

HEALTHY FAMILIES VIRGINIA

FY 2000-2004

Executive Summary

Statewide Evaluation Report



Prepared for:

Prevent Child Abuse, Virginia
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EXECUTIVE SUMMARY

Healthy Families Virginia (HFV) has been providing home-visiting services to Virginia's most overburdened families for a decade. What started as a pilot project has now grown into a statewide initiative defined by four overarching goals: improving pregnancy outcomes and child health, promoting positive parenting practices, promoting child development, and preventing child abuse and neglect. HFV helps parents provide a safe and supportive home environment, gain a better understanding of their child's development, obtain access to health care and other supportive services, use positive forms of discipline, and nurture the bond with their child, reducing the risk factors linked to child maltreatment (Prevent Child Abuse America, 2002).

The multiple evaluations summarized in this report span more than a decade and document that families enrolled in the program are healthier, use medical services more appropriately, and have higher immunization rates than similar families who did not receive home-visitation services. Participants are more likely to seek out early prenatal care and have fewer low birth weight babies. Home visitors work with parents to increase their sensitivity and responsiveness toward their children, to build a strong parent-child relationship, and to teach them positive forms of discipline. The programs ensure developmental delays are detected early, and, if necessary, services are provided to address delays. Home visitors also help develop home environments that stimulate healthy cognitive, emotional, and social development. The program has been successful in delaying subsequent pregnancies so mothers will be in a better position to complete school, to obtain employment, and to provide positive child rearing environments. The aggregated findings from ten years of evaluation also demonstrate this approach results in reduced child maltreatment among participating families across Virginia.

Part I: Introduction

The Department of Psychology at the College of William & Mary and Huntington Associates, Ltd. produced this report at the request of Prevent Child Abuse Virginia (PCAV). The primary purpose of the report is to provide an objective appraisal and a set of recommendations allowing PCAV to evaluate the development and impact of the Healthy Families Virginia (HFV) Initiative. This is the sixth in a series of annual HFV evaluation reports (Galano & Huntington, 1999a, 2000, 2001, 2002, 2003) designed to provide accurate and useful information about the functioning of HFV programs, their growth and development, and ways to improve the statewide evaluation. The report spans the first ten years of the Healthy Families initiative in Virginia.

The United States spends an estimated \$258 million each day because of the health and social problems associated with child abuse and neglect.

In 2002, the Centers for Disease Control and Prevention (CDC&P) estimated that approximately **40% of all maltreatment might be prevented** if communities across America implemented home visiting programs (Task Force on Community Preventive Services, 2002).

Across 32 sites and 2,272 HFV families, the rate of founded cases of child maltreatment was 1.1%.

To reduce the social and economic costs the United States spends millions of dollars on home visitation programs both to prevent child abuse and neglect and to achieve a wide variety of other important goals. A major objective of the report is to provide evidence concerning the implementation and efficacy of Healthy Families programs to local, state, and national audiences, including the members of the Virginia General Assembly, a source of ongoing support for this initiative.

Part II: The Relationship of Childhood Abuse and Family Dysfunction to the Leading Causes of Death in Adults

The long-term consequences and the enormous associated monetary costs of childhood abuse on mental illness and substance abuse, school failure, criminal health, and serious physical illness in later life are delineated in the full HFV Statewide evaluation (Galano & Huntington, 2004; Appendix A: “*The Relationship Between Child Abuse and Neglect and Other Major Social Problems.*”)

Now, medical investigators are providing remarkable insights into the association among childhood abuse and adult health risk and disease decades later. This relationship is critical because it demonstrates that the ten leading causes of morbidity and mortality in the United States are related to health behaviors and lifestyle factors— factors that are strongly related to adverse experiences in childhood.

Moreover, the risks and lifestyle factors studied were virtually identical to the risks and household characteristics (i.e. having been physically or sexually abused as a child, parental substance abuse, or domestic violence) that describe many HFV participants.

This research demonstrates the true impact of child abuse and neglect and associated household conditions may actually exert an even greater toll on adults’ health status, quality of life, health care utilization, and mortality than previously recognized. These conclusions are emerging from the Adverse Childhood Experiences (ACE) study, jointly sponsored by the Centers for Disease Control and Prevention and the Kaiser Permanente’s Department of Preventive Medicine. The ACE study is the largest contemporary epidemiological study ever done to examine the health and social effects of adverse childhood experiences over the life span (Felitti et al., 1998; Felitti, 2002). The first wave of the study, with over 18,000 participants analyzed the relationship between current health and earlier adverse childhood experiences. The adverse experiences studied included: three categories of abuse (psychological, physical, or sexual); violence against mother; living with household members who are substance abusers, mentally ill, suicidal, or imprisoned; and not living with both biological parents. Wave two of the study, begun in 1997, is prospective and will track 19,000 participants, to examine the relationship between these eight adverse childhood experiences and pharmacy utilization, emergency room visitations, outpatient visits, morbidity, and mortality.

The findings from the ACE study provide new insights into the etiology of illness.

The findings are medically, socially, and economically vital . The ACE study reveals a powerful relationship between adverse emotional experiences as children and our physical and mental health as adults.

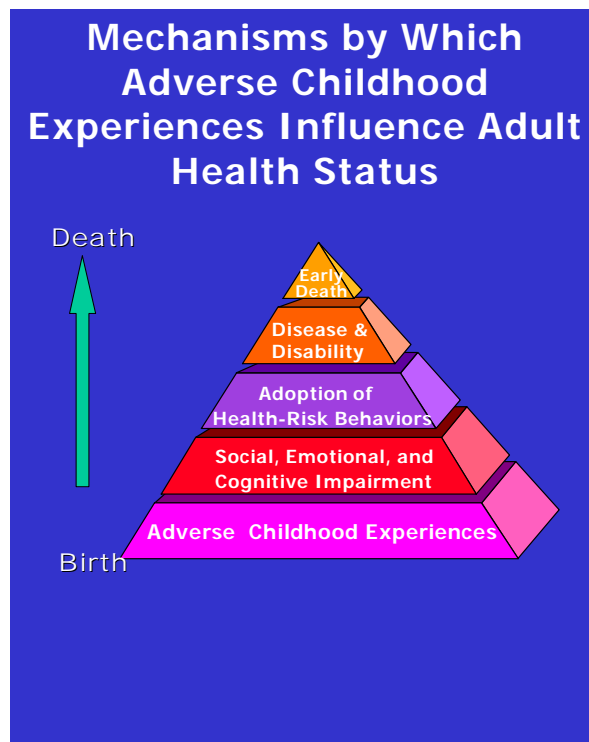
The ACE study is highly relevant because the eight adverse experiences studied share much in common with the risks and household circumstances of HFV participants. HFV strives to reduce these risks and their impact.

Individual adverse childhood experiences have clear negative effects; however, it was the impact of four or more adverse experiences that was startling.

Persons who had experienced four or more categories of adverse childhood experiences, compared to those who had experienced none, had:

- a four- to 12-fold increase health risk for alcoholism, drug abuse, depression, and suicide attempt
- a 200% to 400% increase in smoking, poor health, greater than 50 sexual intercourse partners, and sexually transmitted diseases

The figure below depicts the mechanisms by which ACEs lead to social, emotional, and cognitive impairment that result in children, adolescents, and young adults adopting high-risk behaviors (such as smoking, substance use, or promiscuous sexual behavior) that ultimately result in social problems, disease and disability, and early death.



These adverse childhood experiences were strongly related to the 10 major causes of adult mortality in the United States (Felitti, 1998).

The researchers concluded that the prevalence of these ACEs and their strength as a predictor of health risks and disease makes ACEs the leading determinate of health and well-being in the United States.

The researchers state that the prevention of adverse childhood experiences has proven difficult, but that recent research on the long-term benefit of early home visitation on reducing the prevalence of adverse childhood experiences is promising. Next, the findings from the Virginia early home visiting initiative are presented.

Part III: A Statewide Statistical Profile of the Healthy Families Virginia Initiative

This section provides an up-to-date statewide statistical profile of the 26 HFV sites participating in the statewide Program Information Management System (PIMS) during FY 2004¹. Although this summary reflects neither all of the programs operating nor all of the participants receiving services through the HFV initiative, it does present information that should prove very helpful in understanding the general characteristics and organization of individual programs in various communities across the Commonwealth. The data were collected using the PIMS adopted by HFV.

The 26 programs served 79 Virginia localities with an average population of 156,083. Benchmarks of community well-being indicate many families are at-risk and the need for home-visiting services has not decreased over the last five years. Each Healthy Families site has defined their target population based on available resources and agency collaborations providing access to parents. Within their target population, 17 programs served only first-time parents, five served first-time parents as well as teen or unwed mothers, and four programs had sufficient resources to serve all pregnant women. The fact that only 15% of Healthy Families Programs can offer prevention services to women who already have other children at home represents a significant unmet need.

Half of the communities (51%) had populations of at least 25% African Americans. Host agencies were most frequently health departments and hospitals, followed by family support, mental health, and social services agencies. State funding from all sources accounted for less than a third (30%) of all grant funds. The proportion of state funding as a percentage of total funding has continually decreased. Sites have continued to diversify the sources of funding they depend upon and, consequently, enjoy support from a wide array of constituencies.

Programs report numerous and long-lasting collaborative relationships with local hospitals, clinics, and community-based agencies. In fact, these relationships increased by approximately 33% compared to just two years earlier. The high level of integration and collaboration indicates both that these relationships serve the mission of the organizations involved and that Healthy Families programs are viewed as contributing to the positive health and well-being of the community. Fifty-nine percent of the HFV staff are college graduates and approximately 93% had some college education.

Fifty percent of the staff described themselves as White, 31% as Black, and 17% as Hispanic. Staff members included Family Support Workers providing home visits (56%), Family Resource Specialists (23%), and Program Managers or Supervisors (15%).

Part IV: Healthy Families Virginia Evaluation Results

A. Participants Screened, Assessed, Enrolled, and Engaged

HFA credentialing requires all Healthy Families programs to adopt specific critical elements as a way of ensuring, measuring, and improving program quality. These critical elements begin with initiating services prenatally or at birth, systematically identifying families most in need, and successfully engaging families in services. This section presents a summary of the activities performed by the 26 sites participating in PIMS.

Healthy Families performs exceptionally well in the domains of systematically identifying families most in need and successfully engaging those families in services. Since FY 2000, the 26 Healthy Families sites participating in the statewide evaluation conducted more than 26,770 screens and provided

¹An additional eight non-PIMS sites whose data are included in this evaluation report are not included in this statistical profile.

assessments to over 8,000 women². Approximately 16% of these assessments occurred during the most recent fiscal year. This reflects a slowing in the initiative's rate of growth compared to the 25% increase in the previous fiscal year. Ninety percent of these families received assessments prenatally or within two weeks of delivery. This performance easily surpasses the HFA national standard of 80% for credentialed programs. All of the assessments used standardized scientific measures. Of the 8,137 individuals who had final assessment dispositions, 78% assessed positive. Of the 5,054 positively assessed families offered services, approximately 86% accepted. A total of 3,587 participants enrolled. Based on the risk assessment interview, 50% of the enrolled participants were at moderate-risk and 47% were considered high-risk. Statewide, the factors that most frequently warranted assessment of families as at-risk were stressors and childhood history of abuse. These assessment data suggest the family histories and current mix of risk factors and needs of Healthy Families participants place them at higher than average risk for child maltreatment as well as other poor childhood outcomes.

On a sobering note, since the initiative began nearly half of the families enrolled in programs across Virginia were at high-risk for serious negative child and family outcomes.

Most of the families enrolled were unmarried (85%). Approximately 57% had less than a high school education. Although 40% of the participants had graduated from high school, only 2% had earned a college degree. The average age was 21 years. The largest single category of participants (47%) were Black, 33% were White, and 18% were Hispanic. Another 2% were Multiracial or Asian/Pacific Islander. After six months, 96% of enrolled participants were engaged successfully. Healthy Families meaningfully engages more families than ever which is frequently a major challenge for prevention programs attempting to engage families who initially may be distrustful or defensive and who are faced with circumstances potentially reducing the likelihood of continued involvement.

Following a positive trend, this year's rate of engagement was the highest ever.

²These statistics under-represent the total scope of Healthy Families activities across the state because they do not include eight non-PIMS sites. The screenings, assessments, and enrollment at these 26 sites represent almost 80% of all individuals who were served by Healthy Families.

B. Outcome Summary and Conclusions

The outcome findings are organized within the framework of the Statewide Goals and Objectives adopted in June 1999. Evaluating a statewide initiative that has been steadily growing means that there is considerable variability in the number of sites represented in each analysis. This variability is not a shortcoming of HFV, but rather a necessary stage in the development of a statewide initiative. The major HFV evaluation domains are to:

- **Achieve positive pregnancy outcomes and maternal and child health outcomes.**
- **Promote optimal child development by screening for suspected delays, referring children for developmental evaluations, and monitoring participation in therapeutic programs.**
- **Promote positive parent-child interaction and stimulate home environments that support child development.**
- **Prevent abuse and neglect.**

1. Child Health

Overall, the results in this health domain, especially in the areas of children's and maternal health, are very encouraging.

- **Healthy Birth Weight:** Eighty-eight percent of the babies born to the 1,562 prenatal enrollees were within the healthy birth weight range surpassing the state criterion. The percentage of full birth weight represents a considerable improvement over the FY 2001 77% statewide rate.

CHILD HEALTH OUTCOMES

- **Birth Weight** - Goal: 85% of prenatal enrollees will deliver babies weighing at least 2500 grams.
88% of all children were born with healthy birth weights.

- **Connection to Medical Care Providers:** Approximately 88% of the 3,130 births to mothers enrolled in Healthy Families programs using PIMS had a primary medical care provider within two months of enrollment. In addition, 92% of those children continued with health care providers after six months of participation in the program. This overall level of performance is the best to date, surpassing the statewide criterion for established programs, and demonstrating that HFV succeeds statewide in ensuring children have access to a physician and the medical care they need.
- **Immunizations:** Age appropriate immunizations is one of the most important indicators of well-being for children. HFV has established a goal that 80% of all target children will receive all immunizations as recommended by the American Academy of Pediatrics and the Virginia Department of Health. Eighty-two percent of the 4,121 children enrolled in both PIMS and non-PIMS Healthy Families programs received 100% of their 16 scheduled immunizations.

The U.S. Department of Health and Human Services (2004) estimated that the national base rate was 69.7% in FY 2003 for children receiving the recommended immunizations (4:3:1:3:3:1 vaccine series). For a more direct comparison with HFV programs, the 2003 U.S. National Immunization Survey conducted by the Centers for Disease Control and Prevention estimated the FY 2003 vaccination completion rate was 74.6% for the Virginia general population. Furthermore, the Virginia Department of Health (VDH) FY 2002 Sentinel Report estimated the vaccination

completion rate for Health Department clients was 57.34% (all of the 2002 rates are based on the 4:3:1:3:3 vaccine series, a series that actually includes two fewer immunizations than the recommended 16 tracked by HFV). This finding from the recent 2002 immunization survey by VDH is sobering and attests to the lack of successfully protecting our most vulnerable children.

HFV's performance (82%) surpasses the demanding statewide objective, exceeds the Virginia average of 74.6% for the general population, and far exceeds the immunization rate for comparable high-risk families of 57.34%. Healthy Families programs can take pride in this level of performance. This immunization completion rate is clearly superior not only to the rates for high-risk families, but also to the rates for the Virginia general population. Moreover, since the Virginia statistics are based on fewer immunizations, HFV is actually being evaluated on a higher standard.

CHILD HEALTH OUTCOMES (CONTINUED)

- **Connection to Medical Care Providers** - Goal: 85% of participating children will have a medical provider at birth or within 2 months.

88% of all children had a primary health care provider within two months of birth.

- **Continuation with a Medical Care Providers** - Goal: 80% of participating children with a medical provider will continue to receive services from the medical provider.

92% of all children continued to have medical care providers after six months.

- **Immunization** - Goal: 80% of participating children will receive 100% of scheduled immunizations.

82% of all children received 100% of their 16 scheduled immunizations. (HFV's immunization rate was not only higher than the rate for similar high-risk families, but also substantially higher than the rate for the Virginia general population).

Note: The VDH FY 2002 Sentinel Report estimated the vaccination completion rate for Health Department clients is 57.34%. The 2003 rate for the VA general population is 74.6%. These rates are based on the 4:3:1:3:3 and 4:3:1:3:3:1 vaccine series, respectively. HFV is actually being evaluated on a higher standard since the Virginia rates are based on fewer immunizations.

- **Pregnancy Risk and Birth Complications:** In the one site that followed prenatally enrolled women in order to assess pregnancy risk and birth complications, participants experienced one-third of the pregnancy risks and less than half of the birth complications experienced by women receiving all of the standard health department services but not participating in Healthy Families.
- **Longer Term Health Outcomes:** The same site that tracked pregnancy risk and birth complications also compared the health of Healthy Families children to similar control group children after three years. The follow-up produced consistent findings favoring the better physical development, medical care, and health of the Healthy Families children.

These positive child and maternal health findings complement the results emerging from other HFA programs nationally, which have demonstrated improved health care status, service utilization, and high rates of immunization. Virginia is one of the only states to have documented impacts on pregnancy risks

and birth complications.

2. Maternal Health

HFV has also established statewide goals in the area of mothers' health to reduce closely-spaced births and delay/reduce repeat pregnancies.

Of the 4,535 mothers (1,136 teen and 3,399 non-teen mothers) enrolled in HFV programs, 2052 were enrolled long enough (i.e., a minimum of 24 months following the birth of a child) to merit inclusion in this evaluation component. This sample size is 65% larger than FY 2003's sample, indicating the continued growth of the statewide evaluation. After the targeted 24-month interval, 91.2% of the teen mothers had no subsequent births. In addition, 2% had a subsequent birth after the targeted 24-month interval and 6.8% of teen mothers have a subsequent birth before the 24-month interval. This represents a 93% success rate with teen mothers. Eighty-eight percent (88.2%) of the non-teen mothers had no subsequent births, and four percent (4.4%) had births after the targeted 24-month interval, representing a 93% success rate for non-teen mothers. Sites have performed positively in both domains, and have easily surpassed the HFV evaluation criteria.

HFV's success in this critical domain has been highly consistent across the state. These data suggest Healthy Families programs effectively helped women reduce closely-spaced and unintended pregnancies. These delays in subsequent child birth are associated with higher educational attainment, improved child health, and increased future job status.

MATERNAL HEALTH OUTCOMES

- Goal: 85% of teen mothers will have no subsequent births or will have an interval of at least 24 months between the target child's birth and the subsequent birth.

91.2% of teen mothers had no subsequent births and 2% had a subsequent birth after the targeted 24-month interval. **This represents a 93% success rate statewide.**
- Goal: 75% of non-teen mothers will have no subsequent births or will have an interval of at least 24 months between the target child's birth and the subsequent birth.

88.2% of non-teen mothers had no subsequent births and 4.4% had a subsequent birth after the targeted 24-month interval. **This represents a 93% success rate statewide.**

These delays in subsequent child birth are associated with higher educational attainment, improved child health, increased future job status, and decreased infant homicide. The performance of Healthy Families sites in this domain has been highly uniform across communities.

3. Child Development

All of the sites endorsed the objectives to monitor child development by systematic developmental screening, referring those children with suspected delay to early intervention services for further assessment, and following-up referred children. Approximately 76% of the 3,052 children were appropriately screened for developmental delays and that rate rose to 79% in FY 2004. While many programs have experienced difficulty attaining the goal of conducting semi-annual screenings, this objective has shown continued moderate improvement across each of the past three years and the FY 2004 performance is the best to date. In addition, 89% of all the programs have successfully ensured the referral of children with suspected delays to further assessment. Similarly, 88% of programs monitored children with confirmed delays to track whether the family followed through to connect those children to services.

CHILD DEVELOPMENT

- Goal: 90% of participating children will be screened for appropriate development semiannually for the first three years and annually thereafter.

76% of the 3,052 eligible children were appropriately screened for suspected delays.
In FY 2004, 79% of 1,963 children who were actively enrolled were appropriately screened.

- Goal: 90% of children with suspected developmental delay will be referred for further developmental assessment and services where appropriate.

24 of 27 (89%) sites surpassed the criterion.

- Goal: 100% of children with confirmed developmental delay will be monitored for follow-through with recommended services.

21 of 24 (88%) sites surpassed the criterion.

Healthy Families Programs succeeded in ensuring the referral of children with suspected delays to early intervention services and following children to ensure the receipt of services. Many programs, however, experience difficulty in conducting semi-annual screenings of all children.

4. Parenting and the Home Environment

This important domain provides a cornerstone for the effects of HFV, therefore, the evaluation uses two highly regarded scientific measures (the NCAST and the HOME) to examine parent-child interaction and the quantity and quality of the developmental stimulation families provide children in their home environments.

Of the 491 children who were old enough for an assessment of parent-child interaction, 406 had at least one assessment completed. Of those 406 families, 94% of the assessments were within normal limits. During FY 2004, HFV's performance was even stronger; 99% of all active families with an NCAST assessment were within normal limits. HFV's performance clearly exceeds the 85% evaluation criterion for established sites. There were 1,156 families whose children were old enough for the HOME and 818 of those families received one or more in-home assessments. Of those 818 families, nearly 96% had home environments that were within normal limits. This performance easily exceeded the statewide objective in this domain.

Overall, Healthy Families participants displayed greater sensitivity to their children's cues, greater understanding of their children's development, greater knowledge of alternative methods of discipline, and less overall distress and rigidity.

PARENT-CHILD INTERACTION AND THE HOME ENVIRONMENT

- Goal: 85% of participants will demonstrate positive parent-child interaction or show improvement.
94% of the 406 NCAST assessments of parent-child interactions were within normal limits.
During FY 2004, 99% of the NCAST assessments for all active families were within normal limits.
- Goal: 85% of participants will have optimal home environments to support child development or their home environments will show improvement.
96% of the 818 HOME assessments were within normal limits.
During FY 2004, 95% of the HOME assessments for all active families were within normal limits.

Overall, Healthy Families participants displayed greater sensitivity to their children's cues, greater understanding of their children's development, greater knowledge of alternative methods of discipline, and less overall distress and rigidity.

5. Child Abuse and Neglect

Since the implementation of the Hampton Healthy Start program in 1992, the examination of rates of founded cases of child abuse and neglect for Healthy Families participants have been examined in a number of contexts. The six-year, random-assignment study of Hampton Healthy Start indicated the annual rate of founded cases never exceeded 1.5% (Galano & Huntington, 1999b). Additionally, Northern Virginia Family Services programs have consistently found rates of 3% or less.

This year's report provides strong new evidence for the effectiveness of Healthy Families as a child

maltreatment prevention program. First, the statewide rate of confirmed cases of child abuse and neglect was 1.1% based on 2,272 families, the largest sample of Central Registry searches to date. In addition, the performance of 100% of the individual sites met or surpassed the Healthy Families objective in this domain. Finally, of the 2,272 families, 101 mothers (5.5%) had reports as victims, with the percentage of mothers as victims ranging from 0% at some sites to as high as 17% at others. The fact that more than five times as many Healthy Families participants were in the CPS Central Registry as childhood victims of maltreatment than as perpetrators demonstrates that HFV is contributing successfully to its goal of breaking the cycle of violence.

Child Abuse and Neglect

- Goal: 95% of participating families will not have a founded case of abuse or neglect after one full year of participation in the program.

Across 32 sites and 2,272 families the rate of founded cases of child maltreatment was 1.1%.

HFV's rate of child abuse and neglect is very low, especially considering the characteristics of the participating sample and the fact that these are not annual rates, but rates based on the entire period of participation in the program.

More than five times as many Healthy Families participants were in the CPS Central Registry as childhood victims of maltreatment than as perpetrators.

Assessing impacts on child maltreatment is a challenging and complex task. For a more complete discussion of the issues involved and the limitations of these analyses the reader is referred to *Healthy Families Virginia FY 2001: Statewide Evaluation Report* (Galano & Huntington, 2001).

6. Community-Wide Impact: The Hampton Healthy Families Partnership Benchmark Study

Initiating services in 1992, the Hampton Healthy Families Partnership (HFP), including Hampton Healthy Start program, stands as one of the most comprehensive and well-established programs in Virginia. Spanning from 1992-1998, the most extensive evaluation conducted by the Center for Public Policy Research of the Thomas Jefferson Program in Public Policy at the College of William and Mary (Galano & Huntington, 1999b) provided the strongest evidence of the program's impact. After repeatedly demonstrating the effectiveness at the participant level, partnership leaders wanted to know if the initiative produced similar effects at the community level. The Benchmark Study, commissioned by the city of Hampton, examined Hampton's performance between 1984-2000 on eight community-wide benchmarks of child and family health. The study compared Hampton to Hampton Roads, Greater Richmond, Richmond, and three pairs of Hampton Roads communities. The investigation examined the eight-year period preceding the initiation of HFP as well as the eight-year period following the initiative. Hampton improved in five areas, remained the same in two, and declined in one. The one area of decline, low birth weights, followed the national trend. The city outperformed all the comparison regions/cities in reducing the rates of infant mortality and child abuse and neglect. In several areas Hampton's performance during the last decade was similar to its peer communities' performances. In

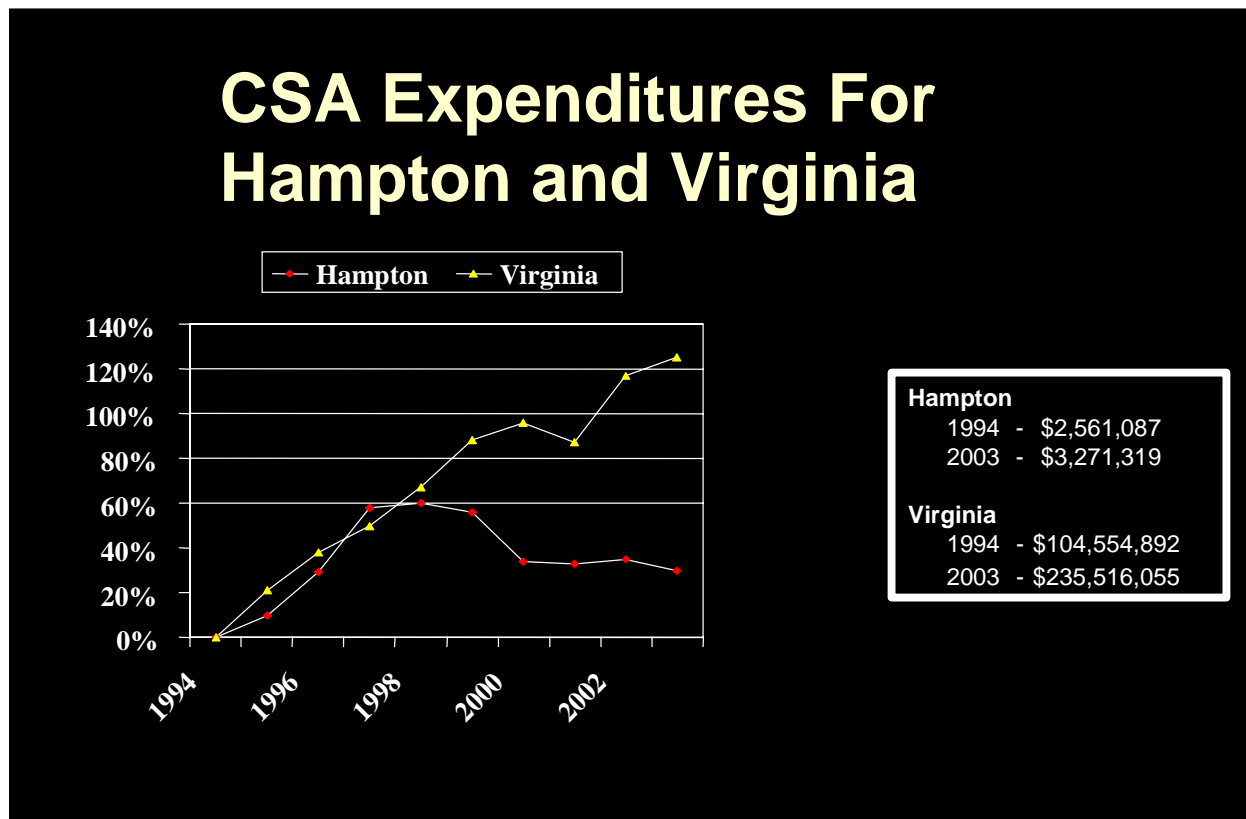
the case of childhood fatalities, however, Hampton’s performance resembled the lower-risk, higher-resource comparison communities. Significantly, Hampton’s progress occurred during a decade when Hampton’s families became at higher-risk on a number of factors having negative influence on health outcomes. These findings are encouraging, especially since the program is only now going to scale (community-wide). The full impact of the initiative will not occur until 2005 or later.

7. The Benefits of Healthy Families Virginia: Declining Community Services Act (CSA) Costs in Hampton, Virginia

In 2004, the Senate Finance Committee of the Virginia General Assembly requested testimony designed to address whether the positive child and family health outcomes experienced by Hampton were associated with reductions in treatment and rehabilitation costs. The figure below presents CSA expenditures for Hampton compared to Virginia between 1994 and 2003. This time frame corresponds to the initiation of HFP and HFP’s “going to scale.” The significant difference between the trends in Hampton and the rest of the state is dramatic and clearly understood by citizens and policymakers alike. State officials across Virginia and in Hampton believe that HFP is one of the major reasons for this declining trend in Hampton. HFP, which began in 1992, has expanded rapidly, and it is both the *size* of the investment that Hampton has made in the Partnership and the *duration* of that investment in prevention that the city believes have resulted in the declining trends in CSA costs. Unless we are determined to eradicate child abuse, we can expect the cost of remedial and therapeutic services associated with it to go up endlessly. It is only by investing in prevention that we can address the root of

the
pro
blem.

The Benefits of HFV: Declining CSA Costs



PART V. RECOMMENDATIONS

A. Program Recommendations

After five years of extensive program evaluations, the HFV initiative has continued to demonstrate strong results in the most recent fiscal year and build on its earlier record of success. However, much more can be done. Research has confirmed home-visiting programs effectively reduce child maltreatment among high-risk families. Additionally, research has contributed to a richer understanding of best practices and strategies for home-visiting programs. The challenge for HFV is to translate this research into policies and practices that will improve the quality of HFV programs. Implementing these recommendations can further reduce child abuse and neglect and improve the lives of children and families served by Healthy Families.

- **Strengthen Healthy Families Virginia capacity to ensure that Virginia’s children enter school ready to learn and succeed.**

Ensuring that Virginia’s highest-risk children enter school ready to learn and succeed represents an important goal of HFV and the Commonwealth. Home visitors already help parents learn ways to stimulate healthy brain development and to develop strong, nurturing parent-child bonds so children will be cognitively, emotionally, socially, and behaviorally ready to enter school. Healthy Families also focuses on the family and the larger neighborhood and community in which families are embedded. HFV should continue to support the “Bonding With Baby Books,” a Freddie Mac funded demonstration program to promote pre-literacy, reading, and school readiness. The program, now in 20 Virginia sites, promotes infant stimulation, positive parenting, and language development. Moreover, to become mobilized around school readiness, sites should become familiar with the recommendations of two statewide plans to be completed in early 2005. They are the Blue Ribbon Plan to Prevent Child Abuse in Virginia and the Virginia Health Department’s Statewide Early Childhood Strategic Plan.

- **Increase the number of HFV programs that enroll mothers prenatally.**

Many HFV programs enroll women in the postnatal period because they lack sufficient resources to enroll mothers prenatally or because they lack the interagency relationships permitting access to pregnant women. This situation represents a missed opportunity to prevent low birth weight, infant mortality, and poor developmental outcomes. Prenatal enrollment allows for earlier education regarding nutrition, exercise, avoidance of alcohol and drugs, earlier detection and intervention for pregnancy related problems, and prevention of complications during pregnancy.

In addition, key risk factors for infant homicide include late or no prenatal care, second or subsequent births to an unmarried teenage mother, and low education. Nationally, infant homicide rates have more than doubled since 1970 (from 4.3 to 9.1 per 100,000 children under age one), and homicide risk is greater in the first year of life than in any other year of childhood before age 17 (Paulozzi & Sells, 2002).

Nationally, a greater proportion of new HFA programs enroll mothers prenatally; however, in Virginia, the opposite trend has occurred. HFV and the program directors network should consider serving more prenatal families. To accomplish this, they will need to educate leaders at prenatal access points to engage them in helping to counter this trend.

- **Eligible Healthy Families sites should demonstrate their adherence to nationally accepted standards by completing the HFA credentialing process or re-credentialing process as soon as possible.**

A critical function of program management is to ensure that programs are delivering the intended services to participants. Achieving a high level of program fidelity is essential to maximizing benefits to children and families. To accomplish this national objective, HFV has hired, trained, and deployed regionally-based technical assistants/quality assurance (TA/QA) staff from three regions of the state to provide technical support on program development, credentialing, and evaluation to sites in their regions.

- **Develop a five year plan to expand local capacity so that all HFV sites are able to serve at least 75% of the families estimated to need home visiting services.**

In 2002, CDC&P's Task Force on Community Preventive Services strongly recommended the implementation or continuation of early home-visitation programs (Task Force on Community Preventive Services, 2002). The Task Force estimated the approximately 40% of all maltreatment could be prevented if this recommendation were followed. Although Virginia can take pride in the growth of Healthy Families programs, very few communities have taken their programs to scale (i.e., community-wide), and this limited capacity prevents helping many families in need of services. This lack of capacity will surely result in the Commonwealth having more cases of child abuse and neglect, more infant fatalities, and ultimately, more school failure, mental illness, substance abuse, criminality, and serious adult illness.

HFV can expand capacity by helping all sites grow proportionally or by identifying key communities that are ready to take their initiatives to scale. HFA's theory of change acknowledges that child abuse and neglect is multi-determined. Therefore, mechanisms within individuals as well as within communities must be targeted. Having both a targeted home-visiting program for high-risk families while also creating community-wide prevention services and supports for all families may be the most effective strategy to both reduce child maltreatment and strengthen families.

- **Implement effective prenatal curricula and provide comprehensive training for HFV staff.** Poor or insufficient prenatal care is related to low birth weight, infant mortality, and poor developmental outcomes. Good prenatal care can be particularly important for females at higher-risk (low income, young, or minority). Those women typically experience the highest levels of inadequate prenatal care and are less likely to enter care early. HFV has recognized this need and should continue plans to provide comprehensive training to all sites.

B. Program Evaluation and Technical Assistance Recommendations

- **Comply with the recently promulgated DSS evaluation expectations.** At the end of FY 2003, DSS presented a series of expectations for the Healthy Families evaluation to the statewide Healthy Families Directors' Network. The expectations were consistent with the established goals and objectives for the Healthy Families initiative; however, they emphasized greater accountability on some of the objectives that the program has found difficult to measure, such as parent-child interaction. Consequently, HFV staff identified an additional credible tool for measuring parent-child interaction. Simpler to use than the NCAST, the new tool provides programs with an alternative (although the NCAST is a validated instrument, it is difficult and expensive to implement). The new instrument, the Keys to Interactive Parenting Scale [KIPS], now is being used in several sites and its utility will be evaluated in 2005. The Directors Network should continue development of the resources and capacity for implementation of all of the goals and objectives.

- **Implement a comparison study of the NCAST and the KIPS**
The NCAST parent-child interaction assessment instrument is considered state-of-the-art as both a clinical and a research instrument. Implementation of the instrument, however, has proven particularly difficult for the Healthy Families sites. Several sites should collaborate on a study of the comparability of the NCAST and the KIPS. Because both instruments use videotaped observations of mother-child interaction, a study could be accomplished by having the observations cross-scored by two sites. This study would allow HFV to examine whether the KIPS is an appropriate replacement for the NCAST.
- **Collaborate with the TA/QA Specialists to design a training on the use of PIMS and the Supplemental System for program management.**
Most PIMS sites have developed the capacity to collect and maintain most of the required evaluation data. As they go forward, sites should receive advanced training in the uses of available reports. For example, supervisors should familiarize themselves with the PIMS caseload management and monthly contact reports and the other tools and use these reports in supervision meetings with their staff. Using the data in this way will improve the sites' organization and attainment of program goals. Similarly, program managers should understand the uses of data to facilitate the credentialing process.
- **Participate in the HFV Quality Assurance training to be piloted in 2005.**
This training will assist sites in developing an annual quality assurance plan incorporating multiple sources of data. The plan will provide each site with specific targets concerning enhanced service delivery and improved outcomes.