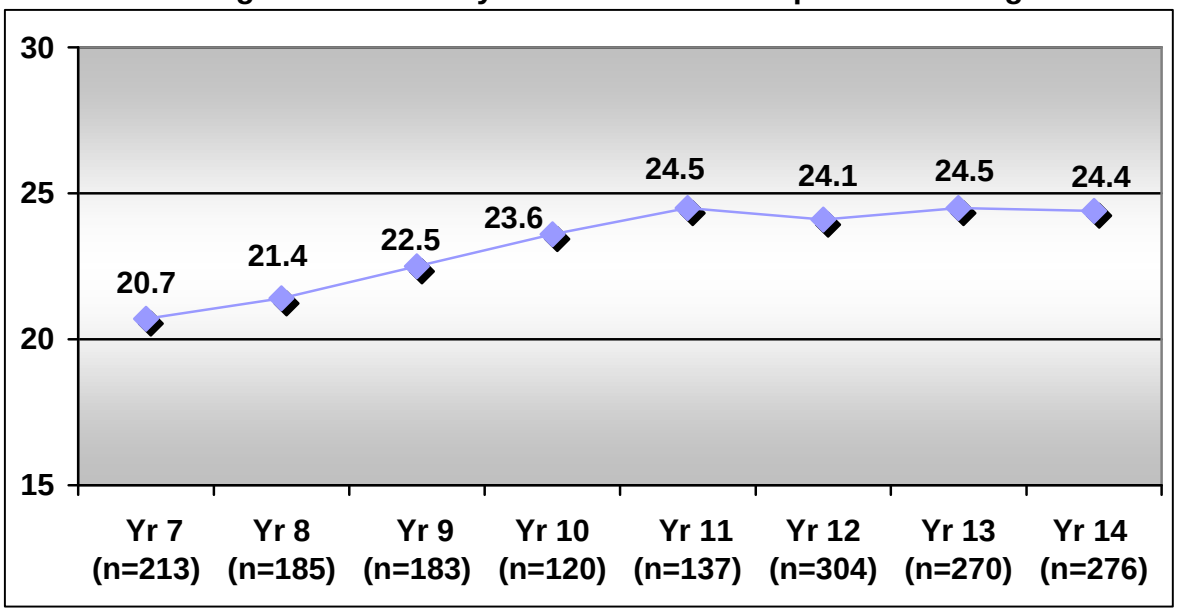
Figure 11. MOB Age at Program Entry – Year 14
(n=276)



[1] DC Department of Health (2007). Reported Pregnancies and Pregnancy Rates in the District of Columbia, 2001-2005. Washington , DC.
[2] National Center for Health Statistics (2008). Information Sheet: NCHS Data on Teen Pregnancy-October 2008

As seen in **Figure 12**, the mean age of participants at entry has steadily rose from Year 7 to Year 11, but has remained fairly consistent at about 24 years of age since then. The average age of program participants in Year 14 was x=24.4 years.

Figure 12: Seven-year Trends in Participants' Mean Ages

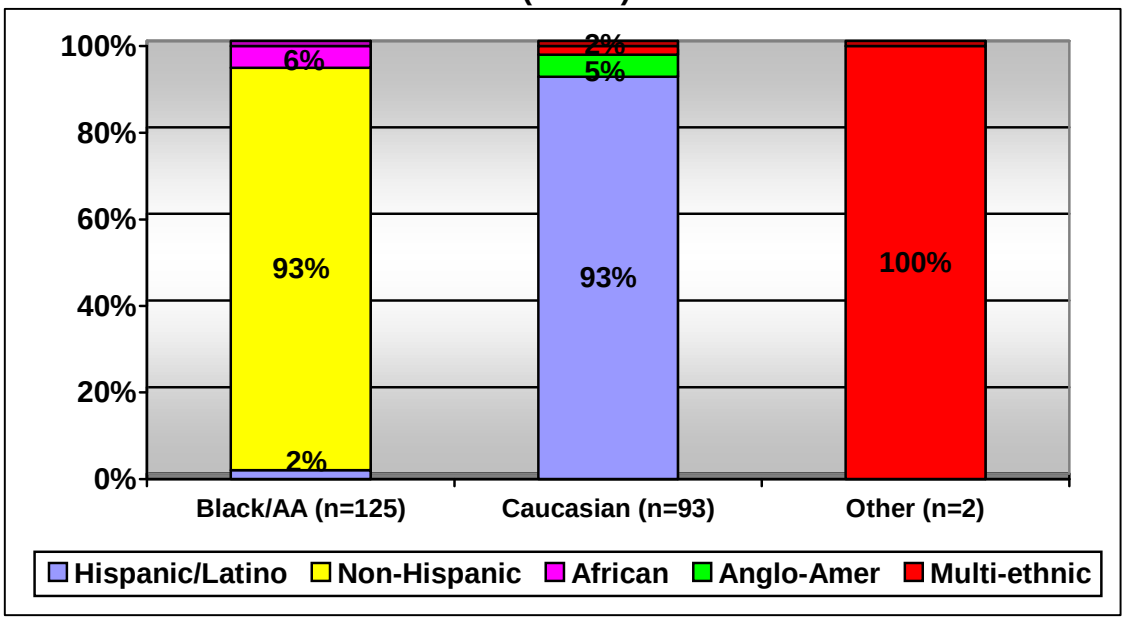


Mother's Race and Ethnicity

Race, ethnicity and cultural factors are potent mediators of parenting knowledge, values, and behavior. Risk and protective factors may also be influenced by race and ethnicity. Many newly immigrated families are at increased risk for social and cultural isolation due to language barriers and inexperience with community resources. HSHF places particular emphasis on offering services that are sensitive and responsive to these factors and employs staff that is culturally representative of its participant population.

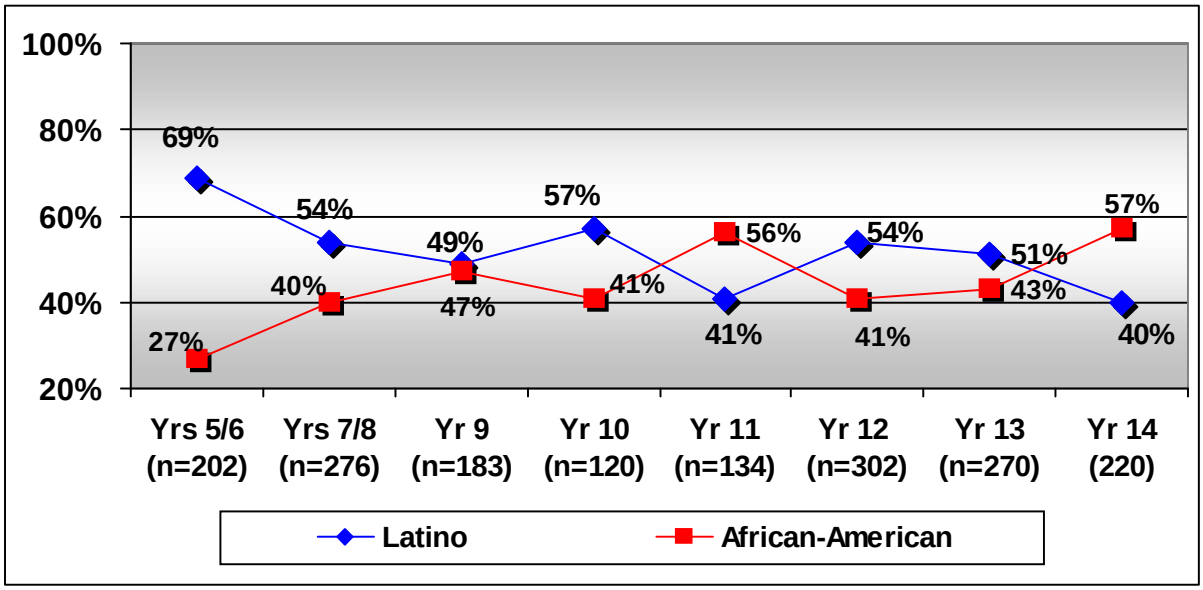
Data on race and ethnicity was available for 220 mothers who were active in Year 14. The majority of mothers were Black or African American (57%), while an equally large percentage of mothers were Caucasian (42%). Two mothers identified their race as Multi-ethnic. As seen in **Figure 13**, when race is further analyzed by subgroups, the majority of Black mothers were African-American (93%) and only a small percentage identified themselves as either African (6%) or as Hispanic/Latino (2%). Likewise, the majority of Caucasian mothers were Hispanic/Latino (93%), while only small percentages were Anglo-American (5%) or Multi-ethnic (2%)

Figure 13. Race and Ethnicity - Year 14 (n=220)



The pattern for Year 14 parallels the ethnic composition of the program since its inception and has consistently been comprised primarily of Latino and African-American mothers. However, the relative percentages have varied over the years. As seen in **Figure 14**, the percentages of Latino and African-American families have largely reflected the wards served in that program year. In Year 14, the relative percentages once again changed for African-Americans (57%) as compared to Hispanic/ Latinos (40%), reflecting the expansion of services at the Kennedy St site.

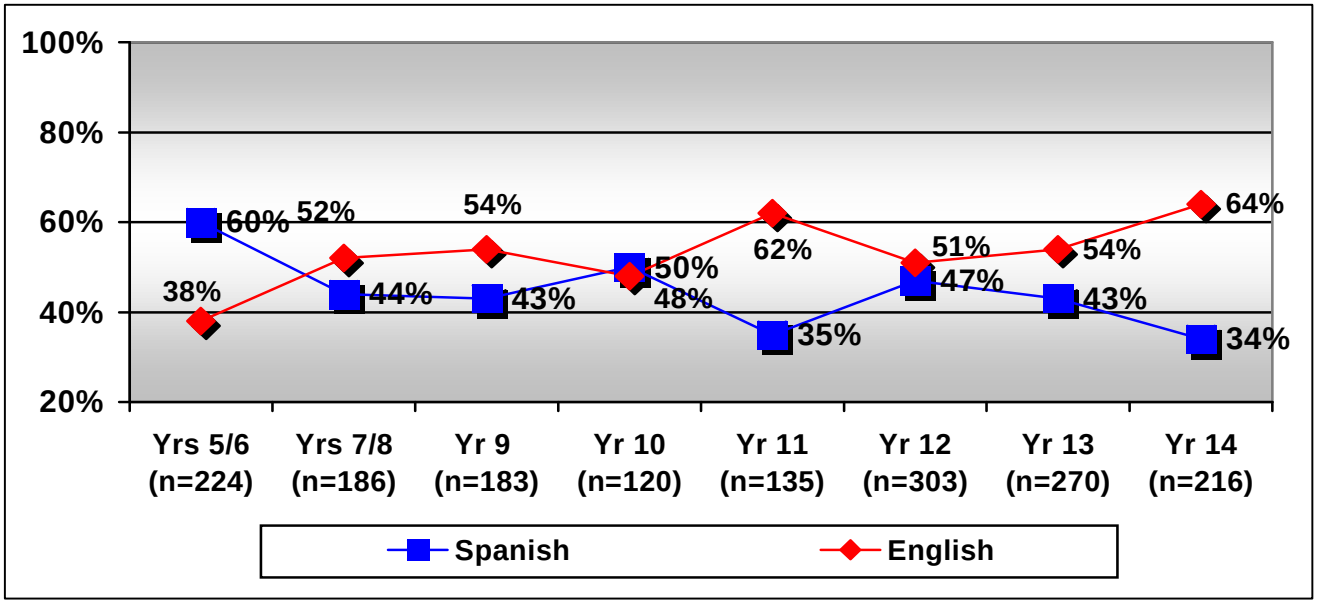
Figure 14. Trends in MOB Ethnicity- Year 5-Year 14



Language

Reflecting the ethnic trends described above, participant language has also varied accordingly. As seen in **Figure 15**, the trend in primary language mirrors the larger percentage of African-American participants who report English as their primary language. Of the 34% of mothers who report Spanish as their primary language, many do not speak any English at all, limiting their ability to access services and community supports, as well as to find employment. HSHF provides bi-lingual staff and linkages to ESOL in order to address these communication issues.

Figure 15. Trends in MOB's Primary Language-Year 5-Year 14

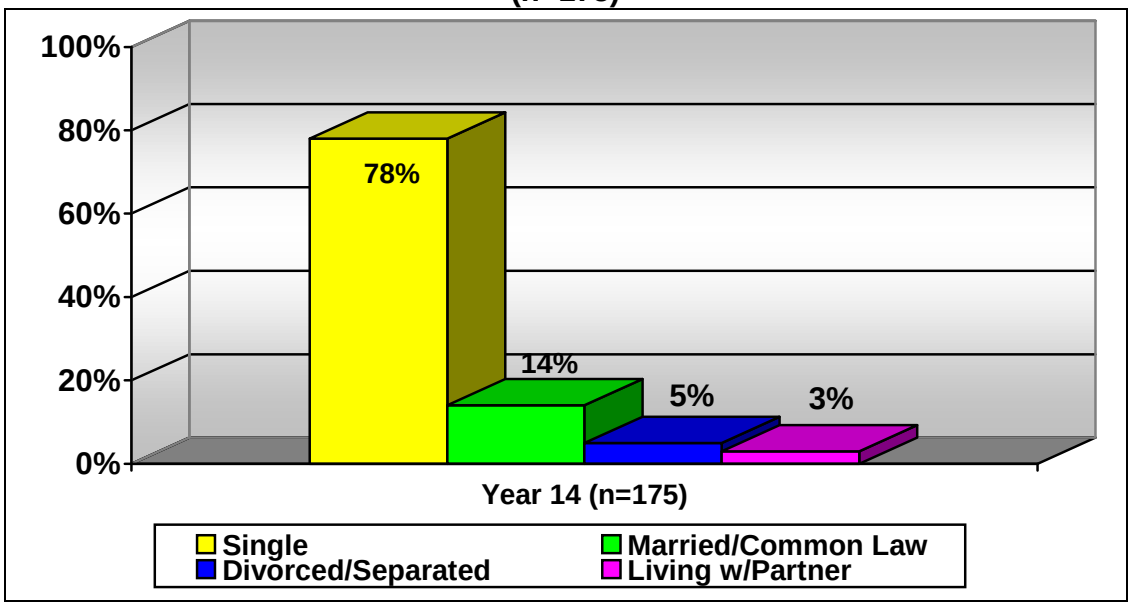


Marital Status

Marital status is associated with economic status, social and parenting support, and education status. Single mothers are more likely to achieve lower levels of education, have lower paying jobs, and have more depressive symptoms than married mothers.[3] As such, it is significant that more than three-fourths of participants in Year 14 were single (see **Figure16**). This represents an increase from previous years, as well as a decrease in percentage of mothers who are living with their partner. The large number of single mothers in the program indicates that the children are likely at a disadvantage without the economic and emotional resources of two parents..

[3] Luster, T; Okagaki, L. (2005) Parenting: An Ecological Perspective, Second Edition. Routledge.

Figure 16. Marital Status - Year 14 (n=175)



Mother's marital status at entry was examined for both primary ethnic groups, Hispanic/Latinos and African-Americans. As in previous years, there were significant differences in the marital status between the two groups (Pearson Chi Square x^2 (24,1)=45.536; p=.005). These differences have implications for how HSHF tailors its services for each group. As seen in **Table 20,** there has been a trend for decreasing percentages of African-American mothers to report single marital status, while an increasing percentage of Hispanic/Latino mothers indicated they were single at the time of enrollment.

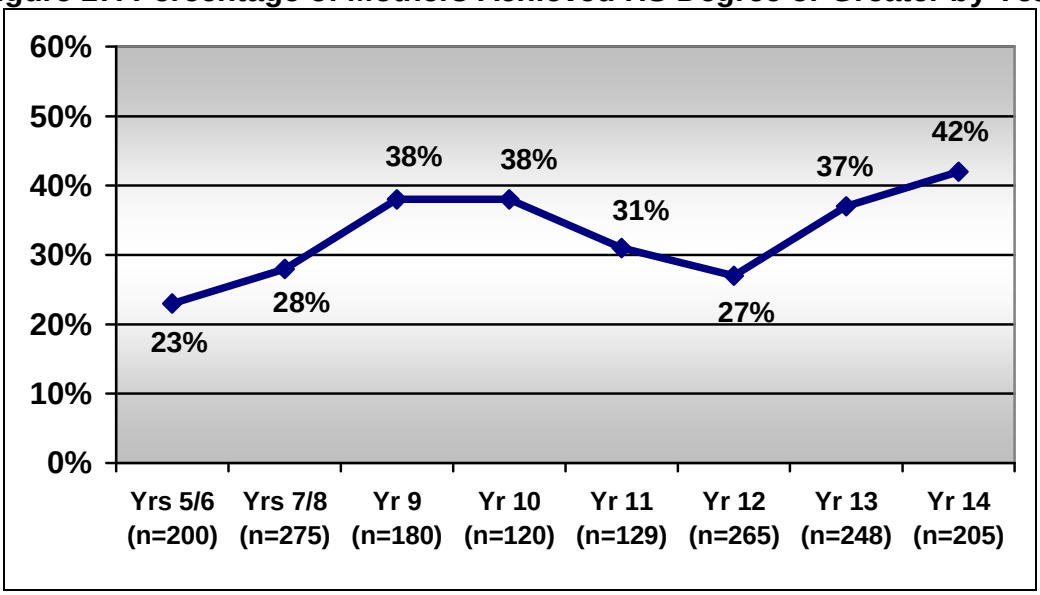
Table 20. Percentage of Single Parents by Ethnicity –Years 11-14

	Year 11 (n=127)	Year 12 (n=245)	Year 13 (n=238)	Year 14 (n=174)
Hispanic/Latino	56% (n=28/50)	70% (n=85/122)	73% (n=83/113)	78% (n=53/68)
African-American	90% (n=66/73)	92% (n=102/111)	85% (n=93/110)	83% (n=76/92)

Mother's Education

Mother's level of education is strongly associated with self-sufficiency, literacy, and parenting knowledge. Over the past seven years, there has been a trend for an increasing percentage of mothers who have achieved a high school degree or greater at enrollment into the program (see **Figure 17**). In Year 14, the percentage of mothers who had earned a high school degree or GED by the time of enrollment increased to the highest level since Year 5.

Figure 17. Percentage of Mothers Achieved HS Degree or Greater by Year



In comparing the educational status of both primary ethnic groups, Latinos and African-Americans, there are significant differences in the level of education between the two groups. It is evident that the increase in the rate of high school graduates was largely due to the change in demographics and increase in enrollment of African-American families during the expansion to Wards 5, 6, 7 and 8. **Table 21** show the comparative education statistics on these two groups for Years 11-14. Although both groups have steadily increased the percentage of mothers with a high school degree or higher, African-American mothers were twice as likely to have a high school degree or higher at the time of enrollment (Pearson Chi Square x^2 (5,1)=29.026; p=.000).

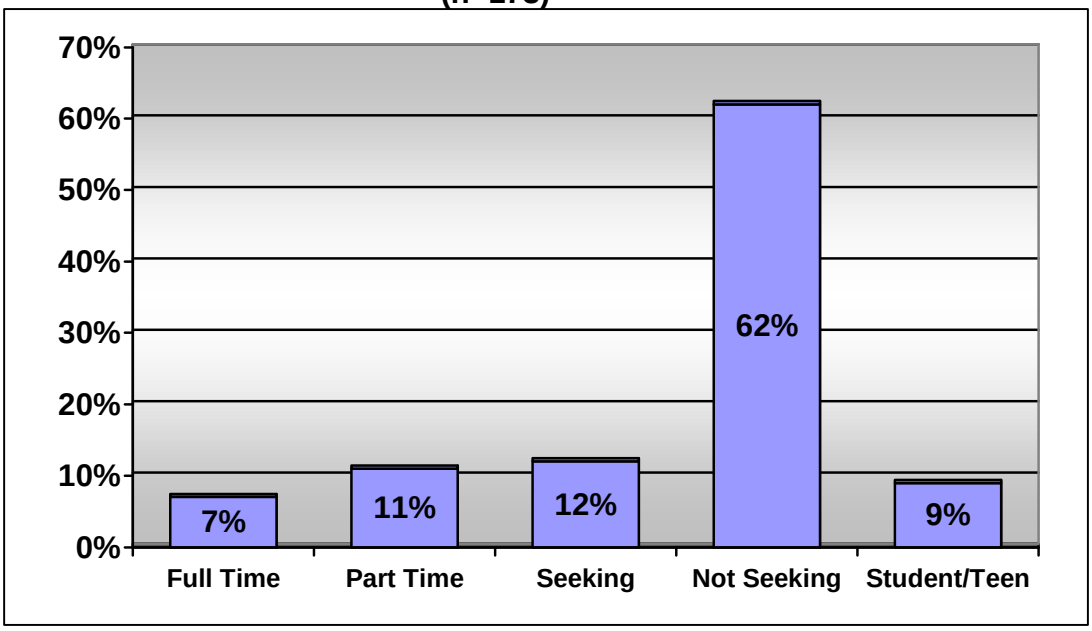
Table 21. HS/GED Degree or Higher by Ethnicity – Years 11-14

	Year 11 (n=127)	Year 12 (n=263)	Year 13 (n=248)	Year 14 (n=197)
Hispanic/Latino	15% (n=8/53)	19% (n=25/135)	18% (n=22/122)	23% (n=18/77)
African-American	41% (n=29/70)	33% (n=38/116)	53% (n=59/111)	52% (n=54/104)

Mother's Employment

Data on employment status at enrollment was examined for mothers active in Year 14. A small percentage of unemployed mothers who were not seeking work were teens under the age of 17 years. As seen in **Figure 18,** approximately two-thirds of mothers were unemployed when they entered the program. Most of these were not seeking work, primarily due to various barriers. However, a small percentage of unemployed mothers (12%; n=20) were looking for work when they enrolled in the HSHF program.

Figure 18. Mothers' Employment Status at Entry – Year 14 (n=173)



Mother's employment at entry was examined for both primary ethnic groups, Latinos and African-Americans. As with education level at enrollment, there were significant differences in the employment status between the two groups. **Table 22** shows the comparative employment percentages for Years 11-14, which have been fairly consistent for the Hispanic/Latino mothers, but increased significantly for African-American mothers from Year 11 to Years 12-14. As seen in the table, Hispanic/Latino mothers were twice (26%) as likely to be employed full-time or part-time at enrollment than African American mothers (12%) (Pearson Chi-Square Analysis x^2 (5,1)=12.599; p=.027).

Table 22. MOB Employment Status by Year and Ethnicity

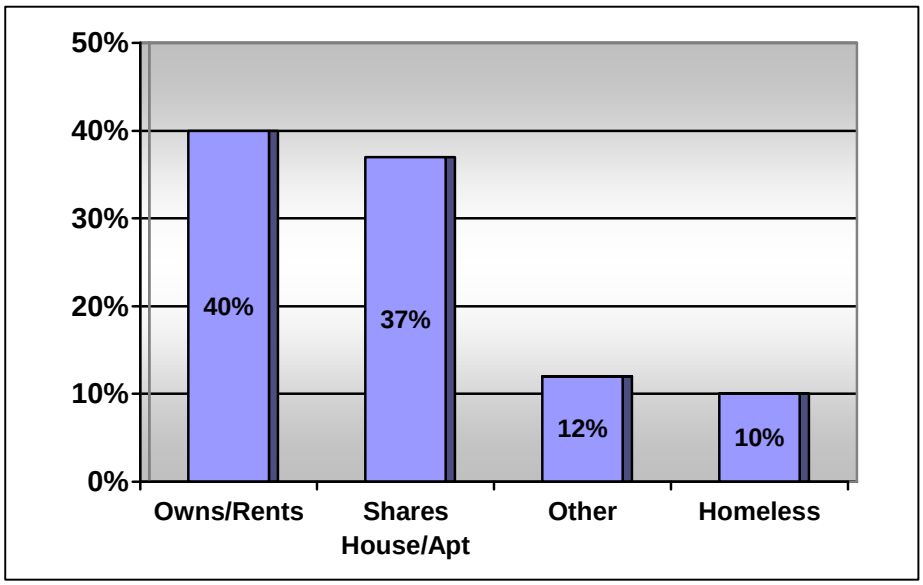
	Year 11 (n=125)	Year 12 (n=206)	Year 13 (n=206)	Year 14 (n=173)
Hispanic/Latino	26% (n=14/39)	21% (n=22/103)	27% (n=26/98)	26% (n=17/66)
African-American	6% (n=4/68)	15% (n=14/93)	13% (n=12/94)	11% (n=10/90)

Mother's Housing Status

Stable housing is essential to the well-being of both mother and baby. It is also indicative of the self-sufficiency and economic stability of the family. The stress associated with unstable housing and homelessness increases risk for poor childhood outcomes and for child abuse and neglect. As seen in **Figure 19**, most families in Year 14 had stable housing at enrollment. This could include either owning or renting a house or apartment; sharing a house or apartment with family or friends; or other situations, such as living in a dorm. However, a small percentage of mothers (10%; n=17) had no permanent housing or

were homeless, increasing their risk significantly. The HSHF program links these mothers to community resources to find stable housing. There was no significant difference in housing status by ethnicity.

Figure 19. MOB Housing Status at Entry - Year 14 (n=171)



Risk Factors of the Population

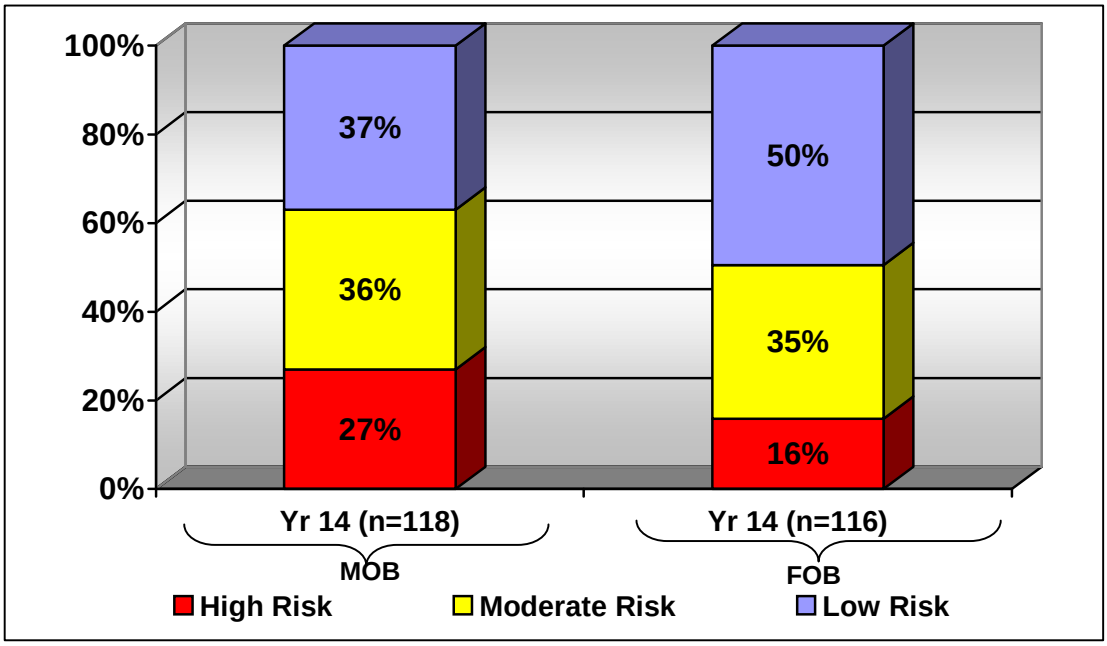
Research has identified several factors that increase risk for abuse and neglect. Parents and/or caregivers that are young, lack a high school degree, live in poverty, and do not have supports to help cope with stressful life situations are at greater risk. The demographic profile of HSHF participants at enrollment is consistent with this risk profile. Most program participants continue to be single, young mothers who have limited formal education and who are challenged by acculturation stresses such as limited English, social isolation and barriers to accessing supports and services. In addition to these factors, a number of health and mental health issues are associated with increased risk for child abuse and neglect. The screening and assessment tools for the HFHS program measure these factors to determine eligibility for the program and to support planning for individual families and program wide services.

FSC Risk Scores

Eligibility assessments are conducted using the C.H. Kempe Family Stress Checklist (FSC), with scores examined to determine participants' risk for child abuse and neglect. The FSC is a 10-item scale that measures risk for parenting difficulties based on responses to a thorough psychosocial interview. It covers a variety of domains, including psychiatric history, criminal and substance abuse history, childhood history of care and child rearing practices, emotional functioning, attitudes towards and perceptions of children, intended discipline strategies for children, and level of stress in the parents' lives. The profiles of mothers and father assessed in Year 14 are presented in **Figure 20.** The disparity between

mothers' and fathers' scores is likely attributable to the amount of unknown and second hand information about fathers, typically provided by mothers at the time of the assessment. Mothers with scores in the low-risk range can still be enrolled in the HSHF program based on medical risk. Also, they could also be eligible based on the FOB's score. In Year 14, about one third (37%) of mothers scored in the Low Range, while the remainder scored at Moderate Risk (36%) and High Risk (27%).

Figure 20. FSC Risk Scores-Year 14



Overall, mothers enrolled in Year 14 are characterized by a constellation of risk factors. Most (83%) are single or divorced, with low levels of education (only 42% with HS degree) and employment (64% unemployed). Most are between 20-35 years of age (61%), but almost one third (31%) are teens under the age of 20 years. More than half of the mothers are African-American (57%) while the other half is comprised primarily of Hispanic/Latino mothers (40%) and 'Other' (3%; African; Caucasian; multi-ethnic). Most of the mothers reside in DC Wards 1, 4, 7, and 8, the highest risk wards in the District. Although most mothers (90%) had stable housing at program entry, the remaining 10% had no permanent housing or were homeless. The risk status of mothers is confirmed by scores on the Family Stress Checklist (FSC), on which 63% of mothers and 51% of fathers scored at moderate to high risk.

Outcome Evaluation

Achievement of Goals and Objectives

The Healthy Start Healthy Families (HSHF) program has consistently met with success over the past 14 years in achieving its goals and objectives, and has exceeded many of its targets for key outcomes. It is important to note that this was accomplished despite the significant organizational changes and restructuring that occurred during the merge of the Healthy Families DC and Healthy Start programs. Outcome results are presented by program goals and objectives. *Goal I* and the related objectives are discussed in the Process Evaluation section of this report under *Screening, Assessment and Enrollment.* Outcome findings are summarized by year and objective in **Table 18** and with comparative local and national statistics in **Table 19** following the summary.

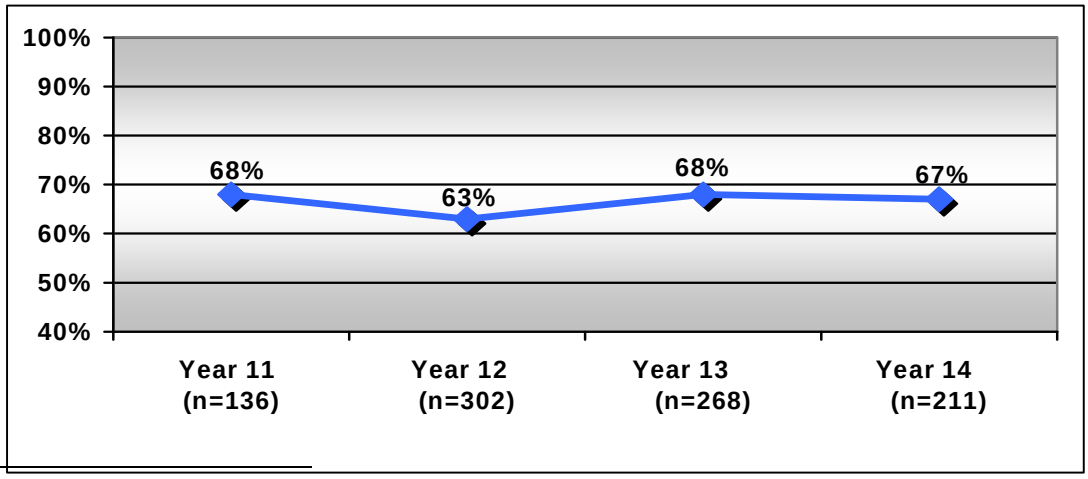
Goal II. Promote Optimal Birth and Child Health Outcomes

Objective 1: 90% of families entering the program will enroll prenatally.

In *A Healthy Start, Begin Before Baby's Born*, the U.S. Department of Health and Human Services, Maternal and Child Health Bureau states that "babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight and five times more likely to die than those whose mothers received prenatal care."[4] As such, a primary goal of the HSHF Program is to enroll families prenatally. In accomplishing this objective, the program supports participants in accessing prenatal care, thus detecting any potential physical health complications and providing referrals to appropriate specialists, if necessary. In addition, the HSHF program helps mothers to recognize the importance of their own health behaviors during pregnancy and the relationship of early prenatal care to the positive birth outcomes of their babies.

As seen in **Figure 21**, the HSHF program did not reach its goal of 90% prenatal enrollments in Years 11-14. However, ***the majority of mothers (67%) in Year 14 enrolled prenatally***, many of whom enrolled in the first or second trimester.

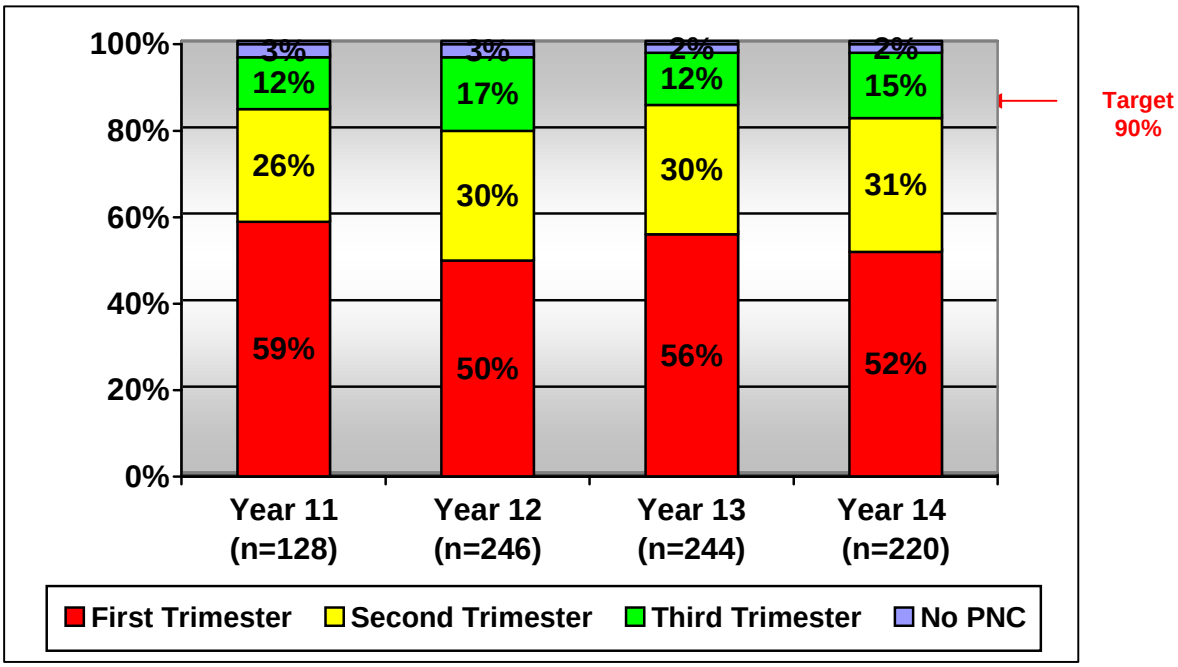
Figure 21. Percentage Enrolled Prenatally-Years 11-14



[4] Maternal and Child Health Bureau. A Healthy Start: Begin Before Baby's Born. Health Resources and Services Administration. Rockville: MD. Obtained 2/5/2006 from http://mchb.hrsa.gov/programs/womeninfants/prenatal.htm.

The HSHF screening and assessment process is often initiated much before enrollment occurs, mothers may be linked to prenatal care during this time, but not be enrolled yet. As such, it is important to examine the trimester that first prenatal care was received. As seen in **Figure 22**, the overwhelming majority of mothers (97%-98%) received prenatal care, while most (80%-85%) initiated prenatal care in the 1st or 2nd trimester. In Year 14, more than half of mothers (52%) received prenatal beginning in the 1st trimester, while an additional 31% began prenatal care in the 2nd trimester.

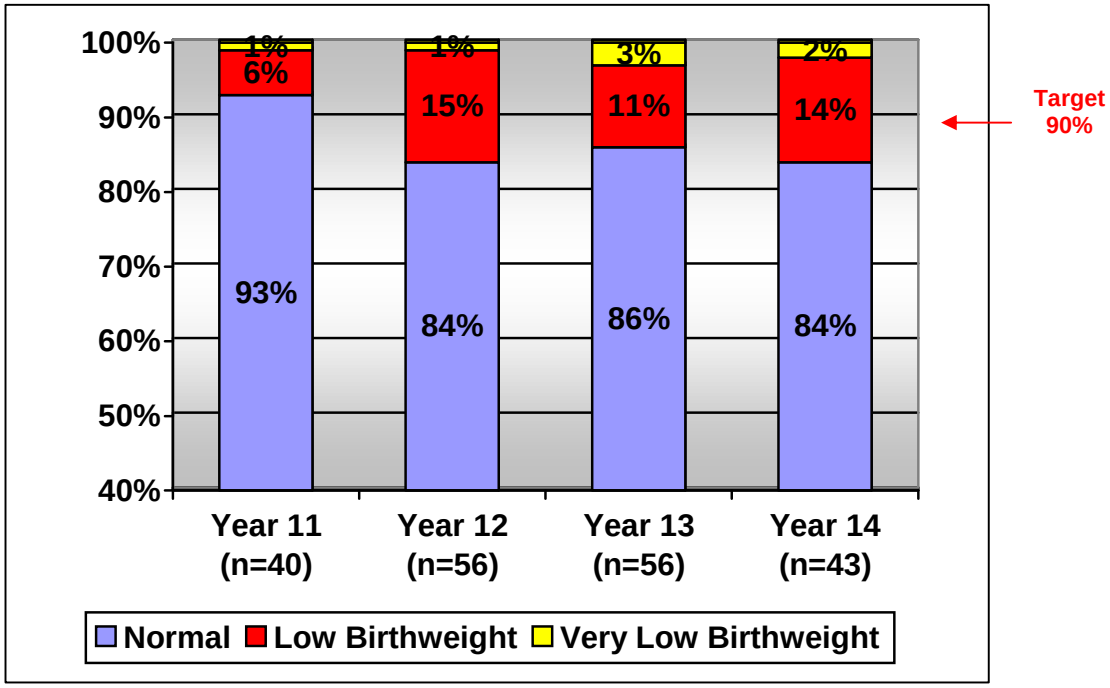
Figure 22. Trimester of Prenatal Care - Years 11-14



Objective 2: 90% of families who enrolled in the 1st or 2nd trimesters will deliver babies with healthy birth weights.

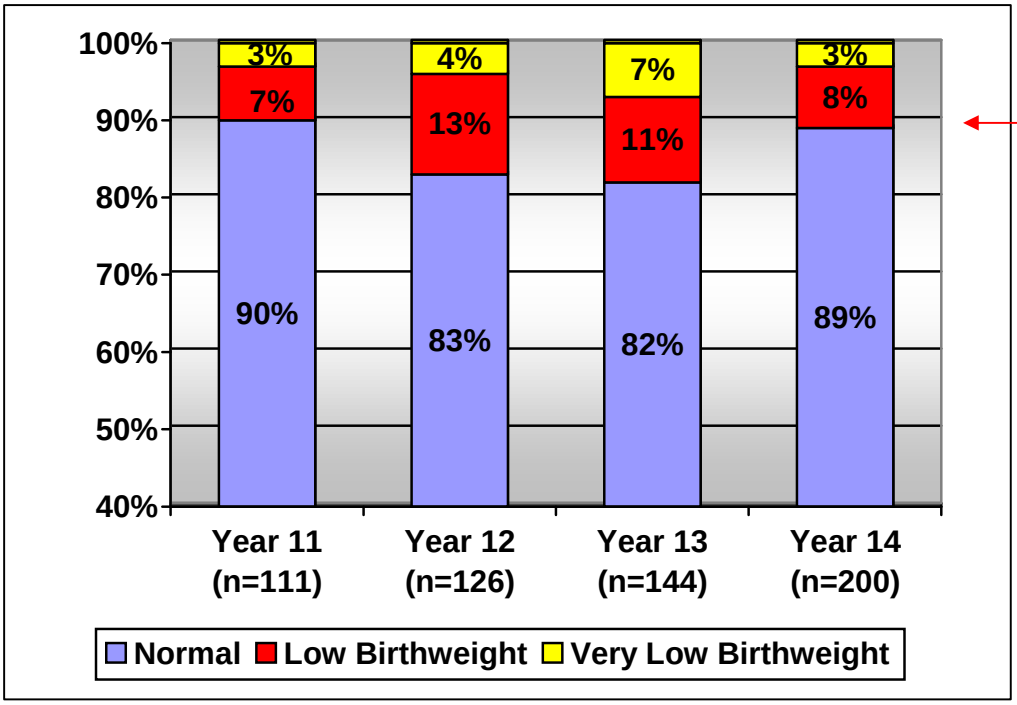
Through the promotion of early prenatal care for its participants, the HSHF program plays a pivotal role in enhancing the positive maternal and child health outcomes in the District of Columbia. The HSHF program strives to educate participants about what they can do to impact positive health outcomes for their baby by ensuring all prenatal enrollees attend regularly scheduled prenatal care visits and providing information on healthy eating and lifestyle habits during pregnancy. Babies born during the three reporting periods include: Year 11 (n=66); Year 12 (n=70); and Year 13 (n=100). There were 105 babies As seen in **Figure 23**, When examining only the participants ***who enrolled in their 1st or 2nd trimester prenatally and who had their babies by the end of the reporting period, 84% delivered babies with a healthy birth weight.***

Figure 23. Healthy Birth Weight: 1st and 2nd Trimester Enrollees Only Babies Born During Fiscal Years 14



Although this objective focuses on the impact of enrollment in the HSHF program in promoting early prenatal care, the screening and assessment process is instrumental in linking mothers to prenatal care. As indicated in Objective 1, most HSHF participants (83%) received their first prenatal care in the first or second trimester. As such, it is helpful to examine the birth weight of all children born to participating mothers. **Figure 24** displays the percentages for the **entire sample** of babies born in Years 11-14**.** In Year 14, HSHF achieved 89%, almost meeting the program target. Also, the percentage of babies born with LBW (8%) and VLBW (3%) decreased significantly in Year 14. Results for all children born are comparable or exceed National (92%) and the District of Columbia (88%) rates. This is particularly noteworthy since the HSHF program enrolls a maternal population that is primarily African-American and Hispanic/Latino, and that is at high-risk for poor birth outcomes.

Figure 24. Healthy Birth Weight: All Children Born to Mothers Active in Years 11 - 14



**Years 12 and 13 mark the inclusion of Healthy Start mothers who are identified as at high medical risk for infant mortality*

Consistent with national and local statistics, when birthweight is broken out by ethnicity, Latino participants have higher percentages of babies with a healthy birthweight than African-Americans. ***In Year 14, Latinos (92%; n=66) were more likely to have babies with a healthy birthweight than African-Americans (86%; n=98).*** These percentages exceed HSHF Years 12 and 13, and are comparable to national and DC rates.

- **2006 Nat'l Rates - Latino=93%; African-American=86%**
- **2006 Wash DC - Latino=92%; African-American=85%**
- HSHF Year 11 - Latino= 96%; African-American=91%
- HSHF Year 12 - Latino= 87%; African-American=84%
- HSHF Year 13 - Latino= 87%; African-American=83%
- **HSHF Year 14 - Latino= 92%; African-American=86%**

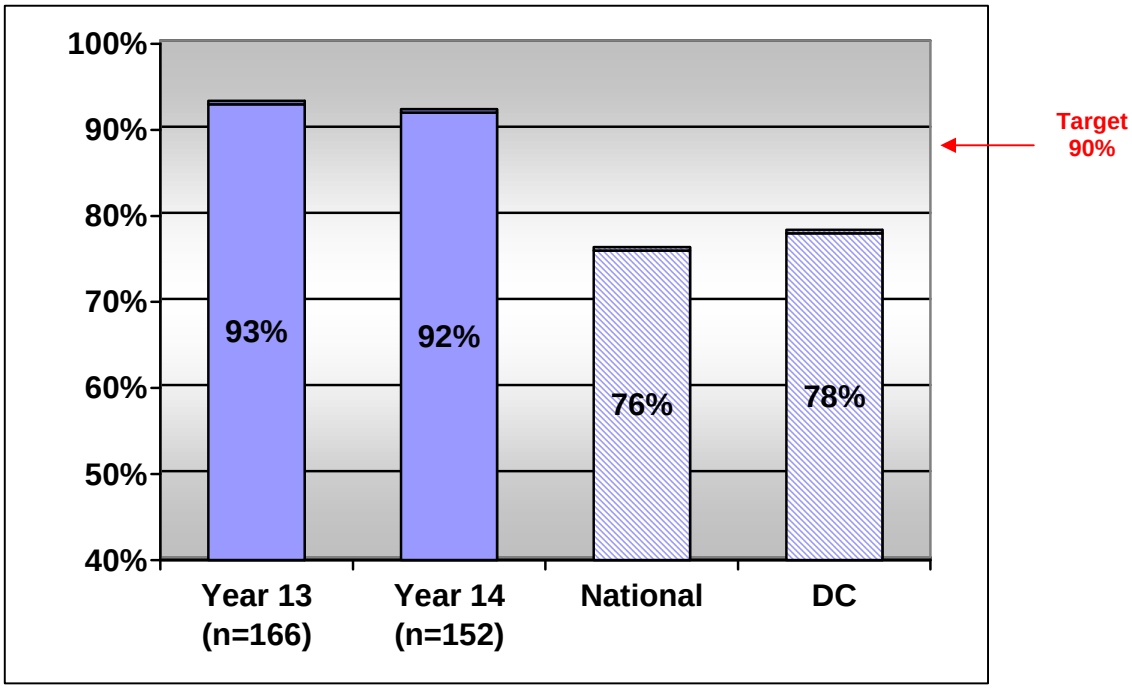
Objective 3: 90% of children will be up to date on their immunizations.

FSWs work with families to ensure that babies get their immunizations in a timely fashion. This is done through providing information to families on the importance of immunizations for preventing very serious medical diseases, and also through assisting with linkage to healthcare providers, helping to set up appointments when needed, arranging for transportation to appointments and reminders about appointments as necessary. Because of these efforts, HSHF has achieved impressive success rates with children receiving their immunizations. Families are more likely to follow up on immunizing their children if they have both health insurance and a medical provider, as they do not

have to worry about payment. As such, this goal is closely linked to the next goal, which is assisting parents and children in securing medical insurance and providers.

HSHF follows the 4:3:1:3:3:1 combined immunization series as the benchmark for full immunization status. Data was available for 152 children in Year 14. As seen in **Figure 25**, in Year 14, ***92% of children were current with their immunizations.***

Figure 25. Child Immunization Rates – Years 13 & 14



Center for Disease Control and Prevention: Vaccines and Immunizations Data Table, 2008 (4:3:3:1:3:3:1 series). Available at http://www2a.cdc.gov/nip/coverage/nis/nis_iap2.asp?fmt=r&rpt=tab26_431331_race_iap&qtr=Q1/2008-Q4/2008

Consistent with national and local statistics, when child immunization rates are broken out by ethnicity, Year 14 HSHF Latino participants (96%; n=55) had significantly higher child immunization rates than African-American participants (85%; n=68) (Pearson Chi Square x^2 (8,1)=17.614; p=.024).

- **2008 Nat'l Rates - Latino=78%; African-American=73%**
- **HSHF Year 14 – Latino= 96%; African American=85%**

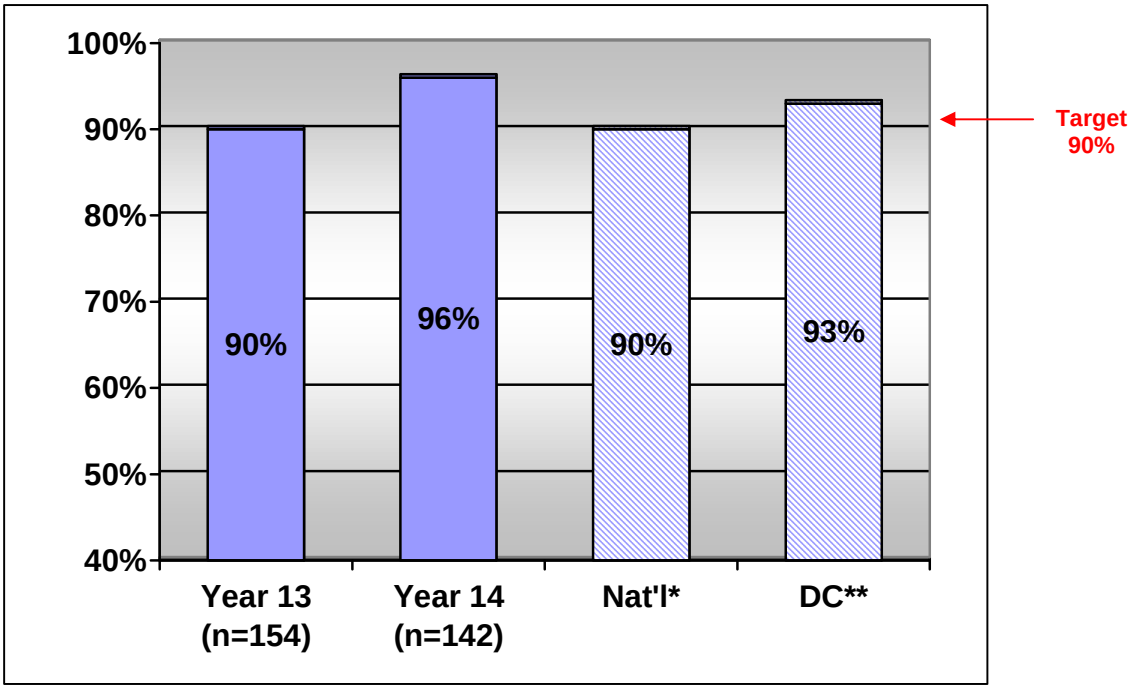
Objective 4: 90% of children will be enrolled in a health insurance program.

An important goal of the HSHF program is ensuring that both mothers and babies are lined with health insurance and primary care providers. The two major federal funding sources for low-income children's public health insurance are Medicaid and the State Children's Health Insurance Program (SCHIP). States enjoy some flexibility in their Medicaid programs for children, but federal requirements establish minimum benefit

packages and strictly limit cost-sharing. SCHIP funds allow states to increase coverage for children through expanding their Medicaid programs ("Medicaid SCHIP") and/or creating separate SCHIP programs. The District of Columbia provides health insurance for low-income children through its Medicaid and SCHIP programs, as well as coverage for mothers pre and post-partum.

In addition to the primary care and insurance enrollment services available through Mary's Center, HSHF has established strong partnerships with medical providers throughout the city, enabling the program to successfully enroll qualifying children in Medicaid/SCHIP insurance and link them to primary care providers. In Year 14, data on children's health insurance was available on 142 children. Of these, ***96% were enrolled in a public or private health insurance program*** and linked to a primary care provider. As seen in **Figure 26,** this percentage exceeds both National and District of Columbia comparative rates.

Figure 26. Child's Medical Insurance: Year 13-Year 14

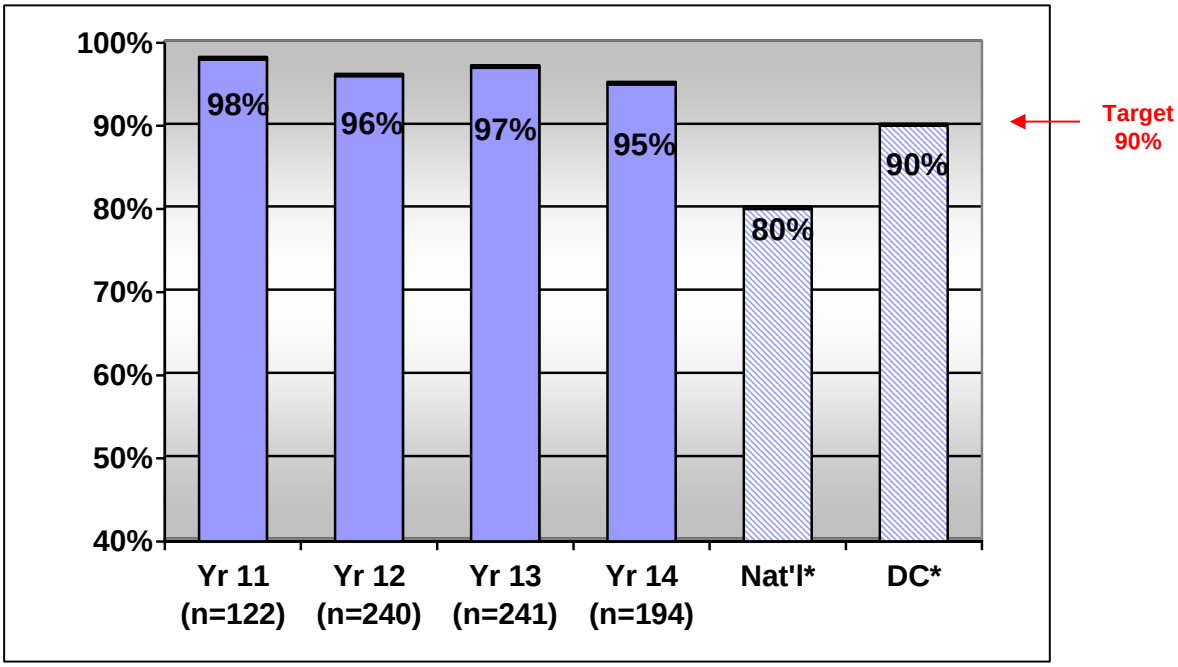


**US Census Bureau: Health Insurance Coverage 2008. Available at*
http://www.census.gov/hhes/www/hlthins/hlthin08/hlth08asc.html
*****National Center for Children in Poverty: State Profiles-Maryland 2007. Available at***
http://www.nccp.org/profiles/MD_profile_32.html

Mother-Linkage to Health Insurance and Medical Home

In the District, prenatal and postpartum health care visits are usually provided through public insurance or programs. HSHF emphasizes the importance of ongoing preventive health care, particularly for mothers pre/post-partum. **Figure 27** shows that, of the 194 mothers on whom insurance data was available, ***95% (n=134) have been linked to health insurance.***

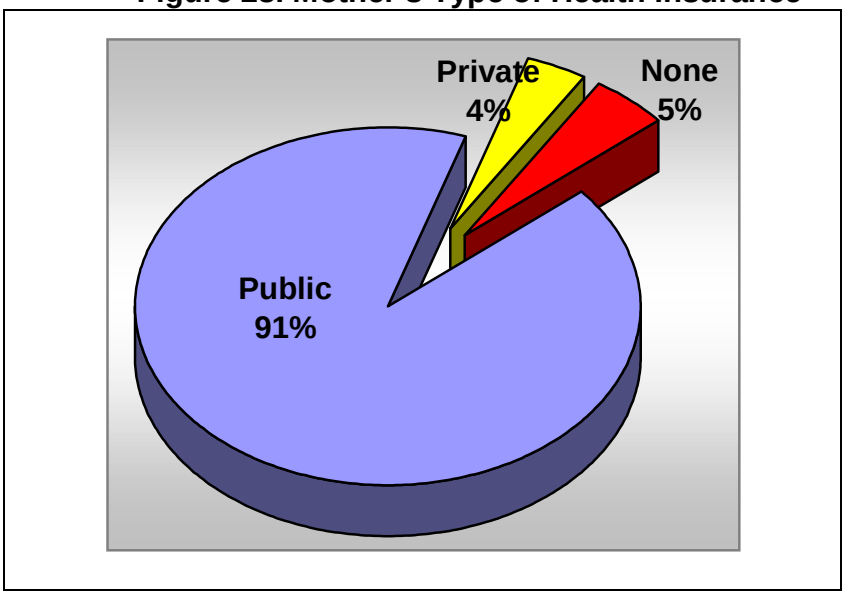
Figure 27. Mothers' Linkage to Health Insurance (n=367)



**US Census Bureau: Health Insurance Coverage 2008. Available at http://www.census.gov/hhes/www/hlthins/hlthin08/state.xls*

Most of the mothers were linked to public sources of insurance (91%; n=177), while a small percentage (4%; n=7) were linked to private providers. The remaining 5% (n=10) did not have insurance yet or were not eligible.

Figure 28. Mother's Type of Health Insurance



After securing medical insurance, HSHF ensures mothers are linked to a medical home. Of the 417 mothers for whom provider data was available***, almost all (97%, n=/154) have also been linked to a medical home/primary care provider.***

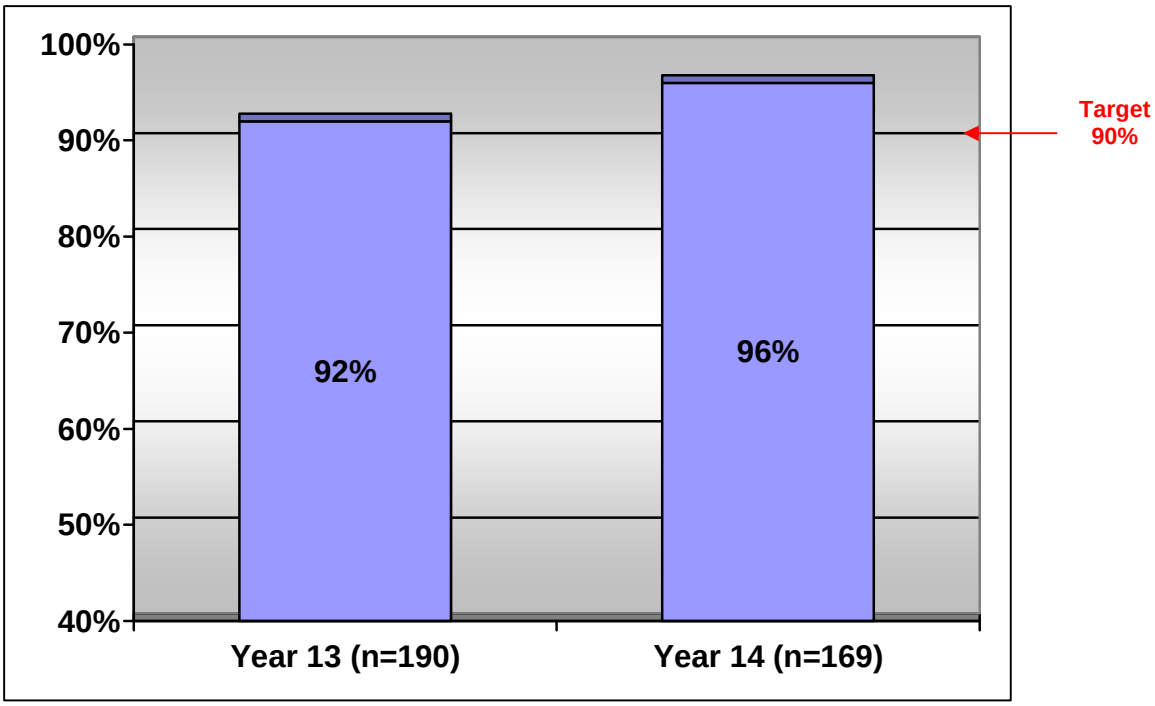
Goal III. Promote Optimal Child Development and School Readiness

Objective 1: 90% of children will be screened for potential developmental delays at regular intervals (every 6 months during the first year and annually thereafter).

Healthy Families DC utilizes the Ages and Stages Questionnaire (ASQ) to monitor children's cognitive, motor, language, social and emotional development. The program aims to screen each target child regularly between the ages of 4 months and 5 years, administering the ASQ at 4, 6, 8, 12, 16, 18, 20, 24, 30, 36, 48, 54, and 60 months. Use of the ASQ enables program staff to identify infants and young children who demonstrate potential developmental delays in any one of five areas: (1) communication, (2) gross motor, (3) fine motor, (4) problem solving, and (5) personal social. Each item, focusing on performance of a specific behavior, is marked "yes", "sometimes", or "not yet". These regular screenings with the ASQ enable HSHF staff and parents to monitor the children's developmental progress, provide appropriate stimulation at each stage, and identify potential delays.

In Year 14, there were 169 children that were due for a developmental screening. Of these, ***94% (n=162) received an ASQ screening***. This percentage exceeds that achieved in HSHF Year 13 (see **Figure 29**).

Figure 29. Percentage Children Screened for Developmental Delay – Years 13 & 14



Goal IV. Foster Positive Parenting and Parent-Child Interaction

Objective 1: 85% of parents will score at or above normal range for knowledge of child development after 1 year of enrollment and annually thereafter.

The Knowledge of Infant Development Inventory (KIDI) is used to assess knowledge of parental practices, developmental processes, infant norms of behavior, and child health and development. As seen in **Table 11**, there has been a trend for slightly higher percentages of passing scores from Year 11 to Year 13 at both baseline and 12-month follow-up. This may represent the program's merger of Healthy Start parents in Year 12 who have already received parenting support through that program before the merge, and the inclusion of mothers who are not first time parents at the time of enrollment.

Of the parents in the Year 14 active sample, a total of 131 were administered a baseline KIDI. Of these, 63% earned passing scores (=>8). Of these, 49 participants were enrolled long enough to complete a 12-month KIDI. As seen in **Table 11**, the percentage of participants increased 11 percentage points over one year in the program as ***74% achieved passing scores, indicating an adequate knowledge of infant development***.

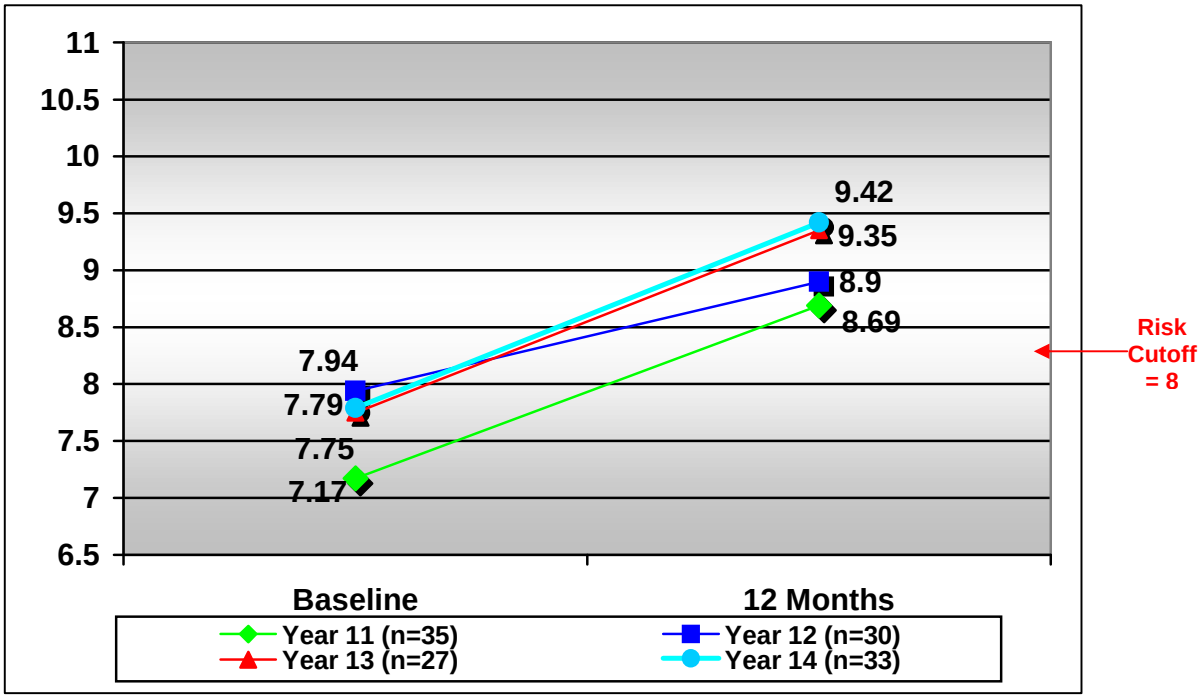
Table 11. Percent Mothers with Adequate Parenting Knowledge-Year 11-14 Baseline and 12-Month Follow-up

	Baseline KIDI	12-Month Follow-up
Year 11 Active Sample (n=145)	55% (n=46/83)	79% (n=30/38)
Year 11 Research Sample (n=91)	52% (n=34/66)	77% (n=27/35)
Year 12 Active Sample (n=309)	66% (n=64/97)	76% (n=31/41)
Year 12 Research Sample (n=170)	64% (n=46/72)	77% (n=30/39)
Year 13 Active Sample (n=272)	62%(n=77/124)	84% (n=37/44)
Year 13 Research Sample (n=156)	65% (n=53/82)	83% (n=29/35)
Year 14 Active Sample* (n=276)	**63% (n=83/131)**	**74% (n=36/49)**

GLM repeated measures analyses, which calculate pre-post score variance within the same individual participant groups, were conducted on KIDI scores of ***active families in Year 14 from Baseline to 12-months.*** As seen in **Figure 30**, across the Baseline to 12-month period, there was ***a statistically significant increase in Year 14 KIDI scores from program entry to one year of enrollment. These results parallel significant findings in Years 11, 12 and 13.***

- **Year 14 GLM: F (1,32) = 12.532; p=.001). X score increases: 7.79 to 9.42**
- Year 11 GLM: F (1,34) =15.097; p>.001). X score increases: 7.17 to 8.69.
- Year 12 GLM: F (1,30) = 5.344; p>.028). X score increases: 7.94 to 8.90.
- Year 13 GLM: F (1,39) =13.602; p>.001). X score increases: 7.75 to 9.35.

Figure 30. Mean Parenting Knowledge (KIDI) Scores-Baseline & 12-Months Years 11 - 14

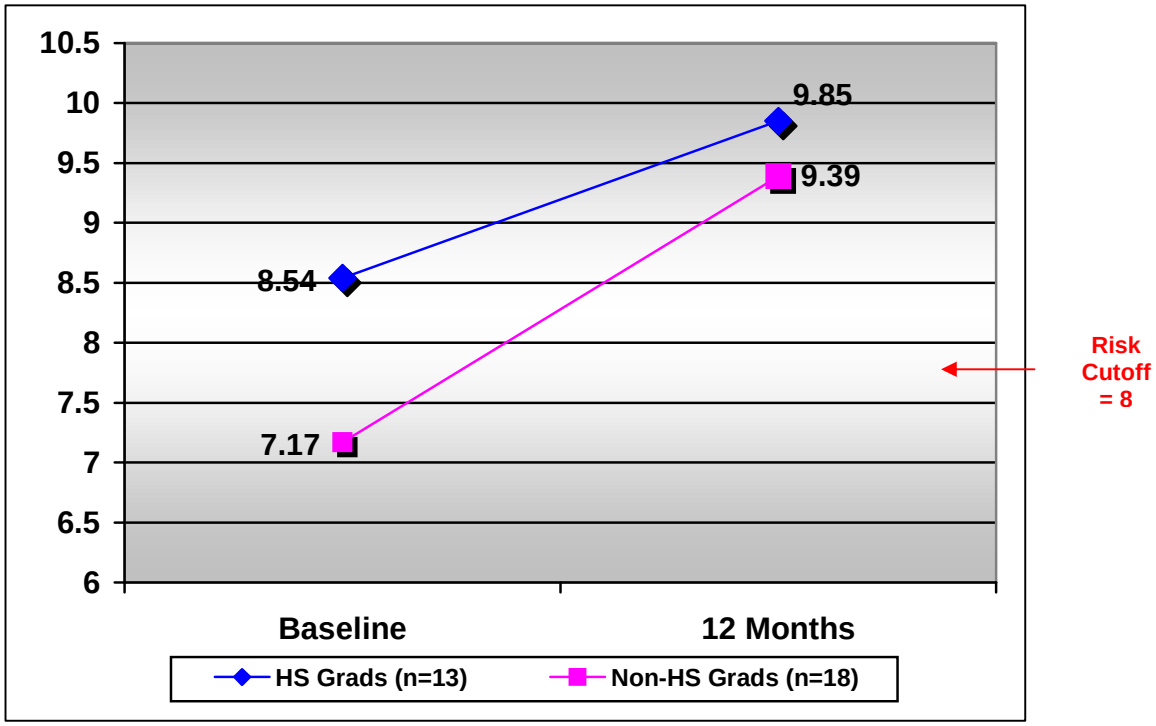


Parenting Knowledge and Mother's Education

In past years, there has been a significant difference in KIDI scores between mothers with a high school degree or greater and mothers with less than a high school degree. In order to determine if mother's level of formal education continues to be related to her parental knowledge, baseline and 12-month follow-up KIDI data on the two groups of mothers, high school graduates and non-high school graduates, were examined. As seen in **Figure 31** below, both groups significantly increased their parenting knowledge. Note that the although the high school graduates had higher scores at baseline, ***the HSHF program is able to achieve significant increases in knowledge for both groups so that after 12-months in the HSHF program, the differences between the groups are non-significant.***

Further, the effect size for non-graduates was greater than for the HS degree/GED group. Using partial eta squared, the effect size for HS graduates was .281, indicating that 28% of the total variance in mean KIDI scores is accounted for by time in the program, while the effect size for non-graduates was .386, indicating that the program accounted for 39% of the improvement.

Figure 31. Mean Parenting Knowledge (KIDI) Scores Baseline & 12 Months -Year 14 High School vs. Non-High School Graduates



- HS Graduates GLM: F (1,12) = 22.231; p>.05). X score increase: 8.54 to 9.85.
- Non-Graduates GLM: F (1,39) =13.602; p>.001). X score increase: 7.17 to 9.39.

Parenting Knowledge and Mother's Ethnicity

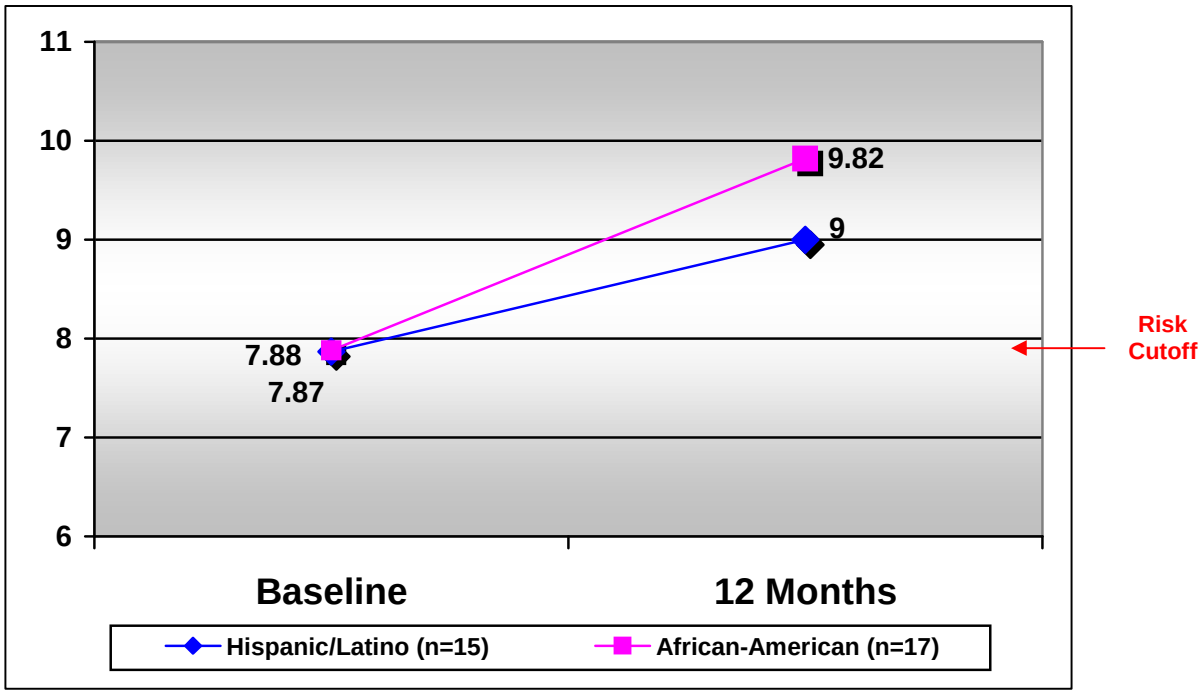
As noted in the demographic section, the HSHF program is comprised primarily of Hispanic/Latino and African-American families who differ significantly in education level at entry. KIDI scores were examined by ethnicity and, as seen in **Figure 32**, results indicate a significant difference in mean scores at the 12-month follow-up. African-American mothers were more had a higher mean score of parent knowledge after 12 months of program participation than Hispanic/Latino mothers. This difference may be largely due the education levels, but may also be attributable to cultural differences.

GLM repeated measures analyses, which calculate the pre-post score variance within the same individual participants in each group, found that across the Baseline to 12-month period, both ethnic groups demonstrated a significant increase in KIDI scores, indicating that despite ethnic differences, the HSHF program is successful at improving the parenting knowledge of all mothers after 12 months of participation.

In terms of ethnicity, African-American mothers made greater gains in parenting knowledge than Hispanic/Latino mothers. However, when effect size is calculated, the program appears to have a slightly stronger impact on Hispanic/Latino participants in parenting knowledge. Using partial eta squared, the effect size for Hispanic/Latinos was .364, indicating that 36% of the total variance in mean KIDI scores is accounted for by time

in the program, while for African-Americans an effect size of .261 was calculated, indicating only 26% of change is accounted for by time in the program. This may be attributed to the association of education level and parenting knowledge and how this covaries with African-American mothers' experience in the program to increase parenting knowledge.

Figure 32. Mean Parenting Knowledge (KIDI) Scores Baseline & 12 Months Year 14 by Ethnicity



- Hispanic/Latino GLM: F (1,14) =7.996; p>.013). X score increase: 7.87 to 9.0.
- African-American GLM: F (1,16)=5.664; p>.030). X score increase: 7.88 to 9.82.

Goal V. Promote and Support Family Self Sufficiency

Objective 3. 80% of mothers will not have an additional birth within two years of the target child's birth.

It is recommended that mothers, and particularly young teenage mothers, wait a period of at least 24 months between pregnancies. The HSHF program provides information on family planning to participants immediately upon enrolling in the program. FSWs alert new parents to the fact that additional pregnancies can happen at any time, even when the mother is breastfeeding just after the birth of the baby. The necessity of using family planning methods to prevent unwanted pregnancies is stressed. Related to its success in linking mothers to a health care provider and to health insurance, the HSHF program has also been successful in educating participating mothers in family planning with the goal of decreasing unwanted pregnancies.

There were 127 babies born during Year 14. Of these, six were siblings to the target child. Only one of these siblings was born in less than 24 months of the target child.

Therefore, *the* ***HSHF achieved 99.6% (n=127) of mothers did not have a repeat birth within a 24-month period*** during their enrollment in the program. No teen mothers had a repeat birth within 24 months. HSHF's success rate in this area has consistently exceeded both national (adults=65%; teens=80%) and local District of Columbia (teens=83%) statistics.

Objective 4. 95% of mothers will be screened at least once for depression.

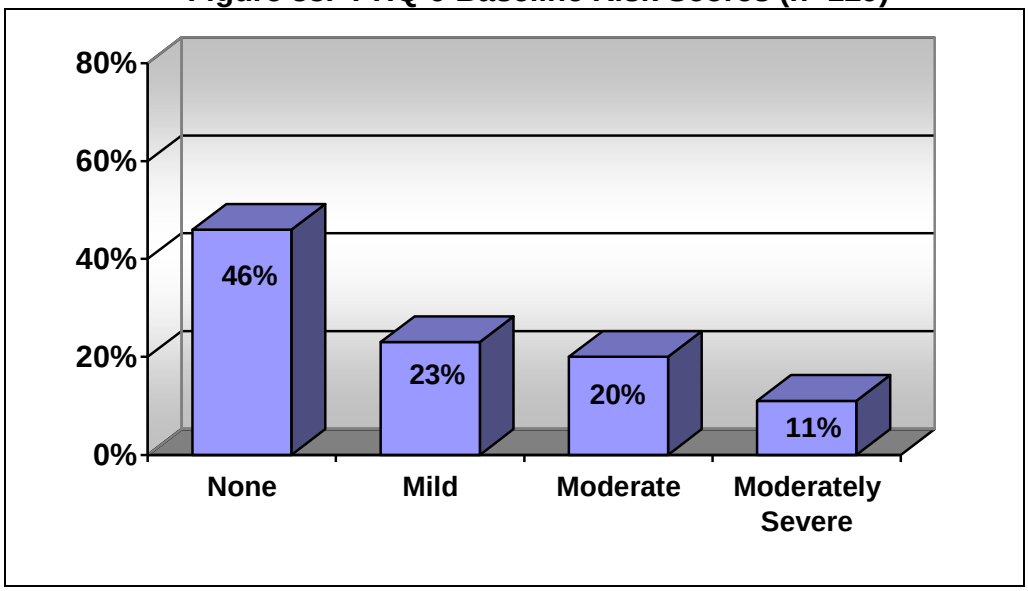
Maternal depression has a direct negative impact on children's development and behavior in that it impedes a mother's ability to bond and effectively discipline her children. Given the projected prevalence of depressive symptomology in the population targeted by HSHF, the program strives to identify those participants most at risk and provide appropriate intervention services as soon as possible.

To measure maternal depression, the HSHF program administers the PHQ-9, the nine-item depression scale of the Patient Health Questionnaire, to screen for symptoms of maternal depression and to assess the level of severity for risk of depressive disorder. This measure replaced the CES-D in January 2008. As a result, the number of participants who have received a baseline and follow-up administration of the PHQ-9 may seem small relative to the number of active families. However, families who enrolled before January 2008 were screened with the CES-D and those results have been reported in previous reports. ***During Year 14, there were 278 active mothers, of these, 71% (n=196/278) received at least one screening for depression.***

Maternal Depression

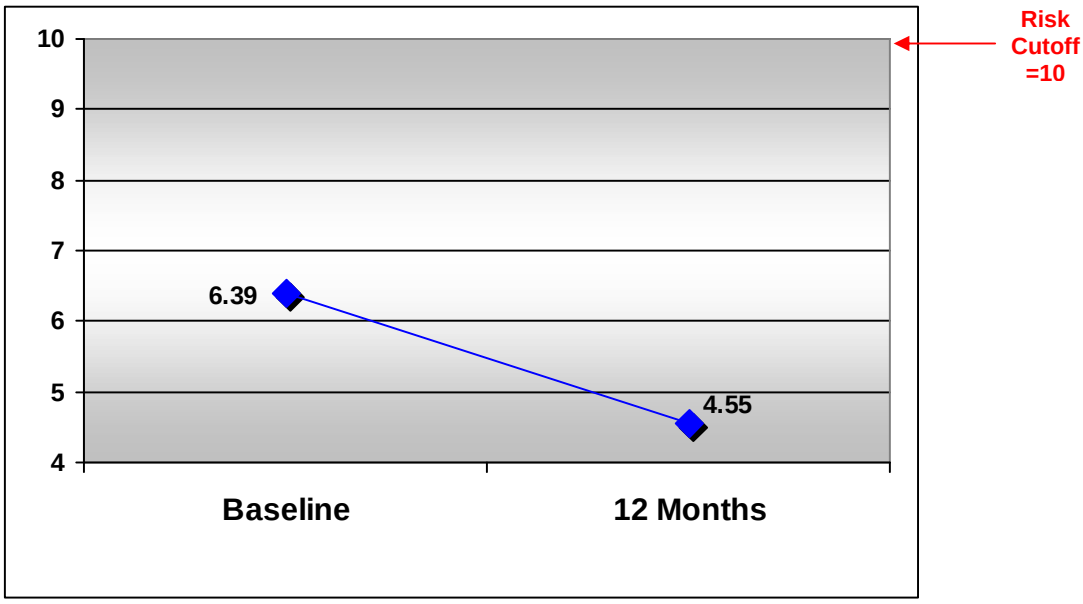
Of the active sample of mothers in Year 14, n=129 mothers were administered a baseline PHQ and n=25 mothers had been screened at baseline using the CES-D. As seen in **Figure 33**, **about one third of mothers (32%; n=49) scored in the Moderate-Moderately Severe range on the PHQ-9 or at-risk on the CES-D, suggesting risk for depression at the time of enrollment.** An additional 20% (n=30) mothers scored at Mild risk on the PHQ-9. Of the 14 mothers who scored at moderately severe risk, all were referred to mental health services. Overall, 20 mothers received mental health services from the HSHF therapist in Year 14.

Figure 33. PHQ-9 Baseline Risk Scores (n=129)



GLM repeated measures analyses were conducted on PHQ-9 scores to calculate the pre-post score variance within the same individual participants over time. As seen in **Figure 34**, there were 33 participants that were administered both a baseline and 6-month follow-up PHQ-9. Results indicated a significant decrease in PHQ-9 scores (F (1,32) =7.608; p=.01), from Baseline to 6-months of enrollment. This provides evidence that ***the HSHF program is successful at significantly decreasing depressive symptoms and risk for depression within six months of participation.*** Additionally, using partial eta squared, the effect size for depression risk was .192, indicating that 19% of the total variance in mean PHQ-9 scores can be accounted for by time in the program.

Figure 34. PHQ-9 Mean Scores-Baseline & 6-Months – Year 14 (n=33)

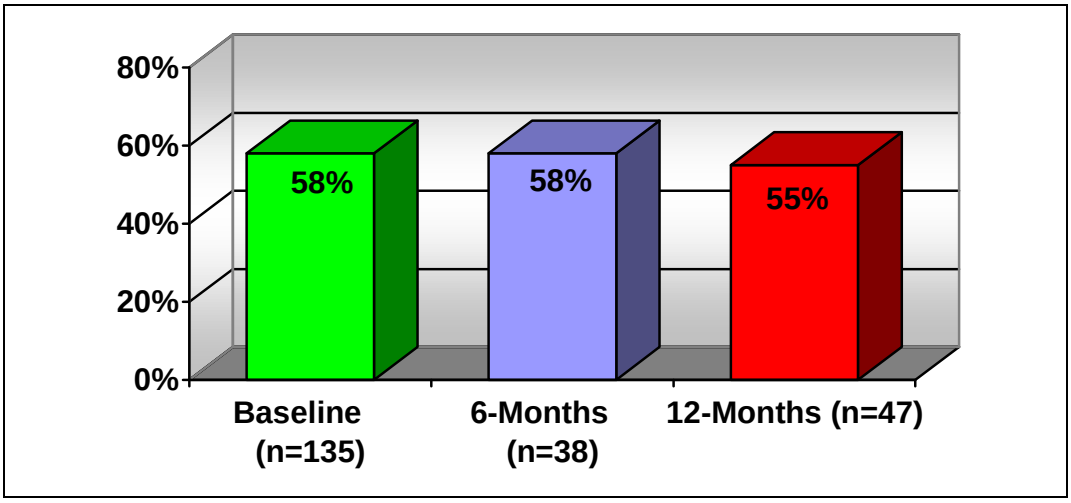


Parental Social Support

In order to assess program mothers' risk for social isolation, the Carolina Parent Support Scale (CPSS) is administered at program entry (baseline), after 6 months of enrollment, and annually thereafter. The CPSS is used to assess the amount of informal (family and friends) and formal (organized professional services) support available to participating families. The CPSS was administered to 135 families at program entry, however only 38 families received a 6-month follow-up and 47 received a 12-month CPSS. Scores below 25 are considered indicative of risk for inadequate social support.

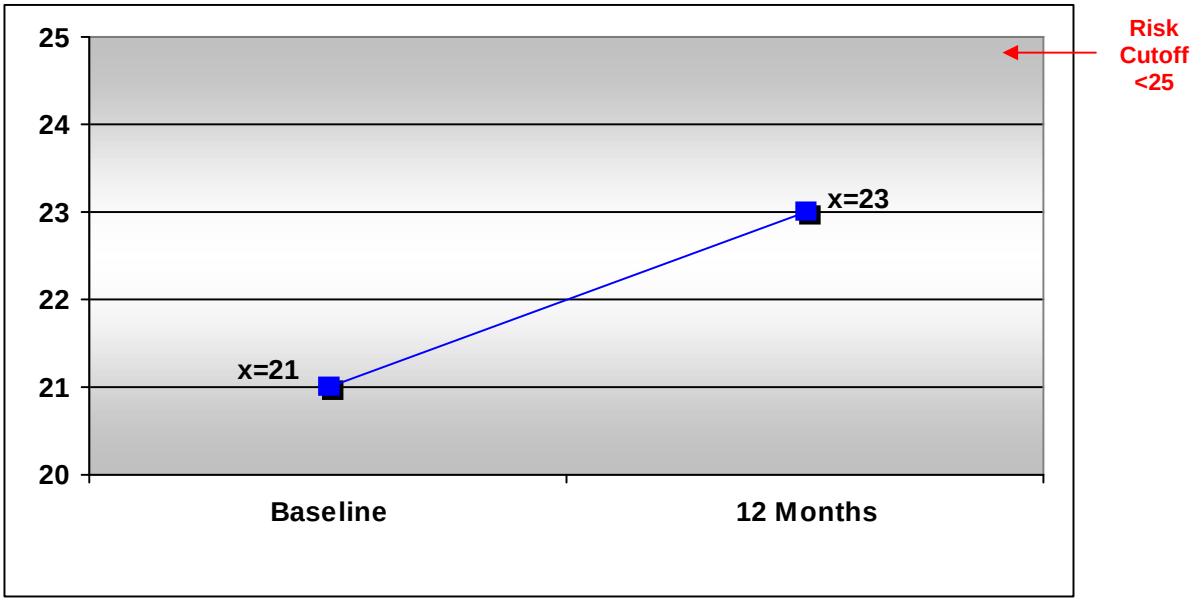
As seen in **Figure 35**, although the number of participants is greatly reduced at the 6- and 12-month follow-ups, the percentage of mothers risk for social isolation remained fairly consistently at each timepoint.

Figure 35. Percentage Mothers at Risk for Social Isolation -Year 14



A more accurate analysis was completed using GLM repeated measures Results indicate a modest strengthening of social support among families who have been administered the 12-month follow-up. As seen in **Figure 36**, from Baseline to the 12-month time period, mean scores increased, but the change over time was not statistically significant. It should also be noted that the mean score at follow-up was still below the cut-off for adequate social support. These results are in contrast to findings from previous years in which statistically significant increases in social support were measured. It is possible that the organizational changes that occurred in HSHF over the past three reporting periods resulted in lower levels of perceived and real support from the program.

Figure 36. Mean CPSS Scores-Baseline & 12-Months-Year 14
N=



Goal VI. Prevent Child Abuse and Neglect

Objective 1: 95% of enrolled families will not have substantiated reports of child abuse and neglect with the Child and Family Services Administration.

The HSHF program targets families with a range of high risk factors for child abuse and neglect. While the majority of families are able to balance the many stresses in their lives while maintaining a warm, caring, and nurturing relationship with their children, some become overwhelmed with their life situations, and referrals to Child and Family Services Agency (CFSA) are needed. In these few cases, HSHF staff continue to work with and support families as long as the children remain in the home and the family is still agreeable to home visitation services.

HSHF continues to have a strong partnership with CFSA . Through this partnership, the program accepts families referred from CFSA who have had a founded CPS report. HSHF staff work in conjunction with CFSA regarding families that are being served by both, so that services can be more effectively coordinated. None of these families had a founded case of abuse or neglect while in the HSHF program in Year 14.

Overall, the HSHF program surpassed its goal in the area of child abuse and neglect in Program Year 14 with 98% (n=276) of families with no substantiated cases of child maltreatment. This is significantly higher than the 88% rate nationwide in the United States and is especially impressive given the high-risk population that HSHF serves.

Table 18. HSHF: Summary of Goals, Objectives, and Program Outcomes

Goals and Objectives	HFDC Target	Year 3 1996-97	Year 4 1997-98	Year 5/6 1999-01	Year 7-8 2001-03	Year 9 2003-04	Year 10 2004-05	Year 11 2005-06	Year 12 2006-07	Year 13 2007-08	Year 14 2008-09
Goal II: Optimal Birth and Child Health Outcomes 1. Families enroll prenatally	90%	Not yet implemented	Not yet implemented	Not yet implemented	Not yet implemented	Not yet implemented	Not yet implemented	68% n=136	63% n=302	68% n=268	67% n=211
2. Mothers receive early prenatal care*	%	Not yet implemented	Not yet implemented	Not yet implemented	Not yet implemented	Not yet implemented	Not yet implemented	85% n=128	80% n=246	86% n=244	83% n=220
3. Babies will have healthy birthweights**	90%	86% n=96	90% n=51	92% n=65	97% n=57	95% n=22	100% n=8	93% n=40	84% n=56	86% n=56	84% n=43
4. Children immunized on schedule***	90%	97% n=96	97%	100% n=203	97% n=196	95% n=84	88% n=101	Data unavailable	Data unavailable	93% n=166	92% n=152
5. Children will be enrolled in health insurance program	90%	Not yet implemented	Not yet implemented	Not yet implemented	98% n=289	94% n=157	96% n=120	Data unavailable	Data unavailable	90% n=154	96% n=142
6. Mothers will be linked to health insurance	90%	Not yet implemented	Not yet implemented	Not yet implemented	Not yet implemented	Not yet implemented	Not yet implemented	98% n=122	96% n=240	97% n=241	95% n=194
Goal III. ***Optimal Child Development*** 1. Children screened for potential developmental delay	90%	95% n=96	87%	73% n=195	92% n=215	93% n=183	88% n=114	Data unavailable	Data unavailable	92% n=190	96% n=169
Goal IV: Positive Parenting and Parent-Child Interaction 1. Adequate knowledge of child development/parenting	85%	Not yet implemented	Not yet implemented	71% n=35	77% n=91	71% n=91	69% n=48	79% n=38	76% n=41	84% n=44	74% n=49
2. Parents will demonstrate positive parent-child interaction	85%	Not yet implemented	Not yet implemented	Not yet implemented	98% n=45	97% n=64	100% n=39	N/A	N/A	N/A	N/A
Goal V: Optimal family Self-Sufficiency 1. IFSP	75%	97% n=96	86% n=117	89% n=118	64% n=164/256	75% n=141/183	89% n=59/66	Data unavailable	Data unavailable	Data unavailable	Data unavailable
2. Families will demonstrate improved self-sufficiency by housing, education, or employment status	80%	Not yet implemented	Not yet implemented	Not yet implemented	Emp/Ed – 58% Housing – 94%	Emp/Ed – 75% Housing – 100%	Emp–42% Ed – 50% Housing – 97%	Data unavailable	Data unavailable	Data unavailable	Data unavailable
3. Mothers will not have an additional birth within two years of target child's birth	80%	Not yet implemented	Not yet implemented	Not yet implemented	97% n=277 Teens – 97% n=86	97% n=183 Teens- 95% n=78	91% n=120 Teens- 98% n=42	96% n=138 Teens- 98% n=58	98% n=306 Teens- 99% n=94	98% n=270 Teens- 96% n=77	99.6% n=127 Teens- 100% n=88
Goal VI: To prevent child abuse and neglect 1. Families will not have substantiated cases of child abuse and neglect	95%	97% n=96	Not available	99%	>99% n=276/277	98% n=155/158	98%* n=118/120				98% n=276

**** Early PNC is 1st or 2nd trimester ** sample includes only mothers enrolled in 1st or 2nd trimester only *** reflects the 4:3:3:1:3:3:1 series *represents two cases of founded neglect***

Table 19. Year 14 Goals, Objectives, and Comparative Statistics

Goals and Objectives	HFDC TARGET	HSHF Achieved Year 14	DC	National
II. Optimal Birth and Child Health Outcomes Newborns will be of healthy birthweight (>5.5lbs)	90%	89%	88%[1]	92%[1]
Children immunized on schedule	85%	92%	78%[3]	76%[3]
Children will be enrolled in a health insurance program	90%	96%	93%[4]	90%[4]
Mothers will be enrolled in a health insurance program	90%	95%	90%[4]	80%[4]
III. Optimal Child Development and School Readiness Children will be screened for developmental delay	90%	96%	Not available	Not available
V. Optimal family functioning and life outcomes Participants will not have an additional birth within two years of target child's birth. (Teens <20yrs)	80%	99.6% Adults 100% Teens	Teens - 83%[6]	Adults 65% Teens-80%[6]
VI. Prevent child abuse and neglect Participants will not have substantiated cases of child abuse and neglect.	95%	98%	24.2 per thousand[8]	10.6 per thousand[8]

Sources:

1. Birthweight DC 2006 http://datacenter.kidscount.org/Databook/2009/OnlineBooks/StateProfiles/AEC189%20profile_District_of_Columbia.pdf
2. Infant Mortality DC 2006 http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=DC&group=DataBook&loc=10 ==11.3/per thousand
3. Immunizations [3] Center for Disease Control and Prevention: Vaccines and Immunizations Data Table, 2008 (4:3:3:1:3:3:1 series). Available at http://www2a.cdc.gov/nip/coverage/nis/nis_iap2.asp?fmt=r&rpt=tab26_431331_race_iap&qtr=Q1/2008-Q4/2008
4. Health Insurance-*US Census Bureau: Health Insurance Coverage 2008. Available at http://www.census.gov/hhes/www/hlthins/hlthin08/hlth08asc.html
5. Adequate prenatal care DC 2007 available at http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=DC&ind=4569 ==63%
6. Repeat Births- http://www.childtrends.org/Files//Child_Trends-2009_08_31_FG_RepeatBirths.pdf
7. Child Maltreatment –US--US Department of Health & Human Services, Child Maltreatment Fact for 2007 (Spring 2009). Available at http://www.cdc.gov/ViolencePrevention/pdf/cm-datasheet-a.pdf
8. Child Maltreatment –DC http://www.acf.hhs.gov/programs/cb/pubs/cm07/table3_3.html

APPENDIX A

Healthy Start Healthy Families Program Funding
July 2008-June 2009

Private Foundations

Children Youth Investment Trust Corporation (Parent Centers)
Weissberg Foundation
Freddie Mac Foundation

Public Funding

Greater Southeast Hospital
HHS HRSA, Healthy Start
HHS HRSA Eliminating Health Disparities
DC Children & Family Services Administration
DC DHS ECEA Home Visitors Program
DC Dept. of Health, Maternal and Family Health Administration
DC Council
Child & Family Services Agency

Individual Donations

APPENDIX B

Healthy Start Healthy Families Advisory Board
2008-2009

Tamara Smith, Chair
President / CEO
Chartered Health

Linda Wright-Fuller
Executive Director
For Love of Children (FLOC)

Laura Charles-Horne
Director of Assessment
Healthy Families DC

Kendra Dunn
Director
Prevent Child Abuse Metropolitan Washington

Maria Gomez, RN MPH
President/CEO
Mary's Center for Maternal & Child Care, Inc.

Angela Jones
Executive Director
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Rhonda Waller, PhD
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Healthy Babies Project, Inc.

Joan Yengo
Vice President of Programs
Mary's Center for Maternal & Child Care, Inc.

Diane Hymons, LICSW
Consultant

Katy Gingles
Director of Community Healthy Start
Mary's Center for Maternal & Child Care, Inc.

Earl B. Ettiene
Regional Health Care Manager
CVS Drug Stores, Inc.

Robyn Webb-Williams
Director of Resource Development

APPENDIX C

Critical Elements of Successful Home Visitation Programs

1. Initiate services at birth or prenatally.

2. Offer services voluntarily and use positive, persistent outreach to build family trust in accepting services.

3. Use a standardized assessment tool to differentiate between families who need intensive service and those who do not.

4. Offer home visits intensively (1x per week) with well-defined criteria for changing intensity of service and maintaining service over the long term (3-5 years).

5. Services should be culturally competent.

6. Services should focus on supporting the parent-child relationship and child development as well as supporting the parent.

7. Link families to community services as needed, including medical home.

8. Limit caseloads of staff or ensure time and energy for quality services.

9. Select service providers for their personal characteristics that reflect their ability to do this demanding work.

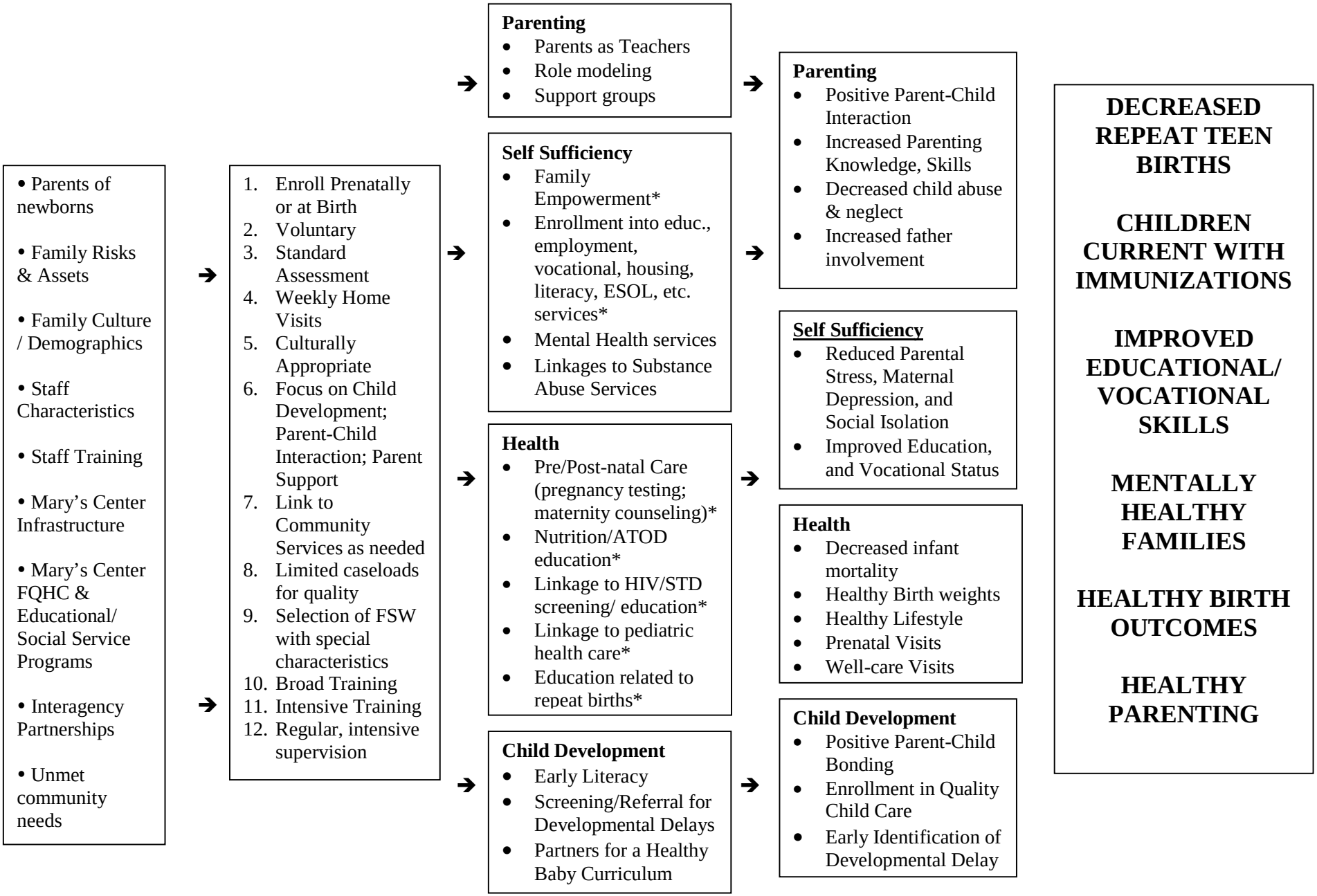
10. All service providers must have a framework for handling the variety of situations they may encounter and therefore must receive training on a broad range of topics.

11. Service providers must receive intensive training specific to their role.

12. Regular, ongoing, effective supervision is required for all staff.

Appendix D

HEALTHY START HEALTHY FAMILIES LOGIC MODEL



APPENDIX E

HSHF Service Level Descriptions

ACTIVITY LEVELS		
Level	**Definition**	**Number of Home Visits Due**
P1	Prenatal and until baby is due, or baby's birth, which ever arrives first. All participants must be placed on P1 if they enter at or beyond their third trimester of pregnancy.	4 per month (weekly)
P2	Prenatal and until the month the baby is due or the baby arrives, whichever comes first.	2 per month (biweekly)
SS	Prenatal or after the baby is born and average length of time is 3-4 months with exceptions documented in files. Family requires more than 4 visits per month due to a particularly difficult period confronting family. It is identified that the FSW is spending more than merits based upon the assigned level with the family and/or linking the family to additional resources. Temporary placement for a family if a second child is born.	Minimum of 4 per month Can be more if necessary
1	Begins last month of pregnancy, or day of baby's birth, whichever arrives first. Continues for at minimum 6 months.	4 per month
2	Average length of time is 6 months to 1 year. Criteria for promotion/less intensive services are met.	2 per month
3	Average length of time is 6 months to 1 year. Criteria for promotion/less intensive services are met.	1 per month
4	Family is achieving independence from HSHF. Criteria for promotion are met.	1 per quarter
X XC	Creative Outreach. Three months are provided to work to engage or re-engage family in program. Average length of Creative Outreach is 3 months with extensions documented in files. Family may remain on Creative Outreach throughout pregnancy, as cases are not closed during pregnancy unless family clearly indicates they are not interested in receiving services. As a family is not yet enrolled until the consent form is signed, families referred to an HSHF agency for home visits without a signed consent form carry an Intake status. Once a family is referred from Intake & Assessment and has not been formally enrolled by the FAWs (i.e. no consent form, but the family has agreed to services), the family is assigned to a site and FSW and placed on Level X for immediate creative outreach methods as an Intake status. Note: These families are included in FSW's caseload total and weight. Once contact is made and the consent form is signed, the family is moved to the appropriate level as an Enrolled family with weight and expected home visits calculated appropriately to meet the new level in the next month's data.	1 per month (Minimal)

E	After baby is born. May remain as long as the situation requires. Should schedules change, family returns to original level. Families work and/or school commitments make scheduling home visits difficult; however family is engaged in the program and wants to continue receiving services. This Level applies only to Level 1 and 2 families. Phone calls allow FSW to maintain engagement with the family and to identify child's developmental milestones, well baby schedule, progress on goals and any additional needs.	1 per month (min) and weekly phone calls. Phone calls documented in client notes. Do not count in statistics.
INACTIVE LEVEL		
T	Case Terminated	

APPENDIX F

Healthy Start/Healthy Families Consent and Confidentiality Participant Protection Procedures

A. *Recruitment and Selection Procedures*-Participation in any and all components of the program is completely voluntary and participating families are free to withdraw from program involvement at any time without risk of any negative consequences to them or their children. Parent/guardians are clearly informed of the voluntary nature of the program and its demonstration/evaluation component, as part of its informed consent procedure. No coercive elements exist in the recruitment and selection of participants

B. *Circumstances for Solicitation of Consent*-Invitations for program participation, which explain the nature of the intervention, the evaluation, and privacy/ confidentiality safeguards are explained by the Family Assessment Workers at the time of assessment and determination of program eligibility and by the FSWs at the time of the first home visit. Once enrollment is completed, a separate agreement form is used to explain and request participation in the evaluation component of the project. All permission/agreement forms are available in both English and Spanish and are read and explained to potential participants as necessary.

C. *Right to Withdraw*-Families are informed in writing of their right to withdraw from any and all aspects of the program and evaluation. At enrollment and during the initial home visit, families are again informed of the voluntary nature and requirements of program participation, as well as their right to withdraw at any time without prejudice.

D. *Release of Information*-Families are informed orally and in writing that all information will be kept confidential and that no individually identifiable information will be released to program evaluators. They are informed in writing on the consent form of exceptions to confidentiality, such as the procedures required if staff becomes aware of continuing child abuse in the family, or requirements regarding youth referred to the program by legal authorities. The consent for evaluation clearly describes the anticipated use of the research data.

E. *Informed Consent* -Consent to participate in the program is obtained in writing (in both English and Spanish as necessary). The program evaluation consent forms include a brief description of the purpose of the evaluation, the name of the evaluator controlling the research data, an explanation of procedures for sending research materials directly to the evaluator, and the names and phone numbers of two people to contact with any questions. These are explained verbally and copies are given to families at the time of the initial interview.

PROCEDURES FOR THE PROTECTION OF PRIVACY AND CONFIDENTIALITY

A. *Administration of Instruments and Interviews*-All instruments are administered by HSHF staff. All administration of instruments is monitored by the evaluator.

B. *Instrument Administration*-Standardized evaluation instruments are administered in accordance with their published procedural and time requirements. Staff members are extensively trained in all test/survey administration.

C. *Coding System*-Program participants will not be individually identifiable in evaluation analyses or reports. Each client is assigned a program number by the staff. All identifying numbers are maintained in a locked file. All data that are forwarded to the evaluator and any data entered into the data file for the purposes of process evaluation identify participants only by their code number.

D. *Access to Information*-The Family Support Worker working with the individual family collects the data and utilizes relevant information in the development of their service plan. General evaluation information, which is not traceable to individuals, is known to the evaluator and is made available to staff and school personnel in summary and report form. Standardized test results and survey results are known to the evaluator by code number only.

E. *Data Storage*-All clinical notes and records of program contacts are stored in locked files at the HSHF offices and maintained in accordance with professional standards. All evaluation instruments, completed score sheets, and test records are stored in a locked file in the evaluator's office and are not accessible to general staff.

APPENDIX G

Healthy Start/Healthy Families Outcome Measures Descriptions

Knowledge of Infant Development Inventory, Short Form (KIDI)
Author: David MacPhee, Ph.D.
Description: The Knowledge of Infant Development Inventory, Short Form (KIDI/SF) is designed to assess one's knowledge of parental practices, developmental processes, and infant norms of behavior, child health and development. The KIDI/SF consists of 14 statements reflecting parents' knowledge of how babies behave, how they develop, and how to best care for them. The statements are rated on a 5-point Likert scale, ranging from "strongly agree" to "strongly disagree." The KIDI/SF may be self-administered or administered by interview. It is used as a baseline measure to obtain information on parental knowledge of infant development, and at follow-up points of 6, 12, and 24 months.

The Carolina Parent Support Scale (CPSS)
Author: Marie Bristol, PhD
Description: The Carolina Parent Support Scale, a 23 item questionnaire, is used to measure the number and perceived helpfulness of various sources of social support at the individual, family, neighborhood and community level for families with infants with disabilities. Adjusting for the population served, the HSHF program uses a modified version of the 23-item CPSS in which specific references to support for families with infants with disabilities has been removed. The program's modified 15-item version measures 8 sources of informal and 7 sources of formal support. Informal support is provided through unorganized resources such as family members and friends; whereas formal support is provided through organized professional resources. In addition to measuring these separate support levels, a total support score is also generated.

Parents are asked to rate a list of people or services on a 5-point Likert scale from "Not at all helpful" to "Extremely helpful" as they consider how or if each has made their lives easier.

Patient Health Questionnaire (PHQ-9) (adopted January 2008)
Authors: adapted from PRIMEMDTODAY, developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke;Li, MM, Friedman, B, Conwell, Y, Fiscella, K.
Description: The PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire*. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV (Diagnostic and Statistical Manual Fourth Edition). The measure can help track a patients overall depression severity as well as the specific symptoms that are improving or not with treatment. There are two components of the PHQ-9: 1) Assessment of symptoms and functional impairment to make a tentative depression diagnosis; and 2) Deriving a severity score to help select and monitor treatment. Source: Validity of the Patient Health Questionnaire 2 (PHQ-2) in

Identifying Major Depression in Older People. *Journal of the American Geriatric Society. 2007; 55:596-602.*

Ages and Stages Questionnaire (ASQ)
Author: Jane Squires, LaWanda Potter, and Diane Bricker
Description: The ASQ is a child-monitoring system designed to identify infants and young children who demonstrate potential developmental problems. Questionnaires are used when the child is 4, 8, 12, 16, 20, 24, 30, 36, 48, and 60 months of age, with optional forms available at 6 and 18 months. Children are identified as needing further testing and possible referral for early intervention services when scores fall below designated cutoff points. In addition to being used as a screening mechanism, the ASQ is a valuable tool for family support workers to use in teaching parents appropriate expectations for their children=s developmental stages as well as play strategies to foster language, motor skills, and cognitive growth.

Each questionnaire consists of 30 developmental items divided into five areas: communication, gross motor, fine motor, problem solving, and personal-social. For each item, the parent responds “Yes” to indicate that the child performs the behavior specified, “Sometimes” to indicate an occasional or emerging behavior, or “Not Yet” to indicate that the child does not yet perform a specified behavior. Responses are converted to point values, which are totaled and compared to established screening cutoff points.

Individual Family Service Plan (IFSP)
The IFSP is an assessment tool used to identify strengths, goals, and accomplishments for individual families. A written plan is developed to help families identify and achieve their goals. Each plan delineates steps necessary to facilitate success. Goals typically center on strengthening the family's capacity to facilitate the child's development and relational health. A team, including the family members and service providers, develops the plan and individualizes it to meet the family’s concern. Ongoing and periodic evaluations are continued throughout the implementation of the plan to judge not only the child and family’s progress but also on the quality of the intervention program.

APPENDIX H

Healthy Start/Healthy Families (HSHF) – Description of Evaluation Measures Schedule

Name of Measure	Administration Schedule
Evaluation Consent	♦ At enrollment
Measures	
ASQ	**Minimum Requirement** ♦ Every four months up to two years of age, and then ♦ Every six months up to five years of age. ♦ Program may decide to administer developmental screen more frequently, as needed (previous 'suspect', or FSW or parent concern)
KIDI	♦ First within three months of enrollment or prior to completion of 8 HV ♦ Annually thereafter (baby's birth date + 60 day window)
CES-D	♦ First within three months of enrollment or prior to completion of 8 HV ♦ Second after the birth of the baby (45-60 days) ♦ Annually thereafter (baby's birth date + 60 day window)
CPSS	♦ 30 days after initial contact ♦ Six months after baseline ♦ Annually thereafter
Individual Family Support Plan (IFSP)	♦ Within 6 weeks of enrollment ♦ Update every 4 months
Parent & Staff Satisfaction Surveys	♦ Completed by the conclusion of the fiscal year. ♦ May also complete for closed families at the time of discharge from the program.

Evaluation Tracking Sheet

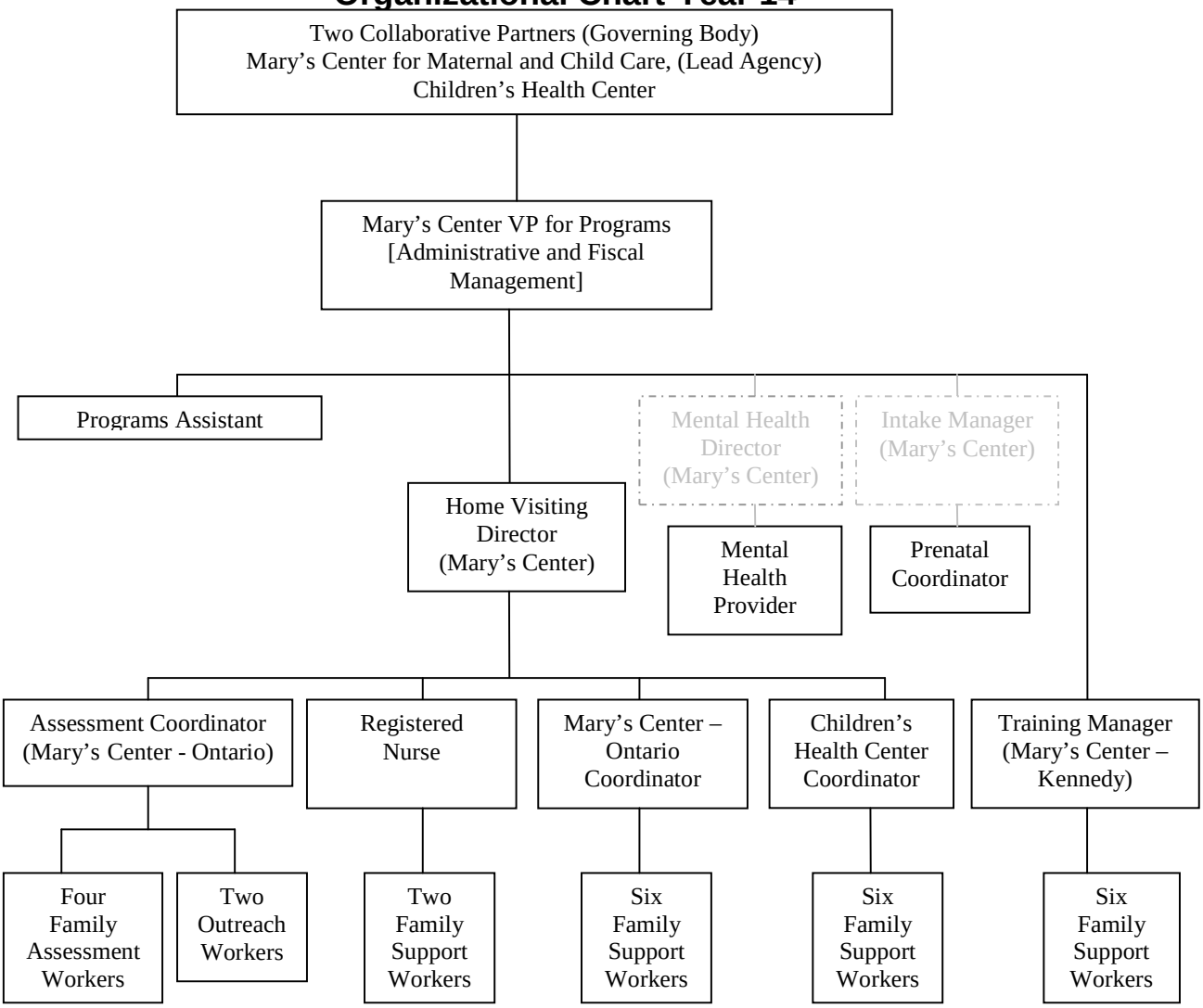
Name: _____ ID#: _____ Initial Contact: _____

Baby DOB: _____

Tool	**30 days after initial contact**	**6 months after that**	**6 months after that**	**One year after that**	**One year after that**	**One year after that**	**One year after that**	
CPSS								***Due***
								Done
KIDI								***Due***
								Done
Tool	**30 days after initial contact**	**6 weeks after baby's birth**	**Child 6 months**	**Child 12 months**	**Child 24 months**			
CES-D/ PHQ-9								***Due***
								Done

APPENDIX I

Organizational Chart-Year 14



Management Structure: Mary's Center's Board of Directors makes up the governing body. The Chief Operations Officer of Mary's Center, supervises the Vice President of Programs. The VP of Programs is responsible for the overall HSHF collaborative. The VP supervises the management team, who in turn supervises and runs the HSHF program for the city.

APPENDIX J

Healthy Start Healthy Families Year 14 Staff Tenure Dates

Administrative and Management Staff

Name	Current Position	Tenure Dates
Beth Perry	Support Director	10/94 – 7/06
Joan Yengo	Vice President for Programs, Mary's Center	7/96 – present
Laura Charles-Horne	Home Visiting Director	7/96 – present
Liz Craig	Quality Assurance Director	7/96 – 9/04
Werner Dubon	Database Manager	1/99 – 8/03
Cristina Bejarano	Intake and Assessment Director	6/06 – 09/07
Yanick Timo	Training Director	8/00 – 07/08
Rachel Nicholas	Site Coordinator	11/00 - 10/02
Dana Kimbrough	Site Coordinator	2/02 – 9/04
Tina Johnson	Site Coordinator	12/02 – 7/03
Misty Cromartie	Site Coordinator	4/04 – 7/09
Ana Reyes	Site Coordinator	10/06 - present
Bethany Sanders	Assessment Coordinator	9/07 – 05/09
Mia Gejdenson/Morrison	Site Coordinator	09/08 – 05/09
Bernadette Aldrich	Site Coordinator	06/09 - present
LaKisha Owens	Site Coordinator	07/09 - present
Fernanda Ruiz	Assessment Coordinator	07/09 - present

Direct Service Staff – Mental Health Providers

Name	Current Position	Tenure Dates
Xiomara Medina	Mental Health Provider	12/02 – 8/04
Rhonda Pope	Mental Health Provider	10/00 – 1/04
Gillian Wood	Mental Health Provider	4/05 -8/07
Diane Miller	Mental Health Provider	8/07 – 07/08; returning 07/09 – 8/09
Adriana Baratelli	Mental Health Provider	07/08 - 07/09

Direct Service Staff – Registered Nurse

Name	Current Position	Tenure Dates
Joyce Day	Registered Nurse	7/01 - present
Julie Law	Registered Nurse	1/09 - present

Direct Service Staff – Outreach Workers

Name	Current Position	Tenure Dates
Luz Montanez	Outreach Worker	11/05 – 12/06
Katie Daily	Outreach Worker	8/06 – 9/07
Adrian Naim	Outreach Worker	11/07 – 04/08
Juan Arroyo	Outreach Worker	03/08 – 12/08
Ruth Goyes	Outreach Worker	10/07 – 08/08
Chelsea Nycum	Outreach Worker	10/08 - present
Rosalia Villalta	Outreach Worker	1/09 - present

Direct Service Staff – Family Assessment Workers (FAW)

Name	Current Position	Tenure Dates
Pamela Morris	FAW I	6/99 – 12/00
Martha Wojtasiak	FAW I	12/99 – 7/00
Kate Heyl	FAW I	7/00 – 5/01
Kim Hammett	Sr. Family Assessment Worker	3/01 – 10/06
Juanita Cabrera-Lopez	FAW I	6/01 – 8/02
Tania Arostegui	FAW I	8/02 – 6/04
Natasha Afonso	FAW I	10/02 – 7/04
Renelle Williams	FAW I	3/02 – 5/03
Nelva Hernandez	FAW I	1/05 – 9/07
Deadra Jackson	FAW I	8/05 – 9/06
Crissaris Sarnelli	FAW	9/06 – 6/07
Ashley Moyer/Price	FAW	9/06 – present
Fernanda Ruiz	FAW	10/06 – 7/09
Mariko Sweetnam	FAW	12/07 - present
Angel Veintidos	FAW	2/08 - present

Direct Service Staff – Family Support Workers (FSW)

Name	Current Position	Site	Tenure Dates
Aisha Williams	FSW II	Calvary	11/99 – 1/02
Cynthia Borrayo	FSW I	Calvary	1/98 – 1/99
Gerice Williams	FSW II	Calvary	2/02 – 10/03
Irma Rivera	FSW I	Calvary	12/03 – 10/05
Kim Hazzard	FSW I	Calvary	4/99 – 10/99
Krimhilde Morales	FSW II	Calvary	2/00 – 12/03
Mayra Figueroa	FSW I	Calvary	11/98 – 11/99
Sobeida Garcia	FSW	Calvary	
Patricia Molina	FSW III	Calvary	1/95 – 11/99
Sarai Romero	FSW I	Calvary	11/99 – 6/01
Xiomara Martinez	FSW I	Calvary	12/03 – 2/04
Zulma Aparicio	FSW III	Calvary	8/01 – 10/05
Aishya Martin	FSW I	CHC	6/05 – present
Amber Robles Gordon	FSW I	CHC	10/01 – 9/03
Avis Belk	FSW I	CHC	9/01 – 7/03
Harmony Garrett	FSW I	CHC	12/03 – 2/05
Lakia Lockett	FSW I	CHC	10/03 – 11/04
Nikia Burgess	FSW I	CHC	9/02-5/02
Reina Julian	FSW II	CHC	11/00 - 9/02
Rita Pridgen	FSW I	CHC	8/02 – 11/02
Roberta Morris	FSW I	CHC	2/01 – 8/01
Lynesse Hayes	FSW II	CHC	8/05 – 04/09

Name	Current Position	Site	Tenure Dates
LaKisha Owens	FSW	CHC	02/08 – 07/09
Biodun Kajopaiye	FSW	CHC	02/08 – 12/08
Tahneezia Hammond	FSW	CHC	01/08 – 7/09
Kiera Leonard	FSW	CHC	06/09 - present
Denise Day	FSW II	Mary's Center - Kennedy	8/01 – present
Ebony Copeland	FSW II	Mary's Center - Kennedy	10/02 – 9/06
Asha Moses	FSW	Mary's Center – Kennedy	6/07 - present
Cynthia Duvall	FSW	Mary's Center – Kennedy	7/07 – present
Elisa Turay	FSW	Mary's Center - Kennedy	11/06-5/07
Luis Martinez	FSW	Mary's Center	1/08 – 09/08
Luz Almodovar	FSW	Mary's Center	6/08 – 9/08
Maria Andreina Vethencourt	FSW	Mary's Center - Kennedy	3/08 – 5/09; returned 09/09 - present
Luz Torres	FSW	Mary's Center - Kennedy	11/08 - present
Joanna Bloomfield	FSW	Mary's Center - Kennedy	10/08 – 09/09
Kate Kenealy	FSW	Mary's Center - Kennedy	10/08 – 11/09
Andrea Robinson	FSW I	FLOC	8/00 – 3/01
Eric Reed	FSW I	FLOC	2/01 – 6/01
Rachelle Penn	FSW III	FLOC	7/98 – 11/00
Raminita Bicunius	FSW I	FLOC	11/99 – 8/00
Rebecca Dandois	FSW III	FLOC	10/97 – 6/00
Sasha Clayton	FSW I	FLOC	6/01 – 5/02
Shakeita Boyd	FSW I	FLOC	3/29/04 – 10/05
Sheila Clark	FSW I	FLOC	8/00 – 10/01
Teresa Johnson	FSW I	FLOC	12/10/01 – 8/19/02
Francine Bennet	FSW I	Healthy Babies Project	2/02 – 9/04
Karida Green	FSW I	Healthy Babies Project	10/03 – 6/04
Tenitia Tyler	FSW I	Healthy Babies Project	2/02 – 7/04
Ana Maria Velazquez	FSW I	Mary's Center	1/04 – 8/04
Diana Pinott-Davis	FSW III	Mary's Center	10/97 – 8/00
Eva Morales	FSW I	Mary's Center	4/01 – 4/02
Fiorella Villa Garcia	FSW III	Mary's Center	11/98 – 1/01
Lucia Acevedo	FSW III	Mary's Center	5/98 – 12/01
Martha Claros	FSW III	Mary's Center	8/03 – 3/05
Meghan Wiedl	FSW III	Mary's Center	12/02 – 6/06
Mia Gejdenson	FSW II	Mary's Center - Ontario	2/05 – 09/08
Sandra Tache	FSW I	Mary's Center	2/01 – 9/01
Violetta Chirino	FSW I	Mary's Center	12/01-12/02
Rosalia Villalta	FSW	Mary's Center - Ontario	1/05-1/07

Name	Current Position	Site	Tenure Dates
Shanti Martin	FSW	Mary's Center Ontario	1/04 – 6/07
JaShawn Logan	FSW	Mary's Center - Ontario	1/06-7/07
Kemeka Henry	FSW	Mary's Center – Ontario	1/05 – 11/07
Bethany Sanders	FSW	Mary's Center – Ontario	1/06 – 9/07
Paty Naranjo	FSW	Mary's Center – Ontario	10/00 - present
Jennifer Clarke	FSW	Mary's Center – Ontario	5/07 - present
Laura Somel	FSW	Mary's Center - Ontario	9/07 - present
Maria Fernanda Garcia	FSW	Mary's Center - Ontario	5/08 – 04/09
Carolyn Summer	FSW	Mary's Center - Ontario	3/08 - present
Julie Kselman	FSW	Mary's Center - Ontario	8/08 – present
Laura Dri	FSW	Mary's Center - Ontario	1/09 - present
Megan McCarthy	FSW	Mary's Center - Ontario	1/09 - present
Daniela Kuhn	FSW	Mary's Center - Ontario	05/09 - present

APPENDIX K

HSHF Year 14 Trainings

Year 14 Trainings (July 2008-June 2009)

July 2008
- Cultural Competency 7/11/08
- Cultural Diversity 7/11/08
- Gangs 7/24/08

December 2008
- Substance Abuse 12/11/08

February 2009
- Shaken Baby Syndrome 2/10/09

March 2009
- Infant Care 3/10/09

April 2009
- Car Seat Safety 4/14/09

May 2009
- Nutrition 5/12/09
- Mental Health 5/14/09
- Domestic Violence 5/15/09

APPENDIX L

Healthy Start Healthy Families
Year 14 Staff Survey

Site_____ **Date**_____

Please share your experiences with the Healthy Start Healthy Families (HSHF) program by taking a few minutes to answer the questions below. Your answers and recommendations are important to us and will assist us as we continue to suggest program improvements and plan future activities. All surveys are confidential. Please do <u>not</u> put your name on your survey. We want them to remain anonymous. Thank you!

1. **In what capacity do you work with HSHF? (Please check one)**
   - ❒ Administrative
   - ❒ Management/Supervisory
   - ❒ Direct Service (Outreach, Assessment Support, Nursing, Mental Health)
   - ❒ Other ___

2. **How long have you worked with HSHF?**
   - □ Less than one year
   - □ One year to two years
   - □ More than two years

3. **Please respond to the following statements by checking the appropriate box. *Please add comments to any area and to those marked "strongly agree" or "strongly disagree".***

Program Services	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
I understand the HSHF combined model					
I understand the goals and objectives of HSHF					
I receive an adequate amount of supervision to help me get my job done in a quality manner.					
HSHF is designed to optimize child development through comprehensive support to families					
The program management is responsive to the needs of staff.					
HSHF is strength-based and family centered.					
I have participated in training that adequately prepared me for my position.					

I have participated in training in the past six months.					
The agency and program management represent the target population.					
The staff is culturally representative of the families served.					
The program uses materials that are culturally appropriate.					
The program uses bilingual materials as appropriate.					
I feel comfortable working with culturally diverse families.					
HSHF helps prepare children to be ready for school					
The enhanced mental health services have significantly helped HSHF families					
The enhanced health services have significantly helped HSHF families					

Job Satisfaction	**Strongly Agree**	**Agree**	**Not Sure**	**Disagree**	**Strongly Disagree**
I enjoy my work.					
I find my work worthwhile.					
I find the work that I do is hard.					
I find my work boring.					
The work I do uses my skills.					
I am satisfied with my position.					
I am appropriately compensated for my position.					
I feel appreciated by HSHF management for the work I do for the program.					
I believe I have made a positive impact on the children and families I work with.					

4. **What do you think are the best things (Strengths) of Healthy Start Healthy Families program for *staff*?**

_____
_____

5. **What do you think are the best things (Strengths) of Healthy Start Healthy Families program for *families*?**

_____
_____
_____

6. **What have been the most difficult issues faced (Challenges) of Healthy Start Healthy Families program for *staff*?**

_____
_____
_____

7. **What have been the most difficult issues faced (Challenges) of Healthy Start Healthy Families program for *families*?**

_____
_____
_____

8. **Are there additional trainings that you feel would help you in your job? Yes ☐ No ☐**

   If Yes, please describe.

_____
_____
_____

9. **How stressful is your job? (Please check one)**

   - ❒ Always stressful
   - ❒ Usually stressful
   - ❒ Sometimes stressful
   - ❒ Rarely stressful
   - ❒ Never stressful

10. **Which of the following benefits have you received as a result of your participation in work related trainings?**

    None_____ Promotion___ Wage increase_____ Bonus_____
    Certification_____

Other (Please specify)_____

Additional Comments:

_____

_____

_____

_____

_____

_____

THANK YOU VERY MUCH!

APPENDIX M

HEALTHY START HEALTHY FAMILIES

Participant Satisfaction Survey

Dear Parents:
Healthy Start Healthy Families at _____ has enjoyed working with you and your family. One of our goals is to make sure that our program provides quality services and meets the needs of families. Therefore, we would like to know what you and your family find helpful about the program and ideas on how we can better meet your needs. By giving us this information, you are helping us to make the program work for you and the rest of the community. We ask that you do not put your name on the survey. Please respond honestly and return the survey in the stamped envelope by _____. Thank you for taking the time to fill out this survey!!!

1. How often does (did) your FSW visit you at home?
_____once a week
_____twice a month
_____once a month
_____more often *(specify)*_____
_____less often *(specify)*_____
_____don't remember
_____no answer

2. Where else do you see your FSW?
_____your doctor's office
_____your child's pediatrician's office
_____FSW's office
_____other *(specify)*_____
_____the park
_____I don't know
_____no answer

3. When did your FSW last visit you? *(check one answer)*
_____within the past week
_____within the past two weeks
_____within the past month
_____longer than a month ago*
_____no answer

4. *(If longer than a month) Why has it been so long since your FSW visited you? *(Check all that apply)*
_____work schedule
_____school schedule
_____family reasons
_____too busy
_____no answer
_____FSW canceled
_____FSW didn't show up for the visit
_____hard to contact, don't have a phone
_____hard to contact, housing problems
_____other *(Specify_____)*

5. When your FSW visits you, how long does s/he stay? *(check one answer)*
_____less than 30 minutes
_____30 minutes – 1 hour
_____1 hour – 2 hours
_____more than two hours
_____no answer

6. Does (did) your FSW arrive on time for visits with you? *(check one answer)*

_____yes _____sometimes/occasionally
_____usually _____rarely
_____no answer

7. Does (did) your FSW usually call you in between visits? *(check one answer)*

_____yes _____no phone
_____no _____no answer
_____sometimes/occasionally

8. Does (did) your FSW visit you often enough? *(check one answer)*

_____yes, s/he visited me often enough
_____no, I wish s/he had come more often
_____s/he came too much
_____no answer

9. Do you think your FSW is (was) aware of your needs and helped you with these needs?*(check one answer)*

_____yes _____don't know
_____no _____no answer

10. What makes you think so?

_____
_____
_____
_____I don't know
_____no answer

11. How would you describe your FSW? *(check all that apply)*

_____knowledgeable/informed _____truthful/honest
_____warm/caring _____calm
_____understanding _____helpful
_____encouraging _____organized
_____respectful _____supportive
_____available _____scattered
_____firm _____insensitive
_____smothering _____too business-like
_____understand/respect my culture/heritage _____don't know
_____other _____ _____no answer

12. Do you think that your Family Support Worker respects you, tries to understand things about you, like where you were born, what are your likes and dislikes, and different things about your family values? Yes _____ No _____

If yes, in what ways?:_____
_____
_____

If no, what would help your FSW in this area?_____

_____
_____

13. Since enrolling in the program, how many FSWs have you worked with? _____. If more than one, what do you think about having more than one FSW while in the program?_____
_____
_____
_____
_____I don't know _____no answer

14. Has this program been helpful to you in raising your child? *(check one answer)*
_____yes
_____no
_____no answer

15. I feel I know more about: *(check all that apply)*
_____babies' growth and development and what to expect
_____taking care of baby
_____resources in the community
_____parenting information/I feel I am a better parent
_____coping with problems/stress in daily life and other relationships
_____talking to other parents with young babies
_____well baby care visits and/or immunizations
_____other *(specify_____)*
_____no answer

16. Have you been satisfied with the group gatherings (play groups, fathers' groups, parties, parenting classes)?
_____yes *(specify which ones_____)*
_____I haven't attended any
_____no *(specify which ones_____)*
_____no answer

17. Suggestions on how to make group gatherings better or more convenient.
_____
_____

18. What do (did) you like the best about the program? *(check all that apply)*
_____advice/suggestions/information about parenting
_____advice/suggestions/information on baby's health, growth, development
_____having someone visit me at my home
_____parent groups/play groups/activities
_____respectful of culture
_____assistance with transportation
_____having someone around to listen and help
_____have someone go with me to appointments
_____help getting my child into daycare and/or school
_____helps me get resources on the community
_____help my family find doctors.

_____other *(specify* _____*)*
_____none of the above. Why? _____
_____
_____no answer

19. What do you like best about the home visits?
_____activities with me and my child
_____information given
_____ASQ
_____help me think of goals
_____other (specify _____)

20. Sometimes on the home visit your Family Support Worker asks you questions from forms to better understand the needs of your family, support you and identify other ways we can support you and the community. How do you feel about these questionnaires?

The questions are easy to understand? Yes_____ No_____
I am okay with answering them? Yes_____ No_____
I feel that the reason for the questionnaires was explained well. Yes____ No_____
Please provide additional comments about them in the space below:
_____
_____
_____
_____Don't Care _____Never Done One

21. Please add suggestions of how Healthy Start Healthy Families or your home visitor can better assist or support you.
_____
_____
_____
_____

22. Overall, how satisfied are (were) you with this Healthy Start Healthy Families program?
_____very satisfied _____dissatisfied
_____satisfied _____very dissatisfied
_____no answer

23. Would you recommend the program to a friend?
_____yes _____no _____no answer

24. How long have you been a Healthy Start Healthy Families participant? _____

25. Are you familiar with the Parent Advisory Board (PAB)? _____yes _____no

26. Are you already a member of the PAB? _____yes _____no

27. If not, are you interested in becoming a member of the PAB?

_____yes _____no

If not, why not:

_____Childcare issues – don't have anyone to watch my child
_____Don't feel I have anything to contribute
_____Don't understand what the purpose of the PAB is
_____Don't have time generally
_____The time the group is held is not good for me
_____Transportation difficulties
_____Other. If other, please explain:

_____
_____
_____
_____

28. What could the program do to make you more interested in participating in the PAB?

_____Offer meetings directly after other family gatherings such as playgroups
_____Offer meetings at a particular time of day that is more convenient for me

Please check when would be a better time:
___Evenings ___Weekends ___Mornings ___Afternoons ___Other, please explain:_____
_____

Thank you for taking the time to complete our survey!!