COMMONWEALTH of VIRGINIA

Office of the Governor

Marilyn B. Tavenner
Secretary of Health and Human Resources

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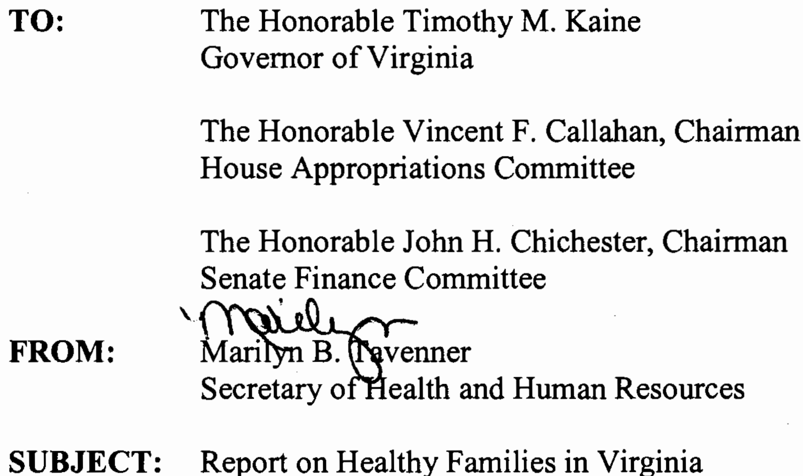

TO: The Honorable Timothy M. Kaine
Governor of Virginia

The Honorable Vincent F. Callahan, Chairman
House Appropriations Committee

The Honorable John H. Chichester, Chairman
Senate Finance Committee

FROM: Marilyn B. Tavenner
Secretary of Health and Human Resources

SUBJECT: Report on Healthy Families in Virginia

The report herein has been prepared pursuant to the 2007 General Assembly Appropriation's Act (Act of Assembly Item 278 F) which directs the Secretary of Health and Human Resources in coordination with the Virginia Department of Social Services (VDSS) to conduct a study on Healthy Families Virginia and make recommendations on the possible expansion of that program.

As a part of this report, VDSS has reviewed Prevent Child Abuse Virginia's strategic plan and the Hampton Healthy Families Benchmark Study. VDSS has also conducted its own field research and has designed an evaluative tool for determination of Healthy Families sites most appropriate for expansion. As a result of this work, a number of recommendations have been made that will allow Healthy Families Virginia to continue to serve Virginia's at risk youth.

MBT:lrm
Attachment

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Report on Healthy Families Virginia

PREFACE

The 2007 Appropriation Act (Item 278 F) requires the Secretary of Health and Human Resources in coordination with the Virginia Department of Social Services to study and make recommendations related to the possible expansion of Healthy Families Virginia. The report is to be presented to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees.

Report on Healthy Families Virginia

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Report on Healthy Families Virginia

Executive Summary

The Virginia Department of Social Services (VDSS), in collaboration with Prevent Child Abuse Virginia (PCAV), has prepared the following legislative study examining the possible expansion of the Healthy Families program in Virginia. Healthy Families is a national initiative designed to provide support to all new parents. With an overarching mission, the Healthy Families model encourages collaboration of all community partners working with young children. Key services offered include an initial brief screening and in-depth assessment of pregnant women or parents shortly after birth to determine their strengths and their needs.

Research examining the Hampton Healthy Families Partnership has demonstrated that community wide investment in the Healthy Families model can yield positive outcomes. Since the inception of the Healthy Families program in the City of Hampton in 1993, outcomes measuring community health have shown positive movements. Hampton has seen dramatic decreases in both its infant mortality rate and its various child abuse and neglect indicators. The Comprehensive Services Act (CSA) expenditures in Hampton have also grown at a remarkably slower rate than the rest of the Commonwealth. By expanding other Healthy Families programs across the state, it is believed similar results will be observed.

The following report provides an overview of PCAV's strategic plan for Healthy Families Virginia, a description of the evaluative process for site expansion, a review of the Hampton Healthy Families Benchmark study, and a summary of focus groups held with various members of the Hampton Healthy Families Partnership. Based upon all aggregated research, the following recommendations have been made:

- Maintain the current level of funding to **ALL** Healthy Families sites;
- Providing funding to significantly expand the scope of services for at least 4 existing programs;
- Prioritize for expansion those programs with a track record or clear ability to realize the "initiative concept" as part of the Healthy Families model and where strong local support exists as evidenced by local funding, private partnerships/funding, and vigorous boards; and
- Prioritize for growth those Healthy Families programs located in communities exhibiting significant risk factors.

Report on Healthy Families Virginia

Study Mandate

The 2007 Appropriations Act, Item 278 F states:

The Secretary of Health and Human Services, in coordination with the Department of Social Services, shall review and report on the strategic plan for Healthy Families Virginia. The review shall examine Prevent Child Abuse Virginia's survey of site capacity and sites that would be appropriate for expansion. As part of the report, the Secretary shall review the findings of the Hampton Healthy Families Benchmark Study and recommend strategies that other communities may adopt to further reduce child abuse and neglect. The Secretary shall provide this report, no later than October 1, 2007, to the Governor, and the Chairmen of the House Appropriations and Senate Finance Committees.

Program Background

Healthy Families is a national initiative designed to provide support to all new parents. With an overarching mission, the Healthy Families model encourages collaboration of all community partners working with young children. Key services offered include an initial brief screening and in-depth assessment of pregnant women or parents shortly after birth to determine their strengths and their needs. Through this research-based approach, parents deemed most at-risk for challenges in this role are offered voluntary home visiting. Other parents indicating fewer risks receive referrals to community resources matched to their needs and interests.

The Healthy Families model first took root in Virginia in 1991 in Fairfax as an effort to support Hispanic families. In 1992, Prevent Child Abuse Virginia (PCAV), the state chapter of Prevent Child Abuse America, assisted the City of Hampton in advocating for state funds to begin a demonstration program using this prevention model. Responding to increasing requests for assistance from other local communities, PCAV began building the capacity to coordinate the development of more Healthy Families sites in Virginia. Funding of the Healthy Families program by the General Assembly began in state fiscal year (SFY) 1993 for Hampton ($150,000.00), with additional sites being added in SFY 1997. In 1994, with support from the Freddie Mac Foundation, PCAV began offering technical assistance, training, and evaluation to foster the growth of 10 additional sites. By 2007, 38 sites have developed and serve vulnerable families in 87 Virginia communities. The Virginia Department of Social Services (VDSS) administrates the funds appropriated by the General Assembly for the Healthy Families program. Financial assistance from the General Assembly currently constitutes 30 percent of the total statewide Healthy Families budget which stands at $18,420,519.00.

Review of Healthy Families Virginia Strategic Plan

Healthy Families Virginia (HFV) is guided by a Strategic Plan which is currently in place for 2005-2007. The HFV Strategic Plan is comprised of five goals that address statewide system development including expansion of at least four sites to be able to offer voluntary services to all new parents, building statewide collaborations, gaining national accreditation status for all 38 programs, improving technical assistance and training, and measuring and achieving all program evaluation outcomes. The following section summarizes each goal with its main objectives and key activities.

GOAL 1: TO BE RECOGNIZED AS A STATE LEADER IN PREVENTION SERVICES FOR CHILDREN AGES 0-5

Objectives: Improve public awareness of HFV; strengthen partnerships that build the statewide continuum of services for families of young children; and enhance leadership ability of HFV staff in maintaining a strong statewide system. **Key activities include**: 1. successfully establishing a statewide Advisory Council for HFV; 2. establishing a marketing committee; 3. collaborating on the State Child Abuse Prevention Plan, the New Parent Kit project, and the statewide Home Visiting Discussion Group; 4. coordinating training activities with CHIP of Virginia; and 5. successfully creating a full-time HFV Director position and a new part-time Technical Assistance/Quality Assurance position for Central Virginia.

GOAL 2: TO SUPPORT THE FINANCIAL STABILITY AND GROWTH OF THE HEALTHY FAMILIES INITIATIVE IN VIRGINIA

Objectives: Achieve stable funding for all current Healthy Families sites by the 2007-2008 biennium and pursue avenues to grow the statewide system. **Key activities include**: 1. completing a chart of all current funding sources; 2. advocating for permanent state support for all sites; 3. seeking full funding for statewide infrastructure needs including evaluation and quality assurance; 4. assessing sites' current capacity and determining a process for some sites to grow to scale.

GOAL 3: TO ACHIEVE AND DEMONSTRATE EXCELLENCE IN THE STATEWIDE IMPLEMENTATION OF THE HEALTHY FAMILIES MODEL

Objectives: Provide responsive, high quality, and well-developed technical assistance, by January 2005; complete credentialing and re-credentialing within 12 months of eligibility; assess quality of state system through development of an annual Quality Assurance Review; and increase pre-natal enrollment statewide in order to impact birth outcomes. **Key activities include**: 1. developing best practice standards to guide service delivery (surpassing HFA credentialing standards); 2. training program administrators in quality management skills and tools; 3. distributing a list of top quality curricula for use on home visits; 4. providing intensive training and technical assistance on credentialing, 5. surveying sites' current pre-natal enrollment status and development of prenatal goals

with justification for including prenatal parents in the target population and provision of training on effective home visiting during the pre-natal period.

GOAL 4: TO MAXIMIZE POSITIVE PROGRAM OUTCOMES

Objectives: Attain an effective, comprehensive and fully funded statewide evaluation system; monitor and strengthen state evaluation outcomes with special focus on any objectives that are below target. **Key activities include**: 1. developing strategies for improving performance on outcomes; 2. establishing accountability in the evaluation process; 3. advocating for increased funding to offset evaluation costs; and 4. use existing data to answer more questions about program effectiveness.

GOAL 5: TO ENSURE A WELL-TRAINED STAFF ABLE TO PROVIDE EFFECTIVE, PROFESSIONAL SERVICE

Objectives: Continue development of regional core and wraparound training opportunities; provide specialized training to address ongoing skill development needs; and explore additional training resources in order to provide accessible, high-quality training**. Key activities include**: 1. maintaining regular schedule of core trainings; 2. collaborating with training entities like VISSTA, Square One, and the Center for Health Outreach; 3. surveying staff and developing new training packages to meet the needs of all staff positions; 4. exploring train the trainer opportunities; and 5. cataloguing web-based trainings.

Review of Hampton Healthy Families Benchmark Study

The evolution of the Hampton Healthy Families Partnership and the results of a benchmark study conducted in 2002 in Hampton, Virginia (1991-2000) warrant further review. During this time, Hampton's Healthy Families Partnership evolved from serving 25 percent of eligible families interested in long-term home visiting toward "going to scale" or serving all families. By 2003, Hampton hoped to have been reaching all families.

While Hampton's Healthy Families Partnership was providing intensive home visiting to a growing number of families, programmatic and community structural elements may have also contributed to their success. The original steering committee drew department heads from numerous organizations including: social services, health, mental health, schools, libraries, the Center for Child and Family Services, the Housing Authority, and local hospitals. Focusing on prevention, they coalesced around a mission statement of "ensuring all children are born healthy and enter school ready to learn." Using a partnership investor model, they developed an executive committee which designed two components: Healthy Start, a targeted intervention for at-risk families, and Healthy Community, a set of comprehensive parent education and support services for all Hampton families. Both components represented congruence with the Healthy Families America model beginning to spread nationwide.

Some of the strongest evidence supporting the effectiveness of the Healthy Families Model has been found in the evaluations of the implementation of Healthy Families in the City of Hampton. Upon implementation of the Healthy Families Model in Hampton, community leaders felt it necessary that an evaluative component be incorporated to not only measure the effectiveness of a preventative approach to community well-being, but also as a method of ensuring continued local funding. Hampton's performance between the years of 1991 and 2000 was measured against eight community wide benchmarks. These benchmarks, selected because they mirrored Hampton's Strategic Plan and the Hampton Healthy Families Partnership's (HHFP) mission statement, are: prenatal care beginning in the first trimester, low birth weight babies, infant mortality, child abuse and neglect, childhood fatalities attributable to child abuse and neglect, healthy birth index, assessment of reading/school readiness in kindergarten and first grade (PALS) and births to teens. The Hampton Healthy Families Benchmark study not only evaluated the prescribed benchmarks, but also compared Hampton's progress to other similar demographic localities (Newport News/Suffolk, Chesapeake/Virginia Beach, Norfolk/Portsmouth, Greater Richmond, and Richmond City).

The 2002 Hampton Healthy Families Benchmark Study revealed that Hampton had improved in five areas since the inception of the HHFP, remained the same in two, and declined in only one area (which mirrored national averages). The City performance rated exceptionally strong in the areas of infant mortality and child abuse and neglect. In these two areas, Hampton outperformed all the comparison regions/cities, including areas selected that featured greater community resources and fewer sociodemographic risk factors. For example, the infant mortality rate was falling in Hampton by nearly one infant death per 1,000 infants per year, while the rates for Hampton Roads and Greater Richmond were falling by .23 and .32 infant deaths per 1,000 annually. The Hampton Healthy Families Benchmark Study highlights this finding by citing sources that note "It [infant mortality] is often regarded as an indicator of a community's overall well-being because it is associated with a variety of factors such as maternal health, the quality and access to medical care, nutrition, socioeconomic conditions, and public health practices" (HHFPBS 26). Similarly, Hampton's trend of declining child abuse and neglect rates was stronger than other regional localities (HHFPBS 34). The Hampton Healthy Families Benchmark Study's focus on trending data over time has allowed for a high level quantitative analysis of the Partnership's progress on explicitly set goals. There is little doubt that Hampton's performance in the areas of infant mortality and child abuse and neglect can be at least partly attributed to the HHFP. The successes in these two benchmark areas are congruent with HHFP's specific objective to "systematically invest in parents, prevention, and health promotion".

Currently, a newer version of the Hampton Healthy Families Benchmark Study is being completed. While not yet published, preliminary outcome findings have been released. The 2007 Benchmark Key Outcome Findings continues to show Hampton's progress in meeting their prescribed benchmarks. The 2007 findings note that Hampton continued to improve on six of the eight benchmarks, and outperformed all comparison cities on both child abuse and neglect benchmarks, as well as CSA cost per child. While a direct correlation cannot be made between low CSA costs and the HHFP at this time, it is

highly likely that Hampton's community based approach to preventative family health plays a direct role.

Hampton's impressive performance in the Benchmark Study cannot be totally attributed to the Healthy Families initiative. Study authors noted that "indicators that can be affected by many agencies and services make poor measures of the effectiveness of any specific initiative such as HHFP." Influences may range from "government policies and programs across many agencies, as well as economical and social forces completely outside of government." Additional research was requested by VDSS to further examine the role played by HHFP and focus groups were assembled to collect qualitative data to further assess the role HHFP played.

Focus Group Findings

On June 18, 2007, representatives from VDSS conducted three focus groups at the Hampton Healthy Families office in Hampton, Virginia. The focus groups were comprised of three different populations: families enrolled in HHFP programs, HHFP staff, and the HHFP executive committee. It was anticipated that information obtained from these three focus groups would allow for further examination of the successes of HHFP.

The first focus group conducted was with families participating in HHFP programs. Participation in these programs ranged from enrollment in the Healthy Start program (home visiting component), to participation in play groups, to attending parenting classes. The majority of the parents in the focus group participated in multiple programs. All participants in the family focus group spoke very highly of the HHFP and the programs offered. The focus group offered a wide array of individual stories with the common themes involving building relationships and providing support. Many of the participating mothers were single parents who referred to their Healthy Start program home visitor as not only a provider of helpful parenting advice, but also as a provider of personal support that was previously absent from their homes. These sentiments were reiterated when parents discussed participation in HHFP play groups. They noted that children were given a chance to socialize in a healthy environment and that play groups allowed parents to meet one another and form relationships that often strengthened their parenting skills.

The second focus group held was with HHFP staff members. Results recorded in this focus group paralleled those expressed in the participant group: the importance of building relationships with families and the continued focus on HHFP's espoused goals. Worker's described daily interactions with families and expressed the importance of honesty and a genuine sense of caring. Staff members stressed the importance of building relationships with each participating parent and attributed their success in building positive relationships to the high level of intensive training that HHFP provides. HHFP provides a five tier training process that involves 32 hours of core curriculum and ongoing training. Staff members noted that the quantity and quality of training has made them more successful in their positions and has helped keep levels of employee retention high.

The final focus group held was with the HHFP executive committee. The executive committee attributed the success of HHFP to (1) a strong focus on prevention, and (2) coalition building. They cited strong community support for HHFP's youth development programs as a very important component in HHFP's success, as was the strong support HHFP received from many of Hampton's public and private entities. With the many partners working together, HHFP was launched with significant local backing and support. The executive committee strongly stressed the importance of community support to the success of the program and the importance of strong commitment from local leaders in order for a Healthy Families program to experience the successes Hampton has seen.

Review of PCAV Site Survey

Many Healthy Families programs in Virginia are serving their communities well, but expansion of some of these programs is necessary to realize the benefits identified in Hampton. Currently, only five Healthy Families sites, excluding Hampton, are serving above 25 percent of at risk families in their communities. In order to determine which of the Healthy Families sites are most appropriate for expansion, it was determined that the development of an evaluative tool measuring two critical criteria was necessary. These criteria are: community need and program goal attainment.

The HHFP executive committee recommended looking at community need as one criteria to assess a program's readiness for expansion. Localities exhibiting high risk factors would likely have the most to gain from a transition from treatment based care to prevention. Five factors are weighed in evaluating community need. These factors are represented in ***Figure 1***.

Figure 1 – **Community Need Contributing Factors and Measurements**

Community Need Contributing Factor	**Measure**
Infant Mortality Rate	Infant Deaths / Live Births * 1000
Average CSA Expenditure per Child	CSA Expenditures / CSA Children
CSA Children per 1000	CSA Children / (Children 0-17 / 1000)
Child Abuse and Neglect Rate per 1000	Founded Child Abuse and Neglect Victims / (Children 0-17 / 1000)
CPS Family Assessment Rate per 1000	Responses to Child Abuse and Neglect Reports: Family Assessments / (Children 0-17 / 1000)

The five contributing factors are then ranked and averaged to determine an overall Community Need ranking for each Healthy Families site (several sites are comprised of more than one community). The following figures provide an illustration of the Community Need and Goal Attainment rankings for 37 localities excluding Hampton,

who can currently serve a majority of its families. Individual site rankings for each Community Need contributing factor can be viewed in ***Appendix A***.

Figure 2 **- Community Need Ranking Chart**

Site	Community Need Ranking
Richmond City	1
Warren County	2
Portsmouth City	3
Petersburg City	4
Southwest Virginia	5
Halifax/South Boston	6
Loudoun County	7
Henrico County	8
Danville/Pittsylvania County	9
Charlottesville/Albemarle	10
Arlington County	11
Virginia Beach City	12
Central Virginia	13
Three Rivers	14
Alexandria City	14
Charles City/New Kent	16
Page County	17
Eastern Shore	18
Hopewell/Prince George	18
Piedmont	18
Newport News City	21
Blue Ridge	22
Chesterfield/Colonial Heights	22
West Piedmont	24
Rappahannock Area	25
Chesapeake City	26
Northern Shenandoah	27
Norfolk City	28
Shenandoah County	29
Culpeper County	30
Prince William	31
Suffolk/Isle of Wight	32
Fairfax/Falls Church	33
Madison County	34
Orange County	34
Rappahannock County	36
Fauquier County	37

The second critical criterion used to measure whether expansion of a program should occur is program goal attainment which measures how sites are measuring and attaining HFV goals. HFV adopted specific outcome based goals and objectives, and sites work toward measuring and achieving these goals and objectives. The majority of sites are

measuring at least 10 of the 12 core goals (two additional goals are applicable only to sites serving prenatal parents and two goals are optional). For the complete list, see ***Appendix B.*** Attainment of goals for SFY 2006 is used as a determinant of successful delivery of services. ***Figure 3*** illustrates the ranking of each Healthy Families program in relation to goals achieved.

Figure 3 **- Goal Attainment Ranking Chart**

Site	Goals Attained	RANK
Loudoun County	13	1
Newport News City	13	1
Culpeper	13	1
Blue Ridge	12	4
Alexandria City	11	5
Charlottesville/Albemarle	11	5
Chesterfield/Colonial Heights	11	5
Eastern Shore	11	5
Hopewell/Prince George	11	5
Shenandoah County	11	5
Three Rivers	11	5
Virginia Beach City	11	5
Warren County	11	5
Fairfax/Falls Church	10	14
Northern Shenandoah	10	14
Rappahannock Area	10	14
West Piedmont	10	14
Arlington County	9	18
Madison County	9	18
Piedmont	9	18
Portsmouth City	9	18
Prince William	9	18
Rappahannock County	9	18
Southwest Virginia	9	18
Faquier	9	18
Richmond City	9	18
Central Virginia	7	27
Charles City/New Kent	7	27
Chesapeake City	7	27
Danville/Pittsylvania County	7	27
Henrico County	7	27
Norfolk City	7	27
Orange County	7	27
Suffolk/Isle of Wight	7	27
Petersburg City	5	35
Page County	5	35
Halifax/South Boston*	1	37

* New site that only recently began measuring goals.

Both the community need and goal attainment criteria carried an equal weight in the determination of whether a community is ready for expansion. An overall ranking was assigned to each site based upon the point total with the lowest total receiving a "1" and the highest receiving a "37". The *lower* a site's point total, the more likely it is that site is ready for expansion according the evaluative tool and criteria measured. ***Figure 4*** provides the overall ranking for each Healthy Families site.

Figure 4 - **Overall Ranking Chart**

Site	Community Need Ranking	Goal Attainment Ranking	Point Total	Overall Rank
Warren County	2	5	7	1
Loudoun County	7	1	8	2
Charlottesville/Albemarle	10	5	15	3
Virginia Beach City	12	5	17	4
Three Rivers	14	5	19	5
Alexandria City	14	5	19	5
Richmond City	1	18	19	5
Portsmouth City	3	18	21	8
Newport News City	21	1	22	9
Eastern Shore	18	5	23	10
Hopewell/Prince George	18	5	23	10
Southwest Virginia	5	18	23	10
Blue Ridge	22	4	26	13
Chesterfield/Colonial Heights	22	5	27	14
Arlington County	11	18	29	15
Culpeper County	30	1	31	16
Shenandoah County	29	5	34	17
Henrico County	8	27	35	18
Piedmont	18	18	36	19
Danville/Pittsylvania County	9	27	36	19
West Piedmont	24	14	38	21
Rappahannock Area	25	14	39	22
Petersburg City	4	35	39	22
Central Virginia	13	27	40	24
Northern Shenandoah	27	14	41	25
Charles City/New Kent	16	27	43	26
Halifax/South Boston	6	37	43	26
Fairfax/Falls Church	33	14	47	28
Prince William	31	18	49	29
Madison County	34	18	52	30
Page County	17	35	52	30
Chesapeake City	26	27	53	32
Rappahannock County	36	18	54	33
Fauquier County	37	18	55	34
Norfolk City	28	27	55	34
Suffolk/Isle of Wight	32	27	59	36
Orange County	34	27	61	37

Recommendations

1. Maintain current level of funding to ALL Healthy Families sites

In 15 years, 38 Healthy Families programs have grown to serve 87 Virginia communities. The most recently launched program opened in 2004. Local communities have dedicated resources to the success of the Healthy Families Program. In spite of several funding challenges and local changes in host agencies, no sites have dissolved.

The General Assembly appropriation represents critical budget support for all Healthy Family programs. In most cases, programs have grown in total funding, varied sources of funding, staffing, and number of families served. A statewide infrastructure that provides leadership, technical assistance, a quality assurance process, training and evaluation has created a network of support that enables these programs to be successful. The lessons learned from developing the Healthy Families model in multiple diverse communities under the auspices of a variety of host agencies has enriched the statewide Healthy Families system. Each community has made an investment in prevention, and participating families' lives are proven to be safer and healthier because of the Healthy Families program.

2. Providing funding to significantly expand the scope of services for at least 4 existing programs.

Given the successes illustrated in the Hampton Benchmark Study, reaching most or all families in a locality appears to reap significant rewards in a community. These rewards involve lower costs associated with infant mortality, child abuse and neglect, and increased readiness for children entering kindergarten. According to Hampton officials, social problems such as child abuse, teen pregnancy, and drug abuse were failing to respond to "quick fix" solutions. Community leaders recognized that major, lasting changes in how the community served its families was needed. Based on the results of the Hampton Benchmark Study, they believe their investment in prevention is paying off and propelling them toward their goal that every child is born healthy and enters school ready to learn.

With the exception of Hampton, none of the 38 Healthy Family program sites has the resources and capacity to reach all interested parents. Last year, programs identified hundreds of parents who were clearly at risk, but who could not be offered home visiting due to full caseloads. Based on the history of risk assessment and acceptance rates for home visiting in Virginia, an estimated 19,080 new families could be served each year (based on 106,000 births in 2006). Together, the 38 sites had the resources last year to provide home visits to 4485 ongoing and new families

Significant growth in several additional Healthy Families programs would both benefit families receiving services and create the opportunity to study the community wide impact over time of a heavier front-end focus on prevention. If at least four sites were

selected representing diversity in geography, demographics, and community size, the findings would provide a comparison for the Hampton results as well as further testing the Healthy Families model in a variety of conditions. Supporting the ability of selected programs to serve 75 percent of eligible families would lead to a greater overall community impact than providing small increases in the budgets of a larger number of programs.

Research from the Benchmark Study demonstrated that measurable changes in community outcomes began increasing after 50 percent of all families eligible to participate in the Healthy Families program were provided services. However, if a program is serving only 15-20 percent of eligible families who would accept voluntary home visiting, they are unlikely to achieve a tipping point of positive impact that would shift their community's profile over time. Serving only a small portion of families is less likely to significantly reduce the costs of possible treatment and intervention services health care costs, mental health/substance abuse treatment, foster care, special education, and juvenile delinquency. Growth funds would need to address increased costs for infrastructure, staffing, training, and a high quality evaluation process that would allow for accurate appraisal of impact over time.

3. **Prioritize for expansion those programs with a track record or clear ability to realize the "initiative concept" as part of the Healthy Families model and where strong local support exists as evidenced by local funding, private partnerships/funding, and vigorous boards.**

Central to the philosophy of Healthy Families is the intent to be the catalyst for a community extending its array of services for all parents of young children. This is what is meant by the "initiative concept." Enacting this philosophy involves bringing together community civic leaders, service program administrators, educators, elected officials and business leaders. Together they identify the social problems in the community and the resources available for all parents, from those with the fewest challenges to those who are most overburdened. Collaboration among service providers is important in order to work together to address the gaps in the spectrum and address unmet needs.

In order to be successful, communities must achieve a high level of community commitment and planning. Communities must maintain active planning structures and work together to build their resources for all parents ranging from excellent library materials for parents, to parent education classes, to intensive home visiting for those parents with the most serious challenges. Communities must maximize their partnerships, coordinate services well, and hold true to a community wide vision founded on commitment to proven preventative approaches for pregnant women and families with children from birth through age five.

Effective leadership is crucial to a successful outcome. Those communities with the ability to demonstrate this level of community commitment are best positioned to expand as part of a community wide vision and to have the infrastructure in place to support the effort. Evidence of this level of commitment would be demonstrated by an active

Healthy Families Board or community planning council staffed by strategic leaders, substantial in-kind resources, and a stable, diverse funding profile.

4. Prioritize for growth those Healthy Families programs located in communities exhibiting significant risk factors.

Some Virginia communities face greater challenges than others. Data on child abuse and neglect, family assessments, infant mortality, and CSA cases and spending reveal differences in community need (see ***Figure 2***). Targeting communities where the greatest impact might be made on reducing community need could yield the greatest savings in human capital and optimal return on investment. The stakes are higher both in individual costs and the costs to the community for treatment services for parents and children. By prioritizing the challenges of Virginia's Healthy Families localities, as was done with the site survey evaluative tool, community need can be adequately assessed.

Measuring a community's need cannot be the only factor used to prioritize growth. HFV has provided measurable benchmarks for each of its thirty- eight sites. These sites have chosen to measure themselves against these benchmarks in order to assess their ability to serve their communities. A site's ability to achieve these prescribed benchmarks would indicate that they are moving toward readiness for expansion. By successfully attaining program goals, these sites have demonstrated a dedication to community wide prevention and an investment in their localities' youth (see ***Figure 3***).

As previously mentioned, the site survey evaluation tool ranked each of the Healthy Families programs based on their readiness for expansion (***Figure 4***). It is the recommendation of this report that the Healthy Families sites appearing at the top end of the evaluation tool will begin an application process that ultimately will determine which four sites receive expansion funds, if such funds become available. Those sites are illustrated in ***Figure 5***:

Figure 5 **- Sites Identified as Ready for Expansion**

Site	Community Need Ranking	Goal Attainment Ranking	Point Total	Overall Rank
Warren County	2	5	7	1
Loudoun County	7	1	8	2
Charlottesville/Albemarle	10	5	15	3
Virginia Beach City	12	5	17	4
Three Rivers	14	5	19	5
Alexandria City	14	5	19	5
Richmond City	1	18	19	5
Portsmouth City	3	18	21	8
Newport News City	21	1	22	9
Eastern Shore	18	5	23	10
Hopewell/Prince George	18	5	23	10
Southwest Virginia	5	18	23	10

Blue Ridge	22	4	26	13
Chesterfield/Colonial Heights	22	5	27	14
Arlington County	11	18	29	15
Culpeper County	30	1	31	16
Shenandoah County	29	5	34	17
Henrico County	8	27	35	18
Piedmont	18	18	36	19
Danville/Pittsylvania County	9	27	36	19

Future Steps

- Prevent Child Abuse Virginia will begin developing a formula for determining the amount of funds necessary for the four selected sites to begin expansion. This formula will be drafted for the upcoming General Assembly session.

- Prevent Child Abuse Virginia and VDSS will begin developing an application process that will allow sites interested in expanding their Healthy Families programs to apply for increased funding.

- Prevent Child Abuse Virginia and VDSS will establish a selection process to evaluate which sites will receive any expansion funds authorized by the General Assembly. It is important to note that while the goal is the expansion of four sites, all expansion efforts are ultimately based on available funding.

- If expansion monies become available, VDSS requests funding for the addition of one full time employee to manage the contracting process that would accompany the expansion.

Appendix A

Healthy Families Site Rankings: Infant Mortality Rates

Site	IMR	Rank
Portsmouth City	17.90	1
Petersburg City	16.26	2
Rappahannock County	14.49	3
Eastern Shore	14.40	4
Newport News City	13.34	5
Richmond City	13.23	6
Danville/Pittsylvania County	12.98	7
Halifax/South Boston	12.47	8
Warren County	11.81	9
Norfolk City	11.23	10
Henrico County	11.22	11
Three Rivers	10.14	12
Chesapeake City	8.63	13
Northern Shenandoah	8.26	14
Virginia Beach City	7.83	15
Piedmont	7.08	16
Charlottesville/Albemarle	6.65	17
West Piedmont	6.39	18
Charles City/New Kent	6.33	19
Southwest Virginia	6.30	20
Shenandoah County	6.25	21
Madison County	6.17	22
Chesterfield/Colonial Heights	6.12	23
Hopewell/Prince George	5.99	24
Prince William	5.96	25
Central Virginia	5.89	26
Rappahannock Area	5.63	27
Orange County	5.25	28
Suffolk/Isle of Wight	5.08	29
Loudoun County	4.85	30
Alexandria City	4.49	31
Blue Ridge	4.36	32
Fairfax/Falls Church	4.25	33
Arlington County	3.92	34
Culpeper County	1.64	35
Fauquier County	1.23	36
Page County	0.00	37

Source: 2005 Infant Mortality Rates – Virginia Department of Health

Healthy Families Site Rankings: Average CSA Cost per Child

Site	AVG CSA cost per Child	Rank
Arlington County	$ 32,035.33	1
Fairfax/Falls Church	$ 30,816.02	2
Petersburg City	$ 28,827.33	3
Charles City/New Kent	$ 28,680.42	4
Loudoun County	$ 27,143.32	5
Warren County	$ 25,249.66	6
Richmond City	$ 24,932.60	7
Halifax/South Boston	$ 23,896.48	8
Chesterfield/Colonial Heights	$ 23,762.69	9
Page County	$ 23,025.56	10
Charlottesville/Albemarle	$ 21,926.89	11
Alexandria City	$ 21,563.20	12
Newport News City	$ 21,127.56	13
Hopewell/Prince George	$ 21,015.35	14
Northern Shenandoah	$ 19,901.39	15
Rappahannock Area	$ 19,806.95	16
Eastern Shore	$ 19,701.69	17
Shenandoah County	$ 19,560.94	18
Henrico County	$ 18,565.96	19
Danville/Pittsylvania County	$ 18,389.12	20
Prince William	$ 17,124.94	21
Three Rivers	$ 17,058.97	22
Blue Ridge	$ 17,037.58	23
Portsmouth City	$ 16,155.41	24
Fauquier County	$ 15,713.93	25
Piedmont	$ 14,966.11	26
Chesapeake City	$ 13,861.71	27
Central Virginia	$ 13,465.40	28
Culpeper County	$ 13,312.26	29
Virginia Beach City	$ 12,824.93	30
Rappahannock County	$ 12,331.51	31
Madison County	$ 11,684.87	32
Suffolk/Isle of Wight	$ 9,754.18	33
Orange County	$ 9,432.22	34
Norfolk City	$ 8,537.28	35
West Piedmont	$ 7,919.88	36
Southwest Virginia	$ 6,896.38	37

Source: Office of Comprehensive Services

Healthy Families Site Rankings: CSA Children per 1000 (0-17)

Site	CSA Kids Per 1000	Rank
Henrico County	27.48	1
Southwest Virginia	21.26	2
Virginia Beach City	17.27	3
Three Rivers	16.99	4
Arlington County	16.83	5
Halifax/South Boston	16.43	6
Richmond City	16.30	7
Loudoun County	16.21	8
Madison County	15.24	9
Portsmouth City	14.99	10
Chesterfield/Colonial Heights	14.92	11
Warren County	14.81	12
Northern Shenandoah	14.74	13
Piedmont	13.91	14
Rappahannock Area	13.31	15
Charlottesville/Albemarle	13.18	16
Charles City/New Kent	11.83	17
Fairfax/Falls Church	11.40	18
Culpeper County	10.95	19
Alexandria City	10.48	20
Chesapeake City	10.41	21
Suffolk/Isle of Wight	9.76	22
Page County	9.38	23
Danville/Pittsylvania County	9.36	24
Central Virginia	8.99	25
Petersburg City	8.88	26
West Piedmont	8.67	27
Fauquier County	8.39	28
Shenandoah County	6.33	29
Orange County	5.76	30
Rappahannock County	4.77	31
Blue Ridge	4.50	32
Hopewell/Prince George	3.96	33
Newport News City	3.76	34
Eastern Shore	3.32	35
Norfolk City	2.66	36
Prince William	1.27	37

Source: Office of Comprehensive Services

Healthy Families Site Rankings: CPS Family Assessments per 1000 (0-17)

Site	Assessment Rate	Rank
Southwest Virginia	31.63	1
Richmond City	24.45	2
Portsmouth City	18.89	3
Charlottesville/Albemarle	17.43	4
Warren County	17.38	5
Hopewell/Prince George	17.13	6
Central Virginia	16.93	7
Blue Ridge	16.29	8
Alexandria City	15.94	9
West Piedmont	14.62	10
Prince William	13.95	11
Shenandoah County	13.77	12
Danville/Pittsylvania County	13.68	13
Petersburg City	13.62	14
Culpeper County	11.70	15
Suffolk/Isle of Wight	11.68	16
Page County	11.16	17
Rappahannock Area	10.57	18
Chesapeake City	10.42	19
Arlington County	10.40	20
Halifax/South Boston	10.39	21
Chesterfield/Colonial Heights	9.77	22
Fauquier County	9.71	23
Charles City/New Kent	9.48	24
Loudoun County	9.44	25
Piedmont	9.32	26
Norfolk City	9.17	27
Newport News City	8.63	28
Eastern Shore	8.40	29
Orange County	8.26	30
Rappahannock County	8.08	31
Three Rivers	7.67	32
Madison County	6.55	33
Northern Shenandoah	6.24	34
Henrico County	6.11	35
Virginia Beach City	4.61	36
Fairfax/Falls Church	2.11	37

Source: Virginia Department of Social Services: Completed Child Abuse and Neglect Reports by Locality

Healthy Families Site Rankings: Founded Investigations of Child Abuse and Neglect per 1000 (0-17)

Site	CA/N	Rate	Rank
Virginia Beach City	989	8.55%	1
Southwest Virginia	156	7.85%	2
Norfolk City	447	7.80%	3
Blue Ridge	360	7.74%	4
Central Virginia	364	6.88%	5
Richmond City	305	6.85%	6
Loudoun County	98	6.76%	7
Page County	36	6.59%	8
Orange County	40	5.79%	9
Henrico County	195	5.58%	10
Eastern Shore	65	5.39%	11
West Piedmont	161	5.36%	12
Danville/Pittsylvania County	127	5.10%	13
Piedmont	99	4.59%	14
Petersburg City	35	4.26%	15
Culpeper County	45	4.21%	16
Newport News City	208	4.07%	17
Portsmouth City	104	3.99%	18
Hopewell/Prince George	280	3.81%	19
Alexandria City	92	3.69%	20
Warren County	29	3.34%	21
Three Rivers	93	3.12%	22
Suffolk/Isle of Wight	86	2.95%	23
Arlington County	86	2.56%	24
Prince William	300	2.46%	25
Chesapeake City	150	2.44%	26
Halifax/South Boston	39	2.35%	27
Fauquier County	39	2.35%	27
Rappahannock Area	195	2.26%	29
Charles City/New Kent	11	2.14%	30
Northern Shenandoah	57	2.10%	31
Charlottesville/Albemarle	48	1.72%	32
Shenandoah County	14	1.59%	33
Chesterfield/Colonial Heights	109	1.32%	34
Madison County	74	0.99%	35
Fairfax/Falls Church	257	0.96%	36
Rappahannock County	1	0.62%	37

Source: Virginia Department of Social Services: Rates of Abuse and Neglect per 1,000 Children

Appendix B

Healthy Families Virginia: Goals and Objectives

GOAL #1: Achieve positive pregnancy outcomes and maternal and child health outcomes.

Objective #1: Families will receive appropriate health care.

	Strategies	Measurement Instrument	How Measured/ Monitored Definitions	Assessment Points	PIMS Users Data Source	Non-PIMS Data Source	Notes
	A. 75%[1] of HF *prenatal enrollees* will receive 80% of their prenatal care visits as recommended by the *schedule* presented by the American College of Obstetrics and Gynecology. Rationale: Healthy People 2010 www.healthypeople website	Prenatal Care Tracking Record	**# of prenatal enrollees who met their recommended PNC schedule / the total number of prenatal enrollees.** *Prenatal enrollee* = All participants who gave birth during the reporting period and enrolled in home visiting at least one month prior to birth *Prenatal care schedule* = table attached	Birth	SDS: Prenatal Care tracking PIMS: Enrolled Participant table First home visit log Birth form Termination form	# of prenatal enrollees during reporting period, # of these prenatal participants enrolled one month prior to birth, # of these prenatal enrollees who met 80% of recommended prenatal visits based on schedule attached	Indicate if PNC appointments are verified by provider or recorded based on participant report

[1] Percentages indicated for all goals are for existing sites with three years or more of service to families. New sites may elect to reduce these percentage goals by 5%.

	B. 85% of HF *target children* will have a *primary health care provider* within two months after enrollment or birth of the target child. Rationale: Healthy People 2010 HFA Credentialing Standard 7-1.C.	Birth Information Form	**# of TC who have a documented provider/ # of TC**. *Target child* = for these purposes, the TC is born to a prenatal enrollee or two months have passed since enrollment *Primary health care provider* = provides well baby checks, immunizations, and/or sick care. An emergency room does not meet this definition.	Birth to 2 months	PIMS: Birth information form Information change form Enrolled Participant table	# of children meeting the definition of target child in the reporting period, # of TC with an identified PCP at birth or within two months of birth	

	Strategies	Measurement Instrument	How Measured/ Monitored Definitions	Assessment Points	PIMS Users Data Source	Non-PIMS Data Source	Notes
Optional	C. 75% of HF *target children* will receive 80% of their recommended *well baby/child care* visits based on the *schedule* provided by the American Academy of Pediatrics. Rationale: Healthy People 2010	Well Baby/Child Visits Form	**# of TC who received 80% of well baby/ # of TC** *Target child* = Child or children of first target pregnancy (the pregnancy that brings the participant to the program) *Well baby/child care schedule* = recommended schedule attached *Age of child* = end of evaluation date – TC's birth date. If closed, age of child = date of last contact – TC's birth date	Child's current age against the recommended schedule or if closed, age at date of last contact	PIMS: Well baby visit form Enrolled Participant table	# of target children in reporting period, # meeting 80% of recommended visits based on schedule attached	Indicate if well visits are verified by provider or recorded based on participant report

	D. 80% of HF *target children* will *continue* with a primary health care provider. Rationale: Healthy People 2010 HFA Credentialing Standard 7-1.C.	Well baby/Child Visits forms Immunization form	**# of TC with 35% or more of well baby and/or immunization/ # of TC** Target Children = Child or children of first target pregnancy (the pregnancy that brings the participant to the program) Continue = receiving at least 35% of immunizations or well baby checks as of the Target Child's current age.	Six months after birth	PIMS: Well baby visit form Immunization completion Form Enrolled Participant table	# of target children during reporting period, # meeting 35% of immunizations or well-baby as of the Target Child's current age.	Indicate if visits or immunizations are verified by provider or parent report.

Objective #2: Pregnancy and Birth Outcomes.

	Strategies	Measurement Instrument	How Measured/ Monitored Definitions	Assessment Points	PIMS Users Data Source	Non-PIMS Data Source	Notes
	A. 85% of babies born to *prenatal enrollees* will weigh at least 2500 grams or 5 pounds and 9.3 ounces. Rationale: Healthy People 2010	Birth Information Form	**# of births to prenatal enrollees weighing 2500 grams or more/ # of births during the reporting period to prenatal enrollees.** *Prenatal enrollee* = all participants who gave birth during the reporting period and enrolled in home visiting at least one month prior to birth. *Multiple births*: This analysis includes multiple births which might strongly influence the rates of sites with low #'s of births to prenatal enrollees. This should be included in the explanation of the sites rate.	Birth	PIMS: Birth information form Enrolled Participants table	# of births to prenatal enrollees # of births to prenatal enrollees weighing 2500 grams or more % of multiple births not meeting criteria	Indicate if baby's weight is verified by provider or parent report Rate of multiple births is low enough to be considered within this goal.

Objective #3: Health Outcomes.

	Strategies	Measurement Instrument	How Measured/ Monitored Definitions	Assessment Points	PIMS Users Data Source	Non-PIMS Data Source	Notes
	A. 80% of HF *target children* will be *up-to-date* with immunizations as recommended by the *schedule* presented by the ACIP, AAP, State Health Dept., or provider. Rationale: HFA Credentialing Standard 7-2 Healthy People 2010	Immunization forms	**# of TC who receive 100% of their recommended immunizations/ # of TC** *Target child* = Child or children of first target pregnancy (the pregnancy that brings the participant to the program) *Up-to-date* = having recommended # of immunizations for the child's age *Immunization schedule* = table attached *Age of child* = end of evaluation date – TC's date of birth. If closed, age of child = date of last contact – TC's date of birth	Child's current age against the recommended schedule or if closed, age at date of last contact	PIMS: Immunization schedule Birth information form Enrolled Participant Table If an alternative schedule is used for a child – contact VA's PIMS administrator for guidance on entry into PIMS.	# of target children during reporting period # of target children with 100% of recommended immunizations for their age.	Indicate if immunizations are verified by provider or parent report

Objective #4: Mothers Health.

	Strategies	Measurement Instrument	How Measured/ Monitored Definitions	Assessment Points	PIMS Users Data Source	Non-PIMS Data Source	Notes
	A. 85% of *teen mothers* will have no subsequent births or will have an interval of at least 24 months between target child's birth and subsequent birth. Rationale: Healthy People 2010 Pathway Mapping Initiative	Birth Information Form	**# of teen moms with target children 24 months or older with no subsequent birth and those with a subsequent birth 24 months or more from the TC/ # of teen moms with target children 24 months or older.** *Teen mother* = a participant who is under 18 years of age at the time of the first birth.	As subsequent births occur	PIMS: Birth information form for TC and subsequent birth Intake form for teen mother's age Enrolled Participant Table	# of teen mothers whose target child is greater than or equal to 24 months. # of those teen mothers with no subsequent births. # of those teen mothers with a subsequent birth with an interval great than or equal to 24 months.	

Optional	B. 75% of *non-teen mothers* will have no subsequent births or will have an interval of at least 24 months between target child's birth and subsequent birth. Rationale:	Birth Information Form	**# of non-teen moms with target children 24 months or older with no subsequent birth and those with a subsequent birth 24 months or more from the TC/ # of non-teen moms with target children 24 months or older.** *Non-teen mothers* = a participant who is 18 years old or older at the time of the first birth.	As subsequent births occur	PIMS: Birth information form for TC and subsequent birth Intake form for teen mother's age Enrolled Participant Table	# of non- teen mothers whose target child is greater than or equal to 24 months. # of those non-teen mothers with no subsequent births. # of those non-teen mothers with a subsequent birth with an interval great than or equal to 24 months.	

GOAL #2: Promote optimal child development

Objective #1: Children will be screened for suspected developmental delays, referred for appropriate services, and monitored for referral outcomes.

	Strategies	Measurement Instrument	How Measured/ Monitored Definitions	Assessment Points	PIMS Users Data Source	Non-PIMS Data Source	Notes
	A. 90% of *target children* will be *screened* for developmental delays. Screening of each child will occur at least semi-annually until 36 months, and annually thereafter. Rationale: HFA Credentialing Standard 6-5	ASQ Denver	**# of children 7 months or older who have received the appropriate number of screens for their age/ the total # of children 7 months or older.** *Target children* = Child or children of first target pregnancy (the pregnancy that brings the participant to the program) *Screened* = developmental progress is measured using a valid and reliable developmental screening tool approved by HFV. *Age of child* = end of evaluation date – TC's date of birth. If closed, age of child = date of last contact – TC's date of	Semi-annually until 36 months and annually thereafter. Screening at every opportunity afforded by the tool used is encouraged.	SDS: ASQ and Denver entry forms (be sure to use the checkbox to indicate delay) PIMS: Birth Information form Enrolled Participant Table	# of children 7 months or older with the appropriate number of screens for their age Total # of children 7 months or older in the reporting period.	

			birth.				
	B. 90% of children with *suspected developmental delay* will be referred (with parental consent) to *appropriate early intervention services* for assessment to determine need and therapeutic services. Rationale: HFA Credentialing Standard 6-5	ASQ Denver	**# of children with suspected developmental delay who were referred/ all participating children with suspected developmental delay.** *Suspected developmental delay* = as defined by the instrument used *Referred* = based on local practices, the site notifies the early intervention services of the suspected delay *Early intervention services* = Infant Toddler Connection of Virginia, Local Education Agency	As stated above	SDS: ASQ and Denver forms (be sure to use the checkbox to denote referral provided) PIMS: Enrolled Participant Table	# of participant children with suspected delay who were referred for services # of participant children with suspected delay	Referrals: sites differ on the decision of when a child will be referred for services.

	Strategies	Measurement Instrument	How Measured/ Monitored Definitions	Assessment Points	PIMS Users Data Source	Non-PIMS Data Source	Notes
	C. 90% of the children with *suspected delays* who were referred for early intervention services are *monitored* to determine the outcome of the referral for services. Rationale: HFA Credentialing Standard 6-5	ASQ Denver users must develop a tracking form	**# of children with suspected delays who were referred and monitored/ # of children with delays who were referred.** *Monitored* = sites follow-up with developmental services provider to determine the outcome of the early intervention service referral.	Same as above	SDS: ASQ (be sure to use the checkbox to indicate f/u provided) PIMS: Enrolled Participant table Denver users will need to develop a tracking system for this information	# of children with suspected developmental delays # of children with developmental delays who were referred for services # of children who were referred and monitored	

GOAL #3: Parents will demonstrate positive parent-child interaction and, positive parenting knowledge and behavior.

Objective #1: Positive Parent – Child Interaction

	Strategies	Measurement Instrument	How Measured/ Monitored Definitions	Assessment Points	PIMS Users Data Source	Non-PIMS Data Source	Notes
	A. Using an HFV approved measurement instrument, sites will assess the parent-child interaction of at least 80% of the *participant dyads* annually. *Sites have three years following implementation of a measurement instrument to meet this goal.* Rationale: HFA Credentialing Standard 6-4	NCAST KIPS	**# of eligible participant dyads assessed/ # of eligible participants.** *Eligible* = participating child has reached the minimum age assessed by the tool used *Participant dyads* = parent and child	Annually	SDS: NCAST data forms KIPS data forms PIMS: Enrolled Participant Table	# of participant dyads assessed in reporting period # of eligible participant dyads	
	B. 85% of *participants dyads* assessed will *demonstrate* an *acceptable* level of positive parent-child interaction or show improvement after one year of participation.	NCAST KIPS	**# of participant dyads with acceptable or improved scores/ # of participant dyads assessed.** *Demonstration of PCI* = parent-child interaction is measured using a tool	NCAST: Teaching- within one month of birth or enrollment, then at 6, 12, 24, 36. KIPS: 3, 6, 12, 24, 36, 48,	SDS: NCAST data forms KIPS data forms PIMS: Enrolled Participant Table	# of eligible participant dyads # of eligible participant dyads assessed # of participant dyads with	

	Rationale: HFA Credentialing Standard 6-4		approved by HFA *Acceptable* = as defined by the measurement tool selected. NCAST indicates within "normal range". KIPS tool currently will rely on showing an improvement in the over-all KIPS scale as the tool has not yet been "normed".	and 60 months		acceptable or improved scores	

Objective #2: Positive Parenting Knowledge and Behavior

	Strategies	Measurement Instrument	How Measured/ Monitored Definitions	Assessment Points	PIMS Users Data Source	Non-PIMS Data Source	Notes
	A. Using an HFV approved measurement instrument, sites will assess the *quality of the home environment* for 80% of the enrolled participants. *Sites have three years following implementation of a measurement tool to meet this goal.* Rationale:	Home Observation for the Measurement of the Environment (HOME)	**# of *eligible* participant homes assessed/ # of eligible participant homes.** *Quality of home environment* = as measured using an HFV approved tool *Eligible* =	Annually	SDS: HOME entry form PIMS: Enrolled Participant Table	# of eligible participant homes in the reporting period # of eligible participant homes assessed	
	B. 85% of families assessed will have an *acceptable* home environment to support child development or will show improvement in home environment after 1 year of participation. Rationale:	Home Observation for the Measurement of the Environment (HOME)	**# of participant homes assessed with acceptable or improved scores/ # of participants assessed** *Acceptable* = as defined by the HOME tool	1, 6, 12, 24, 26, 48, and 60 months	SDS: HOME entry form PIMS: Enrolled Participant Table	# of eligible participant homes # of participant homes assessed # of participant homes with acceptable scores or with improved scores	

GOAL #4: Children will not be abused or neglected

Objective #1: Absence of founded child abuse/neglect reports

	Strategies	Measurement Instrument	How Measured/ Monitored Definitions	Assessment Points	PIMS Users Data Source	Non-PIMS Data Source	Notes
	A. 95% of *HF families* who receive at least 12 months of services will not have *founded reports* of child abuse or neglect on *target child(ren)* while enrolled. Rationale:	Recommended: State CPS registry Local CPS	**# of *participants* with 12 months of services or more without founded complaints/ # of *participants* with 12 months of services or more**. Participants: those searched for in the CPS registry. HF Families: All families active during the reporting period with at least 12 months of services whose consent for conducting a search remains valid. Founded reports: a CPS report is counted if it occurred following enrollment in home visiting services and the participating parent was the perpetrator.	Annually	PIMS: Enrolled Participant Table Length of Service Report Other: Returned search data	# of Participants with 12 or more months of services with a valid consent for a search # of these participants without founded complaints	Recommended that consents for searches are updated yearly – ie: upon enrollment and every January.

Appendix C

References

Galano, Joseph and Huntington, Lee, *FY 2002 Hampton Healthy Families Partnership Benchmark Study: Measuring Community-Wide Impact.* Huntington Associates, Ltd. June 30, 2002.

Galano, Joseph and Huntington, Lee, *FY 2007 Hampton Healthy Families Partnership Benchmark Study: Key Findings and Recommendations.*

Prevent Child Abuse Virginia, *Healthy Families Strategic Plan 2005 – 2007 – Year Two Report.* March 2007.