Health Families Arizona Annual Evaluation Report

October 2020 – September 2021

LeCroy & Milligan
ASSOCIATES, INC.

Healthy Families Arizona Annual Evaluation Report: October 2020 - September 2021

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EXECUTIVE SUMMARY

The Healthy Families Arizona program is designed to help expectant and new parents get their children off to a healthy start. Healthy Families Arizona is in its 30th year and is modeled after and accredited with the Healthy Families America initiative under the auspices of Prevent Child Abuse America. Families are screened according to specific criteria and participate voluntarily in the program, receiving home visits (in home or virtually) and referrals from trained staff. The Healthy Families Arizona program serves families with multiple stressors and risk factors that can increase the likelihood that their children may suffer from abuse, neglect, or other poor outcomes. By providing services to under-resourced, stressed, and overburdened families, the Healthy Families Arizona program fits into a continuum of supportive services provided to Arizona families.

With combined funding from the Arizona Department of Child Safety (DCS), First Things First (FTF), and the Department of Health Services' (DHS) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, Healthy Families Arizona provides services to families in 251 different zip codes in 14 counties through 11 sites, with three family assessment teams and 44 home visitor teams. Healthy Families Arizona served a total of 4,090 families from October 1, 2020 through September 30, 2021. In State Fiscal Year 2021, funding for Healthy Families Arizona included $7,872,395 from DCS/Lottery funds, $1,617,879 from State Opioid Response funds, $2,386,189 from DHS MIECHV funds, and $6,553,660 from FTF, for a total of $18,430,123.

Who Does Healthy Families Arizona Serve?

A total of 4,090 families received services from the Healthy Families Arizona program in FY 2021, a slight decrease from prior years which may be due to the continued impact of the pandemic. Statewide child well-being indicators show that while improvements have been made over time, Arizona continues to perform more poorly than national trends. Arizona ranked 40th out of 50 states (with 50th being the worst ranking) in overall child well-being. These indicators demonstrate a strong need for Healthy Families Arizona programming. Mothers enrolled in the program are more often teen parents, single parents, unemployed, undereducated, and with lower incomes than Arizona mothers overall.

Impacts of the COVID-19 Pandemic

Healthy Families Arizona staff at all levels have continued to step up and meet the challenges of the pandemic including the fluctuation between virtual and in-person home visits with families. From October 2020 through June 2021, Healthy Families Arizona continued to conduct most home visits virtually with a few outdoor, socially distanced visits occurring as well. Starting in July 2021 some sites returned to in-person home visits where possible. However, due to the continued impact of the COVID-19 pandemic, home visits often switched to virtual facilitation due to exposure or illness of families and home visitors, along with recommendations of local

authorities regarding outbreaks. Healthy Families Arizona continued to have a decreased number of systematic referrals (i.e., those regularly coming from hospitals) than prior to the pandemic and an increased number of referrals coming from other community organizations.

Outcomes for Families and Children Participating in Healthy Families Arizona

From baseline to 14-months post enrollment, families reported showed statistically significant improvements in four subscales Healthy Families Parenting Inventory (HFPI): **Home Environment, Mobilizing Resources, Personal Care, and Problem Solving**. In prior years, significant improvements have also been consistently observed in areas of Depression, Parent Self-Efficacy, Role Satisfaction, and Parent-Child Interaction. The evaluation team speculates that these changes may be related factors impacted by the COVID-19 pandemic. Overall, the results indicate that the Healthy Families Arizona program is effective at improving the home environment, connecting parents to resources, improving their sense of self care, and helping to strengthen problem-solving skills. The evaluation team will continue to explore how the HFPI changes over time, as communities recover from the pandemic. Child maltreatment data for Healthy Families Arizona families from the Department of Child Safety (DCS) was not available at the time of this report. Pending availability, this data will be included in future evaluation reports.

Conclusions and Recommendations

The following conclusions and recommendations are put forth to Healthy Families Arizona to consider in 2022.

- Virtual home visiting has made conducting screenings and assessments more difficult. As staff return to in-person visits, efforts should be made to emphasize the importance of assessments as a way to provide families with information about themselves. Information from screenings and assessments should be utilized by staff and supervisors to develop focused interventions and service plans for the families.

- As communities recover from the pandemic, the evaluation team recommends that home visitors continue to emphasize the importance of regular health care for their children and provide additional information and support to families who need it.

- Central Administration and sites should continue to support staff and supervisors in balancing the needs of families with their own needs. Wide-spread accommodations for working from home or in the office, along with reasonable expectations for work flexibility for the safety and comfort of the staff and families, will help staff feel better appreciated and supported.

- Central Administration and sites should explore strategies to improve staff retention, including assessing staff and family satisfaction and impact on retention. Staff and family surveys administered in 2022 should include questions about cultural humility, diversity, equity, inclusion, and belonging (DEIB).
- Healthy Families Arizona will complete the national re-accreditation process in the Fall of 2022. Work will to continue in ETO to develop useful and accurate reports in order to reduce the burden of preparing for the re-accreditation process now and in the future.
- The evaluation team will collaborate with Central Administration and sites to ensure that evaluation efforts in 2022 meet recent changes to the HFA Best Practice Standards for State and Multi-Site Systems.
- The evaluation team will support Central Administration and sub-committees in developing an equity plan. The equity plan will incorporate a summary of site and staff input, as well as what the program learns by completing a formal self-assessment tool related to DEIB. The equity plan will set a course for continuous improvement to achieve greater equity in all aspects of its functional areas (policy, training, technical assistance, quality assurance, evaluation, and administration) and takes into account the culture of those it supports.

INTRODUCTION

Healthy Families Arizona (HFAz) was established in 1991 by the Arizona Department of Economic Security (now housed at the Arizona Department of Child Safety [DCS]) as a home visitation service for at-risk families and is now in its 30th year. The Healthy Families Arizona program is accredited by Prevent Child Abuse America and is modeled after the Healthy Families America (HFA) initiative. HFA began under the auspices of Prevent Child Abuse America (formerly known as the National Committee to Prevent Child Abuse) in partnership with the Ronald McDonald House Charities. HFA was designed to promote positive parenting, enhance child health and development, and prevent child abuse and neglect. HFA has approximately 585 affiliated program sites in 38 States, the District of Columbia, five U.S. Territories, Canada, and Israel. HFA is approved as an "evidence-based early childhood home visiting service delivery model" by the US Department of Health and Human Services. The program model of Healthy Families is designed to help expectant and new parents get their children off to a healthy start. Families are screened according to specific criteria and participate voluntarily in the program. Trained staff provide home visits, in person and/or virtually, and referrals to families that choose to participate. By providing services to under-resourced, stressed, and overburdened families, the Healthy Families Arizona program fits into a continuum of services provided to support Arizona families.

Healthy Families Arizona Statewide System

Healthy Families Arizona is an affiliate of the HFA State/Multi-Site system. Central Administration for all accredited Healthy Families Arizona sites is housed within the Office of Fidelity and Compliance under the Arizona DCS. There are five core functions of Central Administration that are designed to support the statewide system of single sites (Exhibit 1): **(1) quality assurance/technical assistance; (2) evaluation; (3) training; (4) system-wide policy development; and (5) administration.** Each of these functions covers a set of activities and tasks that guide operations at the Central Administration level as well as the program level. The Healthy Families Arizona logic model for prenatal and postnatal families in shown in Appendix A and B.

Exhibit 1. Five Core Functions of Central Administration to Support the Statewide/Multi-Site System

The funding structure for the Healthy Families Arizona Program is supported by three state agencies: the Arizona DCS, First Things First (FTF), and the Arizona Department of Health Services (DHS). The DCS Central Administration supports collaboration with the three state agencies in a fully integrated system to enhance the quality of Healthy Families Arizona services. In State Fiscal Year (FY) 2021, funding for Healthy Families Arizona included: $7,872,395 from DCS/Lottery funds; $1,617,879 from State Opioid Response (SOR) funds; $2,386,189 from DHS through MIECHV funds; and $6,553,660 from FTF. FY2021 funds totaled $18,430,123.

The combined funding allows the Healthy Families Arizona sites and teams to provide services to families living in 14 counties and 251 zip code areas around Arizona. At the end of the reporting period on September 30, 2021, there were 11 sites with three family assessment teams and 44 home visitor teams (16 DCS funded including SOR funding, 4 FTF funded, 4 DHS/MIECHV funded, and 20 receiving funding from more than one source) for a total of 47 teams. Exhibit 2 shows a summary of funding amounts and Exhibit 3 shows the teams funded in FY2021.

Exhibit 2. Healthy Families Arizona Funding

Year	Annual Funding Amount by Source
2008	$18 Million – Department of Economic Security (DES)
2009	$6.1 Million – DES (Year of funding cutback)
2010	$12.3 Million total - $6 Million DES, $6.3 Million FTF
2011	$12.5 Million total - $6.5 Million DES, $6 Million FTF
2012	$12.4 Million total - $6.3 Million DES, $5.9 Million FTF, $117,212 MIECHV
2013	$14.2 Million total - $6.6 Million DES, $5.6 Million FTF, $2 Million MIECHV
2014	$16.3 Million total - $6.6 Million DCS, $6 Million FTF, $3.7 Million MIECHV
2015	$17.9 Million total - $7.2 Million DCS, $5.9 Million FTF, $4.8 Million MIECHV
2016	$15.9 Million total - $6 Million DCS, $4.5 Million FTF, $5.4 Million MIECHV
2017	$18.1 Million total - $9.8 Million DCS, $4.2 Million FTF, $4 Million MIECHV
2018	$16.0 Million total - $8.2 Million DCS, $4.2 Million FTF, $3.5 Million MIECHV
2019	$18.6 Million total - $8.9 Million DCS, $6.1 Million FTF, $3.6 Million MIECHV
2020	$20.0 Million total - $8.4 Million DCS, $2.1 Million SOR, $6.1 Million FTF, $3.4 Million MIECHV
2021	$18.4 Million total - $7.8 Million DCS, $1.6 Million SOR, $6.5 Million FTF, $2.4 Million MIECHV

Exhibit 3. Healthy Families Arizona Program Sites in Fiscal Year 2021

Site	Number of Home Visitor Teams
Apache County / Navajo County	1
Cochise County / Santa Cruz County	4
Coconino County	1
Graham County / Greenlee County	2
Maricopa County	18
Mohave County	4
Pima County	5
Pinal County (including Gila County)	4
Verde Valley (in Yavapai County)	1
Prescott Valley (in Yavapai County)	1
Yuma County	3
Statewide	**44**

Report Overview

The purpose of the Healthy Families Arizona annual report is to provide information on family outcomes, program performance measures, and program process and implementation that can be used to guide program improvement. This report covers Federal Fiscal Year reporting period of 10/1/2020 to 9/30/2021 (FY2021). During this time, the COVID-19 global pandemic continued to affect the standard practices of home visitation within the Healthy Families Arizona program. Starting at the end of March 2020, in-person visits switched to virtual/socially distanced visits, which included a mixture of telephone, video, and open-air distanced visits. In July 2021 many sites transitioned back to in-person home visitation where possible. Home visitation oscillated between in-person and virtual from July through September 2021 based on exposure and illness within families, home visitation staff, and local community outbreaks and guidance. This fluctuation between in-person and virtual home visits led to difficulties in family engagement and the ability of home visitors to collect certain assessments. The impact of the COVID-19 pandemic is evident in this evaluation report.

The evaluation of Healthy Families Arizona includes both process and outcome components. The process evaluation includes a review of statewide program implementation, describes the characteristics of families participating in the program, and provides general satisfaction of families participating in the program. The outcome evaluation typically examines program outcomes across several measures, with comparisons to previous years. The impact of COVID-19 has had a lasting impact this fiscal year and as such, data from 2020 and 2021 should be viewed with caution and not compared to prior years.

EVALUATION DESIGN

The FY2021 evaluation included process (implementation) and outcome (impact) components. This report provides information on program implementation; number and characteristics of families served; parent/caregiver and staff satisfaction with the Healthy Families Arizona program; and the effectiveness of the Healthy Families Arizona model in terms of legislated outcomes.

Process Evaluation

The process evaluation is designed to describe how the Healthy Families Arizona program functions. The process evaluation gathers information about the statewide implementation of the program and how implementation may influence family outcomes. Process data is also used for regular program monitoring and improvement. Process evaluation data is collected from program staff, supervisors, managers, and Healthy Families Arizona Central Administration through discussions at committee meetings, regular updates, and interviews or surveys. Performance indicators on families served are collected ongoing by staff through data collection forms that are entered into ETO. These indicators include:

- Demographic information (e.g., ethnicity, language, education, income)
- Number of children and families served
- Number and types of services provided
- Satisfaction with the program

Performance management information is provided through quarterly reports to each team and statewide to provide feedback on critical program elements. Performance data is also shared at supervisor's meetings, Advisory Board meetings, quarterly management meetings, and data collection trainings, as appropriate. The major components of the process study include describing:

- The overall model and operations
- The program's goals and objectives
- Characteristics of those served
- Performance management information (rates of screening, missing data reports, etc.)
- The prenatal component of the program (especially efforts to reach potential participants early in their term of pregnancy)
- Staff retention and training (gathered by Central Administration)
- The organizational context of Healthy Families Arizona, including the leadership structure and systemic process for organizational development.

Key Process Evaluation Questions

The guiding process evaluation questions that are addressed annually include:

- What are the characteristics of the families participating in the Healthy Families Arizona Program? What are the targeted populations for referral to the program?
- Is the program being implemented consistent with the Arizona Healthy Families Policies and Procedures and best practices found in current literature?
- What are the patterns of service delivery (e.g., timing, frequency, format, purpose, attendance, facilitation) of Healthy Families Arizona?
- What changes have taken place in the statewide system that impact program delivery and/or outcomes?
- What are impediments to implementing the Healthy Families Program?
- Are the participants (families and professionals) satisfied with the Arizona Healthy Families Program process?
- What is the content of the Healthy Families Arizona training?

Outcome Evaluation

The outcome evaluation is designed to assess the impact of the Healthy Families Arizona program on families and children in terms of promoting child development and wellness, enhancing parent/child interactions, and preventing child abuse and neglect. Outcome data from the Arizona DCS statewide child abuse database (CHILDS/Guardian) was not available at the time of this report. Pending availability, this data will be included in future reporting. Outcome data in this report was collected by home visitors and entered into ETO, including:

- Family outcomes measured by the Healthy Families Parenting Inventory (HFPI) across nine domains: social support, problem-solving/coping, depression, personal care, mobilizing resources, role satisfaction, parent/child interaction, home environment, and parenting efficacy;
- Percent of families implementing safety practices and percent of caregivers screened for substance abuse; and
- Percent of children screened for developmental delays.

Key Outcome Evaluation Questions

- Is the Healthy Families Arizona program meeting the objectives outlined in the enabling legislation (e.g., children and maternal health outcomes)?
- Has the program been successful in achieving the program goals and objectives outlined in the program logic model?
- Has the program resulted in successful parenting outcomes?
- Has the program provided for the care and protection of the child (e.g., safety in the home environment and child abuse and neglect indicators)?

ARIZONA KIDS COUNT DATA 2021

Since 1990, the Annie E. Casey Foundation has compiled and published an annual *KIDS COUNT Data Book* (2021a) and state level reports (2021b) to provide national and state level data on the well-being of children in the United States. The KIDS COUNT indicators are collected across all states at least biannually for children from birth through high school. The Foundation derives a composite index of overall child well-being for each state by combining data across four domains: **(1) Economic Well-Being, (2) Education, (3) Health, and (4) Family and Community.** These composite scores are then translated into a state ranking for child well-being with 1 being the highest (best) ranked state and 50 being the lowest (poorest) ranked state. Rankings show how well states are meeting the needs of children and trends over time in child well-being. The 2021 Data Book presents the most recent available data and multiyear trends, comparing data from 2010 with those from 2019, which provides a picture of child well-being prior to the pandemic.

Arizona's rankings in 2019 to 2021 for each domain and overall are shown Exhibit 4. Children in Arizona have seen improvements is the state's overall ranking (40th out of 50, with 50 being the worse ranked state), Health ranking (28th out of 50), and Economic Well-Being ranking (35th out of 50). However, Arizona has ranked consistently poor for the domain of Family and Community (46th out of 50) and has worsened over time in the domain of Education (47th out of 50).

Exhibit 4. KIDS COUNT Child Well-Being Rankings for Arizona, 2019 to 2021

Domain	2019	2020	2021	Change in Arizona's National Rankings Over Time
Overall Rank	46	42	40	Improved
Health Rank	35	33	28	Improved
Economic Well-Being Rank	43	36	35	Improved
Family and Community Rank	46	46	46	Same
Education Rank	46	46	47	Worse

Data from the national *KIDS COUNT Data Book* (2021a) and Arizona's state profile (2021b) for the four domains and indicators are shown in Exhibit 5.

Exhibit 5. KIDS COUNT Profile for the United States and Arizona

Domain and Indicators	United States		Arizona		Change in Arizona Over Time
	Previous	Current	Previous	Current	
Health Rank = 28th out of 50					
Children without health insurance	8% (2010)	6% (2019)	13% (2010)	9% (2019)	**Improved**
Children and teens (ages 10 to 17) who are overweight or obese	31% (2016-2017)	31% (2018-2019)	26% (2016-2017)	25% (2018-2019)	**Improved**
Low-birthweight babies	8.1% (2010)	8.3% (2019)	7.1% (2010)	7.4% (2019)	Worse
Child and teen death rate per 100,000	26 (2010)	25 (2019)	28 (2010)	30 (2019)	Worse
Economic Well-Being Rank = 35th out of 50					
Children in poverty	22% (2010)	17% (2019)	24% (2010)	19% (2019)	**Improved**
Children whose parents lack secure employment	33% (2010)	26% (2019)	35% (2010)	27% (2019)	**Improved**
Children living in households with a high housing cost burden	41% (2010)	30% (2019)	43% (2010)	28% (2019)	**Improved**
Teens not in school and not working	9% (2010)	6% (2019)	12% (2010)	8% (2019)	**Improved**
Family and Community = 46th out of 50					
Teen births per 1,000 births	34 (2010)	17 (2019)	42 (2010)	18 (2019)	**Improved**
Children in single-parent families	34% (2010)	34% (2019)	37% (2010)	37% (2019)	Same
Children living in high-poverty areas	13% (2008-2012)	9% (2015-2019)	22% (2008-2012)	15% (2015-2019)	**Improved**
Children in families where the household head lacks a high school diploma	15% (2010)	12% (2019)	19% (2010)	15% (2019)	**Improved**
Education Rank = 47th out of 50					
Young children not in school	52% (2009-2011)	52% (2017-2019)	66% (2009-2011)	61% (2017-2019)	**Improved**
Fourth graders not proficient in reading	68% (2009)	66% (2019)	75% (2009)	69% (2019)	**Improved**
Eighth graders not proficient in math	67% (2009)	67% (2019)	71% (2009)	69% (2019)	**Improved**
High school students not graduating on time	21% (2010-2011)	14% (2018-2019)	22% (2010-2011)	22% (2018-2019)	Same

Source: Annie E. Casey Foundation, 2021a, 2021b.

Health

Arizona's national ranking of **28th out of 50 for the 2021 Health domain** is the state's best ranked domain in comparison to other states and has improved over time (35th in 2019 and 33rd in 2020). Within the Health domain, the indicator of the percentage of **children without health insurance** has improved over time with a decrease observed in Arizona (from 13% in 2010 to 9% in 2019). The implications on child health of missed opportunities for health care because of being uninsured or underinsured are numerous and significant. Home visitation programs emphasize assisting caregivers with connecting to Medicaid and CHIP when other health insurance is not available. The percentage of **children and teens (ages 10 to 17) who are overweight or obese** has remained the same nationally, but has improved in Arizona, with a slight decrease from 26% in 2016-17 to 25% in 2018-19. Two health domain indicators where Arizona worsened over time include the percentage of **low-birthweight babies** (7.1% in 2010 compared to 7.4% in 2019) and the rate of **child and teen deaths per 100,000** (28 in 2010 to 30 in 2019).

Economic Well-Being

Arizona's national ranking of **35th out of 50 for the 2021 Economic Well-Being domain** is the state's second-best ranked domain in comparison to other states and has also improved over time (43rd in 2019 and 36th in 2020). The Economic Well-Being domain showed positive changes for Arizona in all four areas, mirroring national improvements. In Arizona, the percentage of **children living in poverty** decreased from 24% in 2010 to 19% in 2019. The percentage of **children whose parents lack secure employment** dropped from 35% in 2010 to 27% in 2019. The percentage of **children living in households with a high housing cost burden** decreased markedly from 43% in 2010 to 28% in 2019. Additionally, the percentage of **teens who are not in school and not working** decreased from 12% in 2010 to 8% in 2019. While Arizona showed improvements in these areas, these results may not accurately reflect the current economic situation for the state and country given the impact of the COVID-19 pandemic on income, employment, and cost of living.

Family and Community

Arizona's national ranking of **46th out of 50 for the 2021 Family and Community domain** is the state's second-lowest ranked domain in comparison to other states and has remained poor over time (46th in 2019 and 46th in 2020). However, Arizona saw improvements in three of four indicators measured. Arizona's **teen birth rate** dropped from 42 per 1000 births in 2010 to 18 per 1000 births in 2019. Additionally, the percentage of **children in families where the household head lacks a high school diploma** decreased from 19% in 2010 to 15% in 2019. The percentage of **children living in high poverty areas** has improved from 22% in 2010 to 15% in 2019. While these three indicators improved, the percentage of **children living in a single parent household** has remained at 37% from 2010 to 2019.

Education

Arizona's national ranking of **47th out of 50 for the 2021 Education domain** is the state's lowest ranked domain in comparison to other states and has worsened over time (46th in 2019 and 46th in 2020). However, Arizona saw improvements in three of the four indicators measured. Arizona's rate of **young children not in school** decreased from 66% in 2010 to 61% in 2019. This rate is still higher than the national rate of 52% for both time periods. Student proficiency has improved with the percent of **4th graders not proficient in reading** decreasing from 75% in 2009 to 69% in 2019 and **8th graders not proficient in math** dropping from 71% in 2009 to 69% in 2019. The percentage of **high school students who do not graduate on time** in Arizona has remained the same at 22% observed in 2010-11 and 2018-19.

Arizona ranked 40th out of 50 states (with 50th being the worst ranking) in overall child well-being, showing overall improvement over time (46th in 2019 and 42nd in 2020). However, compared to other states and the national trend, Arizona continues to perform worse than the national trend in 13 of the 16 child well-being indicators reported by KIDS COUNT in 2021. These indicators demonstrate the strong need for Healthy Families Arizona, which provides additional supports to families and helps mitigate the risk of experiencing poor outcomes in early childhood and in transitioning to adulthood.

Arizona is ranked 40th out of 50 states in child well-being (with 50 being the worst ranking).

Arizona has improved in 12 of 16 child well-being indicators over the past year.

However, Arizona rates are worse than the national average in 13 of 16 child well-being indicators measured.

UPDATES IN HOME VISITING

The impact of the COVID-19 pandemic on the physical and mental health of parents and caregivers has created a need for constant innovation in delivery of home visiting services. This section of the report highlights findings from current research on home visitation programs, as they apply to the challenging context that programs are operating within and may have implications for strengthening the Healthy Families Arizona program.

Pandemic Associated Risk-Factors for Families

The COVID-19 pandemic has affected families and communities across the United States in unprecedented ways, including social and economic disruptions, loss of employment, closing of schools and childcare centers, disruption in availability of health care and other services, etc. Families who utilize home visitation services have experienced unique needs due to the pandemic, including financial assistance, parenting support, accessible mental health services, transportation, and housing (Marshall et al., 2020). The pandemic exacerbated inequities in the U.S. healthcare system, with data indicating that certain racial and ethnic populations are at greater risk for severe illness and death from COVID-19 (CDC, 2021). The pandemic is a particularly high threat to vulnerable populations served by home visiting programs. Literature shows that pregnant women, mothers of young children, and mothers of color are at increased risk for contracting COVID-19, as well as depression, anxiety, stress, and parental burnout due to the pandemic (Cameron et al., 2020; Cluver et al., 2020; Dashraath et al. 2020; Griffith, 2020; Gur et al., 2020; Lebel et al., 2020). For expectant women, changes to their birth experience due to the COVID-19 pandemic may exacerbate postpartum mental health symptoms (Liu et al., 2021).

Increased isolation due to social distancing, and the need to keep program staff and families safe, has led to many programs quickly implementing a virtual video visit, or halting services altogether when disease transmission was high. Recognizing the added stress and anxiety that has been widely experienced by adults and children alike throughout this pandemic, Cameron et al. (2020), recorded maternal psychological distress and depression in two groups: one pre-pandemic, and one group after the pandemic had begun. They report that "maternal depression and anxiety appear to be elevated in the context of COVID-19 compared to previously reported population norms"(Cameron et al., 2020). This information indicates that despite the challenges faced by home visitors, their role in assessing and identifying depressive tendencies or anxiety in caregivers is increasingly important at this time. Home visitors must be prepared to identify these traits as well as make appropriate service referrals to mental health providers.

In addition to maternal depression, high-risk behaviors identified in this study included (1) a history of child abuse or neglect, and (2) increased intimate partner violence (IPV) since the onset of COVID-19 and associated stay at home orders (Cameron et al., 2020). When a statistical analysis was performed, the biggest increase in risky behaviors was observed for those families having a history of child abuse or neglect. Identified risk factors for depression and anxiety across different child age ranges can inform targeted early intervention strategies to prevent long-term impacts of the COVID-19 pandemic on family well-being and child development.

Considering that families with risk factors or histories of maltreatment have primarily received services in the home where their needs and skills are addressed in the natural environment, the use of virtual video visits can hamper efforts to identify the needs of caregivers and children alike (Cameron et al., 2020). There may also be aspects of the virtual depression screening experience that make detecting maternal depression more difficult.

Findings also raise concern about specific high-risk groups enrolling in home visitation programs, like mothers exposed to IPV, since IPV exposure was more strongly associated with maternal depressive symptoms after the pandemic had begun. A recent systematic review and meta-analysis found that reports of suspected IPV increased during the pandemic due to stay-at-home and lockdown orders (Piquero et al., 2021), highlighting the need for home visitation programs to screen for IPV and address physical and emotional safety for families (Traube et al, 2021).

Strategies for Virtual Visits

Studies show that virtual visits require use of different strategies than in-person and that these strategies require more intentionality on the part of the home visitor (Cook & Zschomler, 2020; Korfmacher et al., 2021; O'Neill et al., 2020; Solis-Cordero et al., 2021). Intentional actions include strategically coaching caregiver-child interactions in a way that encourages the caregiver to take a more active role as well as describe how their child was responding to them (Korfmacher et al., 2021). Creative ways providers have engaged children in remote visits include singing songs to draw the child's attention to the screen; use of toys, props, background images, and emojis to keep children engaged; and directly asking children to respond to a question or bring an object to show the home visitor as a way of engaging in reciprocal interactions with the child (Cook & Zschomler, 2020).

Administration of assessments or discussion of sensitive or confidential information is also a challenge in a virtual environment. Many programs received additional training and guidance on maintaining client confidentiality and best practices for administering assessments virtually (Bock et al., 2021; Solis-Corder et al., 2021). These studies found that assessment completion rates using family-centered, child development, and depression and anxiety screening tools were not impacted by virtual data collection. Solis-Cordero et al. (2021) identified the following strategies as critical for successful collection of assessment data in a virtual format: give clear

and specific instructions to guide caregivers; provide guidance on the appropriate positioning of their device; use visual aids to facilitate interpretation of Likert scales; give caregivers a simple list of materials to have on hand and/or drop off materials prior to visits; and use of screen sharing by the provider to provide a visual resource for the caregiver.

Racial and Ethnic Disparities

The Center for Health Care Strategies (Lewy & Casau, 2021) provides a timely exploration of racial and ethnic health disparities. Systemic racism within health care and other social institutions has led to large racial and ethnic disparities in access to health care, poor health outcomes, and high mortality rates for women and children of color. The pandemic exacerbated inequities in the U.S. healthcare system, with data indicating that certain racial and ethnic populations are at greater risk for severe illness and death from COVID-19 (CDC, 2021). CHES identified key strategies to enhance home visiting, recognizing that home visiting programs are uniquely poised to address several of the social needs that impact health and wellness (Lewy & Casau, 2021):

1. Use culturally informed practices;
2. Provide individualized interventions;
3. Require anti-racism and implicit bias training for staff;
4. Train staff to support families to self-advocacy efforts;
5. Recruit a more diverse workforce;
6. Address health-related social needs;
7. Disaggregate data by race and ethnicity; and
8. Dedicate funds to address racial disparities.

Among the recommendations are using culturally responsive, community-driven, and anti-racist approaches to support underserved, low-income, or at-risk families can improve maternal and early childhood outcomes (Lewy & Casau, 2021). One example of a well-established evidence-based program that may serve as a model for culturally responsive teaching is the Family Spirit program, developed by the Johns Hopkins Center for American Indian Health and the Navajo, White Mountain Apache, and San Carlos Apache Tribes in 1995.

> *"The [Family Spirit] curriculum covers typical home visiting topics around infant care and maternal health, but also incorporates tribal teachings and practices, information about traditional ceremonies related to pregnancy and childrearing, and classes on cradleboards — an indigenous baby-carrying method. In a randomized control trial, outcomes 12 months postpartum suggest that Family Spirit improved parenting and infant outcomes, including parenting knowledge and self-efficacy, children's psychosocial and behavioral functioning, and home safety strategies, that predict lower lifetime behavioral health and substance use risk for participating mothers and children. This strengths-based, culturally informed approach can be adapted to celebrate cultural practices of additional communities of color"* (Lewy & Casau, 2021), pg. 6).

Also discussed in the CHCS report, a Minnesota-based program developed to respond to high infant mortality rates among African American women suggests developing staff training modules on traditional parenting/nurturing practices, sharing cultural teachings/worldviews, and celebrating all types of family structure (e.g., elder caregivers, extended family) (Lewy & Casau, 2021). The program sought feedback from mothers and recommended recruiting a more diverse workforce, noting that only 41% of home visitors report having similar traits as most of their clients related to race, ethnicity, and culture (Community Voices and Solutions, 2015). The known benefits of having staff that are similar to the families they serve in terms of culture, race, and language include greater retention and engagement, as well as a trusting client-home visitor relationship.

While many state-level and even federally funded programs have a small number of resources dedicated to addressing racial disparities, increased funding for professional development that strengthens culturally sensitive practice and decreases implicit bias may be an effective strategy for increased retention and engagement of caregivers who identify with the groups that are most at-risk. The studies suggest a need for programs to intentionally target racial equity goals to have greater impact on families of color. Expanding quality home visiting programs with anti-racist and culturally competent practices is needed to reach and further support more mothers, infants, and children of color.

Family and Father Engagement

Increasing family engagement and retention is a constant focus of home visitation programs. Similar to the experience of the Healthy Families Arizona program, the COVID-19 pandemic has led to decreased enrollment in other home visiting programs (Traube et al., 2021). Home visiting programs are exploring ways to better engage fathers. A study conducted by Stargel and authors (2020) examined associations between fathers' formal and informal participation in infant home visiting. Results showed that fathers' participation in home visiting supported mothers' retention, particularly when fathers were formally enrolled as participants. Stargel posits that based on their findings, when formally enrolled in the program, "Father engagement in services may be one avenue for supporting continued program take-up for young parents." More exploratory research is needed to examine the relationship between father enrollment and mother's engagement, with recommendations to target a specific group of fathers, as it may yield better results. (Stargel et al., 2020).

Precision Home Visiting

Johns Hopkins School of Public Health and the Home Visiting Applied Research Collaborative (HARC) published a report detailing their progress with the Precision Paradigm (Duggan, et al., 2021; HARC, 2018). This paradigm is a common framework and language to define and test interventions, mediators, and moderators, to identify which interventions within home visiting work best for which families and why. While previous research has mostly included randomized trials of full models, which only estimate the average effect of a full program on select outcomes, this cross-model research can help answer important questions such as "what model works well for which family, in which context, why, and how?" (Duggan, et al., 2021). While the COVID-19 pandemic has required much adaptation of programming, including introduction of virtual video visits, this new approach could shed light on which aspects of a program are most successful when delivered in different modalities.

Precision home visiting research seeks to determine the elements of home visiting that work best for families in their specific contexts (HARC, 2018). Exploring this level of detail can help programs better tailor services to families' unique strengths, risks, and needs. This model could also be used to differentiate which interventions work best at changing behaviors when delivered in virtual visits, socially distanced visits occurring outside of the home, or traditional in-person home visiting. Precision home visiting supports tailoring services to meet families' needs by breaking interventions into individual elements and testing how those individual elements change outcomes for different families or situations. HARC's work on precision home visiting is based on four key hallmarks (HARC, 2018; Center on the Developing Child at Harvard University, 2016):

- A focus on active ingredients to support the scale-up of effective practices;
- Broad-based partnerships between researchers and stakeholders, such as front-line staff and families, to design and test interventions that are relevant and feasible;
- Explicit definitions and measurements to assess how active ingredients achieve specific outcomes for different groups of families;
- Efficiency in testing ingredients, including the use of new research designs like adaptive trials and rapid cycle techniques, to accelerate learning and implementation.

The Precision Paradigm is a promising resource to accelerate research on home visiting models to clarify which interventions within home visiting work best for which families, in which contexts, why, and how.

HEALTHY FAMILIES ARIZONA UPDATES

Response to the COVID-19 Pandemic

From October 2020 through June 2021, Healthy Families Arizona conducted most home visits virtually, with a few outdoor socially distanced visits. Starting in July 2021 some sites returned to in-person home visits where possible. However, due to the continued impact of COVID-19 home visits often had to switch to virtual facilitation due to exposure or illness of families and home visitors along with the recommendations of local authorities regarding outbreaks. Throughout the fiscal year the following adjustments to standard practice continued:

- All forms were available in fillable electronic versions.
- Regular program manager calls were conducted to provide support and shared learning.
- Quarterly supervisor meetings were conducted via Zoom.
- Advisory Board meetings were conducted via Zoom.
- Home visit observations were largely conducted in a socially distanced manner – the majority of which were conducted virtually via telephone or video.
- Core trainings were held virtually starting in the

Training and Professional Development

Several staff trainings occurred between October 1, 2020 and September 30, 2021.

- Two statewide coordinators, two supervisors, one home visitor, and the statewide evaluator presented four sessions at the Healthy Families America conference held virtually from October 20-22, 2020. Several other staff and supervisors attended.
- The Foundations of Family Support Core Training transitioned to virtual with the first session held in November 2020. Some small, socially distanced and masked in-person trainings also occurred starting in November 2020 to help ensure that all staff needed training could be reached.
- Parent Survey trainings for Family Assessment Workers (FAW) and supervisors were also held virtually starting in February 2021.
- Additional trainings were held locally within agencies throughout the state in support of home visiting.
- Several Healthy Families Arizona service staff virtually the FTF Early Childhood Summit and the Strong Families Arizona Conference in August and September 2021 respectively.
- Statewide training in the online data system (Healthy Families Arizona AZ ETO) was conducted for new staff and supervisors in ad-hoc sessions throughout the year.

Interagency Collaboration

Healthy Families Arizona Central Administration housed within DCS continues to participate in statewide coalitions to increase collaborative efforts with FTF and DHS. Healthy Families Arizona Central Administration focuses on maintaining healthy working relationships with FTF and DHS to support model fidelity and consistency across the program's statewide evaluation, training, quality assurance, technical assistance, program development, administration, and any other program related activity. Collaboration occurs in a variety of settings both formally and informally. Healthy Families Arizona Central Administration discusses budget and funding frequently with DHS and reviews monthly reports and billing. In addition, Healthy Families Arizona Central Administration participates in the Inter-agency Leadership Team, which is a joint effort between DCS, DHS, FTF, and several other agencies to work collaboratively to improve services offered to Arizona families. MIECHV funding received through DHS requires participation in a Continued Quality Improvement (CQI) component by MIECHV funded Healthy Families sites to improve outcomes such as child immunizations rates throughout the state.

State Opioid Response Grant

From October 1, 2020 through September 30, 2021, Healthy Families Arizona received $1.6 Million in funding from the Arizona State Opioid Response Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) administered by the Arizona Health Care Cost Containment System (AHCCCS). This money was used to provide services to families who have a history of substance use. This funding was a slight decrease from the $2 Million provided from July 1, 2019 through September 29, 2021. Families who are receiving Healthy Families Arizona services and funded by this source are indicated as such in the overall evaluation. However, there is no separate analysis conducted specific to these families.

PROGRAM IMPLEMENTATION

Staff Survey Results

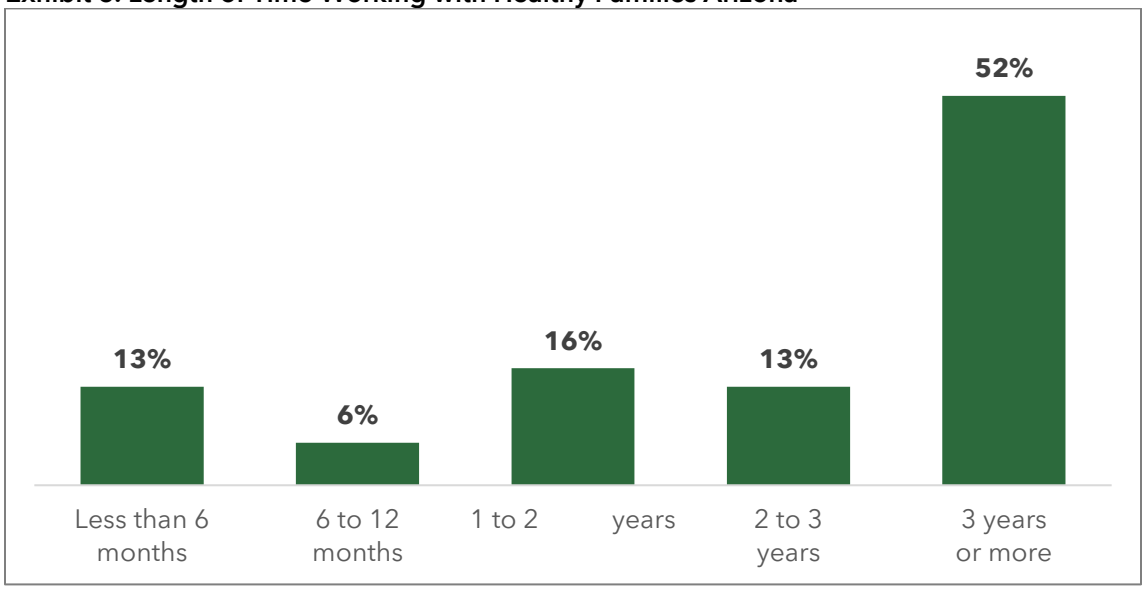
Staff surveys are conducted annually to assess overall satisfaction with various aspects of their job including agency support, supervision, and the Healthy Families Arizona program as a whole. In addition to the satisfaction questions, staff are asked to provide their thoughts on the importance of various training topics, their opinions about the cultural awareness and humility of the curriculum and the program, along with additional questions of interest each year. At the start of the COVID-19 pandemic additional questions were asked about the support staff needed to facilitate the best virtual home visitation methods. The findings from last year were used to guide additional supports for staff. As staff have transitioned back to in-person home visitation, they were asked about their preferences regarding virtual and in-person home visitation.

The staff surveys were administered via the Qualtrics online survey platform in an anonymous fashion. In order to facilitate the anonymity of the survey respondents, all responses were aggregated by site only with no differentiation by job role.

Staff Characteristics

More than half (52%) of the staff has worked at Healthy Families Arizona for 3 or more years (Exhibit 6).

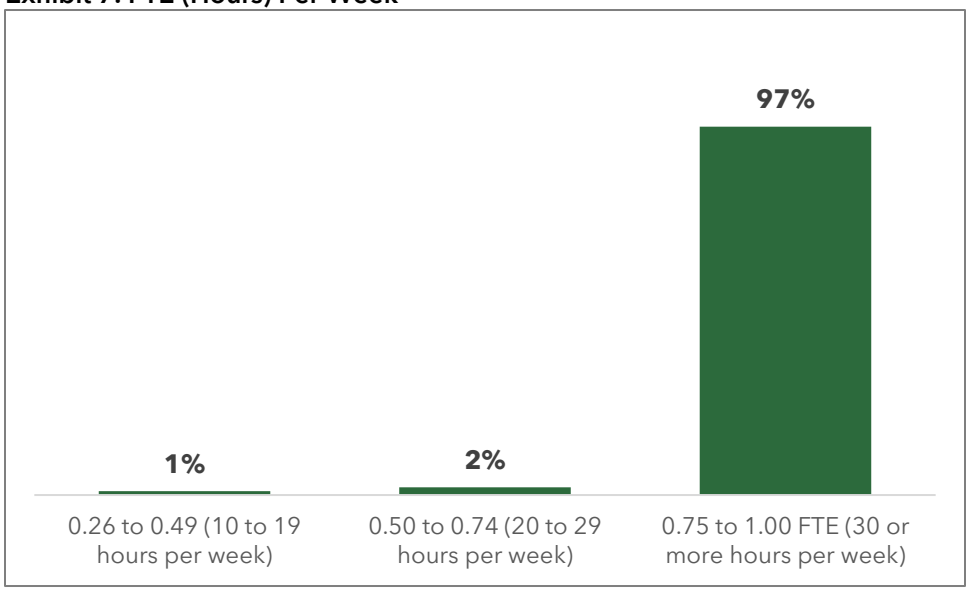
Exhibit 6. Length of Time Working with Healthy Families Arizona



(N=159)

Almost all of the staff were 0.75 to 1.00 full-time equivalent (FTE) (Exhibit 7).

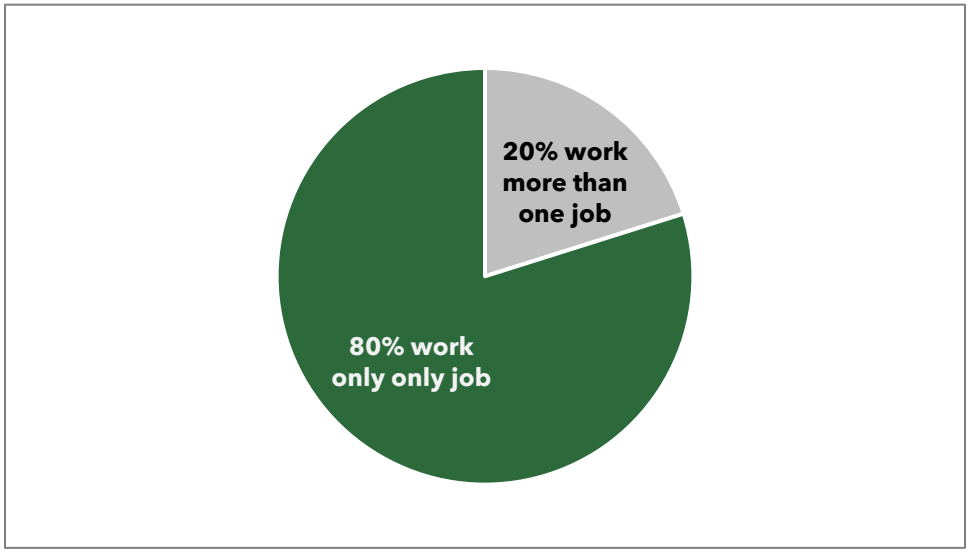
Exhibit 7. FTE (Hours) Per Week



(N=157)

A fifth (20%) of the staff have another job in addition to their work at Healthy Families Arizona (Exhibit 8).

Exhibit 8. Work Another Job



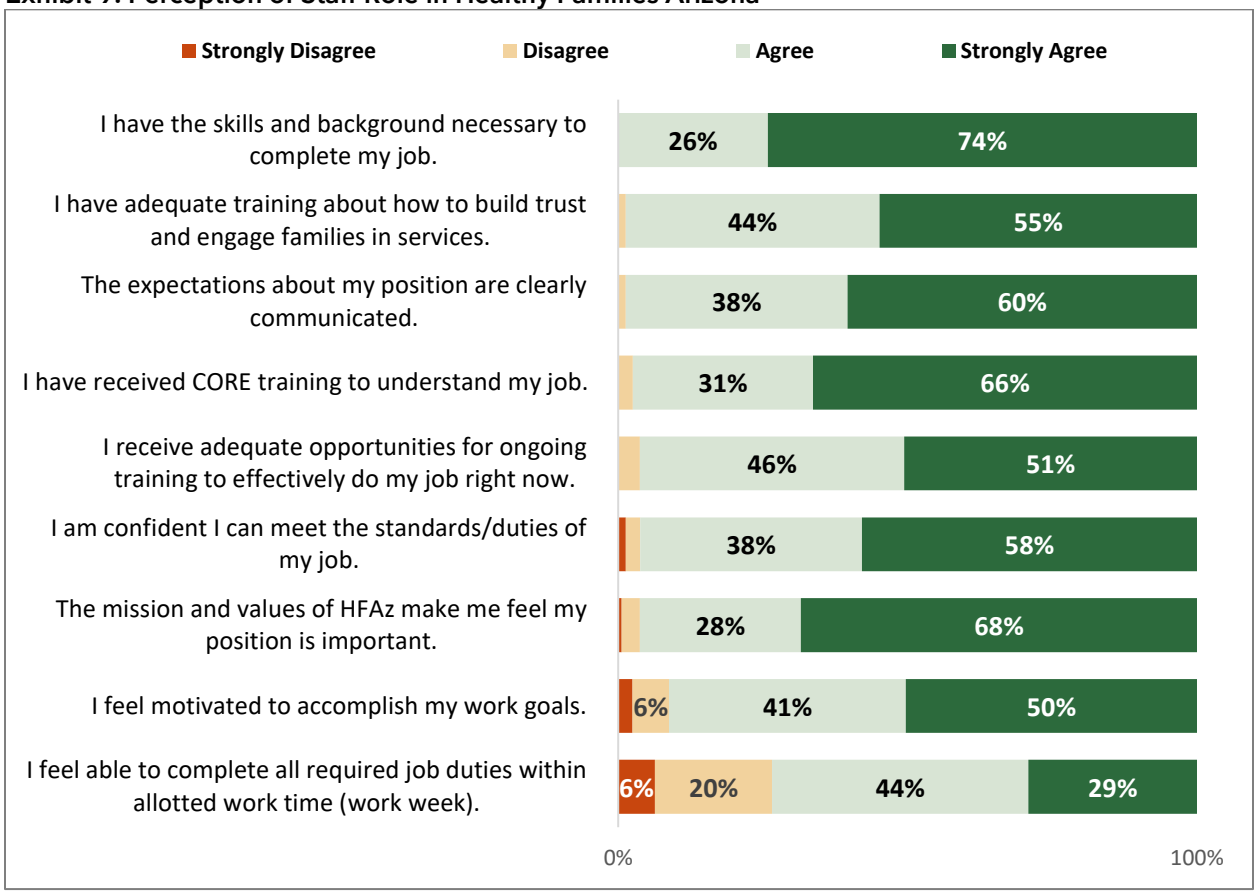
(N=158)

Most staff (91% or more) agreed/strongly agreed with all of the positive statements about their role in Healthy Families Arizona except for one (Exhibit 9). Only seventy-three percent agreed/strongly agreed that they were able to complete all required job duties within their allotted work time. A small number of staff offered comment explaining their responses. These comments included:

- This job has been a great place for sharing, learning, and growing in learning. It has been fulfilling thus far. I appreciate the added supports and reflective supervision; these are all positives.
- I would have liked Core training to have been sooner. After attending core, I felt twice as comfortable being able to do my position.
- I feel I can mostly finish my work in my allotted hours, but sometimes there is too much paperwork.
- Work-life balance has not been ideal this last year.
- Working for Healthy Families has been a life-changing experience. I feel lucky to have the opportunity to work for such an amazing program.

All (100%) of staff agreed/strongly agreed they have the skills and background necessary to complete their job, and almost all staff similarly agreed with most of the other positive statements about their role in Healthy Families Arizona (Exhibit 12). Of all the statements, the smallest proportion of staff agreement (73%) was with one regarding being able to complete all required duties within allotted work time.

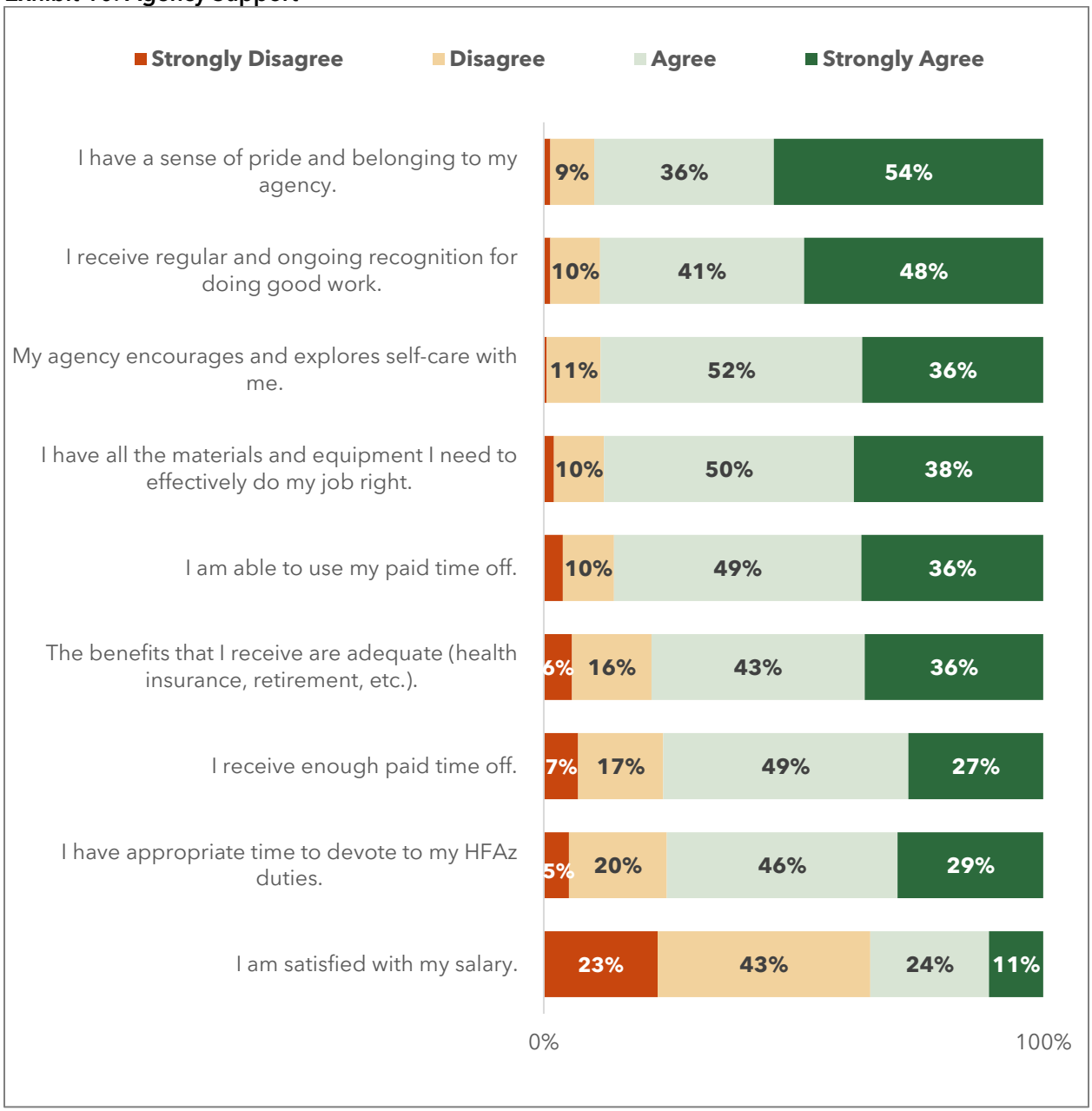
Exhibit 9. Perception of Staff Role in Healthy Families Arizona



(The N varies by statement from N=152 to N=159.)

Staff most agreed/strongly agreed they have a sense of pride and belonging to their agency, and they receive regular and ongoing recognition for doing good work (98% for both). The lowest level of combine agreement and strong agreement (35%) was with being satisfied with one's salary (Exhibit 10). Lower proportions of staff also agreed/strongly agreed that they have appropriate time to devote to their Healthy Families Arizona duties (75%), enough paid time off (76%), or adequate benefits such as health insurance (79%).

Exhibit 10. Agency Support



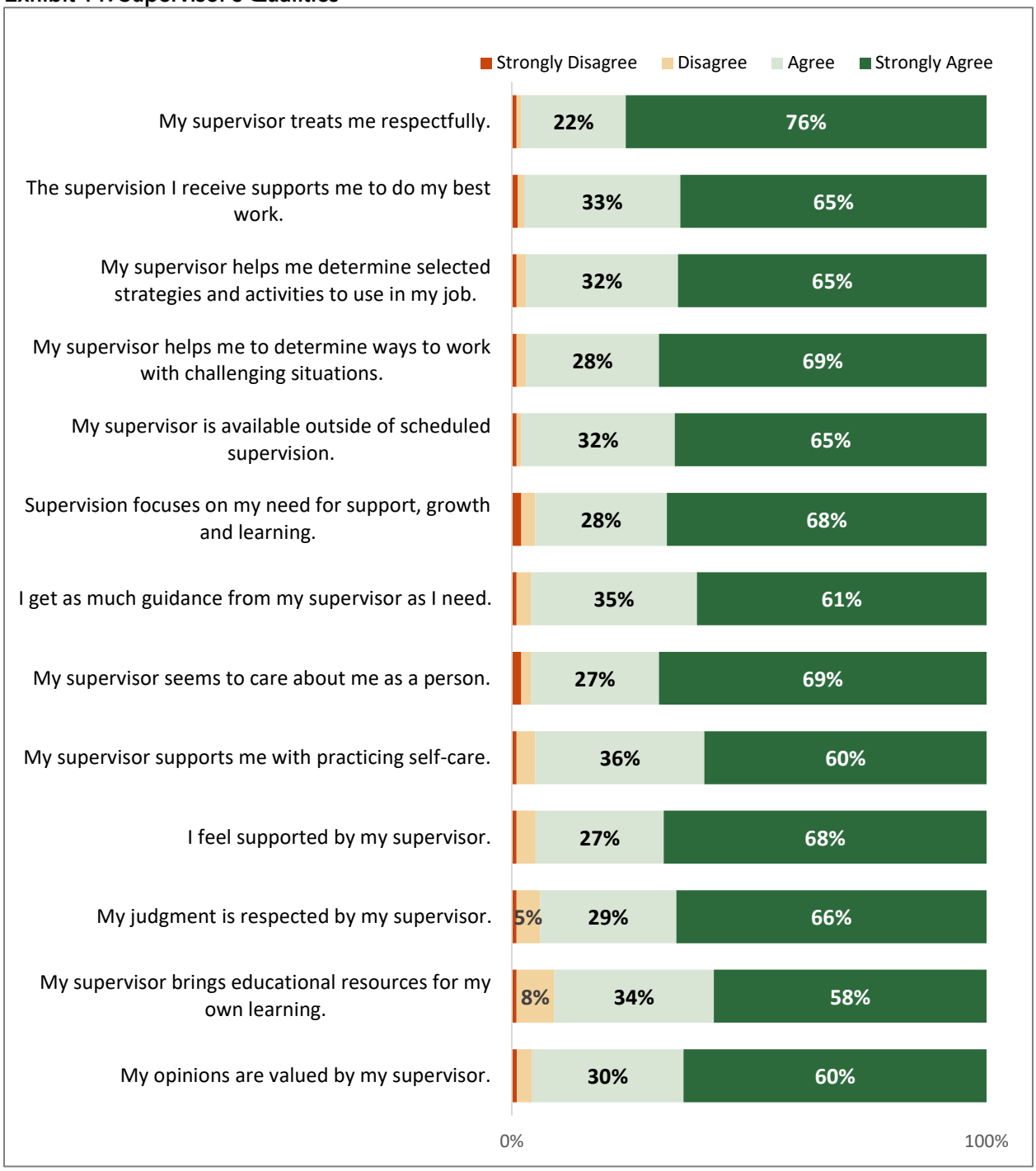
(The N varies by statement from N=152 to N=158).)

The survey elicited only a small number of comments regarding agency support, most expressing one or more aspect of work at Healthy Families Arizona. Some staff expressed opinions about workload expectations and financial compensation along with feeling supported by their supervisors.

- I appreciate the level of supervision I receive. I feel supported and empowered every day.
- Awesome place to work. I just think that more functions were added to the existing ones without measuring the time it takes to perform them with the sole aim of giving an extraordinary service to our families in the program.
- The technology we have been given is old and it is time consuming to fill out each form.
- I often find myself having to spend my own money for activities/demonstrations I do with families. I also think that the pay does not reflect education and experience.
- Time off is great -- but it is stressful knowing the workload is building up while you are away.
- I have a lot of time off that I accumulated over the years, but it is difficult to take the time off. Concerned I will fall behind, not get required work, tasks, duties and requirements complete like documentation, visits, enrollments etc. a substitute who can fill in during my absence would be great. We are understaffed and too many new staff etc. support and ideas are appropriated.
- I will need to leave my position due to salary or take a second job. I do not want to do either.
- The pandemic has brought along so many changes with the work we do. One of the biggest being the huge risk we as FSS's take of contracting COVID by going into the homes of families plus the added pressures without a pay increase to balance that risk.
- Within my team I strongly and positive and feel good and accepted. However, the agency does not know who I am or give recognition for us as a whole. Compensation is not nearly what I deserve. The small cost of living pay raise was nothing and is not anything helpful for me. And I feel car maintenance should be covered more for what we do and use. If my direct boss ever left, I would leave the company in a heartbeat. My boss is my main support in this job. No Christmas bonus.

Staff's responses showed they think highly of their supervisors and how they provide guidance, with 92% or more agreeing or strongly agreeing with all of the positive statements about them (Exhibit 11).

Exhibit 11. Supervisor's Qualities



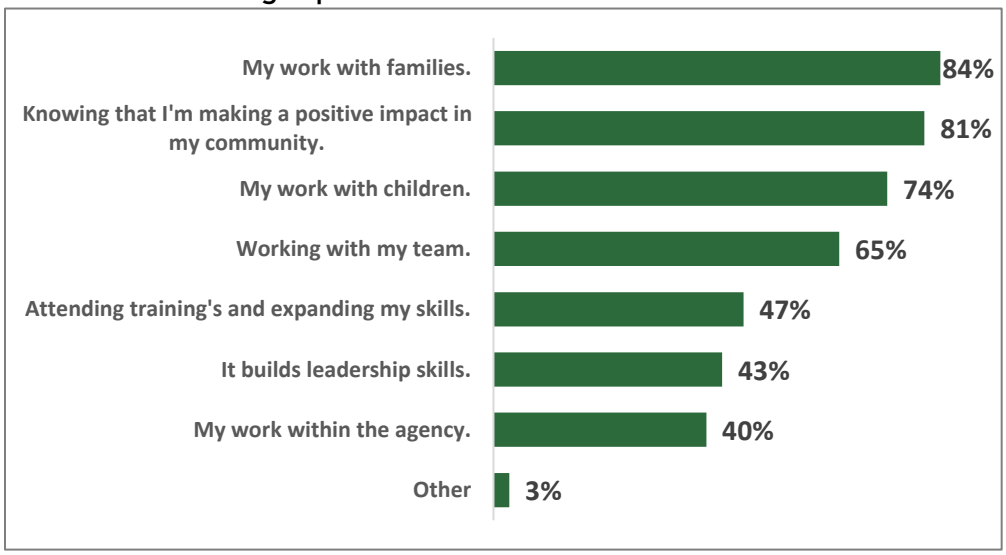
(The N varies by statement from N=146 to N=152.)

Although only a small number of open-ended comments were provided about supervisors, they largely mirrored their high level of agreement with the positive statements about them.

- I have the most supportive supervisors a staff member can have. They are both readily available at a moment's notice either in person or by phone. They are kind, empathic, reflective and professional. They consistently demonstrate and practice the parallel process. They wouldn't expect me to do something they wouldn't be willing to do themselves. They set a great example of what leadership looks like.
- My supervisor does a beautiful job of empowering me and validating me.
- My supervisor is an excellent support. She has stayed after hours to help when needed. She is extremely competent and knowledgeable and very caring as well. She is a truly wonderful supervisor and one of the main reasons I am happy with my job.
- I feel that my direct supervisor supports me the best that she is able; but I feel upper management needs to be more involved and add needed support that direct supervisors are not able to offer.
- I would like more opportunities for further education and training. It appears my supervisor does not get the information from her supervisors, as I have missed several opportunities.

Working with families was the most-cited rewarding aspect of work, selected by 84% of staff, closely followed by knowing that one was making a positive impact in their community, reported by 81% (Exhibit 12). The aspects of work that the smallest proportions of staff selected as being rewarding were work within the agency (40%) and that it builds leadership skills (43%).

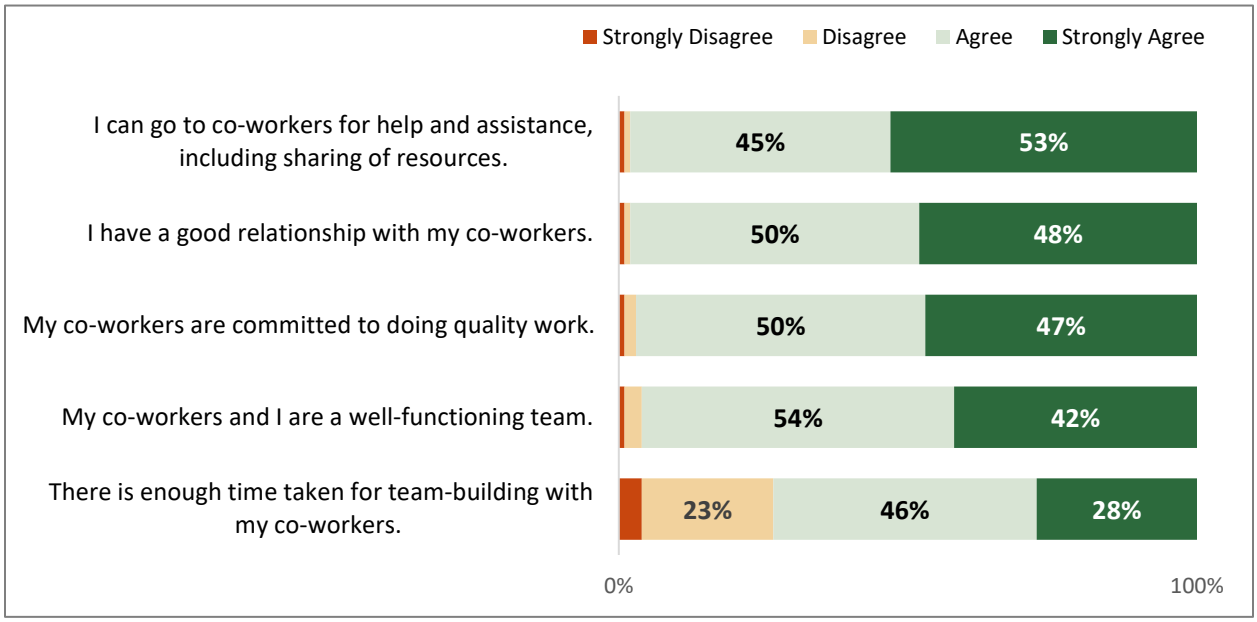
Exhibit 12. Rewarding Aspects of Work



(N=159)

Almost all staff agreed/strongly agreed with most of the positive statements about their relationship their team members (Exhibit 13). Only regarding having enough time for team building with co-workers was the level of agreement/strong agreement somewhat lower (73%).

Exhibit 13. Relationship with Team Members



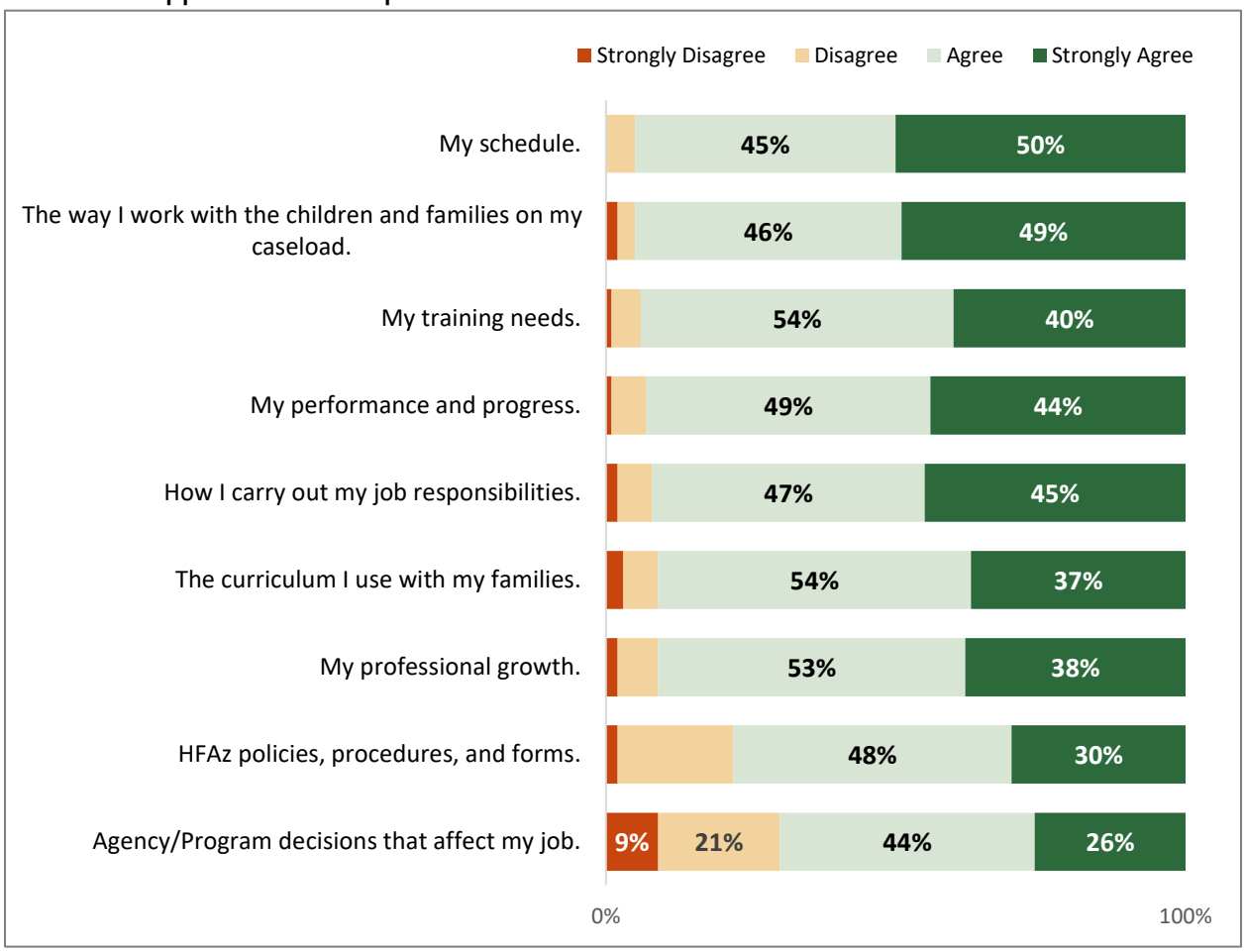
(N=159)

Several staff commented about their teams, with those mostly being a mix of appreciation and the challenges faced in recent times as a result of the COVID-19 pandemic.

- We currently have a strong team and we are all willing to 'fill in the gaps' with each other's strengths and opportunities for growth.
- The culture of our working team has become very strong from my perspective. in spite of all the change and adjustments that have occurred over the past six months.
- Sometimes it seems like there are too many meetings for team building alone. It takes time away from doing the work I need to.
- As admin staff, we rarely get an opportunity to do team-building activities.
- I love our team!
- Removing our permanent workspace where we worked closely and made us feel more connected and accessible for support has created division.
- Now that we don't have desks that are ours, I only see my teammates twice a month in person during our team meetings. I think if we had desks that were ours it might help bring the team into the office more and we would be able to collaborate more as a team.
- Reduce team meetings to twice per month to allow more time for visits and administrative duties.

Ninety-two percent or more of staff agreed/strongly agreed that they had opportunity for input into their schedule, performance and progress, and training needs as well as how they work with children and families and carry out their job responsibilities (Exhibit 14). They felt had less input into things decided or developed at other levels in the agency such curriculum, policies, and forms.

Exhibit 14. Opportunities for Input



(The N varies from N=115 to N=150.)

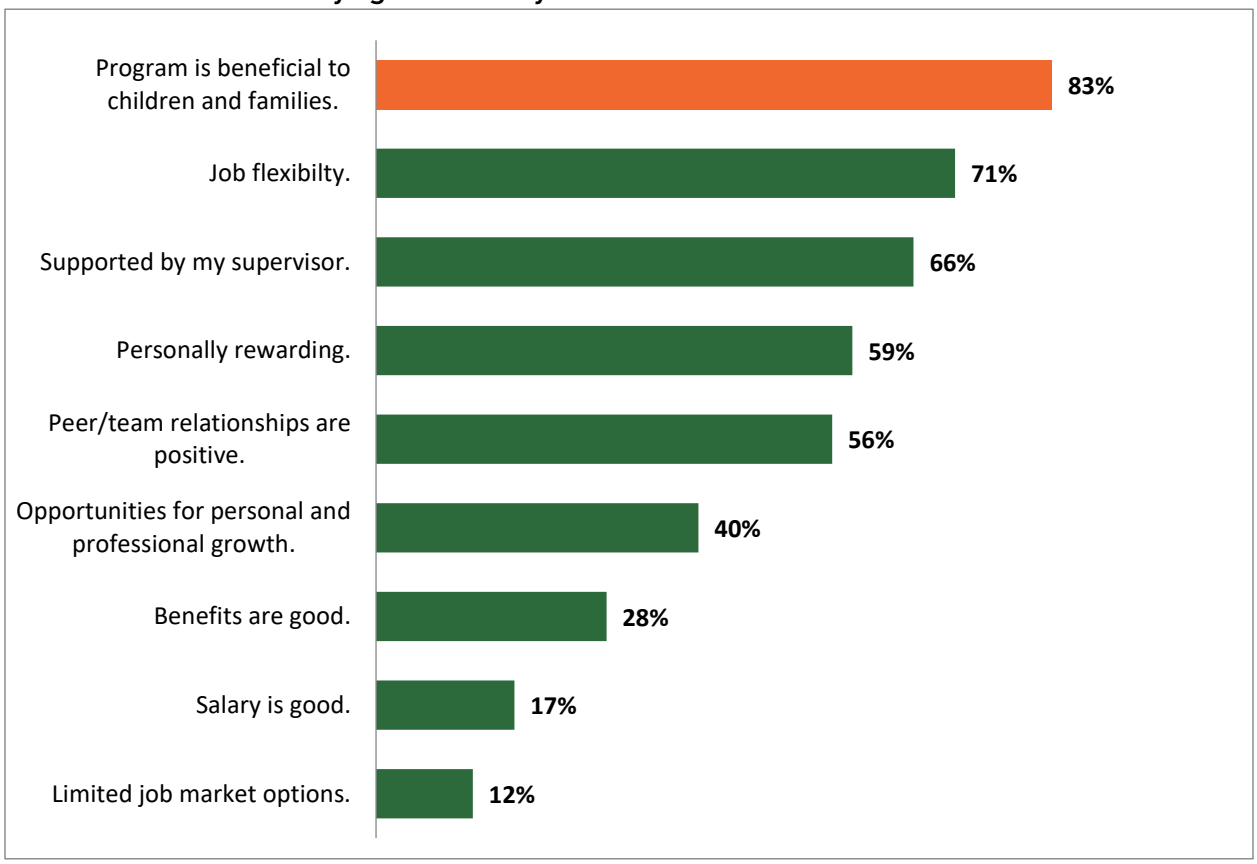
Most of the handful of staff who commented about opportunities for input used their response to express a concern.

- Lack of time to access and participate in trainings, learning, education and team building is a challenge
- Over the several years I have been with the agency I have discussed concerns with how some policies work against employees/make the job more difficult and I feel my concerns consistently fall on deaf ears. Management asks how to improve but makes no changes, which is extremely frustrating as an employee.

- I am not a fan of the evidence-based curriculum and frustrated that none is available to our site for age 36 months plus.
- I also feel like COVID could have been handled much more efficiently. We are basically being encouraged to either risk low performance numbers (which can affect our ability to get raises in the future), or risk getting COVID (by being encouraged to go into homes ASAP after someone has tested positive. I firmly feel that a COVID Creative Outreach should have been put into place to protect staff performance numbers as well as their health.

Feeling that the program is beneficial to children and families was the reason the largest proportion of staff (83%) indicated motivates them to stay will Healthy Families Arizona (Exhibit 15). Job flexibility and being supported by one's supervisor were also major reasons cited by 71% and 66% of the staff, respectively.

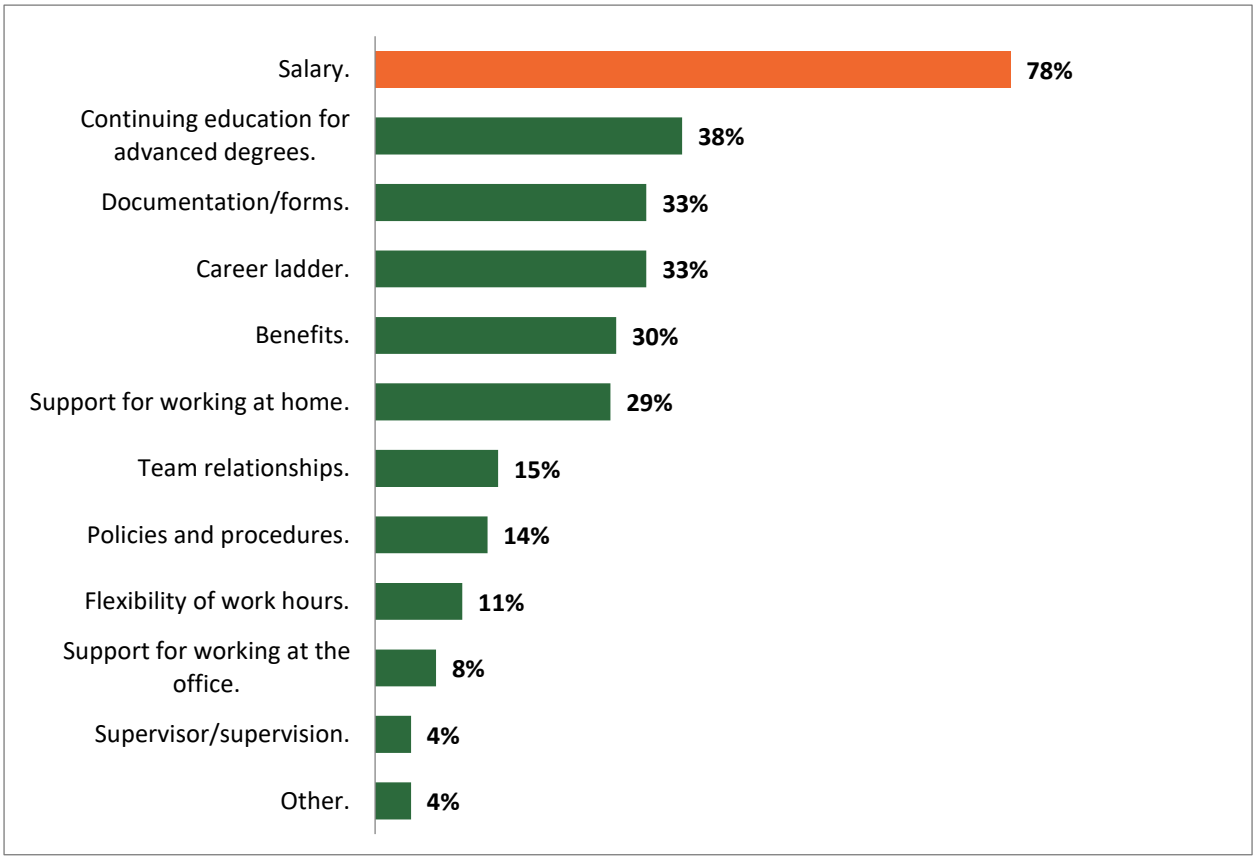
Exhibit 15. Reasons for Staying with Healthy Families Arizona



(N=159)

Salary was the aspect of work most identified by staff (78%) as needing improvement (Exhibit 16). The next most commonly reported aspects of work staff felt needed improvement included continuing education (38%), documentation/forms (33%), and career ladder (33%).

Exhibit 16. Aspects of Work Needing Improvement



(N=159)

Several staff explained their "Other" response.

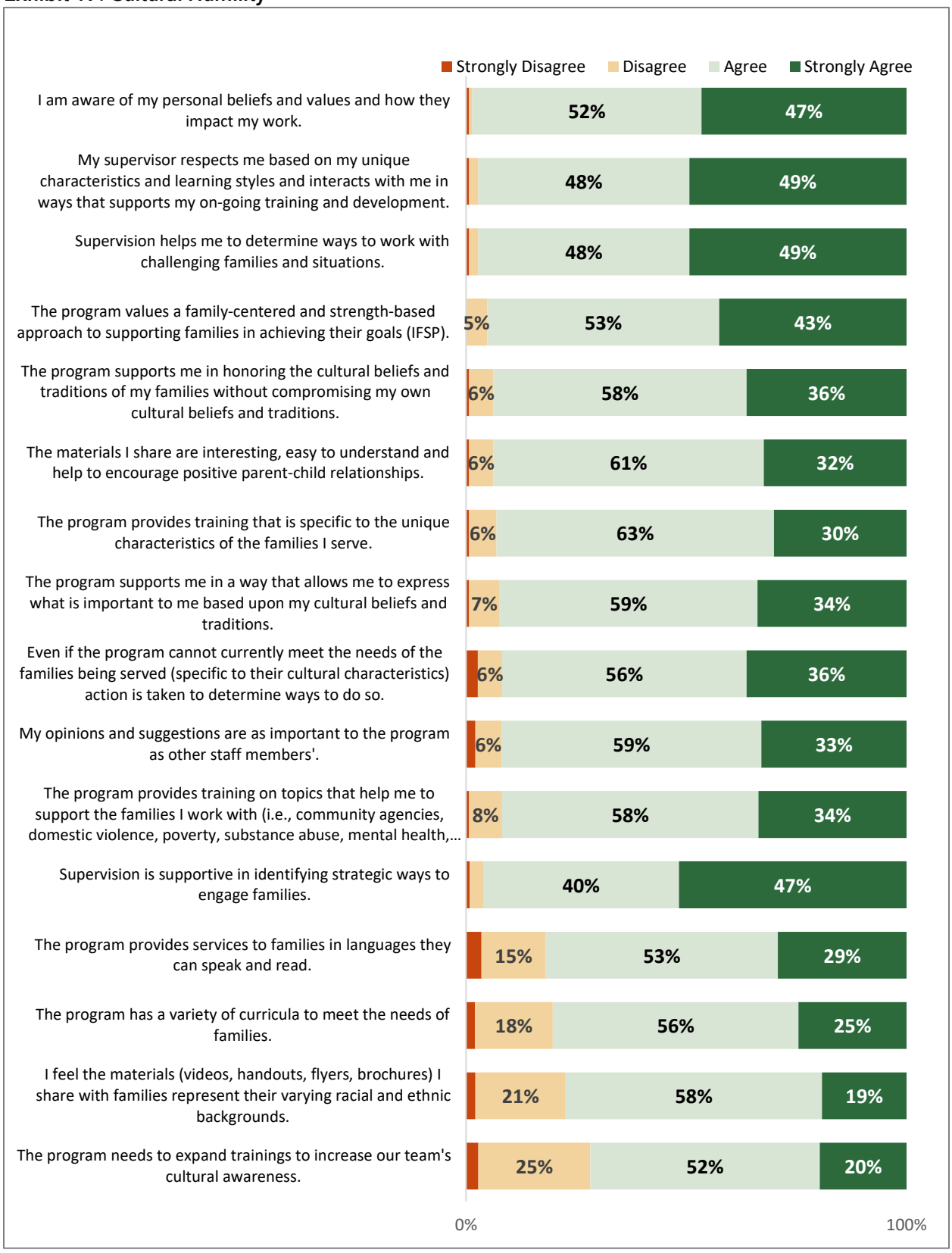
- Professional development opportunities for admin staff.
- Recognition of realistic job expectations.
- There is way too much paperwork and data entry. Not sustainable. Takes away from ability to be better family support specialist with families in home. Paperwork is stressful and overwhelming.
- No increase in mileage pay. And it seems punitive if no begin and end in office, where you do not have a permanent desk.
- Time off/self-care without the worry to take time off. Distributing of job duties/fill in as needed.

Most staff recommendations for improvements focused on reducing paperwork and improving salary or benefits.

- Electronic documentation and files instead of paper files. Documentation training and examples to become faster and more efficient. Not having to document information double and triple. One time documentation in one place. Streamline and improve documentation.
- Increase the mileage pay percentage…Have a credit card to use for gas to transport to the home visits.
- Working from home: equipment, possibly printers? Laptops/tablets that allow for writing on with a pen, to make home visits easier rather than trying to keep children away from laptop keyboard.
- We put a lot of hard work in, and more PTO would be nice. With the increase in cost of living, the increase in gas, and now having to drive more vs staying within a small zip code area, a raise would also be appreciated.
- Maybe a suggestion for overtime. Sometimes we have to work longer hours. Maybe not exceeding 48 hours per week or per two weeks.
- Making video visits an option for those families that wish to do so
- I feel like many of the things we are required to do regarding managing a paper chart, ETO, and the various spreadsheets--are very redundant and create a larger margin for error. I would like to see more progress regarding working on one system and eliminating completing the same document four different ways daily.

The largest proportion (99%) of staff agreed/strongly agreed that they were aware of their personal beliefs and how they impact their work (Exhibit 17). A large proportion of staff (97%) also agreed/strongly agreed that their supervisor respected them based on their unique characteristics and that supervision helps them determine ways to work with challenging families and situation. Seventy-two percent of staff agreed at some level that the program needed to expand trainings to increase their team's cultural awareness. While 77% of staff agreed/strongly agreed that the materials they share with families represent those families' varying racial and ethnic backgrounds, this means 23% of staff did not feel so.

Exhibit 17. Cultural Humility



(The N varies by statement from N=142 to N=147.)

The survey included several open-ended questions not directly related to the rating or multiple-choice questions for which the finding were presented above. A range of responses for each of those open-ended questions are presented below. Staff responses regarding curriculum issues commonly mentioned a lack of curriculum in certain languages, for particular populations, or for children of a certain age (Exhibit 18). Another mentioned by a few staff was that curricula lacked sufficient activities.

Exhibit 18. What curriculum issues are you experiencing related to the families that you serve?

Curriculum Responses
• GGK curriculum is written assuming FSS/ Worker has had children, assuming families are always facing hardship or are in a less-than situation than the worker/FSS.
• Not available in languages other than English and Spanish.
• No curriculum for age 36 months plus. Curriculum is difficult to give to highly educated parents and comes across as condescending and passive aggressive.
• Seems out of date. Not in line with current research.
• Sometimes too basic, too brief, not interesting to all families. Not meeting all families' needs. Difficult to search information. Limited developmentally appropriate activities.
• Some refugee or immigrant families need information in other less common languages.
• Staff who need to be GGK trained.
• I would like easier access to curriculum in electronic forms.
• I believe that the curriculum we use is good but there can be more options for families who come from Mexico. I don't believe the Spanish version of the curriculum is enough as these families go through different experiences.
• Have curricula for indigenous families. The program has an array of take-home books for families, but not curricula.
• Families often find the curriculum offensive and not helpful at all.
• Developing Interesting and engaging curriculum for teen moms.

A few staff offered general comments about Healthy Families Arizona does in regard to serving diverse populations.

- I think for the majority of families we serve we do a pretty good job of being culturally sensitive. There are some less common cultures that may sometimes need some other resources or information in other languages or other further specific support. It is sometimes hard to plan for generally as a program since we don't know what the families need until we meet them and get to know them personally and hear their experiences.
- Maricopa County is culturally diverse, but we still mainly serve families of the majorities.
- We need more staff that speak diverse languages such as sign language, Arabic, African languages etc.

The challenges with home visits reported by staff were varied but a majority involved the impact of the COVID-19 pandemic (Exhibit 19).

Exhibit 19. What are the challenges you are experiencing with home visits (both virtually and in-person)?

Challenges in Home Visits Responses
• A consistent challenge that FSS works have come across is the completion of 4 visits within the month period for level 1 families. Some families appear to show a lack of priority in the FSS's time and energy placed into home visits. A common challenge that has recently come up is the hesitancy families are experiencing with disclosing information out of fears of the children being taken away from them.
• Families enjoy HF but a vast majority report weekly visits are too much. Single parents/working parents report this issue a lot.
• I understand we have to wear masks, but it does make it difficult for the families to see my facial expressions which are important.
• Cancelations, families that are not disclosing COVID exposure right away.
• COVID fears and/or mental health interfering with quantity or quality of visits.
• Doing visit with families that use our time as a counseling session.
• Sixty miles per week in my personal car with my own gas until I present the tracking expenses. Dangerous neighborhoods, visits after 5 p.m. on winter days when dark comes early, raining days in flowed streets. People who do not have symptoms of sickness, because they are within the incubation process.
• Virtually- People are not as engaged or refuse virtual visits.

Challenges in Home Visits Responses
• COVID-19 Omicron--need I say more? In person is very risky right now and I have some team members who are at higher risk than others, so I am concerned for their safety. Some families' apartments are VERY small and nearly none of the families use caution in visits. • Families exposed to COVID, trying to figure out when to visit. Offer virtual and some families have phone but no access to FaceTime or other apps for video virtual home visits. • Families become accustomed to the convenience of virtual visits and will request them when they are busy.

Many staff reported that more of their clients prefer in-person visits, although some appreciated the safety of virtual visits during the pandemic or their convenience (Exhibit 20).

Exhibit 20. How would you describe your families' feelings about virtual and in-person visits?

Families Feelings about Virtual and In-Person Visits Responses
• Families have enjoyed more in person visits as kids were not as engaged when it came to doing activities through video chat. • Families do not like virtual visits because we cannot do activities together. • About half of my families are willing to do virtual if needed, but 100% of my families prefer in person visits. I have some families that are absolutely not willing to do virtual, because it is hard to manage with a child. • Families seemed to form a strong preference for one or the other. Those who enjoyed virtual did not appreciate return to in person. More families than we care to admit closed rather than return to in person visits. • Families prefer in-person visits but are okay with doing virtual when there is illness in the family. • Most of my families agree with virtual visits. They like to have the benefits of the program without the stress of being sick with COVID-19 or other viruses. • Most families enjoy having in person visits and appreciate being able to do virtual when needed. • I feel like most of my families dislike virtual visits and several of my families cannot do virtual visits. I feel like in person visits are going as well as they can, some families resent that I wear a mask and others appreciate it. • I feel like many families prefer the flexibility of virtual visits.

Families Feelings about Virtual and In-Person Visits Responses
• Families would like options for both in-person and virtual when illness arises that is not COVID. Families still want a visit, but we aren't able to offer virtual. For the most part families have adjusted to going back to in-person and have been open to virtual visits as they have been needed unless they have COVID. • Some do not feel comfortable with in-person due to increase of COV1D-19 and variants. Do not want to enroll or continue. • As I mentioned before parents like having the option of FaceTime visits. If something came up, not just because they are sick, but because of lack of time, or being in another place. They don't want to cancel the visit for another time, and sometimes we can't schedule another home visit during the same week.

Most staff expressed strong satisfaction with their supervisions and indicated they are getting the support they need (Exhibit 21).

Exhibit 21. How do you feel about supervision right now? Are you getting the support you need?

Supervision Responses
• I am definitely getting the support I need during supervision and feel confident about having supervision • I feel great about my supervision from my supervisor. • It has been more needed than ever. Absolutely getting the support needed. • I feel great about my supervision from my supervisor. • I am getting the support I need each week, or as needed. • This has not changed, and in fact, I have more communication with my supervisor than before the pandemic. • My supervisor goes above and beyond in supervision. She listens to me and if I have any concerns, she helps me to find a solution immediately. I never feel un-heard. • With the transition to electronic files supervision that is in-person is less effective. • Supervision is going well. However, I feel like supervision weekly is too much with a caseload as team meeting is required every week as well and monthly MHC. It would be ideal to consider supervision every other week. • I think I am getting the support I need. I am able to email or call my supervisor if I have a specific question outside of supervision.

Staff generally provided varied personal concerns in response to a question asking whether they had anything else to share (Exhibit 22).

Exhibit 22. Other Staff Comments

Anything Else to Share Responses
• Healthy Families makes a real difference in the lives of families in our community. I am proud to be a part of Healthy Families.
• As an agency there is a lot of understanding for the community and families we work with. This job is rewarding, and I feel I have thrived in professional growth thanks to the work I am doing. I understand the impact we leave on families. I would like to share that there is a pressure to perform, and I feel it has caused a high turnover from my peers. I hope these annual surveys get taken into consideration as a lot of us do state our needs for increase salary and benefits. As FSS's we sacrifice our own family time, funds, and energy to do the work we do. A little appreciation goes a long way and that appreciation my manager provides is what every FSS needs.
• As an employee I would like the option of virtual visits. When we strictly did virtual visits, I was able to be more efficient with completing visits and documentation within the same day, and I feel the families were able to get the same quality of service because I was less stressed out about being in the families homes/driving/scheduling conflicts. I was able to provide more resources to families because I had extra time to research the resources and get them to the families. I am a better employee with the option of virtual visits, and that helps me in my personal life as well.
• I do enjoy my job. The only concern I have that I shared was the wage increase. As minimum goes up, workers like myself and others will need to get a salary review in order for us to be working towards a livable wage as prices are going up.
• I would like data and documentation to be minimized, as I would like my main focus to be on support for the families, and it is difficult to keep up with the paperwork within the working hours.
• The use of drop by visits to try and re-engage families should be limited and not expected every week. I feel like I am not listening to them when I'm coming over every week and they clearly don't want to have visits. This is why we have creative outreach time. Sometimes life is just too busy for visits and when we don't listen when families are telling us that we aren't helping them.
• I understand being nonprofit and following budget and funding guidelines is essential and important. I do wish that there were more opportunities for raises, especially for job performance. It's difficult knowing and seeing different levels of work being put into the same position and yet everyone is compensated the same.

Overall, staff are feeling supported by their supervisors but are not feeling like they are receiving the compensation they deserve. Home visitators are also feeling stressed by the impacts of COVID-19 changes and expectations along with feeling the time pressures to complete paperwork and data entry along with supporting the families they visit.

Staff Retention Analysis

On average, Healthy Families Arizona has between 200 and 210 home visitors and family assessment workers when all positions are filled. Position changes are common, but most positions are able to be filled with new hires within a few weeks. However, the past year has had challenges to keep up with open positions. At the end of fiscal year 2021 a much larger number of positions were open than has been seen in prior years (Exhibit 23).

Exhibit 23. Staff Retention

Fiscal Year	Position Changes	Open Positions at the end of the Fiscal Year
2019	76	5
2020	62	13
2021	89	32

At the end of the fiscal year, 22 of the 32 positions had been open for more than 60 days. The larger number of openings has had several impacts on the Healthy Families Arizona program. It is harder for current staff to cover the required home visits for all families to meet model fidelity. Newly hired home visitors take on an existing case load rather than starting with new families which can make it more stressful for them. It is also hard for both the families and the new home visitor when there isn't an opportunity for a warm handoff making it harder to build rapport.

During a discussion with supervisors and program managers several additional factors were mentioned that they feel are related to the increase in staff attrition:

- Vaccine mandates;
- The oscillation between virtual an in-person home visits;
- Potential issues with hybrid work models including hoteling, virtual work except for team meetings, etc.;
- Job hazards due to unvaccinated families and taking that exposure risk home to their own families;
- Childcare costs are higher than the take home pay;

- The cost of living has increased faster than the contracts (which has rates locked in for 3 to 5 years) so its hard to keep seasoned staff and attract new staff;
- Changes to the types of families served with more low risk and more high-risk families and fewer middle risk families – this may require staff with a different skill set to address the differences.

Overall, the sense is that the job "feels bigger" and that the pay is inadequate to retain and hire staff. Recommendations include:

- Allowing for regular cost of living increases annually rather than having to remain at flat rates for the full three-to-five-year contracts;
- Allow for hazard pay or obtain additional funding;
- Explore creative ideas for expanding staff resources to make their jobs easier such as new curricula, trainings, and technology to provide a morale boost for staff;
- Find ways to balance at-home and in-office workspaces for staff.

Staff Exit Survey Results

In addition to the supervisor and program manager feedback, staff members who leave Healthy Families Arizona have an opportunity to provide feedback via an online exit survey. Supervisors are asked to provide the online survey link to staff when they leave their position starting. This survey is voluntary for exiting staff members. The evaluation team received 44 completed surveys from staff who exited between October 2020 and September 2021. Staff were asked about their role in the Healthy Families Arizona program, the majority of whom worked directly with families (Exhibit 24). Staff who left Health Families Arizona during 2021 varied greatly in the length of time they had dedicated to the program, ranging from as few as 90 days to as many as 14 years. Of the respondents, 95% (n=42) reported that their position was classified as full-time.

Exhibit 24. Roles of Staff who Completed the Exit Survey

Role	n	%
I mostly worked directly with families.	38	86%
I mostly worked as a supervisor, manager of employees.	5	11%

Staff were asked to indicate the main reason why they left working at their agency within Healthy Families Arizona (Exhibit 25). Staff that moved from the area, retired/left the workforce, or left due to a medical/personal reason accounted for one-fourth of all responses. Another fourth of the staff stated that the position was not a good fit for them or that they left because they wanted better pay and/or benefits. The other half of staff left for a variety of

reason as shown in Exhibit 22, including one staff who left to take a position at another Healthy Families agency in a different location.

Exhibit 25. Reasons for Leaving Their Position with Healthy Families Arizona*

Reason	n	%
I or my family moved away from the area	8	18%
Position in Healthy Families was not a good fit for me	6	14%
I wanted better pay and benefits	5	11%
Returned to school	2	4%
I left the workforce/ retired	2	4%
I left due to a health issue/family member health issue	1	2%
I was transferred to another Healthy Families site	1	2%
The position was dissolved due to loss of funding	1	2%
Other (see comments below)	17	39%

*Percentages do not add up to 100 due to rounding

Other reasons - Many staff gave additional reasons reason for departure, and a common reason for leaving had to do with caring for children/family during the COVID-19 pandemic. Two staff stated they left as a result of not wanting to receive the COVID-19 vaccine. Three staff mentioned a perceived lack of support from management, and burnout from what they felt was a burdensome amount of paperwork or duplicative documentation. Three staff also mentioned they wanted to explore new fields or were seeking professional development. As a retention strategy, Healthy Families Arizona may want to review its policies and practices for supporting employees who have childcare responsibilities, particularly in the context of the pandemic, as well as improving opportunities for professional development.

Exiting staff were asked, "Is there something that could have been changed to keep you from leaving?" and were asked to share what could have changed their decision (Exhibit 26). Nearly half of the respondents (45%, n=20) said that "yes", something could have been changed, while 55% (n=24) said "no." The most common response of those who answered yes was within the theme of wanting more communication and support from management, as well as a decreased caseload or workload. Notably, five staff mentioned that better pay was a significant factor in leaving and would have helped them stay.

Staff members were asked to rate their agreement or disagreement with the following statement, "Most employees I knew and worked with at the Healthy Families program felt positive about their working situation." Almost two-thirds of staff stated that they agree or totally agree with the statement (66%) (Exhibit 26).

Exhibit 26. Exiting Staff Levels of Agreement That Most Employees Feel Positive About Their Working Situation

Rating	n	%
Completely Agree	8	18%
Agree	21	47%
Neutral	11	25%
Disagree	4	9%

Staff members also shared about what they thought the organization did well regarding implementing the Healthy Families Arizona program. The most common theme related to positive feedback about the quality and quantity of trainings for staff (n=14). Many staff also referenced feeling supported by their supervisors.

Exiting staff members were asked to "Please describe the three things you liked best about working with your supervisor and/or at the agency." The most common response was "flexibility" (n=6). The second most common response was "supportive" (n=4). Other notable positive responses include: *"open honest constructive supervision", "reflective supervision", "empathic staff", and "kind and knowledgeable co-workers".*

When asked "What were the three most difficult things about working with your supervisor and/or at the agency", there were several references to the amount of paperwork (n=11) being quite high. Common sentiments included:

- Excessive paperwork
- Conflict with or poor supervisor, feeling micromanaged
- Inconsistencies with direction provided
- Poor communication from management
- COVID related difficulties/changes
- Low pay
- High stress/ high emotional burden
- Lack of upward movement
- Strict regulations/less room for fun

Family Satisfaction Survey Results

The Healthy Families Arizona program model is designed to help expectant and new parents/guardians get their children off to a healthy start. The Healthy Families Arizona family satisfaction survey provides valuable information for program staff and an opportunity for families to reflect on their experiences in the program. If parents and guardians are satisfied with the program and the work of the home visitor, they are more likely to benefit from the program. This year especially, after many adaptations to the program were necessary due to the pandemic, we value participant feedback as it may inform future iterations of the program that we offer.

Survey Design

The Participant Satisfaction Measure is guided by an understanding that outcomes thought to be influenced by home visiting can be examined based on quantity, content, and quality (Korfmacher et al., 2008; Paulsell, Boller, Hallgren, & Esposito, 2010; Raikes, Green et al., 2006). Home visiting content includes the information shared with the caregiver during the home visit. Home visiting quantity is the intensity or amount of home visiting over time. Home visiting quality is the examination of the quality of the services provided and the quality of the relationships in the home visit (Korfmacher, 2007; Paulsell et al., 2010; Raikes, Green et al., 2006). Studies have found that all three home visiting components have positive outcomes for child and family development (Raikes, Green et al., 2006). The overall effort is to measure family satisfaction with their participation in the Healthy Families Arizona program. Additional questions were added in 2021 about virtual home visitation to understand family preferences and satisfaction with different modalities of home visitation. The survey is available in English and Spanish.

Sampling and Data Collection Procedures

For this year, 2021, rather than select a sample of families to participate individual surveys for each home visitor team were created listing each home visitor on the team. The home visitors or their supervisors then provided a link to the online survey to each of their families. The survey was available to complete via any browser including on mobile devices. The survey was available in both Spanish and English and the respondents were able to choose their language preference at the beginning of the survey. Data collection started in August 2021 and ended in September 2021.

Of approximately 1,820 potential respondents, a total of 632 parents and guardians completed this survey, after exclusion of any partially complete surveys, for a response rate of approximately 35%.

Participant Demographics

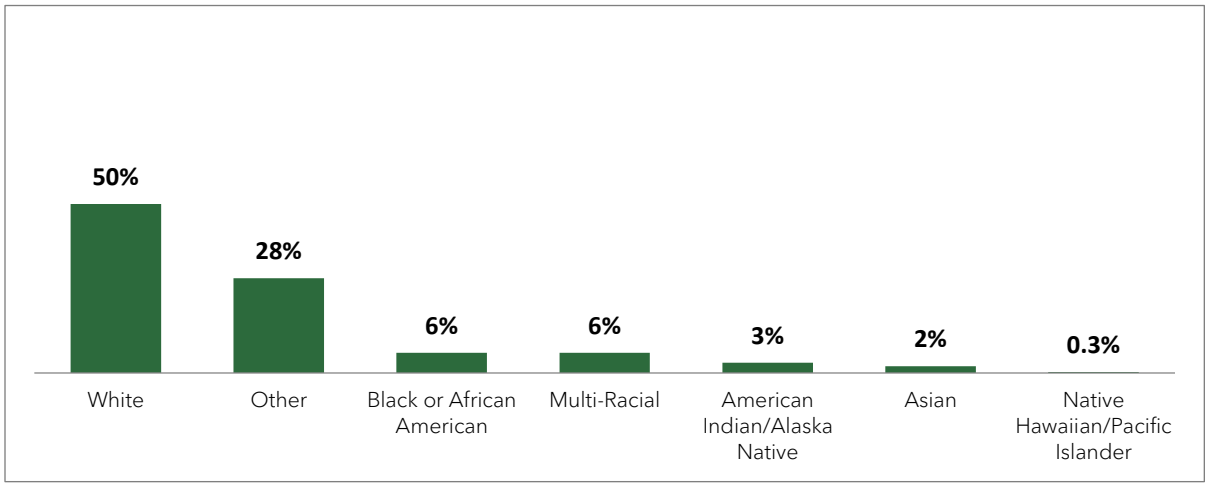
A total of 638 adults served by the program responded to this survey, however some did not respond to demographic questions. The number of respondents is shown for each data point. 87% (n=131) are female and 13% (n=19) are male. Most are the biological mother (85%, n=127) or father (13%, n=19) of the child, however two adults are a grandparent caregiver, one is a foster parent, and one is an aunt. Nearly two thirds of respondents identified as Hispanic (Exhibit 27) and half identified as White (Exhibit 28). The average age of parents and caregivers at program intake is 29 years (7.8 SD) with a range from 14 to 60 years (n=145) (Exhibit 29).

Exhibit 27. Ethnicity of Parent Survey Respondents

Ethnicity	% (n)
Hispanic	60% (372)
Non-Hispanic	40% (251)

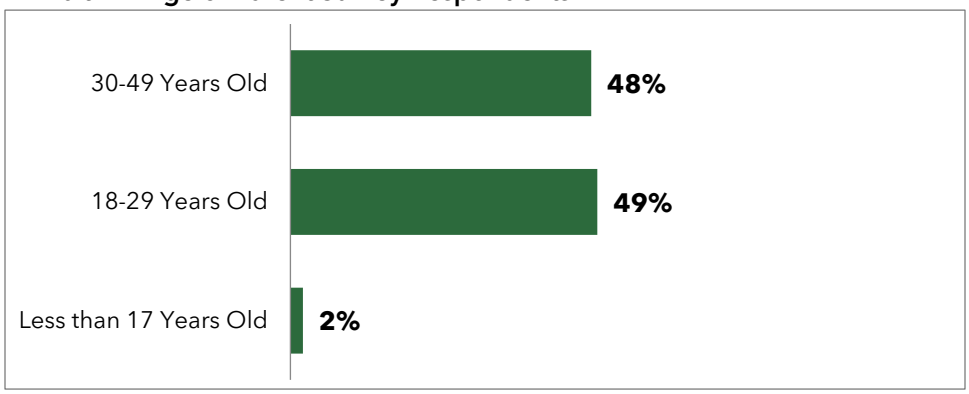
(N=623)

Exhibit 28. Race of Parent Survey Respondents



(n=632)

Exhibit 29. Age of Parent Survey Respondents



(n=633)

Satisfaction Survey Results

Parents were not required to answer all questions and in order to accurately capture that the percentage of no response for each question is included out of the 638 who took the survey. Questions where a smaller total of number of responses is used is denoted by (N=) under the exhibit. More than half of the parents had worked with their home visitor for a year or more (Exhibit 30).

Exhibit 30. How long have you worked with a home visitor from Healthy Families?

	Percentage
Less than Six Months	20%
Six Months to a Year	21%
One Year or More	58%
No response to Question	2%

Parents had an average of nine contacts with their home visitor in the three prior months (Exhibit 31).

Exhibit 31. In the last three months, about how many times did you have contact with your home visitor?

	Average
Average (mean) number of contacts in past three months	9

(N=560)

Three-fourths of (75%) parents reported their home visitor had never cancelled a scheduled visit and 23% indicated this had occurred sometimes (Exhibit 32).

Exhibit 32. How often has your home visitor cancelled a scheduled visit with you?

	Percentage
Never	75%
Sometimes	23%
Usually	0%
Always	1%
No Response to Question	1%

Three-fourths (75%) of parents have sometimes cancelled their home visit (Exhibit 33).

Exhibit 33. How often have you had to cancel a home visit?

	Percentage
Never	22%
Sometimes	75%
Usually	2%
Always	1%
No Response to Question	1%

Almost all (99%) of parents indicated their home visitor always or usually spends enough time with them (Exhibit 34).

Exhibit 34. Does your home visitor spend enough time with you?

	Percentage
Never	0%
Sometimes	0%
Usually	5%
Always	94%
No Response to Question	1%

Almost two-thirds (63%) of the parents always received follow up on referrals from their home visitor or another staff person at the home visitor's agency (Exhibit 35). Another 16% of the parents usually received such follow up.

Exhibit 35. How often did your home visitor or someone from the home visitor's agency follow up with you to see if you were able to use the referral?

	Percentage
Never	2%
Sometimes	7%
Usually	16%
Always	63%
No Response to Question	11%

Almost all (98%) of the parents reported their home visitor had always treated them with courtesy and respect (Exhibit 36).

Exhibit 36. How often did the home visitor treat you with courtesy and respect?

	Percentage
Never	0%
Sometimes	0%
Usually	1%
Always	98%
No Response to Question	1%

Almost all (97%) of the parents indicated their home visitor had explained things to them in an understandable way (Exhibit 37).

Exhibit 37 How often did your home visitor explain things in a way that was easy for you to understand?

	Percentage
Never	0%
Sometimes	0%
Usually	2%
Always	97%
No Response to Question	1%

Eight six percent of the parents reported their home visitor seemed to always up-to-date on what was happening in their family (Exhibit 38).

Exhibit 38. How often did your home visitor seem to know the most recent, most important information about your family?

	Percentage
Never	0%
Sometimes	1%
Usually	12%
Always	86%
No Response to Question	2%

Almost all (99%) of the parents reported their home visitor had provided materials such as educational handouts and videos (Exhibit 39). Ninety-three percent of the parents indicated that those materials represent their race, language, and ethnicity and 98% felt the materials were helpful to them. Most (91%) of the parents reported they or a member of their family had received a referral or contact for other services.

Exhibit 39. Materials and Referrals Provided

	Yes	No	No Response
Does your home visitor provide you any materials such as: educational handouts, videos, etc.?	99%	0%	1%
Does your home visitor provide materials that represent your race, language, and ethnicity?	93%	6%	1%
Were the materials helpful to you?	98%	2%	1%
Has the home visitor provided you or a family member with any referrals or contacts for other services such as the food bank, diaper bank, or counseling?	91%	9%	1%

Most parents indicated that on most visits their home visitor talked with them about parenting their baby and bring an activity for them to do with their child (87% and 80%, respectively) (Exhibit 40). Eighty-four percent of the parents also reported they discuss the goals they and their family want to work toward during most visits.

Exhibit 40. Frequency of Home Visit Interactions with their Home Visitor

	Never	Once in a While	About Half the Time	Most Visits	No Response
How often does your home visitor talk with you about parenting your baby?	2%	3%	7%	87%	2%
How often does your home visitor bring an activity for you to do with your child?	1%	7%	12%	80%	1%
How often do you and your home visitor talk about goals that you and your family want to work toward?	0%	4%	10%	84%	2%

Almost all (98%) of the parents indicated home visiting support had been as helpful as they thought it should be (Exhibit 41).

Exhibit 41. Has the home visiting support been as helpful as you thought it should be?

	Percentage
Yes, Definitely	86%
Yes, Pretty Much	12%
No, Not Really	1%
No, Definitely Not	0%
No Response to Question	1%

Ninety-five percent of the parents reported that their home visitor definitely respected and understood the choice they made for their children (Exhibit 42).

Exhibit 42. Does your home visitor respect and understand the choices you make for your children?

	Percentage
Yes, Definitely	95%
Yes, Pretty Much	3%
No, Not Really	0%
No, Definitely Not	0%
No Response to Question	1%

Ninety-five percent of the parents reported that their home visitor respected and understood their culture and beliefs (Exhibit 43).

Exhibit 43. Does your home visitor respect and understand your culture and beliefs?

	Percentage
Yes, Definitely	95%
Yes, Pretty Much	3%
No, Not Really	0%
No, Definitely Not	0%
No Response to Question	1%

Almost all (98%) of the parents indicated they feel more confident they can do a good job of raising their child because they were a part of Healthy Families (Exhibit 44).

Exhibit 44. Do you feel more confident that you can do a good job of raising your child because you were a part of Healthy Families?

	Percentage
Yes, Definitely	89%
Yes, Pretty Much	9%
No, Not Really	0%
No, Definitely Not	0%
No Response to Question	1%

Parents were asked about their preference for in-person and virtual home visits. Just over half (56%) of the parents expressed a preference for in-person visits while 38% favored a mix of in-person and video visits with only 4% preferring virtual video visits (Exhibit 45).

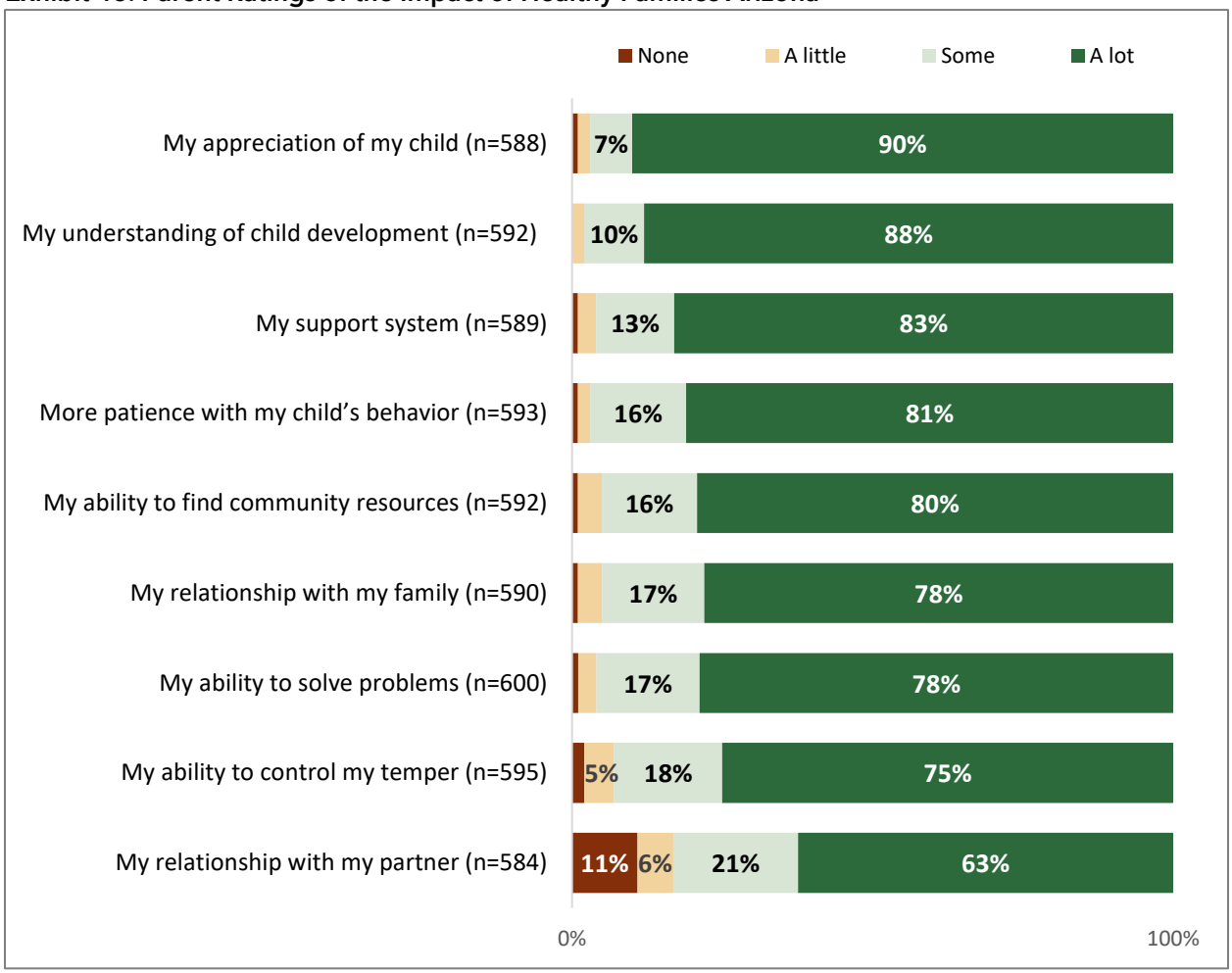
Exhibit 45. If you had a choice, what would you prefer for home visits?

	Percentage
A mix of in-person and video visits	38%
In person visits	56%
Virtual video visits	4%
No Response to Question	2%

Rating of Healthy Families Arizona Program and Improvement in Life

Parents were asked to rate how much the Healthy Families program improved their life in several areas (Exhibit 46). Parents rated the improvement as "A lot" three-fourths or more of the time in the areas of problem solving, patience with their child, their ability to find community resources, their support system, the understanding of child development, their appreciation of their child and their relationship with their family. Just a bit lower at 74% was parents' feeling that the program improved their ability to control their temper a lot. The area with the least improvement was with their relationship with their partner.

Exhibit 46. Parent Ratings of the Impact of Healthy Families Arizona



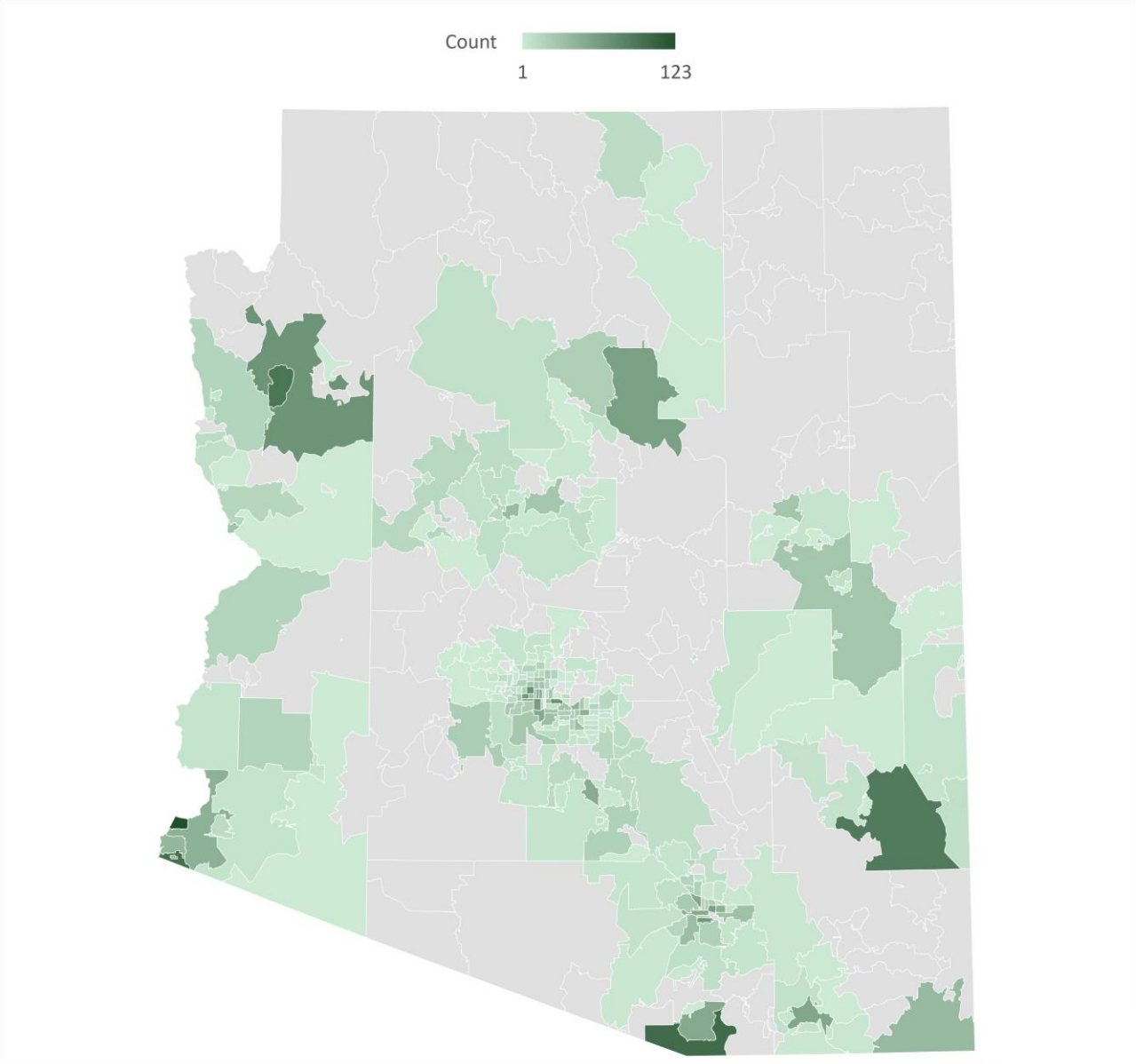
Please tell us what would make Healthy Families a better program for you…

Respondents were provided an opportunity to write in their ideas as to how the program could work better for them. The vast majority of the comments were very positive about the program and services that families have received from the home visiting staff. This feedback is especially encouraging in a year where social distancing and the continuation of the pandemic had a profound effect on social connectedness for many families and home visitors. As in past survey results, most often were statements that were specific to the positive relationship parents and children have with their particular home visitor. For statements that did offer feedback or constructive criticism, a common theme was desire for play groups or new activities to do with their children, and some participants expressed frustration over the difficulties of virtual video visits.

HEALTHY FAMILIES ARIZONA PROGRAM AND PARTICIPANT CHARACTERISTICS

Healthy Families Arizona served a total of 4,090 families from October 1, 2020 through September 30, 2021. A total of 2,043 were funded through the Department of Child Safety including State Opioid Response funding; 1,225 through First Things First; and 783 through MIECHV. An additional 39 families have outside funding in the Maricopa County area. Families come from 251 different zip codes in all 15 counties in the most populous areas of Arizona, as shown in the map in Exhibit 47.

Exhibit 47. Location of Families in Healthy Families Arizona, October 1, 2020 to September 30, 2021



Length of Time in Program and Reasons for Termination

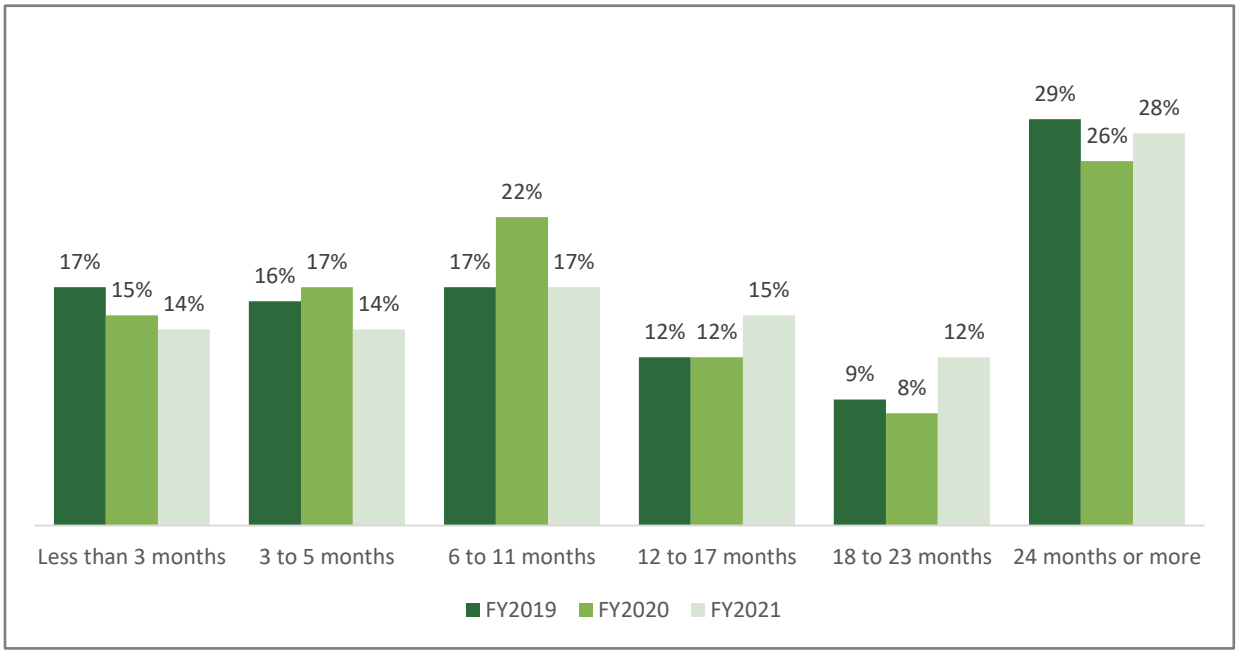
HFA Best Practice Standards recommends that services are offered until the child is at least three years old and can continue up to age five. From October 1, 2020 through September 30, 2021, a total of 1,828 of the 4,090 families closed out of Healthy Families Arizona. New enrollments account for 34% (1,386) of the 4,090 families served (Exhibit 48). This is substantial decrease from 45% of new enrollments in the prior year.

Exhibit 48. Families Served in Healthy Families Arizona, October 1, 2020 to September 30, 2021

Program Name	All Families	New Enrollments	Proportion of New Enrollments
Apache County / Navajo County	53	24	45%
Cochise County / Santa Cruz County	280	107	38%
Coconino County	110	32	29%
Graham County / Greenlee County	141	58	41%
Maricopa County	1,850	570	31%
Mohave County	347	142	41%
Pima County	636	218	34%
Pinal / Gila County	184	82	45%
Prescott Valley (in Yavapai County)	107	32	30%
Verde Valley (in Yavapai County)	49	17	35%
Yuma County	333	104	31%
Total Count	4,090	1,386	34%

For the newly enrolled families 523 closed (38%), for a retention rate of 62% which is lower than the 70% in FY 2020 and closer to the 58% attained in FY 2019. The median length of program service for families from October 1, 2020 to September 30, 2021 was 10 months, which is the same as in FY 2020 and lower than the 12 months for FY 2019 and 14 months for FY 2018. The proportion of families who have participated in the program for more than two years has seen a slight increase to 28% up from 26% in FY 2020 and closer to the 29% in FY 2019 (Exhibit 49).

Exhibit 49. Families' Length of Time in Program for Healthy Families Arizona Families



Of the 1,828 families that closed, 54% did not complete a year of service which is a decrease from 63% in FY 2020. In addition, there was a decrease in the proportion of families that closed within the first three months of services from 17% in FY 2019 and FY 2020 to 14% in FY 2021. Exhibit 50 shows the distribution of length of time that families stayed in the program for all families who closed in FY 2019, FY 2020, and FY 2021.

Exhibit 50. Families' Length of Time to Closure for Healthy Families Arizona Families

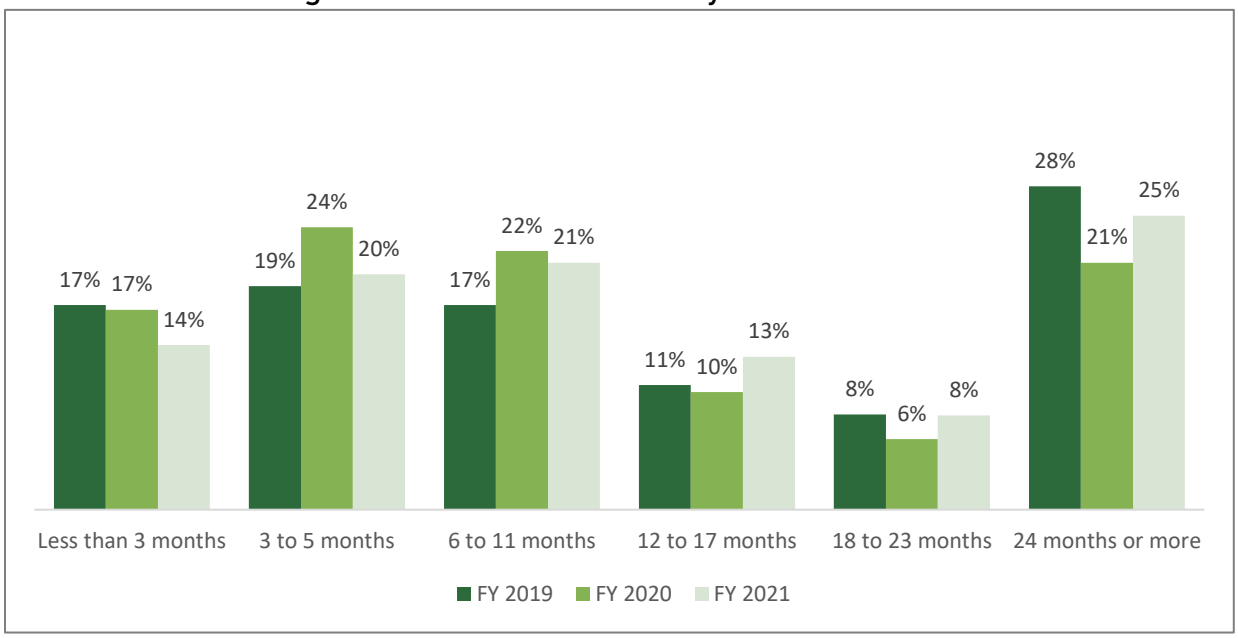


Exhibit 51 shows the most frequent reasons families left the program between October 1, 2020, and September 30, 2021, broken down by all families served and newly enrolled families who exited during the period. The most common reasons for case closures were that the family did not respond to outreach efforts, refused further services, completed the program, or moved. Other reasons for closure are all less than 5% and include adoption or loss of custody, loss of pregnancy or child death, duplication of services, homelessness, returned to school or work, and unable to locate. Of note in the other reasons for closure this year is that 14 families declined a return to in-person visits in July 2021.

Exhibit 51. Reasons for Family Closure in Healthy Families Arizona

Closure Reason	All Families Served		Newly Enrolled Families	
	n	Percent	n	Percent
Did not respond to outreach efforts	501	27%	155	30%
Family declined/refused further services	330	18%	151	29%
Completed program	247	14%	0	0%
Moved	200	11%	66	13%
Declined worker change	163	9%	29	6%
Self-sufficiency established according to parent	119	7%	20	4%
Other reasons for closure	268	15%	102	20%
Total N	1,828		523	

Referral Sources

Families are offered services in the Healthy Families Arizona via various methods. One primary method used by all sites is systematic screenings. These occur at hospitals and clinics throughout Arizona through contractual agreements with the local sites and involve a Family Assessment Worker regularly screening pregnant and postpartum women to offer then services. In addition to this, referrals come from multiple sources including the community (which can include doctors, social service agencies, or community members), self-referrals (which are often because a family has learned of the program through a brochure, website, or an individual), and the Department of Child Safety. The Department of Child Safety provides two types of referrals – general referrals and referrals from families who are offered to participate in the Substance Exposed Newborn Safe Environment (SENSE) program.

In FY 2020 as a result of COVID-19 restrictions there was a decrease in the percent of families coming from systematic referrals and the SENSE program. In FY 2019, 35% of newly enrolled families were systematic referrals and 14% SENSE referrals compared to 31% and 8% respectively in FY 2020. In FY 2021 there was a slight increase in systematic referrals up to 32%, but SENSE referrals continued to decline accounting for only 4% of new referrals.

Community referrals accounted for more than half of all referrals in FY 2021 (52%) up from 48% in FY 2020 and 39% in FY 2019. The increase this year are assumed to be due to the continued impact of the pandemic on limiting access to hospitals and the decline in SENSE referrals. Exhibit 52 shows the referral sources for all families and newly enrolled families for October 1, 2020 through September 30, 2021.

Exhibit 52. Referral Sources for Healthy Families Arizona

Referral Source	All Families Served FY 2021		Newly Enrolled Families FY 2021	
	n	Percent	n	Percent
Unknown	4	<1%	0	0%
Community	1,933	47%	716	52%
DCS	139	3%	48	4%
DCS/SENSE	222	5%	58	4%
Self	378	9%	117	8%
Systematic	1,414	35%	447	32%
Total N	4,090		1,386	

Caregiver Demographics

The Healthy Families Arizona program serves a culturally diverse population. Over half of caregivers enrolled in the program self-identify as Hispanic, and 77% of caregivers identify as White/Caucasian (Exhibit 53). Most caregivers (74%) speak English as their primary language at home, while 19% primarily speak Spanish (Exhibit 54).

Exhibit 53. Caregiver Race and Ethnicity

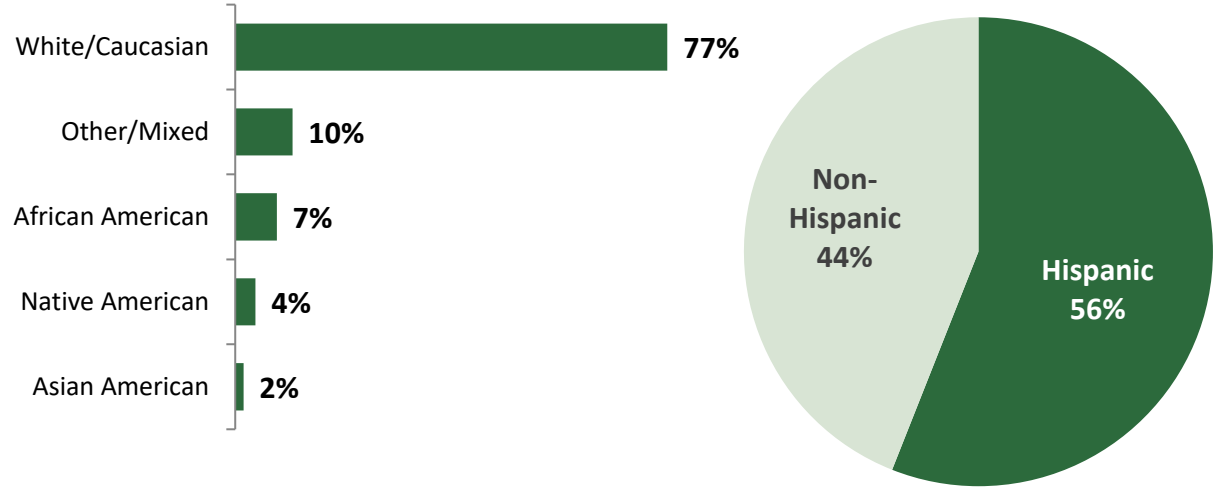
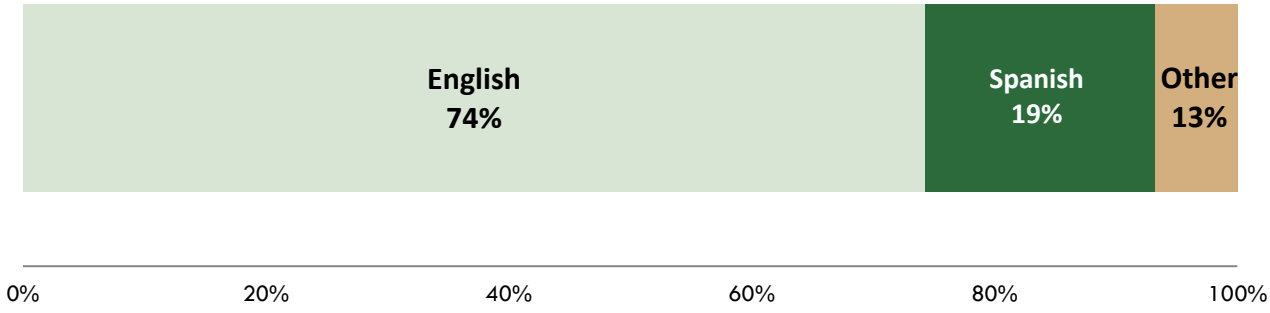
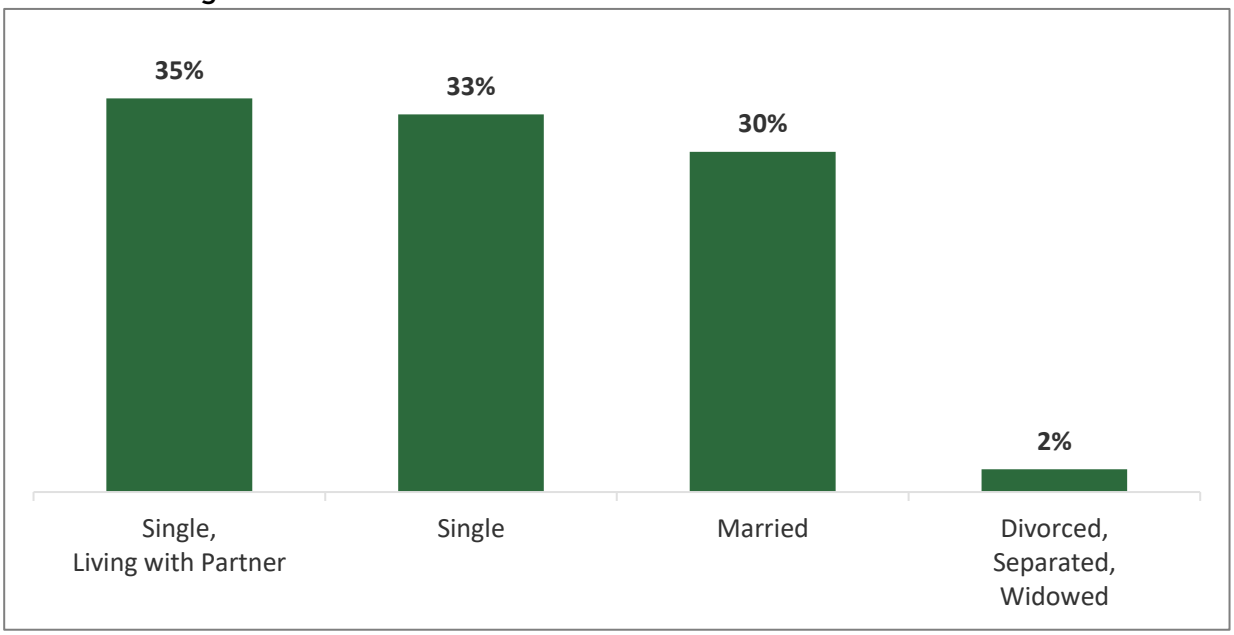


Exhibit 54. Caregiver Primary Language



The majority of primary caregivers are the birth mother accounting for over 99% of all families. Fathers, grandmothers, and other relatives are the primary caregiver in less than 1% of families. Most caregivers are single, with or without a partner, and 30% are married (Exhibit 55).

Exhibit 55. Caregiver Marital Status



Maternal Risk Factors

Mothers have certain risk factors than can lead to less favorable childhood outcomes. Healthy Families Arizona takes these risk factors into account during the screening process and tries to provide services to those at highest need. In the Healthy Families Arizona program, mothers have certain risk factors that are higher than the average rates for all mothers in the State of Arizona. Exhibit 56 presents selected risk factors for mothers compared with state rates.

Exhibit 56. Selected Risk Factors for Mothers

Risk Factors of Mothers	Healthy Families Arizona	Arizona
Teen Births (19 years or less)	11%	6%*
Births to Single Mothers	70%	45%*
Less Than High School Education	25%	16%*
Not Employed	62%	9%**
Median Yearly Income	$20,000	$44,512 **

Source: *2019 data from the Arizona Department of Health Services Vital Statistics records.
**U.S. Bureau of Labor Statistics, 2020 data.

The percentage of Healthy Families Arizona mothers – 11% - who are teenagers at time of birth continues to be higher than the rate of teen births for Arizona at 6%. The rate of teen mothers for the program (11%) slightly increased from 10% in FY 2020. There was decline in the percentage of mothers who are single at time of birth from 76% in FY 2020 to 70% in FY 2021. Currently in Arizona 16% of mothers with infants have less than a high school education while 25% of Healthy Families Arizona mothers have less than a high school education. The percent of Healthy Families Arizona mothers who are unemployed increased from 56% in FY 2020 to 62% in FY 2021. The median household income continues to be less than half of that for Arizona as a whole despite the overall decrease seen in 2020 as a result to unemployment from the COVID-19 pandemic. These data confirm that Healthy Families Arizona participants do represent an "at-risk" group of mothers and that the program has remained successful in recruiting families with multiple risk factors associated with child abuse and neglect and poor child health and developmental outcomes.

Healthy Families Arizona Home Visits in the Context of the COVID-19 Pandemic

This report covers the Healthy Families Arizona program from October 2020 through September 2021. During this time the program has functioned during a global pandemic caused by the COVID-19 virus. As a result of the varying impact of the COVID-19 pandemic, the Healthy Families Arizona program has continued to adapt their home visiting model. At the start of the COVID-19 pandemic, due to public health restrictions, home visits were switched from in-home to virtual visits through phone and video. Rural counties often encountered issues with cell phone and internet coverage making virtual visits more difficult. While many visits were still conducted virtually, other methods of socially distanced visits were used including porch visits, walking visits, park visits and other outdoor approaches.

Starting in June 2021 many sites began transitioning back to in-home visits where feasible. However, local outbreaks, family illness or exposure, staff illness or exposure, and local health recommendations caused some in-person home visits to either be cancelled or switched back to virtual. Exhibit 57 shows the variability across the sites in the proportion of home visits that were conducted virtually throughout the year.

Exhibit 57. Healthy Families Arizona Program Sites in Fiscal Year 2021

Site	Percent of home visits conducted virtually
Apache County / Navajo County	34.7%
Cochise County / Santa Cruz County	55.0%
Coconino County	26.0%
Graham County / Greenlee County	32.3%
Maricopa County	70.5%
Mohave County	45.1%
Pima County	67.9%
Pinal County (including Gila County)	45.1%
Prescott Valley (in Yavapai County)	34.3%
Verde Valley (in Yavapai County)	50.0%
Yuma County	73.9%
Statewide	63.4%

KEY HEALTHY FAMILIES ARIZONA SERVICES

The primary goals of reducing child maltreatment and improving child well-being are most attainable when families stay engaged in the program for an extended period of time and receive the services and support that they need. One important aspect of the Healthy Families Arizona program model is linking families with needed community resources. Home visitors provide not only assistance and guidance in the home, but they also connect families with education, employment and training resources, counseling and support services, public assistance, and health care services.

Developmental Screening and Referrals for Children

Developmental screens are used to measure a child's developmental progress and to identify potential developmental delays requiring specialist intervention. The primary screening tool used by home visitors is the Ages and Stages Questionnaire, Third Edition (ASQ-3). This tool helps parents assess the developmental status of their child across five areas: communication, gross motor, fine motor, problem solving, and personal/social.

The Healthy Families Arizona program administers the ASQ-3 at 4 and 9 months in the first year of the infant's life, with optional ones at 6 and 12 months. Then starting at 18 months every six months until the child is three years of age, and then yearly at age 4 and 5. Screenings can be scored as typical meaning that the child is developing on schedule, questionable which indicates that they may be behind in an area or delayed which indicates that there is a developmental delay in at least one area of child development that should be address. Referrals are given to families when a child scores as delayed.

A total of 4,724 ASQ-3 screenings were completed and entered into ETO between October 1, 2020 and September 30, 2021 for 2,781 children. Four out of five screenings showed typical childhood development (Exhibit 58). For the ASQ-3 screenings, 3,218 were marked in ETO as having received Healthy Families developmental activities. There were 302 referrals for services were made, a decline from 598 in FY 2020 (Exhibit 59).

Exhibit 58. Outcomes for ASQ-3 Screenings

Outcome	n	Percent
Delayed	311	6%
Questionable	643	14%
Typical	3,770	80%
Total	**4,724**	**100%**

Exhibit 59. Services and Referrals Provided for ASQ-3 Outcomes

Services/Referrals for ASQ-3 Outcomes	n*
Provide HF developmental activities	3,218
Referred to AzEIP or School District	169
Referred to other community services	17
Referred to primary care provider or doctor	116

*Multiple referrals can be given to families.

In addition to the ASQ-3, another measure of childhood development is the Ages & Stages Questionnaire: Social-Emotional (ASQ: SE-2). The ASQ: SE-2 is similar to the ASQ-3 but focuses on screening for social and emotional behaviors: self-regulation, compliance, social-communication, adaptive functioning, autonomy, affect, and interaction with people. The scoring is slightly different with Refer, Monitor, and No Concern as the final score designations. During October 1, 2020 through September 30, 2021, for 2,273 children a total of 3,066 ASQ: SE-2s were completed (Exhibit 60). More than 90% scored as no concern, with 157 suggesting a referral with a total of 139 referrals given to families.

Exhibit 60. Outcomes for ASQ-SE-2

Outcome	n	Percent
No concern	2,770	90%
Monitor	157	5%
Refer	139	5%
Total	**3,066**	**100%**

Substance Abuse Screening and Referrals

The relationship between substance abuse and the potential for child maltreatment is strong and well known (Garner et al, 2014). When parents or caretakers have a substance use disorder, children may not be adequately cared for or supervised. While successful substance abuse treatment often requires intensive inpatient or outpatient treatment and counseling, home visitors can still play a critical role in screening for substance abuse, educating families about the effects of substance abuse on their health and the health of their children, and making referrals for treatment services.

Healthy Families Arizona uses the Past 30-Day Alcohol, Tobacco, and Other Drug screening (Past 30-day ATOD) completed shortly after enrollment into the program to screen for substance use. From October 1, 2020 to September 30, 2021, a total of 903 ATOD screenings were completed with newly enrolled parents. Most families did not have current alcohol, tobacco, or drug use (760 families, 84%). The remaining 144 families had the following results:

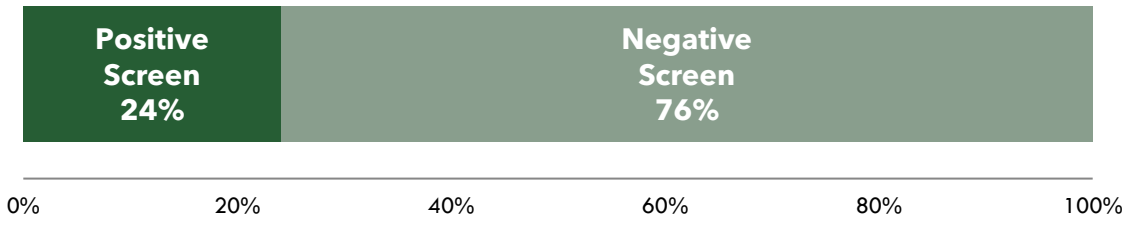
- 2 positive for alcohol, tobacco, and drug use
- 14 positive for alcohol and tobacco use
- 5 positive for alcohol and drug use
- 15 positive for alcohol only
- 70 positive for tobacco use only
- 15 positive for tobacco and drug use
- 22 positive for drug use only

In addition to the ATOD used at intake, two questions regarding the discussion of substance use with families and substance use/abuse referrals were added to the Parent Guardian Data collected every 6 months. From October 1, 2020 to September 30, 2021, home visitors discussed substance use with a total of 2,226 parents/guardians and 273 substance use referrals were made.

Postnatal Depression Screening

The Edinburgh Postnatal Depression Screen (EPDS) was developed for screening postpartum women in outpatient, home visiting settings, or at the 6–8-week postpartum examination. The EPDS consists of 10 questions scored from 0 to 3 by the parent. The overall screening is then scored and scores of 10 or higher are considered to be a positive screen for depression requiring a referral for services unless they are already receiving services to address their depression. Healthy Families Arizona requires that all families receive a screening within 3 months after the birth of each child. A total of 2,053 EPDSs were recorded in the ETO data system between October 1, 2020 and September 30, 2021 for 1,637 parents. This resulted in 495 positive screens with 360 referrals given to the parent (Exhibit 61). An additional 159 were already receiving services to address their depression prior to joining Healthy Families Arizona.

Exhibit 61. Edinburgh Postnatal Depression Screen Results



Child Abuse and Neglect: Collaboration with the Department of Child Safety

A primary goal of Healthy Families Arizona is to reduce the incidence of child maltreatment and abuse. As part of this, Healthy Families Arizona accepts referrals of families directly from Arizona DCS workers as well as the SENSE program. The SENSE program provides services to families after the birth of a substance exposed child. The families receive a coordinated Family Service Plan of which Healthy Families Arizona home visitation is a part of the plan. Healthy Families Arizona provides supportive services for these and other families involved with DCS.

Overall, from October 1, 2020 through September 30, 2021, 19% of all families that received services had some level of involvement with DCS (770 of the 4,090). This is a decrease from FY 2019 at 25% and the 20% in FY 2020. Of the families with DCS involvement, 361 had DCS or SENSE referrals, with the remaining 409 families referred to Healthy Families Arizona through systematic, community, or self-referrals. This is a higher proportion of family who were not DCS or SENSE referrals experiencing involvement with DCS than in prior years. Healthy Families Arizona served a total of 222 SENSE referred families during this time accounting for 29% of all DCS involved families, a decrease from 39% in FY 2020 and 41% in FY 2019. For newly enrolled families, only 58 of the 1,386 new families were SENSE referrals (4%). Healthy Families Arizona supportive services include:

- Acceptance of referrals from DCS;
- Providing screening and assessment for parent(s) if the parent(s) wished to determine eligibility to receive program services;
- Attending DCS case plan staffing;
- Utilizing best practices and a family-centered approach when working with families; and
- Coordinating with DCS staff to identify service needs and development of family and child goals.

FAMILY OUTCOMES

Caregiver Outcomes

While reducing child abuse and neglect is the ultimate outcome, intermediate objectives, such as changes in parenting behaviors, can inform us about progress toward the ultimate goal. The intermediate goals of the Healthy Families Arizona program revolve around key factors known to be critical in protecting children from maltreatment (Jacobs, 2005):

- Providing support for the family;
- Having a positive influence on parent-child interactions;
- Improving parenting skills and abilities and sense of confidence; and
- Promoting the parents' healthy functioning.

Research from randomized clinical trials of the Healthy Families Arizona program (see LeCroy & Krysik, 2011, LeCroy & Davis, 2016) supports the finding that the program can produce positive changes across multiple outcome domains such as parenting support, parenting attitudes and practices, violent parenting behavior, mental health and coping, and maternal outcomes.

Healthy Families Parenting Inventory

The Healthy Families Parenting Inventory (HFPI) is a 63-item instrument that measures family outcomes across nine domains: social support, problem-solving/coping, depression, personal care, mobilizing resources, role satisfaction, parent/child interaction, home environment, and parenting efficacy. The HFPI was developed in 2004 to better evaluate critical goals of the Healthy Families program (LeCroy, Krysik, & Milligan, 2007), in part, because of measurement difficulties identified in the literature (LeCroy & Krysik, 2010). The development of the HFPI was guided by several perspectives and sources: the experience of the home visitors in the Healthy Families Arizona program; data gathered directly from home visitors, supervisors, and experts; information obtained from previous studies of the Healthy Families program; and examination of other similar measures. A validation study showed that the pattern of inter-item and item-to-subscale correlations, as well as an exploratory factor analysis and sensitivity to change analysis, supported the nine-factor model of the HFPI (Krysik & LeCroy, 2012). A recent validation study showed that pre-intervention HFPI composite and subscale scores demonstrated incremental predictive validity of a future official maltreatment report (Kelly & LeCroy, 2022). This study demonstrates that the HFPI can be used successfully during home visitation at the time of program initiation to suggest needs and services that reduce the likelihood child maltreatment, and aid in the prediction of future child abuse and neglect.

Change in HFPI Subscales from Baseline to 14-Months Post

The evaluation team conducted paired *t-tests* for each HFPI subscales. Significance levels (*p*-value) and effect sizes (Cohen's *d*) are shown in Exhibit 62. An effect size gives a sense of how large the improvement is from baseline to follow-up. Effect sizes below 0.20 are considered small changes and those between 0.20 and 0.50 are considered small to medium changes. This analysis was performed with data from participants who completed the HFPI at baseline, approximately two months post enrollment into the program, and 12-months later when the family had been enrolled for approximately 14 months. N-values vary if a participant did not fully complete a subscale, as their total score for that subscale was excluded from the analysis.

From baseline to 14-months post enrollment, there were statistically significant improvements observed for four subscales: **Home Environment, Mobilizing Resources, Personal Care, and Problem Solving**. In prior years, significant improvements have also been consistently observed in Depression, Parent Self-Efficacy, Role Satisfaction, and Parent-Child Interaction. The evaluation team speculates that these changes may be related factors impacted by the COVID-19 pandemic. Families have faced unprecedented challenges during the pandemic that have likely impacted their mental health, satisfaction with being a caregiver, and their relationship with their child. Another possible impact could be the difference in how the HFPI was administered during virtual home visits. Virtually, home visitors read caregivers the questions in an interview style, rather than when parents completed the instrument on paper during in person visits. Overall, the results indicate that the Healthy Families Arizona program is effective at improving the home environment, connecting parents to resources, improving their sense of self care, and helping to strengthen problem-solving skills. The evaluation team will continue to explore how the HFPI changes over time, as communities recover from the pandemic.

Exhibit 62. Change in Subscales of the HFPI from Baseline to 14 Months Post

HFPI Subscale	Total Possible Score	Average Score at Baseline	Average Score at 14 Months Post Baseline	Change in Average Score	P-Value (Two-Sided)	Cohen's d (Effect Size)	N
Home Environment	50	42.5	44.8	+2.2 ↑	<0.001*	-0.367	502
Mobilizing Resources	30	24.4	25.4	+1.0 ↑	<0.001*	-0.202	501
Personal Care	25	18.8	19.4	+0.6 ↑	<0.001*	-0.149	501
Problem Solving	30	24.3	24.6	+0.3 ↑	0.033*	-0.095	501
Depression	45	39.4	39.7	+0.3 ↑	0.358	-0.041	502
Parent Self-Efficacy	30	25.9	26.0	+0.1 ↑	0.360	-0.041	501
Role Satisfaction	30	26.0	25.8	-0.2 ↓	0.360	0.041	502
Parent-Child Interaction	50	45.8	45.6	-0.2 ↓	0.389	0.038	502
Social Support	25	22.0	22.0	0.0 =	0.943	-0.003	502

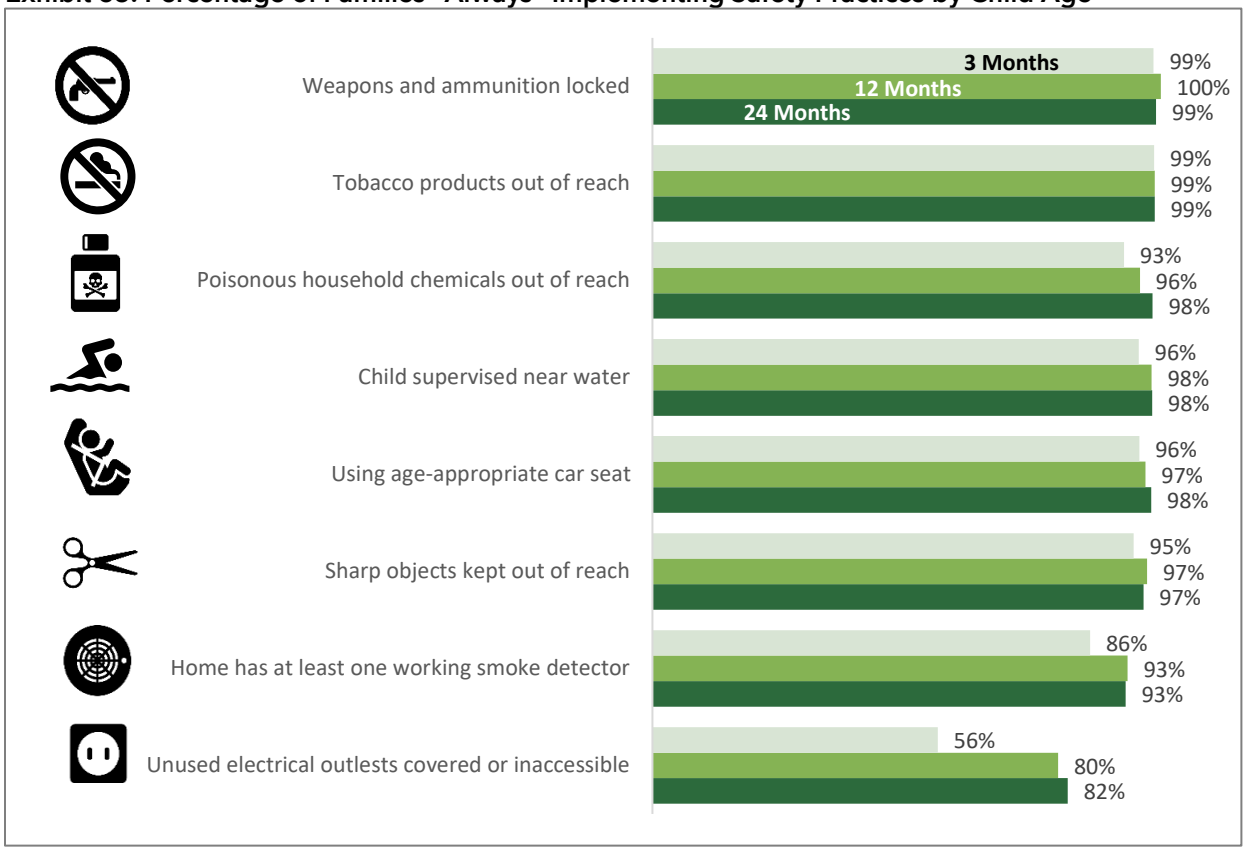
*Statistically significant at the 0.05 level.

Safety Practices in the Home

Unintentional injuries are the fifth leading cause of death for infants under the age of 1 year according to the CDC. Suffocation is the leading cause of preventable infant deaths. One of the first messages that Healthy Families Arizona home visitors deliver to families is the importance of safe sleep practices for infants. All families receive this information within the first couple of visits and it continues to be a topic of discussion throughout their home visits. The Healthy Families Arizona home visitors assess and provide education to families about safe home environments for children by completing the Safety Checklist with them. From October 1, 2020 to September 30, 2021 a total of 2,312 had safety checklist information entered into ETO.

Exhibit 63 shows the various safety practices reported as "always" being followed, based on the age of the child. Safety areas that most families always implement regardless of child age include children being supervised near water, sharp options are kept out of reach, age-appropriate car seats are correctly installed, and tobacco products and related items (matches and lighters) are kept out of reach. The one safety area that could potentially be improved is covering unused electrical outlets. While this is less of an issue for parents of infants, given the mobility of older children, home visitors should encourage this practice.

Exhibit 63. Percentage of Families "Always" Implementing Safety Practices by Child Age



Child Maltreatment

One of the main goals of Healthy Families Arizona is to reduce the incidence of child maltreatment, inclusive of all forms of child abuse and neglect. In order to look at child maltreatment directly, data from CHILDS, the Arizona Department of Child Safety data system, is used to determine the rates for Healthy Families Arizona participants. It is important to acknowledge that using official child abuse and neglect data as an indicator of program success is complex and is unlikely to fully answer the question about the effectiveness of Healthy Families Arizona in preventing child maltreatment. The shortcomings in using official child maltreatment rates to assess the effectiveness of home visiting programs have been discussed in numerous journal articles (see for example, *The Future of Children*, 2009). This data was not available at the time of this reporting. Pending data availability, child maltreatment outcomes will be examined in future evaluation reports.

CONCLUSIONS AND RECOMMENDATIONS

Healthy Families Arizona is in its 30th year of service to families. This report covered October 1, 2020 through September 30, 2021 and covered a period of the COVID-19 pandemic both pre and post vaccine availability. The impact of the pandemic on home visiting was multi-fold. The limited access to hospitals led to a continued decrease in the number of enrollments into the program coming from systematic referrals. The increased number of enrollments from community referrals during this time is a testament to the importance of home visitation in the minds of community organizations. Healthy Families Arizona staff at all levels have continued to step up and meet the challenges of the pandemic including the fluctuation between virtual and in-person home visits with families. A total of 4,090 families received services from the Healthy Families Arizona program in FY 2021, a slight decrease from prior years which may be due to the continued impact of the pandemic. The following conclusions and recommendations are put forth to Healthy Families Arizona to consider in 2022.

Focus for 2022: Normalizing In-Person Home Visitation

Virtual home visiting has made conducting screenings and assessments more difficult and some were not completed. As staff return to in-person visits, efforts should be made to emphasize the importance of assessments as a way to provide families with information about themselves and help home visitors to support them in the best ways possible. Information from screenings and assessments should be used by staff and supervisors to develop service plans for the families and chose appropriate curricula to share with them.

Similar to home visiting, since the start of the pandemic, many families have not had the same level of interaction with medical providers or community services. Reduced interaction has resulted in a decrease in children who are up to date with their immunizations and well child visits. Due to the lack of information available during 2020 and 2021 on immunization rates and well child visits, this data is not included in the annual evaluation report. As communities recover from the pandemic, the evaluation team recommends that home visitors continue to emphasize the importance of regular health care for their children and provide additional information and support to families who need it.

COVID-19 may continue to impact home visitation in 2022, but staff and supervisors have gained experience in maintaining relationships with families during shifts from virtual to in-person visits. Staff and supervisors will continue to need additional support from their agencies and Central Administration to help balance the needs of families with their own needs. Wide-spread accommodations for working from home or in the office, along with reasonable expectations for work flexibility for the safety and comfort of the staff and families, will help staff feel better appreciated and supported.

Focus for 2022: Exploring Staff Retention Strategies

In this past year, staff retention has been a much larger issue than previous years. More than 10% of staff positions were unfilled at the end of the fiscal year with many having been vacant for months. As staff leave the Healthy Families Arizona program, it has been difficult to hire new staff. Some common themes that came up this year from staff surveys and discussions around retention is that the job "feels bigger" and that the pay is inadequate to retain and hire staff. Recommendations for improving staff retention include:

- Allowing for regular cost of living increases annually rather than having to remain at flat rates for the full three-to-five-year contracts;
- Exploring staff satisfaction and its impact on retention as part of the Healthy Families Arizona 2022 equity plan. Staff and family surveys administered in 2022 will include questions about cultural humility, diversity, equity, inclusion, and belonging.
- Exploring creative ideas for expanding staff resources to make their jobs easier, such as new curricula, trainings, and technology to provide a morale boost for staff;
- Finding ways to balance at-home and in-office workspaces for staff and provide them additional support and recognition for their work.

Focus for 2022: National Re-Accreditation and Equity Planning

Healthy Families Arizona will start the re-accreditation process in the Fall of 2022. Several annual and bi-annual data reports will be prepared to support this process at the Central Administration Office and site levels. The sites made good progress in 2021 in correcting errors and omissions in data entered into ETO. Regular reviews of missing and incomplete data should continue to occur this year to provide the best data for the site visitors to review and to continue to make program improvements to best support staff and families. Work will to continue in ETO to develop useful and accurate reports in order to reduce the burden of preparing for the re-accreditation process now and in the future.

Additionally, the evaluation team will collaborate with Central Administration and sites to ensure that evaluation efforts in 2022 meet recent changes to the HFA Best Practice Standards for State and Multi-Site Systems. The evaluation team will support Central Administration and sub-committees in developing an equity plan. The equity plan will incorporate a summary of site and staff input, as well as what the program learns by completing a formal self-assessment tool related to diversity, equity, inclusion, and belonging (DEIB). The equity plan will set a course for continuous improvement to achieve greater equity in all aspects of its functional areas (policy, training, technical assistance, quality assurance, evaluation, and administration) and takes into account the culture of those it supports.

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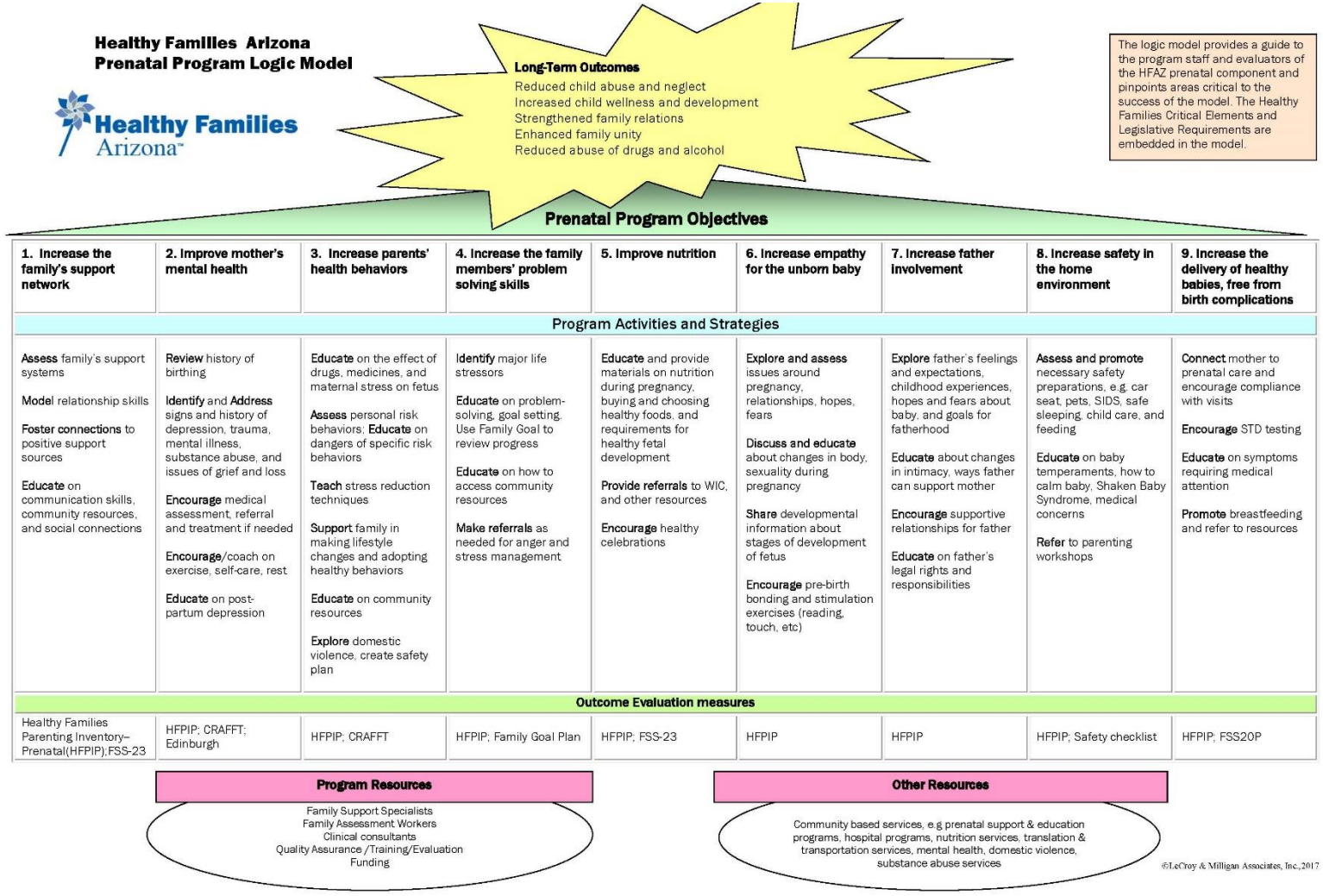
APPENDIX A. HEALTHY FAMILIES ARIZONA PRENATAL LOGIC MODEL



APPENDIX B. HEALTHY FAMILIES ARIZONA POSTNATAL LOGIC MODEL