Healthy Families Arizona Annual Evaluation Report

October 2021 – September 2022

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LeCroy & Milligan
ASSOCIATES, INC.

Healthy Families Arizona Annual Evaluation Report: October 2021 - September 2022

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Acknowledgments:

This evaluation report represents the efforts of many individuals and many collaborating organizations. The evaluation team that contributed to this report includes Michele Schmidt, MPA, Olga Valenzuela, BA, Michel Lahti, PhD, Craig LeCroy, PhD, Elizabeth Hardesty, MPH, and Frankie Valenzuela. We extend appreciation to Healthy Families Arizona Central Administration, in the Office of Prevention for their guidance and support. The members of the Healthy Families Arizona Advisory Board are thanked for their long-term commitment, enthusiasm, and leadership in Arizona. Thank you to the Healthy Families Arizona program managers and supervisors who have worked diligently to ensure data is collected, submitted, and shared with staff for program improvement. Family Assessment Workers, Family Support Specialists, and support staff at the sites have dutifully collected the data and have participated in the evaluation process--all of whom help to tell an accurate story about Healthy Families Arizona. Finally, we acknowledge the families who have received Healthy Families Arizona services.

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Founded in 1991, LeCroy & Milligan Associates, Inc. is a consulting firm specializing in social services and education program evaluation and training that is comprehensive, research-driven, and useful. Our goal is to provide effective program evaluation and training that enables stakeholders to document outcomes, provide accountability, and engage in continuous program improvement. With central offices located in Tucson, Arizona, LeCroy & Milligan Associates has worked at the local, state, and national level with a broad spectrum of social services, criminal justice, education, and behavioral health programs.

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EXECUTIVE SUMMARY

Healthy Families Arizona (HFAz) was established in 1991 by the Arizona Department of Economic Security (DES) as a home visitation service for at-risk families. HFAz is currently housed at the Arizona Department of Child Safety (DCS) and is in its 31st year. The HFAz program is accredited by Prevent Child Abuse America and is modeled after the Healthy Families America (HFA) initiative. The HFA program model is designed to promote positive parenting, enhance child health and development, and prevent child abuse and neglect. 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 participating families. By providing services to under-resourced, stressed, and over-burdened families, the HFAz program fits into a continuum of services provided to support Arizona families.

LeCroy & Milligan Associates, Inc. (LMA) is contracted by DCS to provide evaluation services for the HFAz program. This report covers the State Fiscal Year reporting period of October 1, 2021 through September 30, 2022 (FY22). The purpose of this annual evaluation report is to provide information on program process, implementation, and family outcomes that demonstrate program success and can be used to guide program improvement.

Families Served

HFAz served a total of 3,540 families in FY22, reaching all 15 counties. Services were provided by 11 HFAz program sites, which are made up of 44 Family Support Specialist (FSS) home visitor teams, and three Family Assessment Worker (FAW) teams.

- 38% of these families were enrolled in FY22. Community referrals accounted for 48% of families referred and systematic screenings referred 35% of families.
- 99% of primary caregivers are the birth mothers of children and 62% are single parents.
- Caregiver age at enrollment ranged widely from 13 to 61 years (average of 27 years). 10% were young/teen parents (19 years or less).
- 77% of caregivers identified as White/Caucasian and 56% identified as Hispanic.
- 75% speak English as their primary language, while 19% primarily speak Spanish.

Program Funding

In FY22, funding for HFAz totaled $28,090,843, including $10 million from the Governor's Office General Fund/Health Families Expansion (GOF/HFE); $7.7 million from DCS/Lottery funds; $6.2 million from Arizona's First Things First; $2.3 million from DHS MIECHV; and $1.7 million from the State Opioid Response funds. GOF/HFE funds were available in July 2022, two months before the close of FY22, thus it is anticipated that these funds will impact the number of families served and service areas covered in FY23.

Family Participation

Family participated in HFAz in FY22 at rates consistent to pre-pandemic levels in FY19.

- Families participated in HFAz for a **median of 13 months**, higher than the median number of months in previous years (10 months in FY21 and FY20, and 12 months in FY19).
- **31% of families** participated in HFAz for **24 months or more**, which is the highest rate observed for this length of time compared to the past three years (28% in FY21, 26% in FY20, and 29% in FY19).
- Of the families that closed in FY22, **28% received 24 months or more of services**, an improvement to pre-pandemic levels (25% in FY21, 21% in FY20, and 28% in FY19).
- **16% of families closed in FY22 because they completed the program**, as determined by their home visitor. This completion rate is an increase from the past two years (14% in FY21, 12% in FY20) and is consistent with pre-pandemic levels (16% in FY19).
- Families who completed the program spent **a significantly longer amount of time –** an average of **49 months** (just over four years) **–** in HFAz, compared to families who exited after an average of 12 months due to a non-completion reason.

A total of 53,101 visits were conducted statewide for the 11 program sites and 44 teams.

- **84% of visits statewide were completed in person**, either in the family's home or a community location. Across all program sites, two thirds or more of visits (62% to 91%) were conducted in person. HFAz continues to offer the use of virtual visits based on health needs; however, HFAz requires that families participate through videoconferencing.
- **16% of visits statewide were conducted virtually**, which is a significant decrease from 63% conducted virtually in FY21. This decreased trend is consistent across all program sites. The percentage of virtual visits in FY22 ranged across sites from 9% to 38%. These changes coincide with the lifting of public restrictions due to the pandemic.

Statewide, HFAz had a **family closure rate of 40% and a retention rate of 60% of families who remained active in the program going into FY23**. Site retention rates ranged from 46% to 72%. Most program sites across Arizona retained at least 60% of their families going into FY23.

Program Implementation Highlights

Statewide Accreditation Site Visit – The HFA accreditation site visit for HFAz Central Administration took place over four days in November 2022. All outlined standards were met or exceeded in the areas of training, technical assistance, and evaluation. HFAz was out of adherence for nine standards (six were related to policy, two were quality assurance, and one was administration). HFAz will respond to an HFA panel on these areas and will report on how they have been addressed.

Program Site Visits by HFAz Central Administration - The Site Visit Survey was developed to gather feedback from staff who participated in site visits with HFAz Central Administration. Survey data was collected online in October 2022, voluntarily and anonymously. A total of 31 HFAz staff completed the, representing 11 teams. Most staff rated all areas measured as good or excellent. Most staff felt that there was adequate time for discussion and questions during the visit's exit meeting and they had an overall positive impression of the site visit. Staff appreciated the helpfulness of feedback, the opportunity to learn and improve, and the general site visit process.

Annual Equity Plan Development – As part of the HFA *Best Practice Standards*, HFAz completed statewide and site level equity plans for implementation in FY23. Central Administration made intentional efforts to support equity plan development and implementation. The evaluation team and HFAz leadership revised the annual Caregiver Survey to include questions on diversity, equity, inclusion, and belonging (DEIB). Enhanced data collection efforts and use of incentives increased the survey response rate to 48%, compared to 35% in FY21. Caregiver Survey and staff interview data will be collected in FY23 to inform equity plan revisions.

Staff Retention Efforts – HFAz experienced fewer – 68 – staff position changes in this past year compared to 89 position changes in FY21. At the end of FY22, 28 staff positions remained open compared to 32 in FY21. The following data demonstrates the program's staff retention efforts.

- $6.1 million of GOF/HFE funds were allocated to sites for hiring additional staff.
- $3 million of GOF/HFE funds were allocated for unit rate increases for staff salaries.
- Programs have regular team-building activities and gatherings outside of work, which has increased comradery and helped staff to feel more valued and supported.
- Respondents to the annual Staff Survey highly regard their supervisors. Nearly all respondents agreed that their supervisor respects them and that supervision helps them determine ways to work with challenging families and situations. Almost all staff also agreed with statements about positive relationships with team members. Reasons respondents stay in their position are because they enjoy working with families, making a positive impact in their community, job flexibility, and feel supported by supervisors.

Outcomes for Families and Children

Child Development Screening and Referrals - A total of **3,745 Ages and Stages Questionnaire 3rd Edition (ASQ-3) screenings** were conducted in FY22 for **2,223 children**, including the target child and subsequent children who are served by HFAz. Children received between one and five screenings, depending on the outcome of their initial and subsequent screenings. For all screening time points, 79% screened in the typical range, 14% were questionable, and 7% were identified as delayed. Of the 270 cases that were screened as delayed, 81% were referred to services and 7% were already receiving services. In 12% of cases, documentation in ETO did not indicate that these referrals were completed.

A total of **2,143 ASQ Social Emotional, 2nd Edition (ASQ: SE-2) were completed in FY22 with 1,712 children across four time points**. Most children (88%) showed no concern in social-emotional areas, 6% needed additional monitoring, and 6% needed a referral to services. Of children screened as needing a referral, 48% were referred to services, 8% were already receiving services, and 44% did not have a referral documented in ETO.

Postnatal Depression Screening and Referrals - A total of **1,804 Edinburgh Postnatal Depression Screens** were completed in FY22 with **1,452 parents**. Parents received between one and four screens, with most receiving only one screening. Across all time points, 76% of screens were negative and 24% were positive. Of the 431 parents who screened positive, 67% received a referral that was accepted by the parent, 25% were already receiving services, 1% declined the referral given, and 7% did not have a referral documented in ETO. **Of adults referred to services, 55% engaged in the service and 30% had services that were pending or soon to start.** In 5% of cases the adult refused services or did not take action on the referral, and in 4% of cases the service was full, not accessible (e.g., cost prohibitive, lack of insurance), or the person was not eligible for services. Additionally, 7% of records did not have a referral outcome documented in ETO.

Substance Abuse Screening and Referrals - **766 Past 30-day Alcohol, Tobacco, and Other Drug (ATOD)** screenings were completed with newly enrolled parents. **Most parents at enrollment did not report current alcohol (97% screened negative), tobacco (88% screened negative), or drug use (97% screened negative).** The highest positive screen rate was for tobacco use at 12%. Of positive tobacco screens, 59% received a referral for tobacco cessation services, 3% were already receiving services, and 38% did not have a referral recorded into ETO. Of the adults who discussed substance use with their home visitor at program intake, 12% received a referral for substance use services.

For all child and adult screenings, it is unclear why referrals were not documented into ETO. It may be due to them already receiving such services, but this finding suggests an area for further consideration and program improvement.

Change in Parenting Behaviors and Family Outcomes - From baseline to approximately 12 months post, caregiver data collected from the Healthy Families Parenting Inventory (HFPI) showed statistically significant improvements in **total HFPI Scores** and **four Subscales**. **Families showed improvement in the home environment, connection to resources, self-care, and problem-solving skills**. The evaluation team will continue to explore how HFPI results change over time, as families continue to recover from the pandemic.

Safety Practices in the Home - In FY22, a total of **2,036 families had a safety checklist** administered prenatally and/or postnatally at three months through 60 months, based on the child's age. **Safety areas that most families implement regardless of child age include**: children being supervised near water, age-appropriate car seats are correctly installed, tobacco products and sharp objects are kept out of reach, and weapons and ammunition are locked. **Safety areas that could potentially be improved include**: the home has at least one working smoke detector, poisonous household chemicals are kept out of reach, and unused electrical outlets are covered.

Child Maltreatment Prevention – Families that received at least six months of HFAz services were included in the matching and analysis to determine if they had a substantiated report of child abuse or neglect. The evaluation team performed a matching process with DCS administrative data using HFAz caregiver/parent first name, last name, and date of birth. **Overall, 96.9% of families served in FY22 who received at least six months of services did not have a substantiated child maltreatment report from six months post enrollment to the program.** A total of **3.1% of families** served in FY22 had a substantiated report at some point after they had received at least six months of HFAz services. This substantiation rate of 3.1% is slightly lower but consistent with substantiation rates reported in FY20 at 3.7% and FY19 and FY18 at 3.6% (DCS data was not available for the FY21 report).

Recommendations for Program Implementation

LMA respectfully puts forth the following programmatic recommendations for HFAz Central Administration's consideration, based on evaluation data reported this year.

- **Referrals to Services** - A portion of children and adults who screened positive in various areas did not have documentation in ETO that a referral was made. It is unclear why referrals were not made. It is possible that the individual was already receiving services or that they refused services. It is also possible that a referral was made but not recorded in ETO. Because of the critical importance of screenings and referrals to interventions external to HFAz, Central Administration and program leadership may want to explore this area to ensure that staff are clear on referral processes and are making and documenting appropriate referrals to services. LMA could collaborate with HFAz and ETO Administrators, as requested, to explore the referral data and process, to determine if data collection and entry steps could improve the accuracy of results.

- **Data Entry and Quality Checks** - Central Administration and ETO Administrators could continue to provide training and technical assistance for staff in entering data into ETO, data cleaning, and quality checks. Examples of data quality check needs observed by the evaluation team include ensuring assessment dates are accurate, that assessments are entered in a timely manner, and that referrals made are documented into ETO.
- **Measuring Family Outcomes in 6-Month Intervals** – Based on the recommended frequency of administration in the *HFPI User Manual* (LeCroy & Milligan, 2017), HFAz may want to consider collecting baseline HFPI data as close to program enrollment as possible to provide a "true" baseline of the participant without intervention. The program could also consider collecting data at six-months after baseline, which HFPI data from similar evaluations has shown the most change in subscale scores. Home visitors can utilize HFPI data to identify family strengths, concerns, and solutions that can be incorporated into service plans. LMA will continue providing staff with additional training on the HFPI administration and use with families in FY23.
- **Supporting Families in Pandemic Recovery** – HFPI subscales where less or no improvement was observed could indicate areas where additional resources and support could help families navigate this critical, pandemic recovery environment. For example, in areas of Depression, Parent Self-Efficacy, Role Satisfaction, and Parent-Child Interaction more resources or referrals may be needed. Research shows that mental health needs have dramatically increased since the start of the pandemic, so HFAz could consider enhancing this referral process.
- **Strengthen Referrals from DCS/SENSE to HFAz** - The ADHS 2022 Child Fatality Review Team's recommendations to prevent child abuse and neglect related deaths include increasing home visiting programs throughout the state**.** In FY22, 7% of families were referred to HFAz directly from DCS (3%) and the SENSE program (4%). Given the recommendation of increasing home visiting, HFAz and DCS programs could collaborate to determine ways to increase referrals of families involved in DCS to HFAz.
- **Recognizing Family Language and Culture** – According to the annual Caregiver Survey, Hispanic/Spanish-speaking families and families who speak a language other than English or Spanish would like more materials available in their language and more relevant to their family's culture. Staff Survey respondents suggested the following equity areas as in need of improvement: the program could provide services to families in languages they can speak and read; the program may wish to utilize a variety of curricula to meet the needs of families; and materials shared with families could represent their varying racial and ethnic backgrounds. HFAz could also consider providing home visitors with additional training on specific cultural values and norms of families served.

- **Family Engagement in Services** - While the overall findings from the Caregiver Survey are positive, suggesting Caregivers appreciate the HFAz program, a few findings indicate areas for improvement. Families would like more activities, access to community resources, and outdoor events. Families are also interested in opportunities to meet other families who participate in HFAz, such as group meetings. In addition, there is interest in more information and resources particular to their child's needs. Some families requested additional or longer home visits. Caregivers who reported having a shorter average visit length on the survey (45 minutes or less) were significantly more likely than those with longer visits (46 minutes or more) to have felt that their home visitor "sometimes" or "never" spent enough time with them during visits. To optimize a family's experience, home visitors should continue to strive to meet the HFA Best Practice Standard of holding visits that are 45 minutes or longer.

- **Continue to Refine and Enhance the Site Visit Process -** Staff who completed the Site Visit Survey suggested several areas for continued enhancement of the site visit process. Recommendations include: providing feedback from a neutral person who is not a site/team member; providing feedback in person; clarifying the file review process; and incorporating food into site visits.

- **Explore and Continue to Implement Recommendations Provided by Staff–** Data from the Staff Survey and Staff Exit Survey indicate areas that matter to staff and that HFAz may wish to explore, as feasible, to enhance retention and program improvement efforts. For example, the following areas are important for staff retention: salary (which was enhanced by additional GOF/HFE funding), time off, self-care strategies, employee appreciation, team building, continuing education for advanced degrees, and opportunities for career growth. HFAz could continue to provide staff training in areas important to staff, including family engagement strategies, working with high needs families, and balancing paperwork with family relationship-building. Data collected from staff also suggested areas where operational/process/leadership improvements could be helpful in their work. Staff recommendations reviewed in this report could be considered by HFAz Central Administration and leadership as ways to further improve staff retention and satisfaction.

Recommendations for Evaluation

LMA puts forth the following recommended focus areas for the FY23 evaluation of HFAz. LMA proposes to evaluate equity plan implementation as part of the FY23 process evaluation to identify ways to improve subsequent equity plan development. HFAz Central Administration and the evaluation team could revise the annual Staff Survey to better inform equity plan updates and strategies for staff retention. Staff Exit Survey data collection strategies could also be reviewed to improve response rates.

INTRODUCTION

Healthy Families Arizona (HFAz) was established in 1991 by the Arizona Department of Economic Security (DES) as a home visitation service for at-risk families. HFAz is housed at the Arizona Department of Child Safety (DCS) and, in its 31st year, served a total of 3,540 families, reaching all 15 counties. The HFAz program is accredited by Prevent Child Abuse America and is modeled after the Healthy Families America (HFA) initiative. HFA is an approved "evidence-based early childhood home visiting service delivery model" by the US Department of Health and Human Services and has been designated as "well-supported" (the highest rating) by the Title IV-E Prevention Services Clearinghouse. The HFA program model is designed to promote positive parenting, enhance child health and development, and prevent child abuse and neglect. 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 participating families. By providing services to under-resourced, stressed, and overburdened families, the HFAz program fits into a continuum of services provided to support Arizona families.

LeCroy & Milligan Associates, Inc. (LMA) is contracted by DCS to provide evaluation services for the HFAz program. This report covers the State Fiscal Year reporting period of 10/1/2021 to 9/30/2022 (FY22). The purpose of this annual evaluation report is to provide information on program process and implementation, performance measures, and family outcomes that demonstrate program success and can be used to guide program improvement. When possible, this report compares evaluation data across a four-year time frame from FY19 to FY22 to assess changes experienced by the program from pre-COVID-19 pandemic (FY19) to active pandemic (FY20-FY21) and pandemic management and recovery (FY22).

Healthy Families Arizona Statewide System and Funding

HFAz is an affiliate of the HFA State/Multi-Site system. Central Administration for all accredited HFAz 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 HFAz logic model for prenatal and postnatal families is shown in Appendix A and B.

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

Funding for HFAz in FY22 totaled $28,090,843. Funding sources and amounts are shown in Exhibit 2. Beginning July 1, 2022, HFAz received $10 million from the Governor's Office Fund (GOF/HFE) to build infrastructure to expand the HFAz program. As the GOF/HFE funds became available two months before the close of FY22, it is anticipated that these funds will impact the number of families served and the service area covered in FY23. In FY22, $6.1 million of GOF/HFE funds was allocated for sites to hire additional staff, helping to alleviate a general concern expressed in the past two years about staff turnover; $3 million was allocated for unit rate increases for staff salaries, which helped to address staff concerns expressed in survey data about low salaries; and $900,000 was allocated for administrative, training, and evaluation.

Exhibit 2. Funding Sources for Healthy Families Arizona, FY22

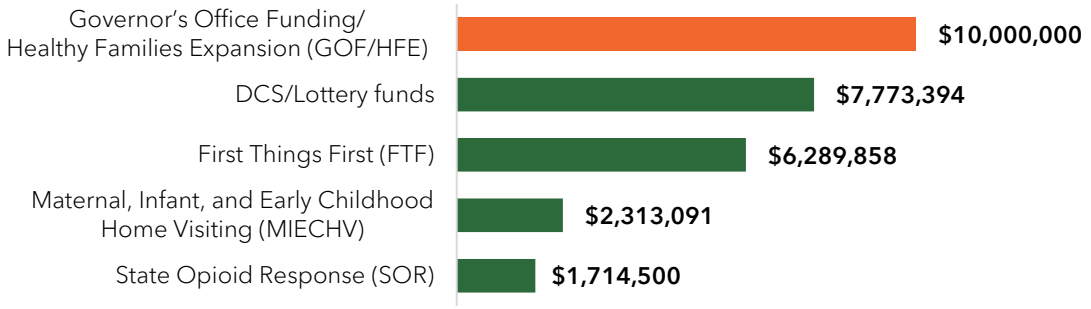


Exhibit 3 shows a summary of funding data, demonstrating how HFAz has diversified and expanded funding support over time. A cost benefit study of home visitation programs in Arizona found that Arizona receives $1.87 in benefits for every $1 invested in its early childhood home visitation programs (Evans & Shoemaker, 2016).

Exhibit 3. Healthy Families Arizona Funding Sources and Amounts, FY08 to FY22

Year	Total Funding	DES/DCS	FTF	MIECHV	SOR	GOF/HFE
2008	$18 Million	$18M				
2009	$6.1 Million	$6.1M				
2010	$12.3 Million	$6M	$6.3M			
2011	$12.5 Million	$6.5M	$6M			
2012	$12.4 Million	$6.3M	$5.9M	$117,212		
2013	$14.2 Million	$6.6M	$5.6M	$2M		
2014	$16.3 Million	$6.6M	$6M	$3.7M		
2015	$17.9 Million	$7.2M	$5.9M	$4.8M		
2016	$15.9 Million	$6M	$4.5M	$5.4M		
2017	$18.1 Million	$9.8M	$4.2M	$4M		
2018	$16.0 Million	$8.2M	$4.2M	$3.5M		
2019	$18.6 Million	$8.9M	$6.1M	$3.6M		
2020	$20.0 Million	$8.4M	$6.1M	$3.4M	$2.1M	
2021	$18.4 Million	$7.8M	$6.5M	$2.4M	$1.6M	
2022	$28.0 Million	$7.8M	$6.3M	$2.3M	$1.7M	$10M

Report Overview

This report is organized into the following sections:

Evaluation Design

Overview of the HFAz evaluation design and guiding questions for the process and outcome components.

Review of Child Well-being Indicators in Arizona

Updated national and state level indicators of child well-being across four domains: economic well-being, education, health, and family and community from the Annie E. Casey Foundation's *2022 KIDS COUNT Data Book* and state level report.

Updates in Home Visiting

A review of recent literature on home visitation and health equity, virtual service delivery, and father engagement.

Program Participation and Family Characteristics

Data on families served, program enrollment, activity, participation, and retention. Caregiver demographics. Maternal risk factors.

Program Implementation

Updates on the HFAz program from Central Administration. Program staffing (retention, training and professional development, staff survey results, site visit survey results, staff exit survey results). Persectives from families (caregiver survey results).

Program Outcomes

Results from key child and adult screening and prevention services. Changes in parenting and family outcomes from baseline to 12 month follow-up, measured by the Healthy Families Parenting Inventory; home safety practices; and child maltreatment data from Arizona DCS.

Recommendations

Recommendations are provided for and program improvement and evaluation focus areas in FY23.

EVALUATION DESIGN

The FY22 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 HFAz program; and the effectiveness of the HFAz model in terms of legislated outcomes.

Process Evaluation

The process evaluation describes how the program is implemented, as well as program outputs recorded in ETO. The process evaluation gathers information about statewide program implementation. The key guiding questions for the process evaluation include:

- What are the characteristics of the families participating in the HFAz Program? What are the targeted populations for referral to the program? What are the patterns of service delivery of HFAz to families (e.g., timing, frequency, format, purpose)?
- What is the program's process of developing an equity plan for FY22? Is the program being implemented in line with HFA Best Practice Standards?
- What changes have taken place in the statewide system that impact program delivery and/or outcomes? What are the impediments to implementing the HFAz Program?
- What training did HFAz staff receive from Central Administration? To what extent does HFAz ensure that staff receive the required training?
- Are families and staff satisfied with the HFAz Program? How is retention of families and staff impacted?

Program implementation data on families served were collected ongoing by staff through data collection forms that were entered into ETO. Process evaluation data was also collected by the evaluation team from program staff, supervisors, managers, and HFAz Central Administration through discussions at various meetings and survey data. Process data is used for program monitoring and improvement on a regular basis. Process data reviewed in this report include:

- Family characteristics (e.g., race/ethnicity, language, education, age, income)
- Number of families and children served
- Program referral, enrollment, activity, retention, and closure
- Caregiver satisfaction with the program
- Staff training, satisfaction, and retention
- HFAz program updates regarding state accreditation, equity plan development and implementation, leadership development, and interagency collaboration.

Outcome Evaluation

The outcome study is designed to assess the impact of the HFAz program on families and children in terms of promoting child development and wellness, enhancing parent/child interactions, reducing the rates of child maltreatment, and promoting positive parental resiliency. The guiding questions for the outcome evaluation include:

- What impact does HFAz have on parenting outcomes (e.g., parent-child relationship and other family indicators)?
- What impact does HFAz have on the care and protection of children (e.g., safety in the home environment and child abuse and neglect indicators)?
- To what extent does the HFAz program meet the objectives outlined in the enabling legislation (e.g., children and maternal health outcomes)?
- To what extent does the HFAz program achieve the goals and objectives outlined in the logic model?

Outcome data presented in this report were collected by home visitors and entered into ETO, including:

- Percent of children screened for developmental delays and referrals made;
- Percent of caregivers screened for substance abuse and postnatal depression and referrals made;
- 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 families with a substantiated incidence of child maltreatment since entering the program.

CHILD WELL-BEING IN ARIZONA

This section provides an update on child well-being indicators in Arizona and the United States using the Annie E. Casey Foundation's ***2022 KIDS COUNT® Data Book*** (2022a) and state level reports (2022b). This data demonstrates the continued need for HFAz home visiting services in Arizona to help improve these child well-being indicators. 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 (worst) ranked state. Rankings show how well states are meeting the needs of children and trends over time in child well-being.

Arizona is ranked 44th out of 50 states in child well-being (with 50 being the worst ranking).

Arizona has improved in 11 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.

Arizona's rankings in 2019 to 2022 for each domain and overall are shown in Exhibit 4. The *2022 KIDS COUNT® Data Book* ranked Arizona 44th in the nation, with 50th indicating the worst ranking when it comes to economic well-being, health, and family and community support. This ranking is worse than Arizona's ranking of 40th in 2021. Additionally, Arizona's Health ranking (29th out of 50) and Economic Well-Being ranking (35th out of 50) worsened in 2022 compared to 2021 rankings. However, Arizona saw an improvement in the Family and Community rank (44th out of 50) and stayed the same in the Education rank (47th out of 50) from 2021 to 2022.

Exhibit 4. KIDS COUNT Child Well-Being Rankings for Arizona, 2019 to 2022

Domain	2019	2020	2021	2022	Change in Arizona's National Rankings Over Time
Overall Rank	46	42	40	44	Worse
Health Rank	35	33	28	29	Worse
Economic Well-Being Rank	43	36	35	41	Worse
Family and Community Rank	46	46	46	44	Improved
Education Rank	46	46	47	47	Same

As the pandemic took hold, diagnoses of depression and anxiety increased noticeably in 3–7-year-olds across the country, however a decrease was observed in Arizona from 11.7% in 2016 to 10.8% in 2020 (CAA, 2022). The data should be interpreted cautiously to determine if this reflects a true improvement in child mental health or is the result of insufficient access to health care and underreporting. The KIDS COUNT report shows other alarming trends in Arizona: higher child and teen death rates, more children living in families where no parent has full-time work, more children without health insurance, and fewer high school students graduating on time are higher than the national average. Though the poverty rate has fallen to an average of 20% throughout the state, it remains higher than the national average of 17%.

The Annie E. Casey Foundation, Children's Action Alliance (CAA), and the Arizona Center for Economic Progress recommend the following solutions to keep children mentally and physically healthy (CAA, 2022):

- Prioritize meeting kids' basic needs. Youth who grow up in poverty are two to three times more likely to develop mental health conditions than their peers. Children need a solid foundation of nutritious food, stable housing, and safe neighborhoods — and their families need financial stability — to foster positive mental health and wellness.
- Ensure every child has access to the mental health care they need, when and where they need it. Schools should increase the presence of social workers, psychologists and other mental health professionals on staff and strive to meet the 250-to-1 ratio of students to counselors recommended by the American School Counselor Association. Currently, Arizona ranks last in the nation with a 716-to-1 ratio.
- Bolster mental health care that considers young people's experiences and identities. Care should be trauma-informed — designed to promote a child's healing and emotional security — and culturally relevant to the child's life. It should be informed by the latest evidence and research and should be geared toward early intervention, which can be especially important in the absence of a formal diagnosis of mental illness.

Data from the national *KIDS COUNT Data Book* (2022a) and Arizona's state profile (2022b) for the four domains and indicators are shown in Exhibit 5 on the next page. Additional discussion on KIDS COUNT indicators in Arizona is available in Appendix C.

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	
Family and Community = 44th out of 50 (Improved from 46th in 2021)					
Teen births per 1,000 births	34 (2010)	15 (2020)	42 (2010)	17 (2020)	**Improved**
Children living in high-poverty areas	13% (2008-2012)	9% (2016-2020)	22% (2008-2012)	12% (2016-2020)	**Improved**
Children in families where the household head lacks a high school diploma	15% (2010)	12% (2016-2020)	19% (2010)	15% (2016-2020)	**Improved**
Children in single-parent families	34% (2010)	34% (2016-2020)	37% (2010)	37% (2016-2020)	Same
Health Rank = 29th out of 50 (Worsened from 28th in 2021)					
Children without health insurance	8% (2010)	5% (2016-2020)	13% (2010)	9% (2016-2020)	**Improved**
Children and teens (ages 10 to 17) who are overweight or obese	31% (2016-2017)	32% (2019-2020)	26% (2016-2017)	27% (2019-2020)	Worse
Low-birthweight babies	8.1% (2010)	8.2% (2020)	7.1% (2010)	7.4% (2020)	Worse
Child and teen death rate per 100,000	26 (2010)	28 (2020)	28 (2010)	36 (2020)	Worse
Economic Well-Being Rank = 41st out of 50 (Worsened from 35th in 2021)					
Children in poverty	21% (2008-2012)	17% (2016-2020)	24% (2010)	20% (2016-2020)	**Improved**
Children whose parents lack secure employment	33% (2010)	27% (2016-2020)	35% (2010)	29% (2016-2020)	**Improved**
Children living in households with a high housing cost burden	41% (2010)	30% (2016-2020)	43% (2010)	30% (2016-2020)	**Improved**
Teens not in school and not working	9% (2010)	7% (2016-2020)	12% (2010)	8% (2019)	**Improved**
Education Rank = 47th out of 50 (Same ranking of 47th in 2021)					
Young children not in school	52% (2009-2011)	53% (2016-2020)	66% (2009-2011)	62% (2016-2020)	**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, 2022a, 2022b.

UPDATES IN HOME VISITING

During a child's early years, home visitation services provide a lifeline for many mothers. These visits serve to identify potential risk factors, teach necessary skills, and connect families to important resources outside of the home. When services are high-quality and evidence-based, they can promote better parent-child relationships, improve mothers' mental health outcomes, and reduce child maltreatment and neglect (Traube, Gozalians, & Duan, 2022). As a result of the pandemic, many organizations quickly pivoted to offering virtual home visits, and there is still much to learn about how providing a hybrid of virtual and in person visits has affected providers and participants and what we can expect in the future. This section provides a review of current literature on topics of interest to HFAz, including health equity, virtual home visiting as part of a hybrid service, family and father engagement, and cost considerations for home visiting programs.

Health Equity

One of the most important topics in healthcare today is that of health equity, which the Centers for Medicare and Medicaid (CMS) defines as the following.

Health Equity	The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (CMS, 2022).

In CMS' *Framework for Health Equity 2022-2032*, they outline priorities on which practitioners should focus to achieve health equity within their organizations. These priorities address areas including expanded data collection, closing policy gaps, building workforce capacity, improving language access, and providing culturally appropriate services (CMS, 2022).

Another report from the National Home Visiting Resources Center (NHVRC) lists five areas on which to focus in order to advance and sustain health equity among home visiting participants: health equity as a strategic priority, antiracist infrastructure, continuous quality improvement promoting health equity, family-centered service delivery, and referrals and advocacy beyond MIECHV with a family-needs focus (NHVRC, 2022).

It is known that the pandemic has exacerbated disparities among marginalized groups, specifically communities of color and low-income populations. Factors such as living in over-crowded housing, holding jobs as frontline workers, and having less access to important safety measures, information and resources also puts communities of color and marginalized groups at a higher risk for becoming ill with COVID-19 (Zivot et al., 2022). Even after accounting for education, studies show that pregnant black women have a mortality rate that is 4-5 times higher than pregnant white women who are over 30 years of age; infants born to black mothers are twice as likely to die during their first year compared to infants born to white mothers. Studies also indicate poorer maternal and infant health outcomes for AI/AN and Latinx populations compared to Whites (Lewy & Casau, 2021).

In one study of the Family Connects program in North Carolina, results from two randomized control trials and a quasi-experiment were compared (Dodge et al., 2022). Researchers found that Black mothers in the control group consistently presented with higher levels of depression and anxiety as compared to White mothers, as well as scoring higher in areas related to father non-support, accessing emergency medical services for young children and child maltreatment investigations. Similar results were found for Hispanic families as compared to White families, although the results were not quite as pronounced. When families were assigned to the Family Connects program many of these identified disparity measures were reduced, and researchers concluded that "when a community intervention program is offered universally (not based on demographics), is implemented with high quality and based on clinically identified, family-specific needs, the level of trust will be increased, self-labelling will be reduced, and participation rates will be high without disparities" (Dodge et al., 2022). The lesson here is that programs that specifically target low-income families, while beneficial in some ways, have a part to play in promoting stigma and labeling among those utilizing services, whereas a program that is universally delivered to all groups but that still contains individually-tailored interventions based on clinical needs – not demographics – should be more successful.

When considering the topic of equity as it relates to virtual home visit practices, access to reliable broadband internet service has become a necessity for many families so they may receive services during a time when in-person meetings are not always possible. Oftentimes, the families who have the greatest need for services have inequitable access to the internet and the technology required to get online (Roben et al., 2022). While many internet providers have improved their quality of service and now offer free or discounted services to those who qualify (FCC, 2020), access is an important topic that agencies must consider when serving clients. In some situations, agencies have sought to use funds that were earmarked for transportation to offer the necessary digital devices and hotspots to families in need (Roben et al., 2022).

Virtual Home Visiting

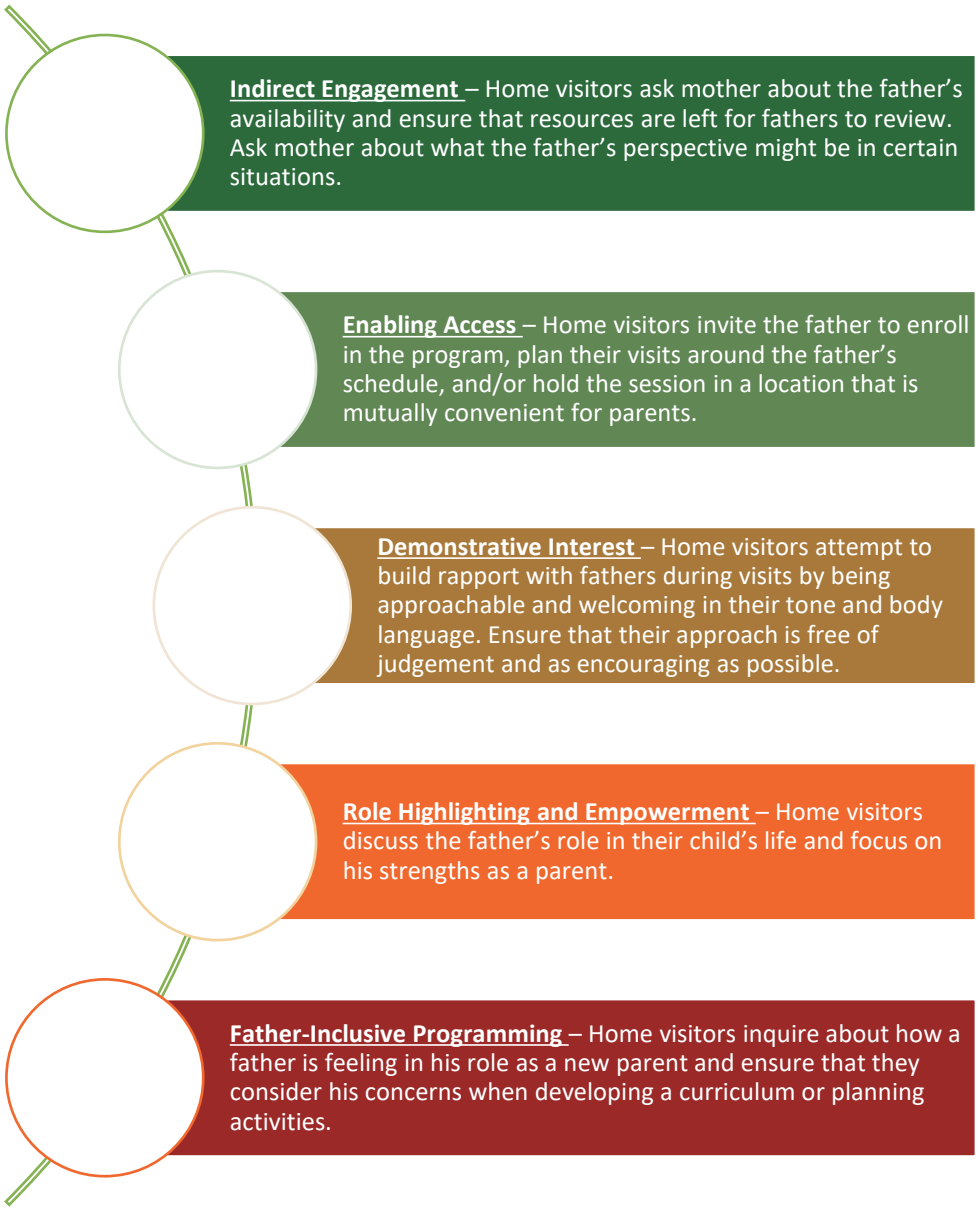
The COVID-19 pandemic's effects continue to reverberate in communities across the country, and while widespread vaccination has allowed many organizations to return to pre-pandemic operational capacity, programs continue to offer virtual home visits as part of a hybrid array of services. Vulnerable populations (e.g., pregnant women, women with young children, and mothers of color) and families with a history of maltreatment are the ones who receive most in-home services, and oftentimes it is more difficult for providers to assess their needs during a virtual session (Cameron et al., 2020).

In one study, data from the evidence-based Family Connects program examined family perceptions of virtual home visits during the first nine months of the pandemic in 2020, compared to data collected in 2019 (Rybińska, et al., 2022). Ultimately, recruitment numbers for the program were similar pre- and post-pandemic, though program completion rates dropped by 10.9%. In this study, education provided (96.4% pre-pandemic / 96.1% post-pandemic) and community referrals (49.9% pre-pandemic / 43.7% post-pandemic) remained comparable. The decrease in referral rates may reflect several reasons: workers have more difficulty observing a household's particular situation virtually and taking the appropriate steps to follow-up; parents are not adequately reporting their needs to staff; families are already receiving resources directly from other community services made available during the pandemic.

Parents reported that their feelings of anxiety and isolation decreased as a result of having virtual home visits when disease transmission rates were the highest (Rybińska, et al., 2022). This finding highlights that virtual home visits addressed families' concerns at a time when in-person interactions were not possible. It is imperative that home visiting programs continually assess virtual home visits protocols so the best possible outcomes can be attained for all participants. Providers are eager to determine what strategies work best to retain clients and adequately engage parents and children in a remote environment while providing quality services that most closely replicate the experience of in-home sessions. In one study, researchers interviewed thirty-five mothers with children ages 0-3 and found themes among the approaches that improved child engagement during virtual home visits (Vicente, et al., 2022). Some of these strategies included playing a specific song before each visit, designating a special learning space free of distractions, allowing children to take breaks as needed, and turning off the parent camera while keeping the coach's camera on throughout the visit.

Father Engagement

Historically, home visiting and family support programs have been very mother centric. In many ways, this is a byproduct of society's views on what a father's role within the family should and should not be. In the past few decades, some programs have made a greater effort to include fathers in their services, as it can help improve the co-parenting relationship, reduce mothers' stress levels, and boost parents' confidence in general (Singhal, et al., 2022). The Healthy Families Massachusetts program uses the following techniques to engage fathers in their program:



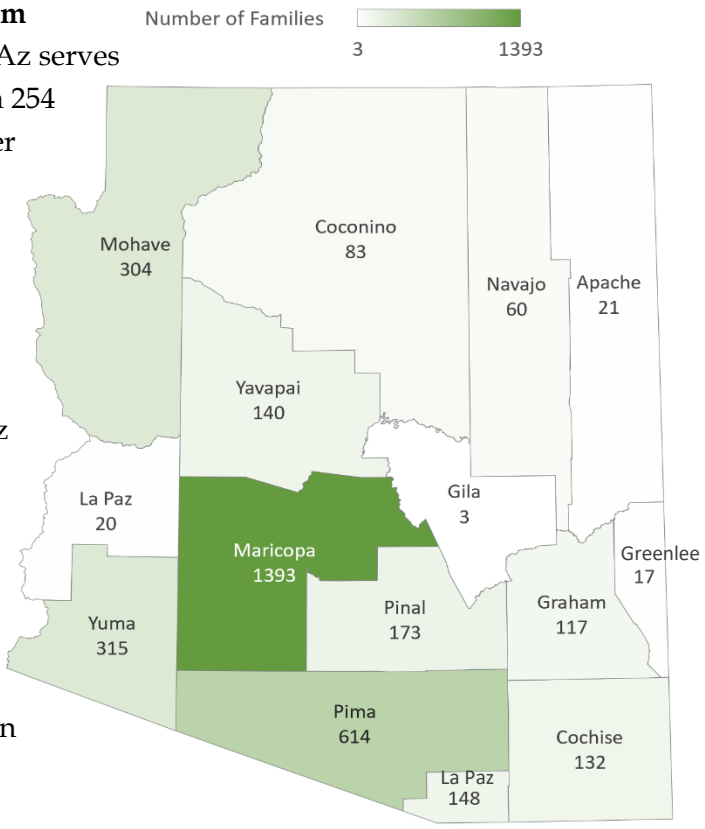
In one study on the topic of father engagement, researchers looked at a group of 181 fathers who were participants in a larger federally funded study of HF in the southeastern US and receiving MIECHV services through the HFA model (Connor & Stolz, 2022). Fathers ranged from age 16-54 and babies were between 1-494 days old. The father's level of education was an important predictor of more supportive parenting, including increased verbal stimulation with toddlers. Race and ethnicity play a role as well, with studies indicating more play and caregiving behaviors exhibited by Black and Latino fathers than White fathers. Yet another predictor of father engagement is the presence of a supportive relationship between both parents – when conflict is present, lower levels of father engagement are observed.

Overall, results of the study point to parenting self-efficacy (PSE) as one of the largest predictors of father engagement; when fathers perceive that they are knowledgeable about their child's needs (whether they are educated in the area of child development or not), this is associated with an increase in verbal stimulation and caregiving behaviors such as feeding, diapering and bathing (Connor & Stolz, 2022). The implication here is that by encouraging and focusing on fathers and not exclusively mothers during home visits, staff can build on a father's existing strengths to improve parenting behaviors overall.

HEALTHY FAMILIES ARIZONA PROGRAM PARTICIPATION AND FAMILY CHARACTERISTICS

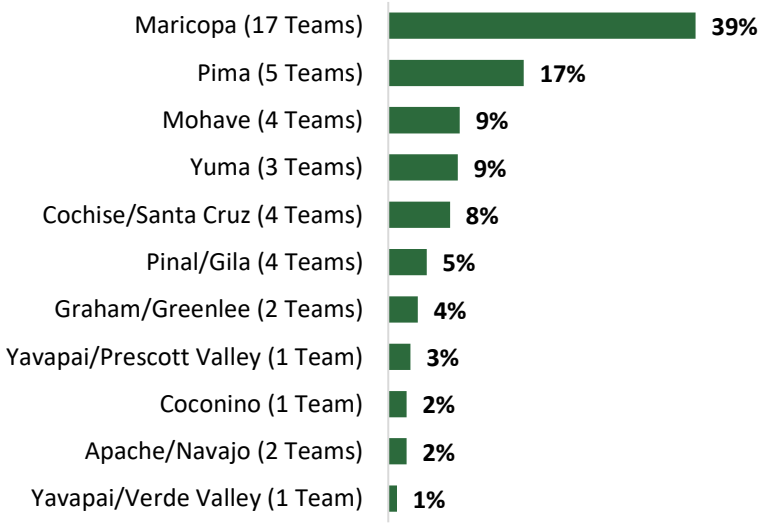
HFAz served a total of 3,540 families in FY22 from October 1, 2021 through September 30, 2022. HFAz serves families living in all 15 Arizona counties, living in 254 zip codes. The map on the right shows the number of families served in each county, with lighter shades indicating a smaller number of families and darker shades indicating a higher number of families served.

Exhibit 6 shows the proportion of families enrolled statewide that are served by the 11 HFAz program sites, which are made up of 44 Family Support Specialist (FSS) home visitor teams, and three Family Assessment Worker (FAW) teams. The largest site, serving 39% (n=1,393) of families enrolled statewide is in Maricopa County and is made up of 17 teams. Additionally, 17% (n=614) of families are served in Pima County, made up of five teams.



Number of Families Served by Healthy Families Arizona by County in FY22 October 1, 2021 to September 30, 2022 (N=3,540)

Exhibit 6. Proportion of Families Served by Program Sites



Program Enrollment and Activity

If FY22, (October 1, 2021 through September 30, 2022), a total of 3,540 families were served by HFAz (Exhibit 7). The number of total families served by HFAz has slowly decreased over the past four years (4,090 in FY21, 4,337 in FY20, 4,420 in FY19). Statewide, the program had an enrollment rate of 38% (n=1,336) of new families enrolling in FY22. The program had a statewide family closure rate of 40% (n=1,428) of families closing in FY22 and a 60% (n=2,112) statewide retention rate of families who remained active in the program going into FY23. Exhibit 7 shows the enrollment, closure, and retention rates for each of the 11 programs.

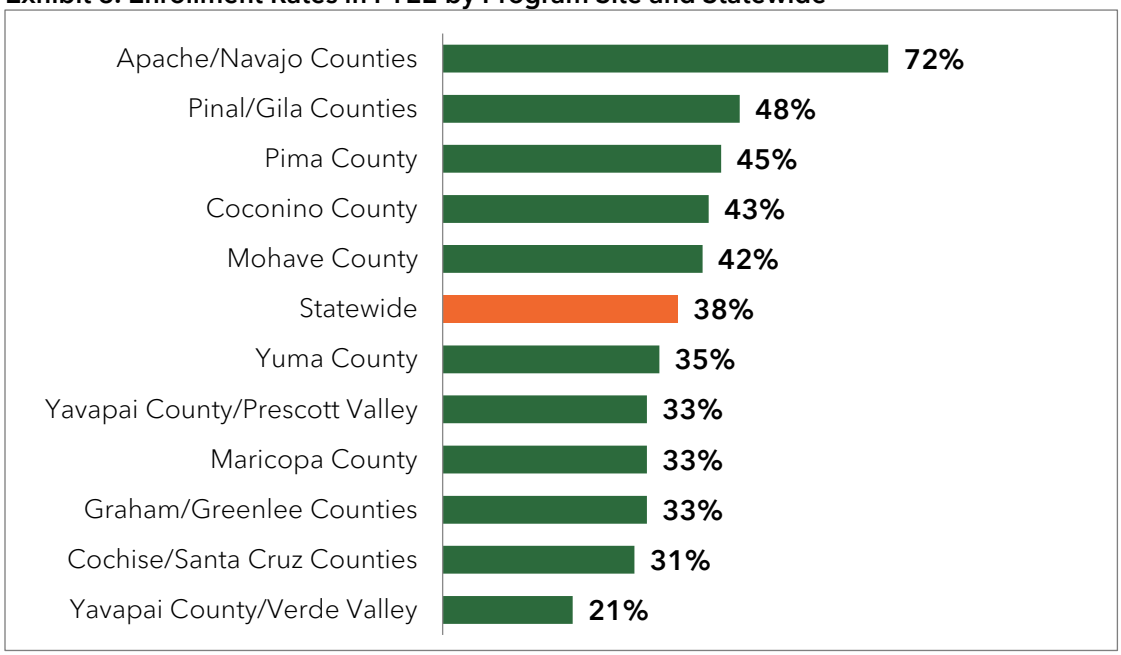
Exhibit 7. Families Served, Enrolled, and Closed in Healthy Families Arizona, FY22

Program Name	Total Families Served in FY22	New Families Enrolled in FY22	Family Enrollment Rate	Families Closed in FY22	Family Closure Rate	Families Remaining Active	Family Retention Rate
Apache/Navajo County	83	60	72%	30	36%	53	64%
Cochise/Santa Cruz Counties	280	87	31%	110	40%	170	60%
Coconino County	83	36	43%	39	47%	44	53%
Graham/Greenlee Counties	134	44	33%	52	39%	82	61%
Maricopa County	1,393	457	33%	588	42%	805	58%
Mohave County	324	137	42%	114	35%	210	65%
Pima County	614	279	45%	243	40%	371	60%
Pinal/Gila Counties	174	84	48%	94	54%	80	46%
Yavapai County/Prescott Valley	101	33	33%	40	40%	61	60%
Yavapai County/Verde Valley	39	8	21%	11	28%	28	72%
Yuma County	315	111	35%	107	34%	208	66%
Total (Unduplicated)	3,540	1,336	38%	1,428	40%	2,112	60%

Enrollment Rates

Exhibit 8 shows the enrollment rates by program and statewide in graphic format. Statewide, the program had an enrollment rate of 38% (n=1,336), which is higher than the 34% in FY21 but lower than the 48% enrollment rate in FY20 and 47% in FY19. Enrollment rates are dependent on the number of staff and teams available to work with families, as well as the number of families that are promoted to less intensive services or close, which opens space for new families to enroll. The program site serving Apache and Navajo Counties had the highest enrollment rate of 72% (n=60) of their total families (N=83) served having enrolled in FY22.

Exhibit 8. Enrollment Rates in FY22 by Program Site and Statewide

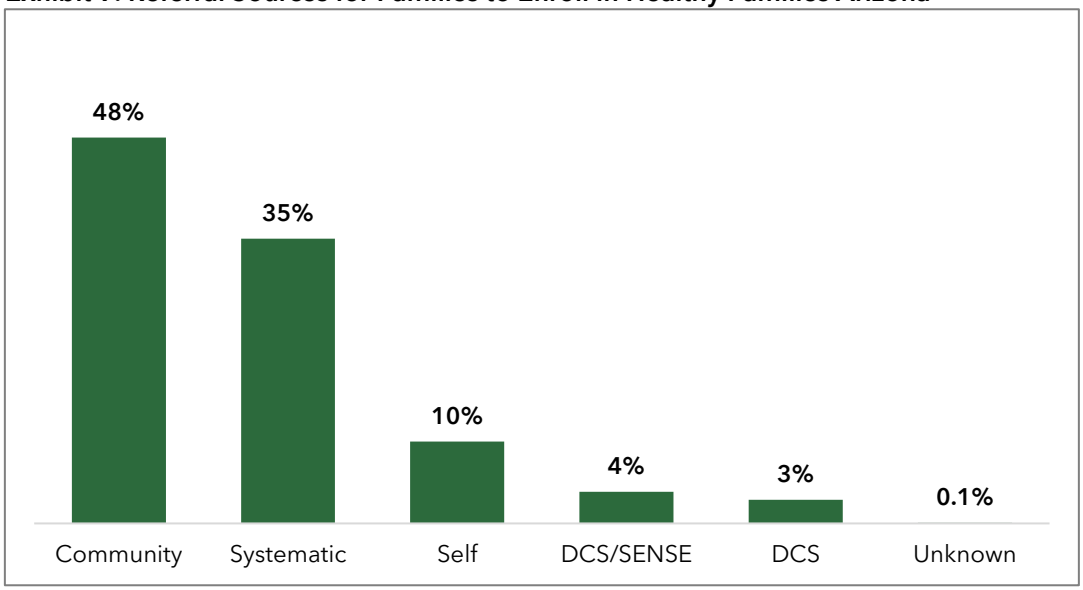


(N=3,540)

Referral Sources

Families are offered services in HFAz through various referral sources. Community referrals accounted for 48% (n=1,690) of family referrals in FY22 (Exhibit 9). Community-based organizations include non-profit organizations, home visiting central referral hotlines, and medical providers, such as pediatrician's offices, behavioral health providers, clinics, hospitals. Over a third (35%, n=1,248) of referrals came from systematic screenings. These screenings occur at hospitals and clinics throughout Arizona through contractual agreements with the local sites and involves an onsite HFAz FAW who screens pregnant and postpartum women to offer them services. A lower portion of families came to HFAz through self-referral (10%, n=358), which are often because a family has learned of the program through a brochure, website, or an individual. Furthermore, 4% (n=138) of referrals came from the DCS Substance Exposed Newborn Safe Environment (SENSE) program and 3% (n=103) came from DCS in general. Exhibit 9 shows the referral sources for all families served in FY22.

Exhibit 9. Referral Sources for Families to Enroll in Healthy Families Arizona

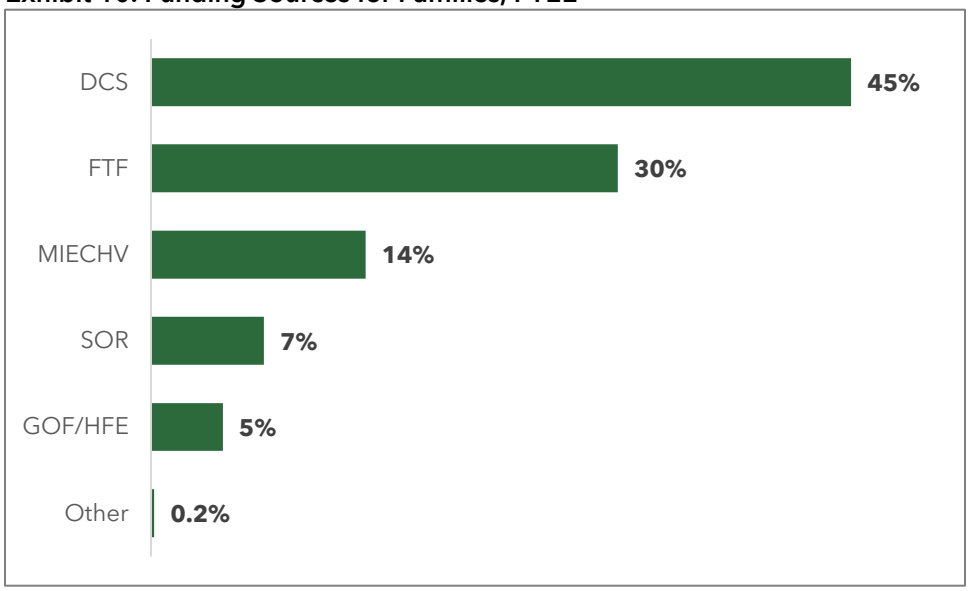


(N=3,540)

Funding Sources

Exhibit 10 shows the sources of funding that supported families served by HFAz in FY22. The most prominent sources include DCS/lottery funds, First Things First (FTF), and MIECHV. Beginning July 1, 2022, HFAz received $10 million dollars from the GOF/HFE to build infrastructure to expand the HFAz program. As FY22 closed on September 30, 2022, GOF/HFE funds are not yet reflected as a major funding source for families.

Exhibit 10. Funding Sources for Families, FY22

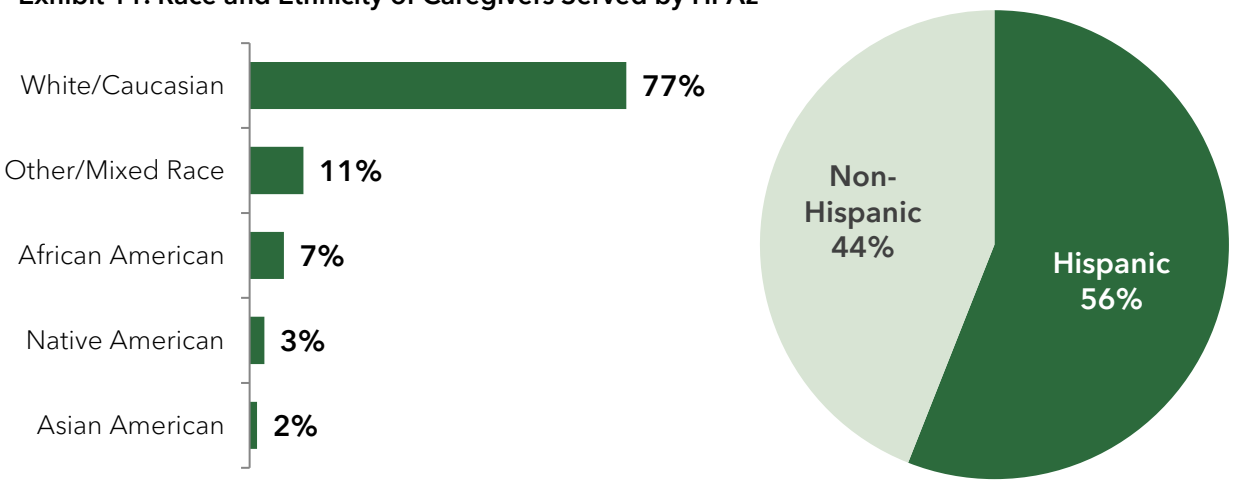


(N=3,540)

Caregiver Demographics

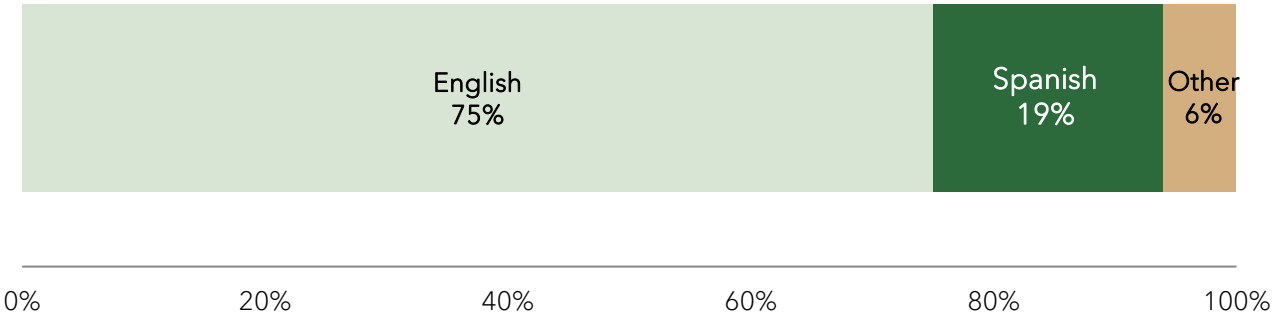
Demographics for caregivers are collected at intake to the program. Demographics shown in this section are for the primary caregiver, of which 99% (n=3,503) are the birth mothers of children served in FY22. Fathers (n=21), grandmothers (n=4), and other relatives (n=3) are the primary caregivers in less than 1% of families served. The age of caregivers at enrollment ranged from 13 to 61 years, with an average and median age of 27 years (n=3,522). Ten percent (n=388) of caregivers served by the program were young/teen parents defined as having given birth at 19 years of age or younger. Over three-quarters (77%, n=2,737) of caregivers identified their race as White/Caucasian and over half (56%, n=1,976) identified as being of a Hispanic ethnicity (Exhibit 11).

Exhibit 11. Race and Ethnicity of Caregivers Served by HFAz



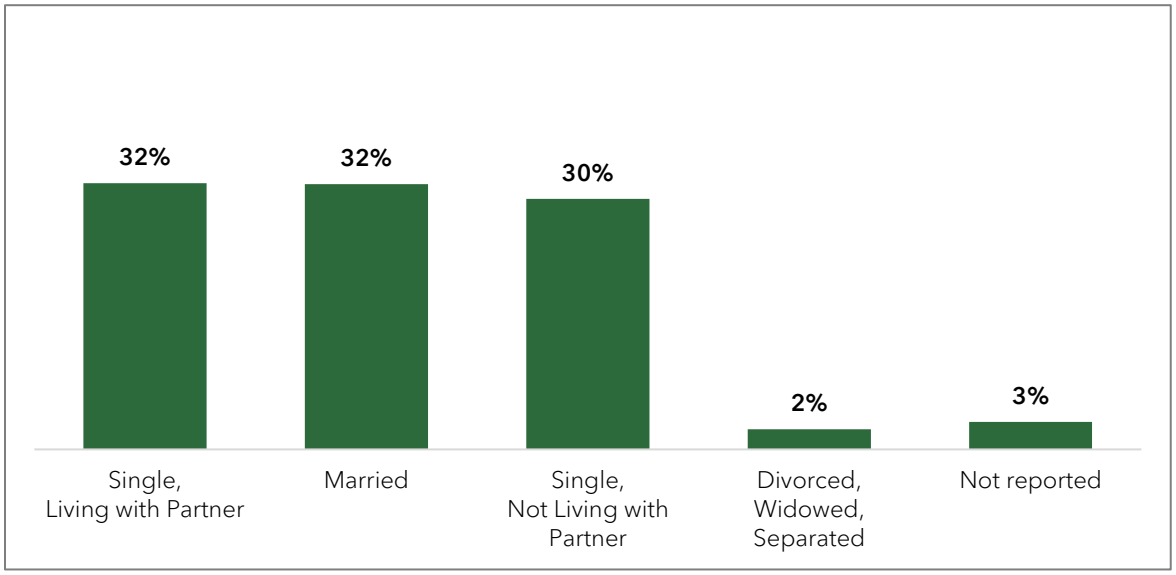
Most caregivers (75%, n=2,642) speak English as their primary language at home, while 19% (n=688) primarily speak Spanish (Exhibit 12). Other languages spoken by caregivers in HFAz include: Arabic, Assyrian, Bengali, Bisaya, Chichewa, Croatian, Dari, Farsi, French, Greek, Hindi, Kinyarwanda, Lingala, Mandarin, Nepalese, Portuguese, Russian, Swahili, Tagalog, Twi, Ukrainian, Vietnamese, and American Sign Language.

Exhibit 12. Primary Language Spoken by HFAz Caregivers



At enrollment to the program, approximately two-thirds (62%, n=2,205) of caregivers reported being single, living with or without a partner, and 32% (n=1,132) reported being married (Exhibit 13).

Exhibit 13. Marital Status of HFAz Caregivers



(N=3,540)

Maternal Risk Factors for Poor Early Childhood Outcomes

Certain maternal risk factors can lead to less favorable outcomes for their children. In the HFAz program, mothers have specific risk factors that are higher than the average rates for all mothers in Arizona (Exhibit 14).

Exhibit 14. Selected Risk Factors for Mothers in HFAz Compared to Arizona

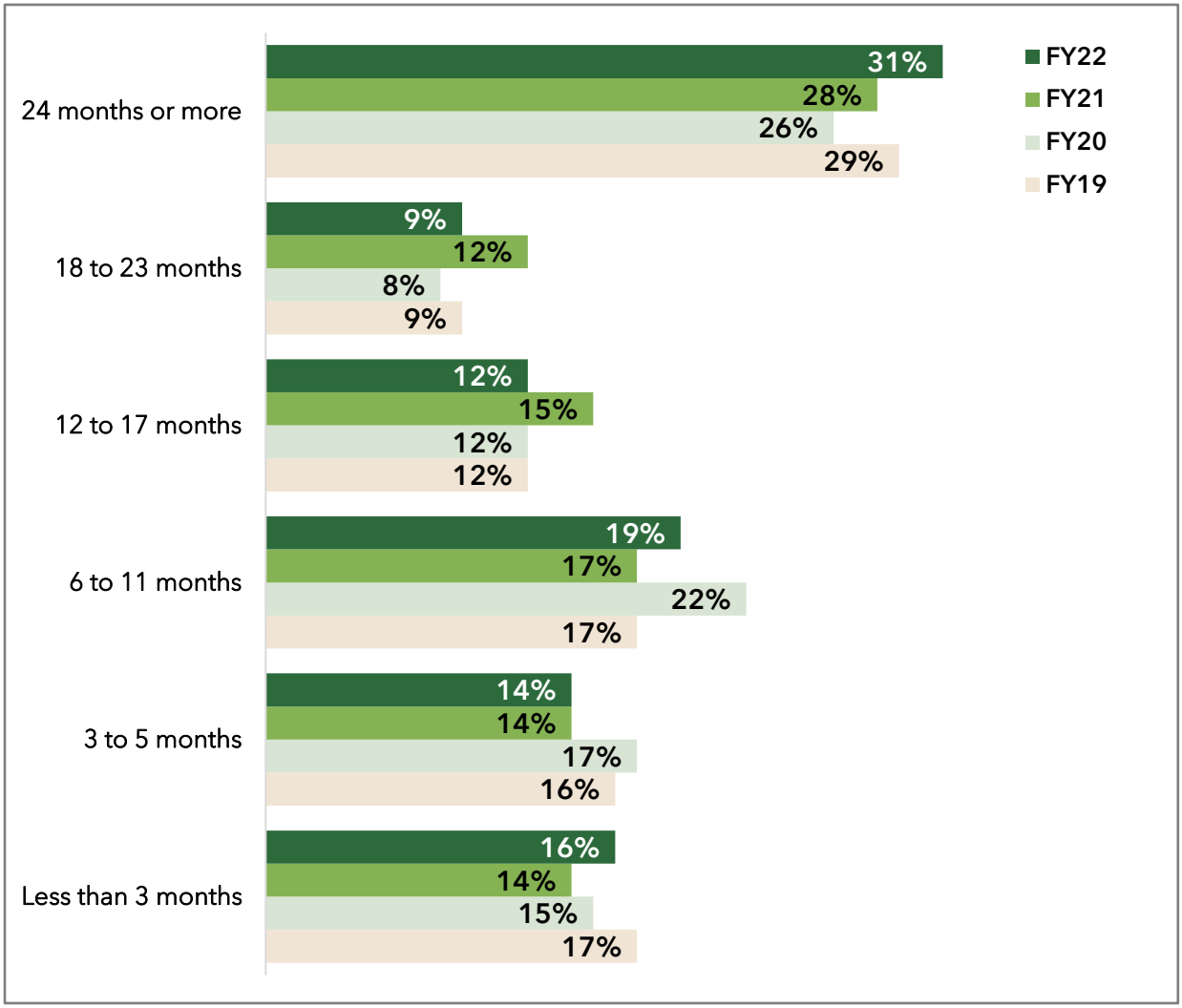
Risk Factors of Mothers	HFAz	Arizona
Teen Births (19 years or less)	10%	5%*
Births to Single Mothers	64%	45%*
Less Than High School Education	23%	10%**
Not Employed/Not in Labor Force	63%	12%**
Participating in Labor Force	32%	56%**
Median Yearly Income	$24,000	$34,174**

Source: *Arizona Department of Health Services Population and Vital Statistics records, 2019-2020. https://pub.azdhs.gov/health-stats/
**American Community Survey 2021-Year Estimates: Arizona. https://data.census.gov/

Length of Time in Program

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. 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. Exhibit 15 shows the length of time that families participated in the program FY19 to FY22. **Families served in FY22 participated in the program for a median of 13 months, which is an increase from the median of 10 months observed in FY21 and FY20, and higher than the pre-pandemic (FY19) median of 12 months.** Also noteworthy is that nearly **a third of families (31%, n=1,105) in FY22 participated in the program for more than two years, which is the highest proportion observed since pre-pandemic in FY19.** Higher retention of families in this past year reflects the lower number of families served overall in the program in FY22 compared to other years.

Exhibit 15. Families' Length of Time in HFAz, FY19 to FY22



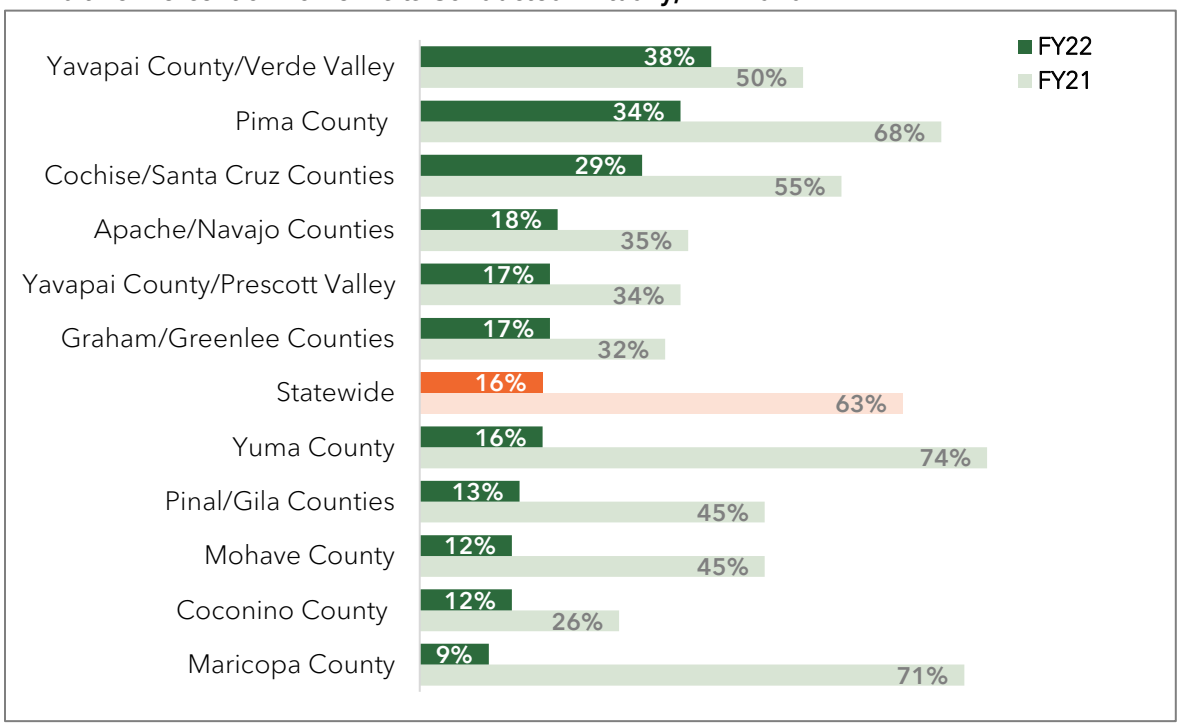
Home Visits Completed

In FY22, a total of 53,101 visits were conducted statewide, as reported in ETO for the 11 program sites and 44 teams. Statewide, approximately 84% of home visits were completed in person, either in the family's home or at a community location. Across all program sites, approximately two thirds or more of visits (a range of 62% to 91%) were conducted in person. HFAz continues to offer the optional use of virtual visits based on health needs, however, FSS need to be able to see the family through video.

Virtual Home Visits

Exhibit 16 compares the percentage of home visits conducted virtually in FY21 and FY22. Compared to the literature reviewed in this report that home visitation programs have continued to offer a hybrid option of services post-pandemic, all HFAz program sites conducted a portion of visits virtually in FY22. Statewide, 16% of visits were conducted virtually, which is a significant decrease from 63% conducted virtually in FY21. This decreased trend is consistent across all program sites. The percentage of virtual visits in FY22 ranged across sites from 9% to 38%. Programs with the highest percentage of virtual visits included Yavapai/Verde Valley (38%), Pima County (34%), and Cochise/Santa Cruz Counties (29%). Interestingly, Maricopa County had the lowest virtual visit rate of 9%. Visits were conducted virtually in cases of local outbreaks of illness (e.g., COVID-19, Influenza, RSV), family and/or staff illness or exposure, and local health recommendations. Visit modality should be determined on a case-by-case basis and related to family and staff health.

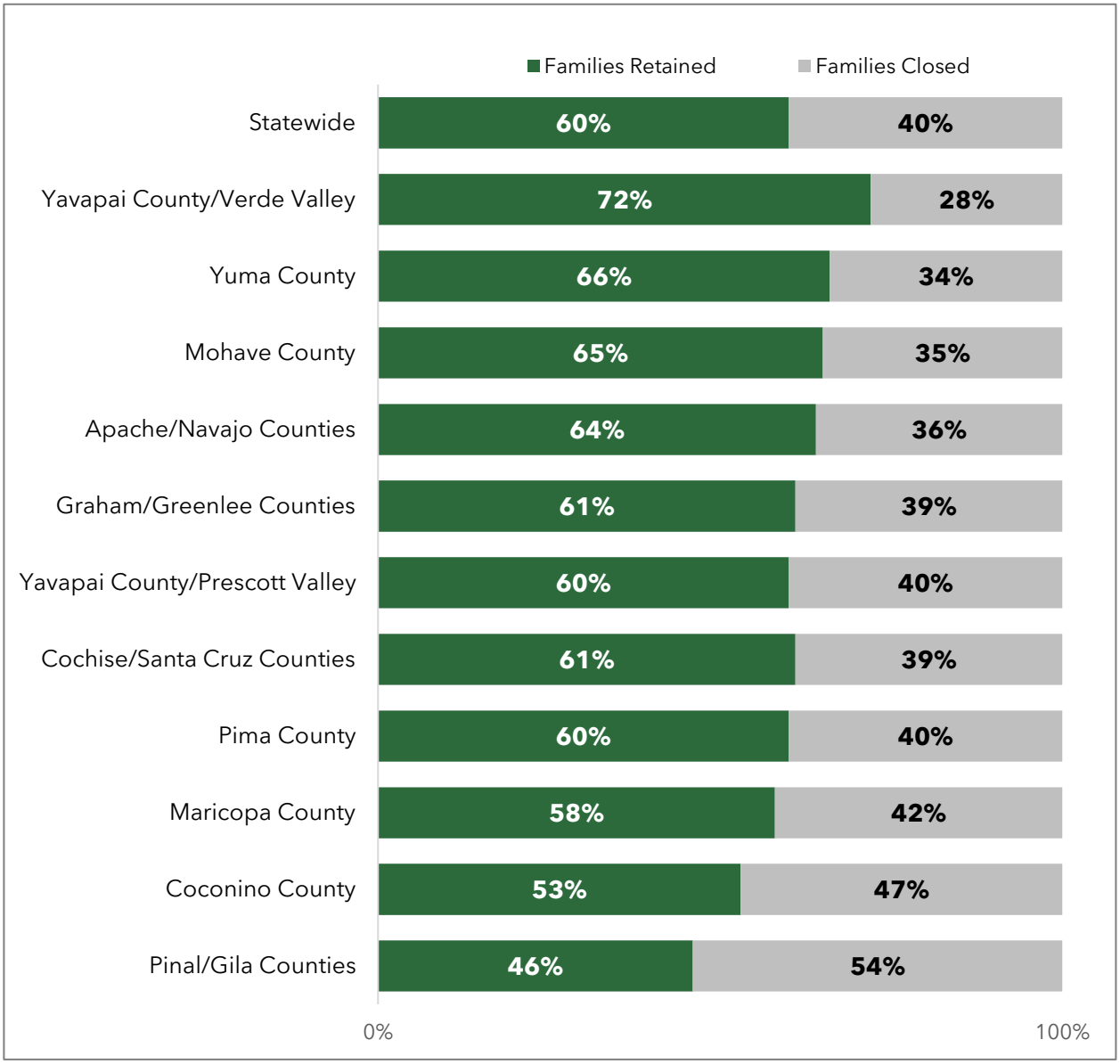
Exhibit 16. Percent of Home Visits Conducted Virtually, FY21 and FY22



Family Retention and Closure

Exhibit 17 shows the family retention and closure rates for HFAz statewide and by program site. The program had a statewide retention rate of 60% in FY22. The program's retention rate has somewhat fluctuated over the past four years (62% in FY21, 70% in FY20, and 58% in FY19). Site retention rates in FY22 ranged from 46% to 72%. Overall, most programs retained at least 60% of their families into FY23. Conversely, 40% (n=1,428) of families statewide exited the program in FY22. Family closure rates statewide have also fluctuated over the past four years (45% in FY21, 35% in FY20, 50% in FY19). Site closure rates in FY22 ranged from 28% to 54%.

Exhibit 17. Family Retention and Closure Rates in FY22 by Program

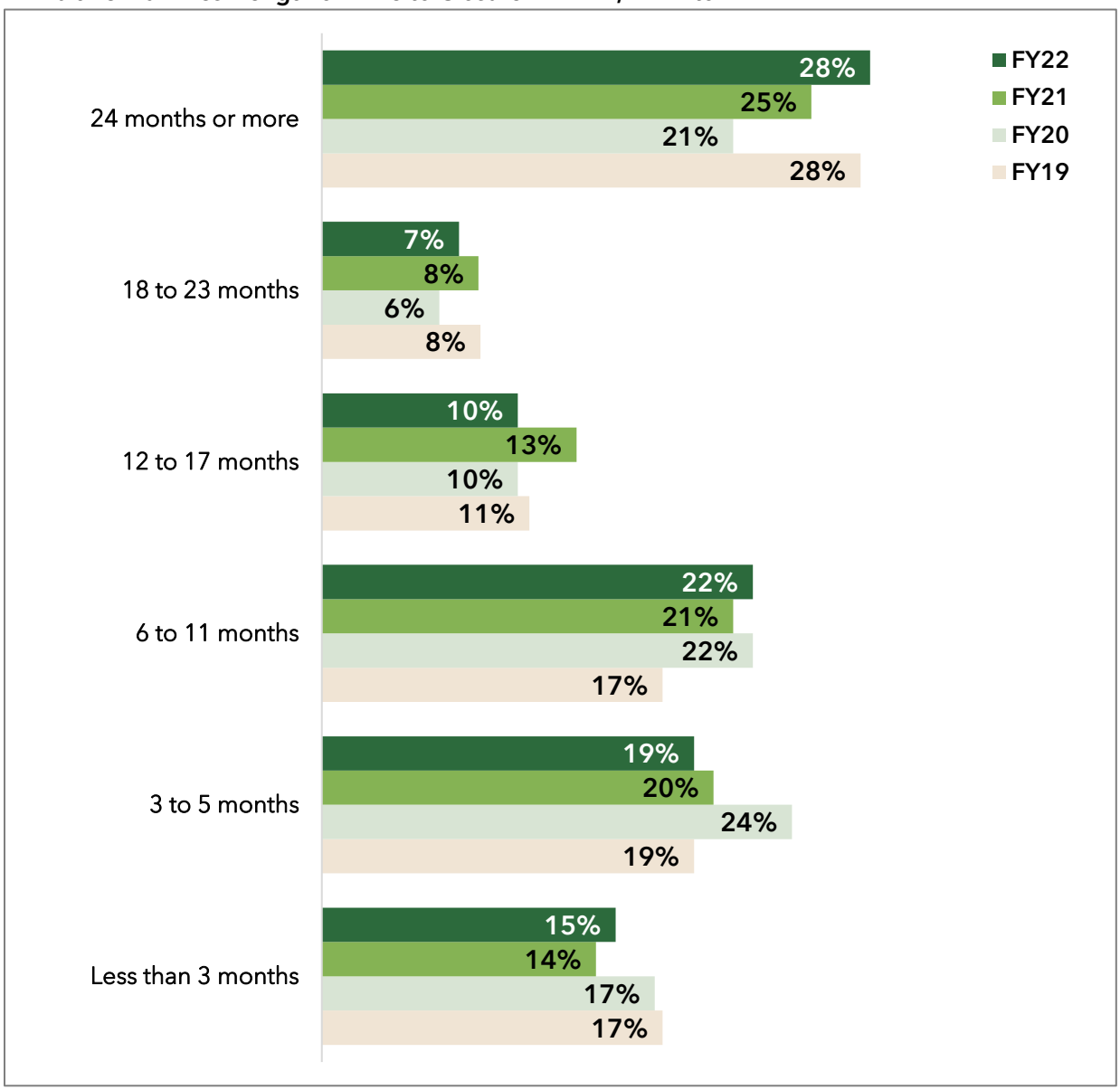


(N=3,540)

Length of Time to Closure

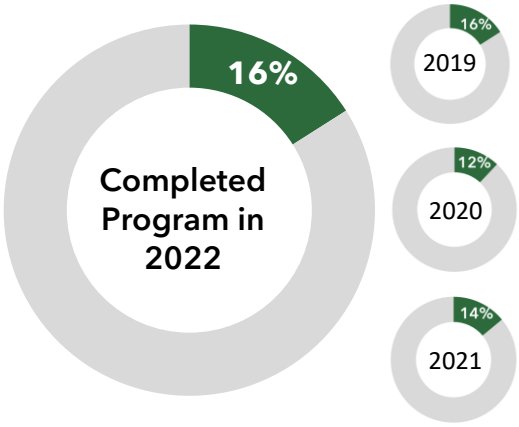
Exhibit 18 shows the length of time that closed families stayed in the program, compared over the past four years (FY19, FY20, FY21, and FY22). A noteworthy observation is that of the 1,428 families that closed in FY22, **28% (n=402) received 24 months or more of services, which is consistent with the 28% of closed families who received this amount of services pre-pandemic in FY19.** Higher retention of families in this past year reflects the lower number of families served overall in the program in FY22 compared to other years. Over half of families (56%, n=798) closed after being in the program for less than one year, similar to 54% in FY21, 63% in FY20, and 53% in FY19. Also, fairly steady over time is that 15% (n=207) of families closed within the first three months of the program, compared to 14% in FY21 and 17% in FY20 and FY19.

Exhibit 18. Families' Length of Time to Closure in HFAz, FY19 to FY22



Reasons for Family Closure

Program Completion



Of the 1,428 families that exited the program in FY22, 16% (n=234) closed because they completed the program, as recorded in ETO by their home visitor. Comparing family completion rates over the past four years, the program's 16% completion rate in FY22 is an increase from the past two years (14% in FY21, 12% in FY20) and is consistent with the pre-pandemic completion rate of 16% in FY19. **Families who completed the program spent a significantly longer amount of time – an average of 49 months (just over four years) – in HFAz**, compared to families who exited after an average of 12 months due to a non-completion reason (84%, n=1,194) (t=37.78, p=.00) (Exhibit 19).

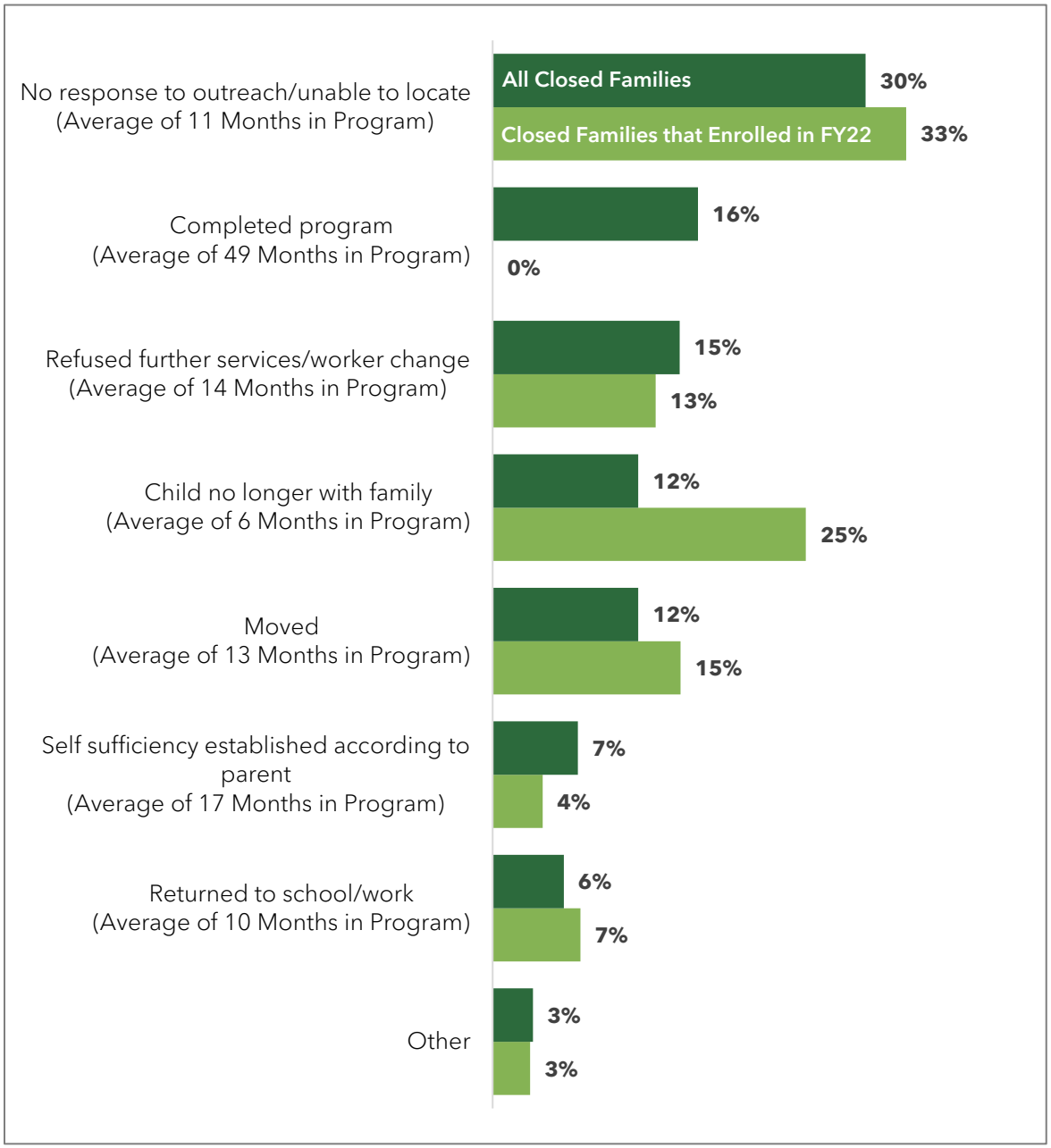
Exhibit 19. Average Number of Months in HFAz Compared by Program Completion Status

Closure Reason	Average Number of Months in Program	SD	N	t	p-value
Completed program	48.9	14.1	234	37.78	.00
Exited program for non-completion reason	11.8	11.0	1,200		

Closure Reasons Other Than Program Completion

Of the 1,428 families that exited the program in FY22, 84% (n=1,194) closed for reasons other than program completion. Exhibit 20 shows the reasons families closed in FY22, differentiated by all closed families (n=1,428) and those who closed in less than 12 months post enrollment into the program (n=423). Common other reasons why families close is that they do not respond to outreach efforts or are not able to be located by staff (30%, n=425), the family refused further services or a worker change (15%, n=213), the child is no longer with the family (12%, 166) (due to adoption or loss of custody, pregnancy loss or child death), or the family moved out of the service area and did not transfer to another Healthy Families team (12%, 166). Of the families who left the program with less than 12 months of services, the most common reasons were that they did not respond to outreach efforts, the child is no longer with the family, and the family moved.

Exhibit 20. Closure Reasons by All Families and Families Closed in Less than 12 Months



Notes:
N = 1,428 for all families that closed in FY22.
N = 423 for families that closed in FY22 who completed less than 12 months of the program.
The average number of months in the program for each closure reason (in parenthesis) is for all families who closed in FY22.

PROGRAM IMPLEMENTATION

Healthy Families Arizona Updates

State Accreditation

The HFA statewide accreditation site visit took place over four days from 11/14/22 to 11/17/22. From the accreditation report, HFAz areas of strength include: a commitment to diversity, equity, and inclusion at quarterly meetings; providing staff with technical assistance and office hours; building connections between Program Mangers and Central Administration through monthly meetings; timely access to trainings for all staff; use of a collaborative approach to develop site-level policies and procedures; and increased opportunities for sites to provide feedback to Central Administration. All outlined standards were met or exceeded in the areas of training, technical assistance, and evaluation. HFAz was out of adherence on nine standards. Six were related to policy, two were related to quality assurance, and one was related to administration. HFAz will submit a written response to HFA in April and a panel session will be held in June 2023 to address areas that were out of adherence. HFAz will receive accreditation by the end of June 2023 for FY24.

Equity Plan Development and Implementation

As part of the HFA *Best Practice Standards (BPS), 8th Edition* (2022), program sites must make intentional efforts to promote equity in all facets of operations with families, staff, and community. This past year, HFAz completed statewide and site level equity plans for implementation in FY23. Each equity plan was developed based on what the site (statewide and program sites) learned about itself, from an equity perspective, in the way it supports staff, families served, and the community. The equity plan sets a course for continuous improvement to achieve greater equity in all facets of its work. Improvement strategies are created, acted on, and reviewed and updated at least annually. The equity plan provides an opportunity to identify strategies to combat implicit bias, address barriers, and work to dismantle the causes of disparity and inequity.

Central Administration made intentional efforts in FY22 to support equity plan development and implementation. Program staff have received training on diversity, equity, inclusion, and belonging. Program sites have increased the emphasis on team and relationship building and there is a system in place to provide staff with guidance on family interactions. Central Administration also utilizes the Advisory Board to advise on local and statewide practices regarding diversity, equity, inclusion, and belonging and these topics have been incorporated as a standing agenda item at quarterly Statewide Supervisor Meetings.

Additionally, the evaluation team and HFAz leadership revised the annual Caregiver Survey in FY22 to include questions on diversity, equity, inclusion, and belonging. The evaluation team

conducted this survey and produced statewide and site level reports to help Central Administration and programs sites develop their equity plans. This survey gathered information from parents and caregivers to ensure that their voices were heard, and that feedback received was used to improve the program's ability to provide culturally respectful and responsive services. The evaluation team and HFAz staff made several intentional efforts to reach families and increase the survey response rate to 48%, compared to the 35% response rate in FY21 (see the section in this report on the Caregiver Survey Results for more information on this evaluation activity). In FY23, HFAz and the evaluation team will update the Staff Satisfaction Survey and retention analysis to inform annual equity plan updates.

Leadership Network Meetings

HFAz Central Administration and Program Managers meet monthly for an hour long "Network Meeting." Network meetings were initially held weekly during the COVID-19 pandemic as a way to support managers during this challenging time and the shift to virtual service delivery. During a recent Network meeting, the evaluation team asked Program Managers about the helpfulness of these continued monthly meetings. The general consensus was that these meetings are helpful and provide a way for staff from around the state to come together, support each other, and problem-solve/strategize with this peer support network. The Network meetings provide team a building opportunity between Central Administration and Managers, which is parallel to the team building that takes place between site level staff and supervisors. Managers have the opportunity to reflect on their position, which helps them feel less isolated in their leadership role. One suggestion made was to create and send out an agenda in advance of meetings for staff to provide input into topics that should be discussed.

Continued Interagency Collaboration

HFAz Central Administration continues to participate in statewide coalitions to increase collaborative efforts with First Things First and Department of Health Services. Central Administration focuses on maintaining healthy working relationships with First Things First and Department of Health Services 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. HFAz Central Administration discusses budget and funding frequently with Department of Health Services and reviews monthly reports and billing. In addition, HFAz Central Administration participates in the Inter-agency Leadership Team, which is a joint effort between state agencies and several other agencies to work collaboratively to improve services offered to Arizona families.

Healthy Families Arizona Program Staffing

Staff Hiring and Retention

On average, HFAz has between 200 and 210 FSS home visitors and FAW staff when all positions are filled. This past year saw fewer position changes (N=68) compared to the 89 position changes that occurred in FY21 (Exhibit 21). At the end of FY22, 28 positions were open, which is less than in FY21, but still higher than the five open positions pre-pandemic at the end of FY19.

Exhibit 21. Retention of HFAz Staff, FY19 to FY22

Fiscal Year	Number of Position Changes	Number of Open Positions at the end of the Fiscal Year
2019	76	5
2020	62	13
2021	89	32
2022	68	28

Program Managers discussed staff retention strategies put in place in FY22 during the Network Meeting conversation with the evaluation team. The additional funds from the GOF/HFE allowed for a pay increase for all HFAz staff. Program sites were also able to offer staff retention bonuses for cost-of-living increases. Programs have held regular team-building activities and staff gatherings outside of work, which has increased comradery and allowed them to feel more valued and supported. In one staff satisfaction survey from last year, staff expressed concerns about being able to use their vacation time as desired; one program developed a shared calendar system that allows staff to better plan for coverage so that they may utilize their earned time off.

When staff have left HFAz, Program Managers commented that they are often moving into a different field of work altogether or are retiring. Program Managers anecdotally feel that frequent staff turnover can affect family attrition rates. Staff in Pinal County noted that it is harder to find and retain Spanish-speaking staff because bilingual staff have moved on to higher paying positions. In Yuma County, they have had great family retention and noted that when an FSS departs, it helps greatly to have a "warm handoff" between the current FSS and the new FSS. Another factor that affects family retention is when a family moves, and staff are unable to reach them. Ideally staff would be notified in advance so the family could be connected with services in their new location, but oftentimes this does not happen.

Exhibit 22 shows the 11 program sites and number of teams from FY19 to FY22, which has remained fairly consistent over time.

Exhibit 22. Number of HFAz Program Sites and Teams, FY19 to FY22

Site	FY 2019	FY 2020	FY 2021	FY 2022
Apache/Navajo Counties	1	1	1	2
Cochise/Santa Cruz Counties	2	4	4	4
Coconino County	1	1	1	1
Graham/Greenlee Counties	2	2	2	2
Maricopa County	18	19	18	17
Mohave County	3	4	4	4
Pima County	4	5	5	5
Pinal/Gila Counties	3	4	4	4
Yavapai County/Verde Valley	1	1	1	1
Yavapai County/Prescott Valley	1	1	1	1
Yuma County	2	3	3	3
Statewide	**38**	**45**	**44**	**44**

Staff Training and Professional Development

Many staff training and professional development activities occurred between October 1, 2021 and September 30, 2022. These include the following.

- Staff attended the HFA National Conference held virtually and the Child Abuse Prevention Conference in Phoenix.
- HFAz increased the number of trainers for the Foundations of Family Support Core Training from two to four.
- All supervisors completed the FROG Scale Supervisor Hop Up virtual training.
- Staff received training in Motivational Interviewing and diversity, equity, inclusion and belonging (DEIB).
- HFAz hired two staff with previous FSS experience to support the ongoing management and maintenance of the HFAz ETO system. With these new staff positions in place, HFAz ETO training was provided statewide for staff in September and October 2022. This training will be held quarterly in the future. ETO office hours were also offered virtually twice a month.
- Every new hire watches an ETO orientation training video developed by DCS ETO and Social Solutions/Bonterra. This video was developed for new staff to complete as part of their onboarding process. There is additional training being developed for more advanced use of ETO by supervisors.
- LeCroy & Milligan Associates provided staff with HFPI refresher training.

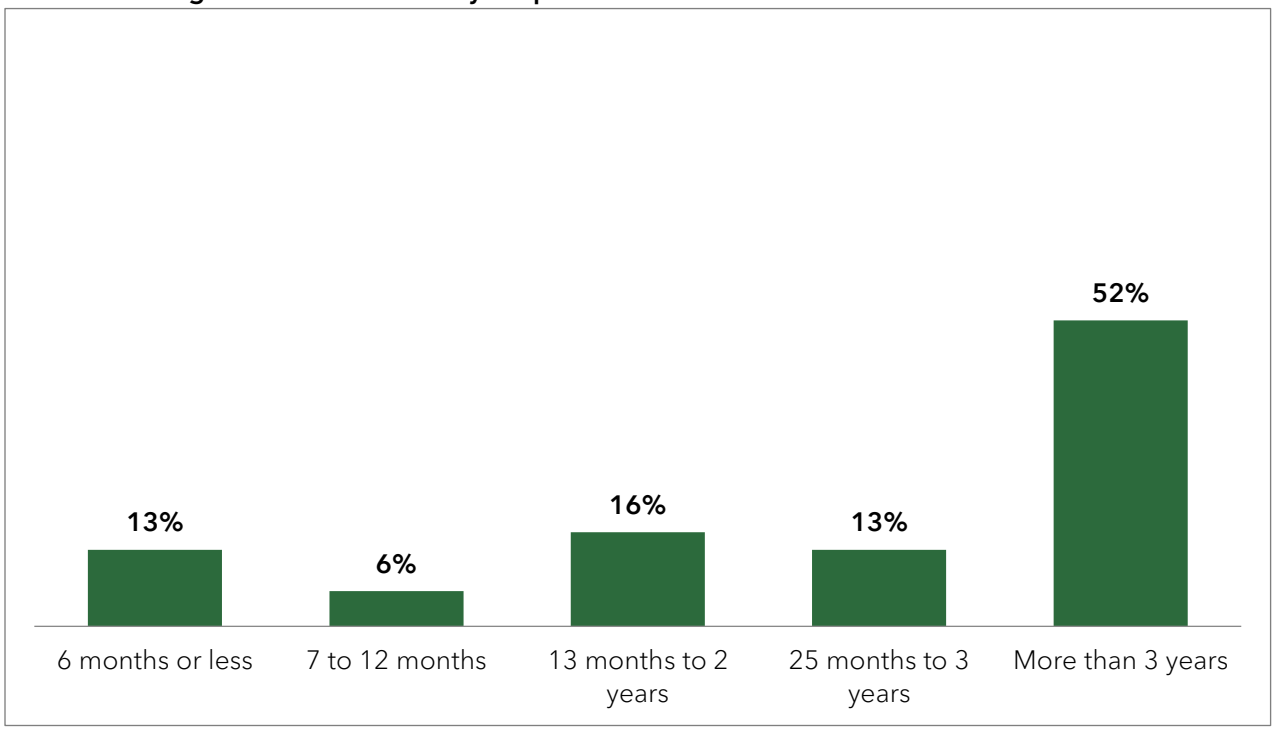
Staff Survey Results

Staff surveys are conducted annually to assess overall satisfaction with various aspects of their job including agency support, supervision, and the HFAz 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. The staff survey was conducted through an online Qualtrics collector that was distributed by HFAz Central Administration in December 2021 and January 2022. The survey was voluntary and collected anonymously. To facilitate the anonymity of the survey respondents, all responses were aggregated by site only with no differentiation by job role. A total of 159 staff responded to the survey. The total N varies by question depending on the number of people who responded to the question.

Staff Characteristics from Staff Survey

More than half (52%) of the staff who responded to the survey has worked at HFAz for 3 or more years (Exhibit 23).

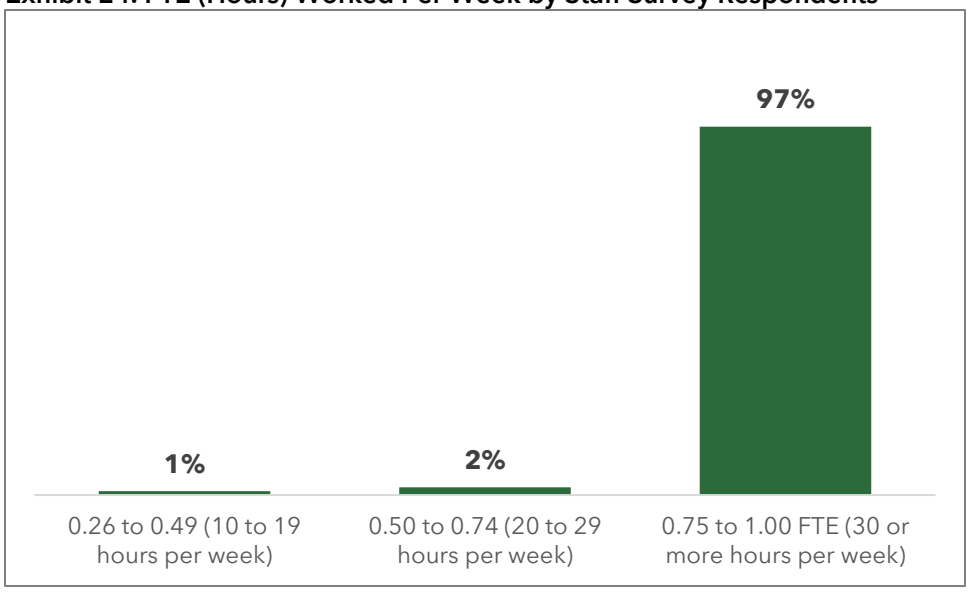
Exhibit 23. Length of Time Staff Survey Respondents have Worked with HFAz



(N=159)

Almost all of the staff were 0.75 to 1.00 full-time equivalent (FTE) (Exhibit 24).

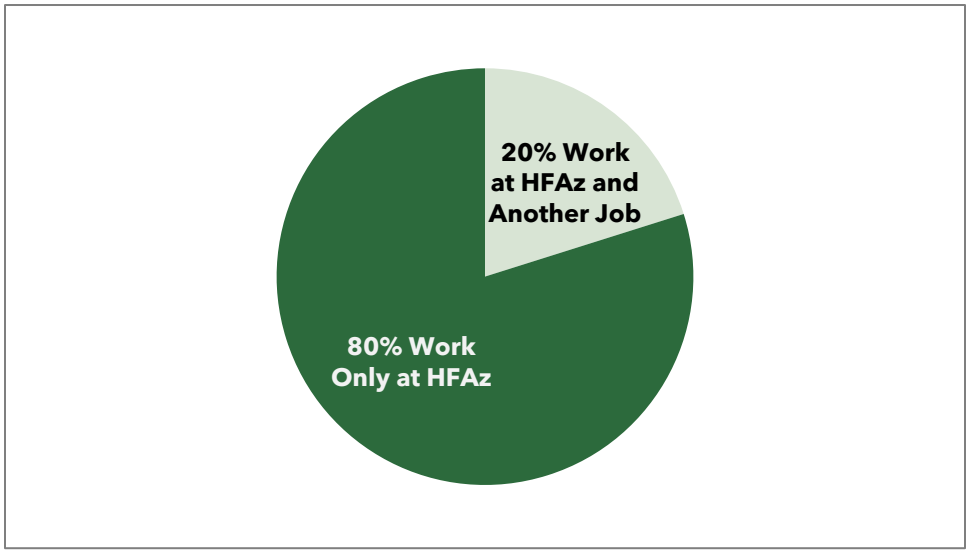
Exhibit 24. FTE (Hours) Worked Per Week by Staff Survey Respondents



(N=157)

A fifth (20%) of the staff have another job in addition to their work at HFAz (Exhibit 25).

Exhibit 25. Proportion of HFAz Staff Survey Respondents Who Work at An Additional Job

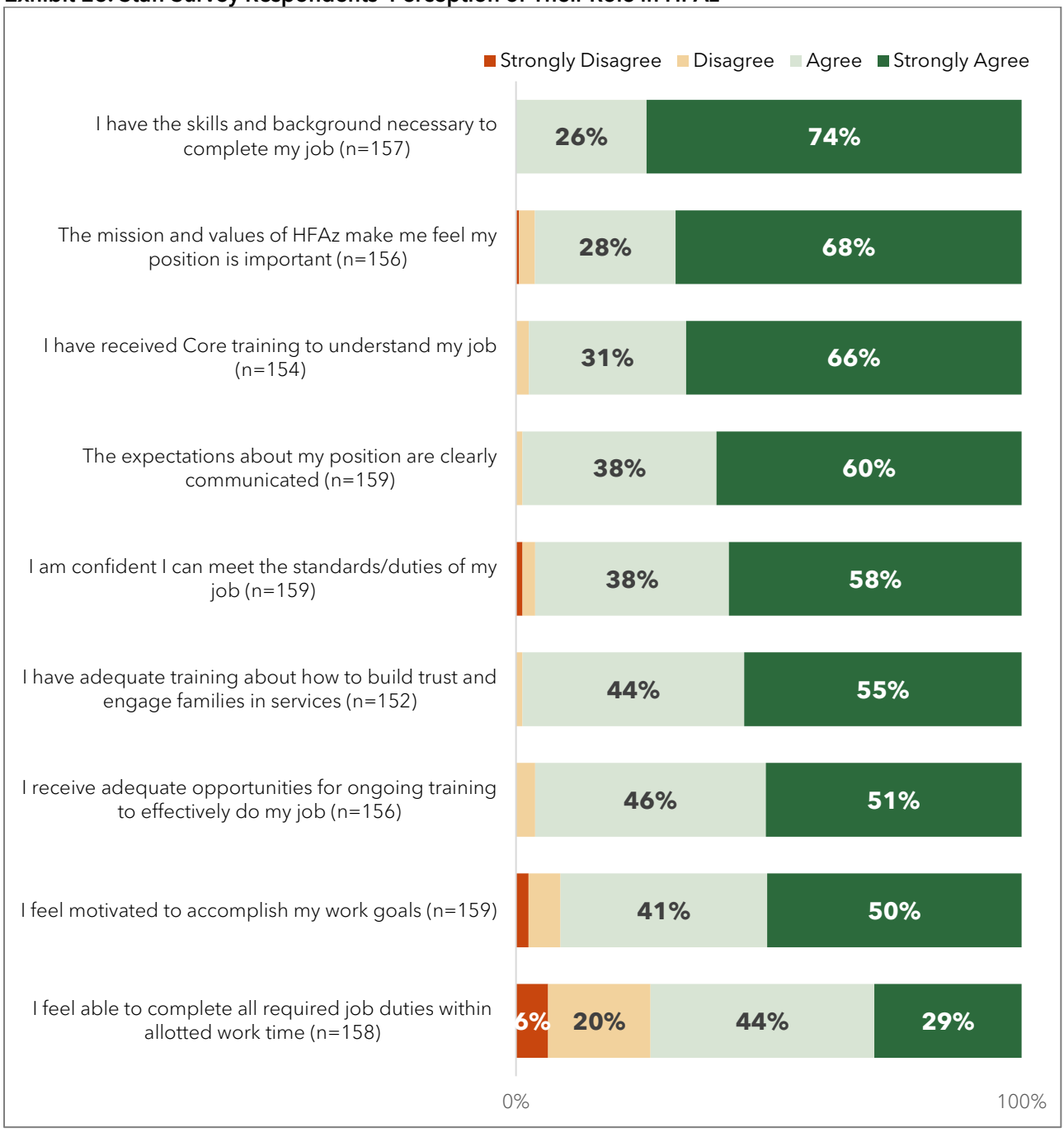


(N=158)

Staff Role

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 HFAz (Exhibit 26). Of all the statements, the smallest proportion of staff agreement was with one regarding being able to complete all required duties within allotted work time and feeling motivated to accomplish work goals.

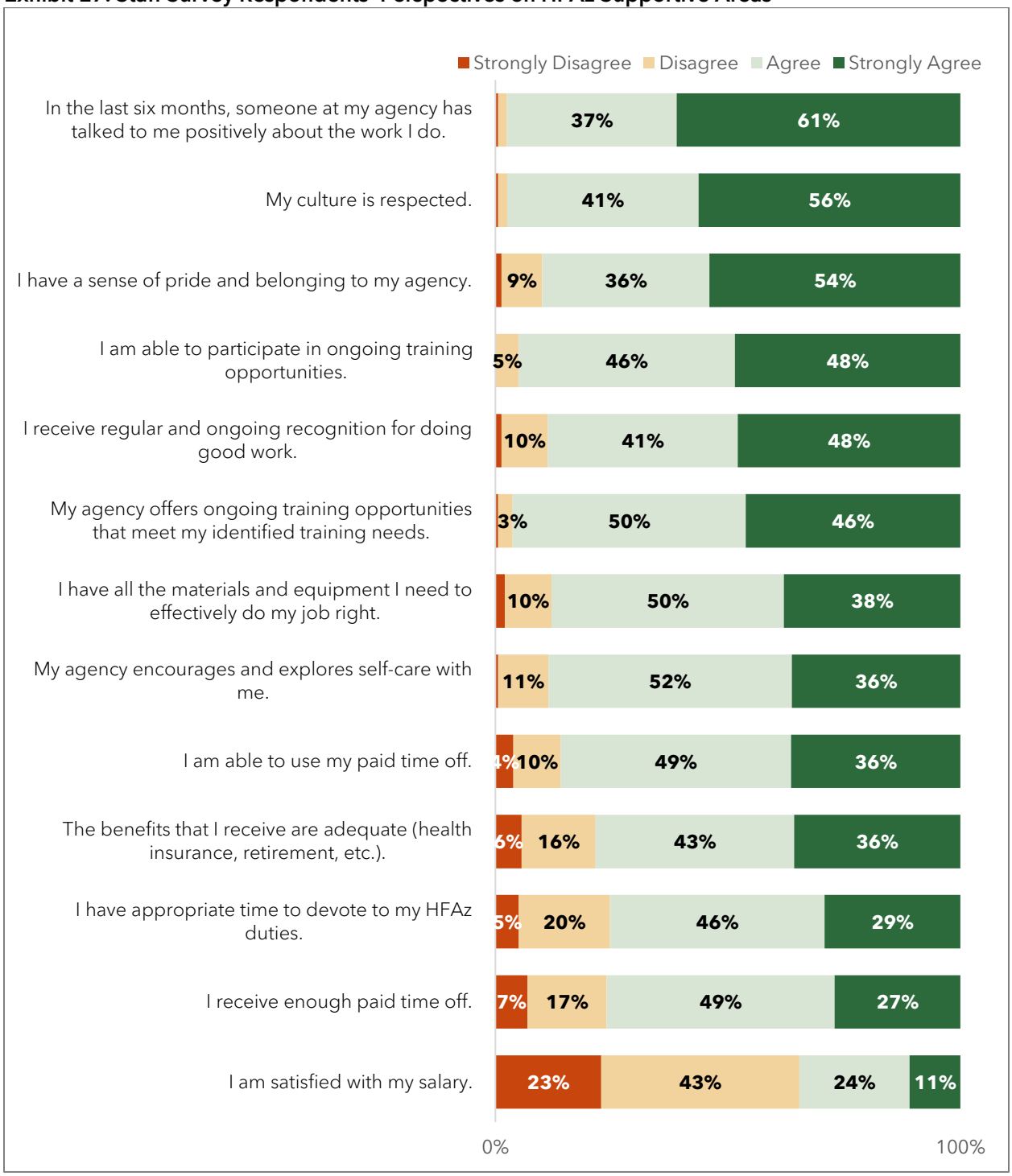
Exhibit 26. Staff Survey Respondents' Perception of Their Role in HFAz



Agency Support

Most staff agreed/strongly agreed that they have a sense of pride and belonging to HFAz and receive regular and ongoing recognition for doing good work (Exhibit 27). The lowest level of combined agreement was with being satisfied with one's salary.

Exhibit 27. Staff Survey Respondents' Perspectives on HFAz Supportive Areas

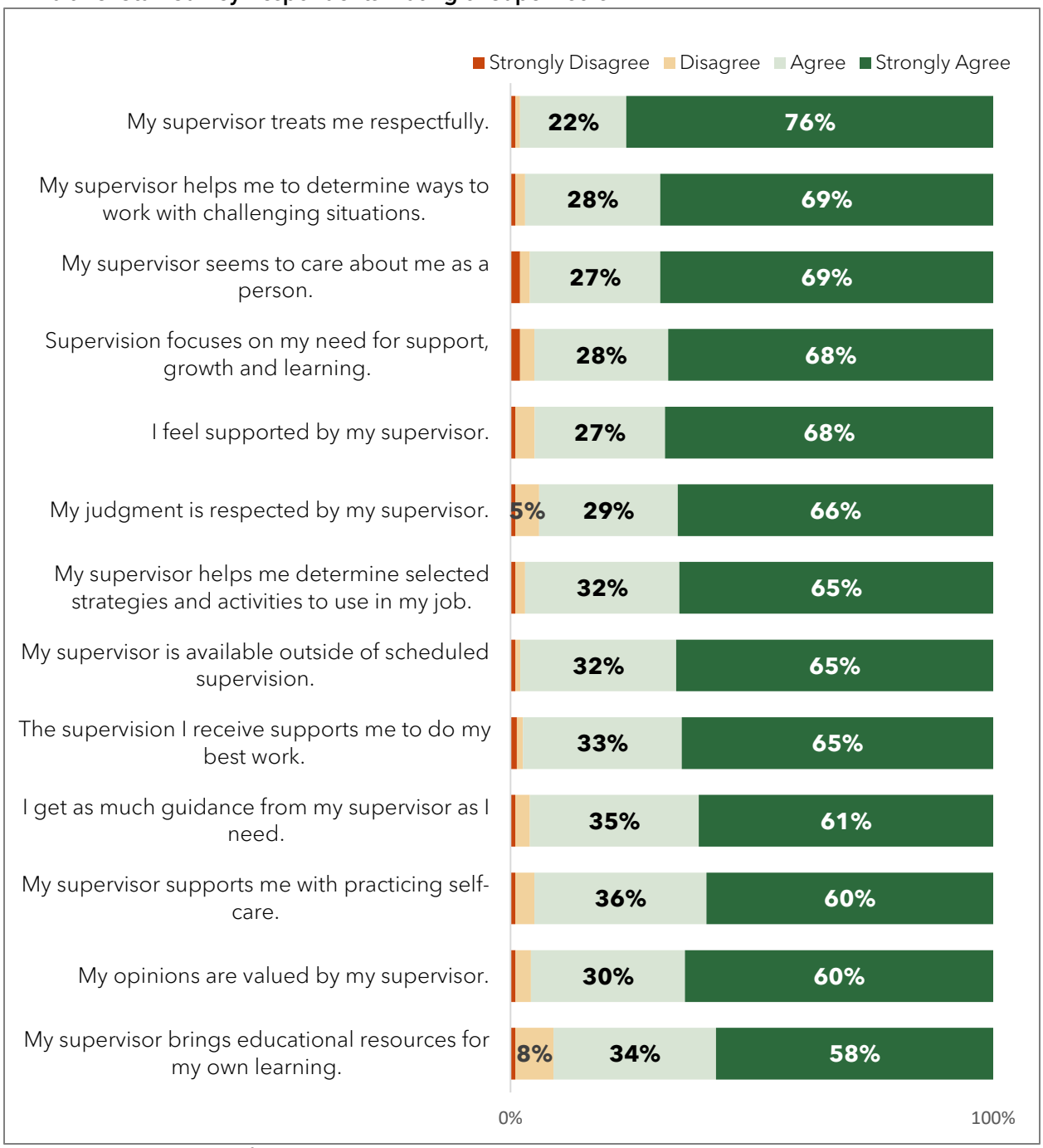


(N varies by statement from 152 to 158.)

Supervision

Staff highly regard their supervisors and how they provide guidance, with 92% or more agreeing or strongly agreeing with all statements about supervision (Exhibits 28 and 29).

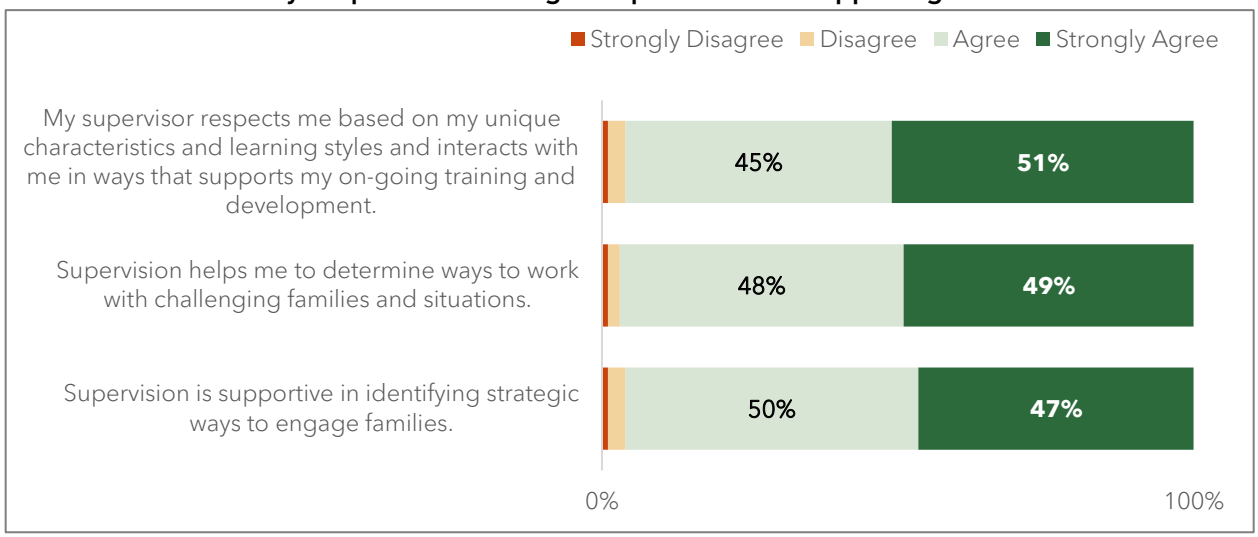
Exhibit 28. Staff Survey Respondents' Rating of Supervisors



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

A large proportion of staff (97%) 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 situations (Exhibit 29).

Exhibit 29. Staff Survey Respondents' Rating of Supervision and Supporting Families



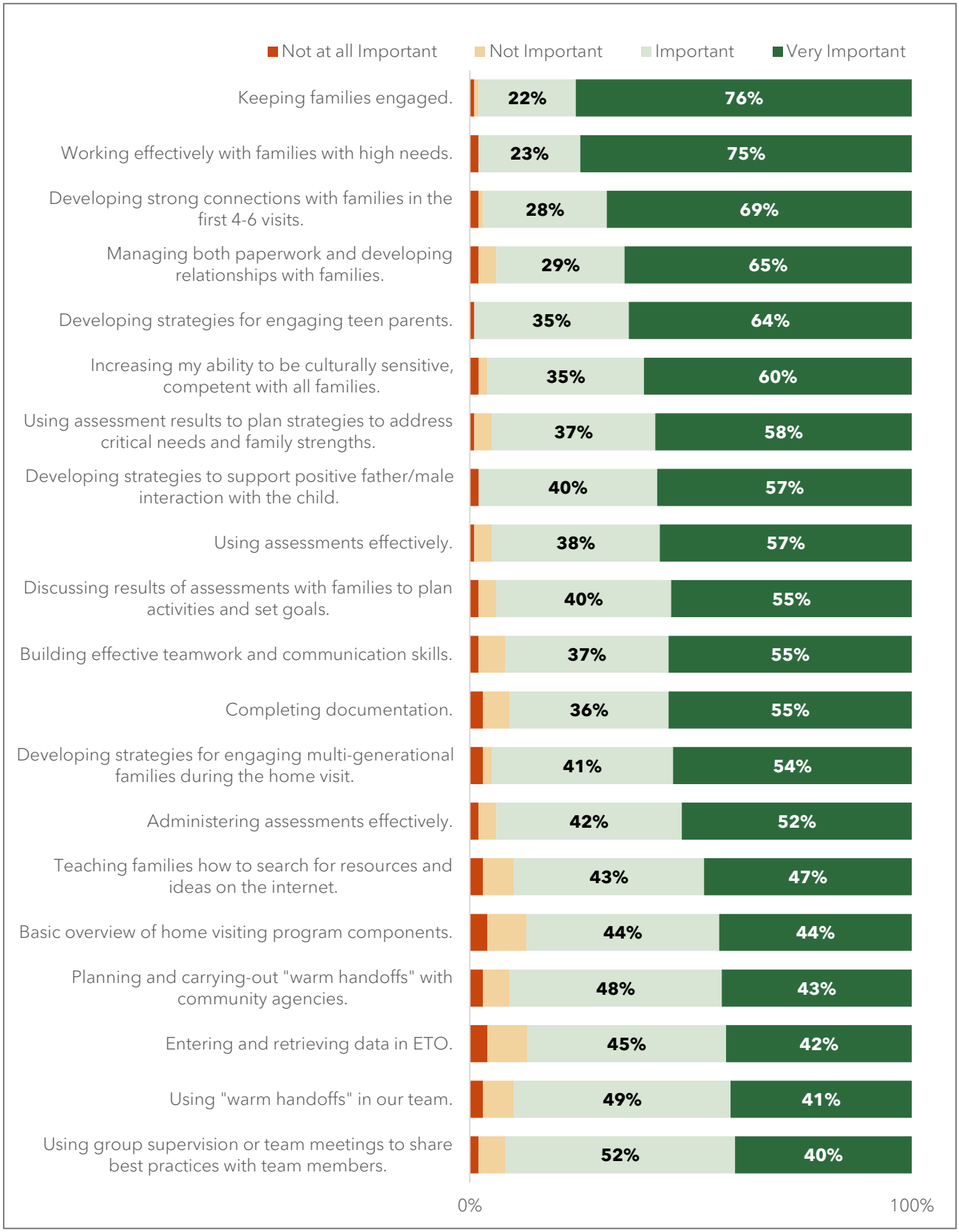
Although only a small number of open-ended comments were provided about supervisors, they largely mirrored their high level of agreement with the statements about them.

- *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 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.*

Training Opportunities

Staff were asked to rate how important they felt certain training areas were to their position (Exhibit 30). The most important training areas rated by staff include family engagement strategies, working with high needs families, and managing the balance between collecting paperwork and relationship building with families.

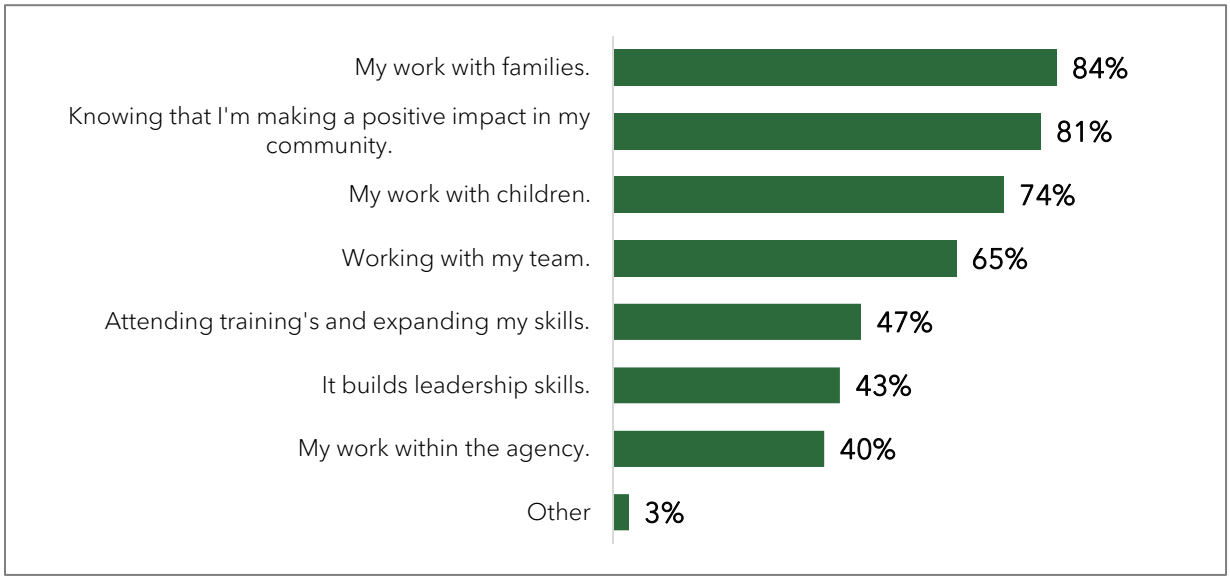
Exhibit 30. Staff Survey Respondents' Rating of Training Areas



Rewarding Aspects of Work and Working With Teams

Working with families, knowing that they make a positive impact in their community, and working with children were viewed as the most rewarding aspect of working with HFAz by a high percentage of staff (Exhibit 31).

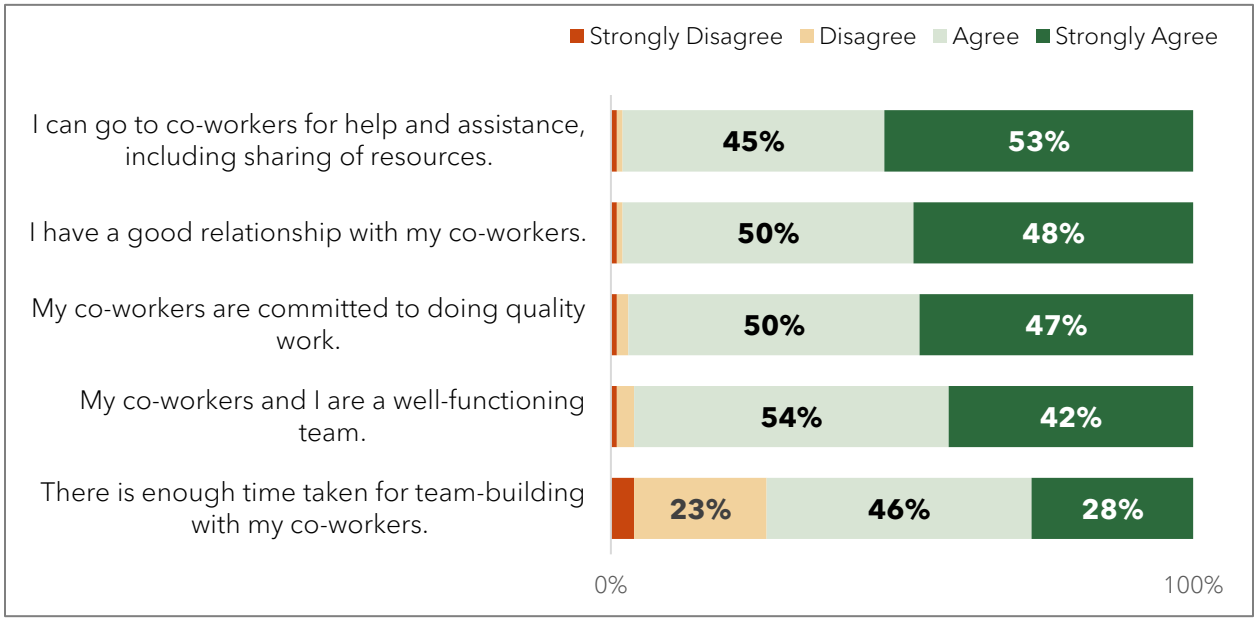
Exhibit 31. Staff Survey Respondents' Rewarding Aspects of Working with HFAz



(N=159)

Almost all staff agreed/strongly agreed with most of the positive statements about their relationship with their team members (Exhibit 32). Only regarding having enough time for team building with co-workers was the level of agreement/strong agreement somewhat lower (73%).

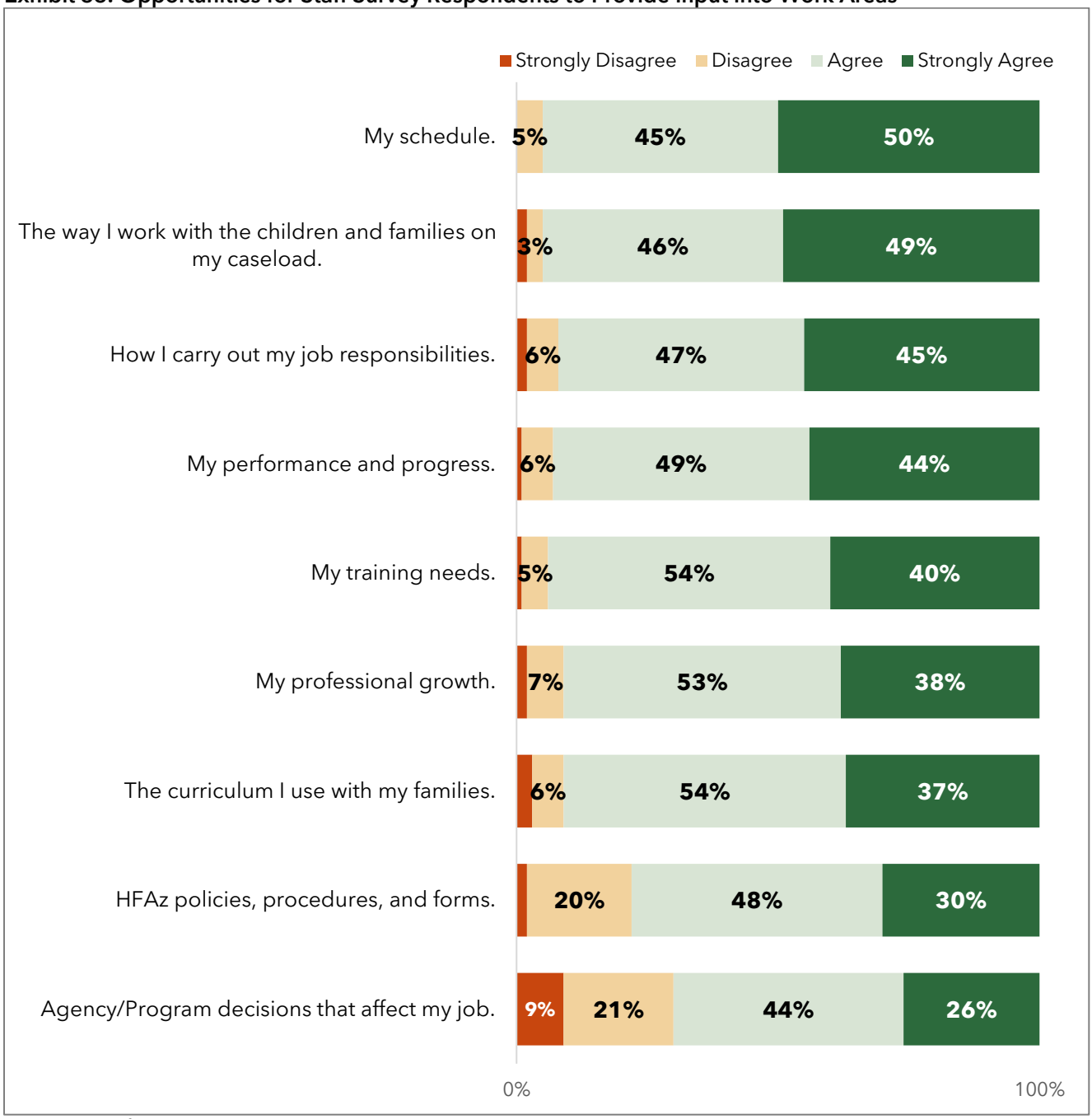
Exhibit 32. Staff Survey Respondents' Relationships with Team Members



(N=159)

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 33). They felt had less input into things decided or developed at other levels in the agency such curriculum, policies, and forms.

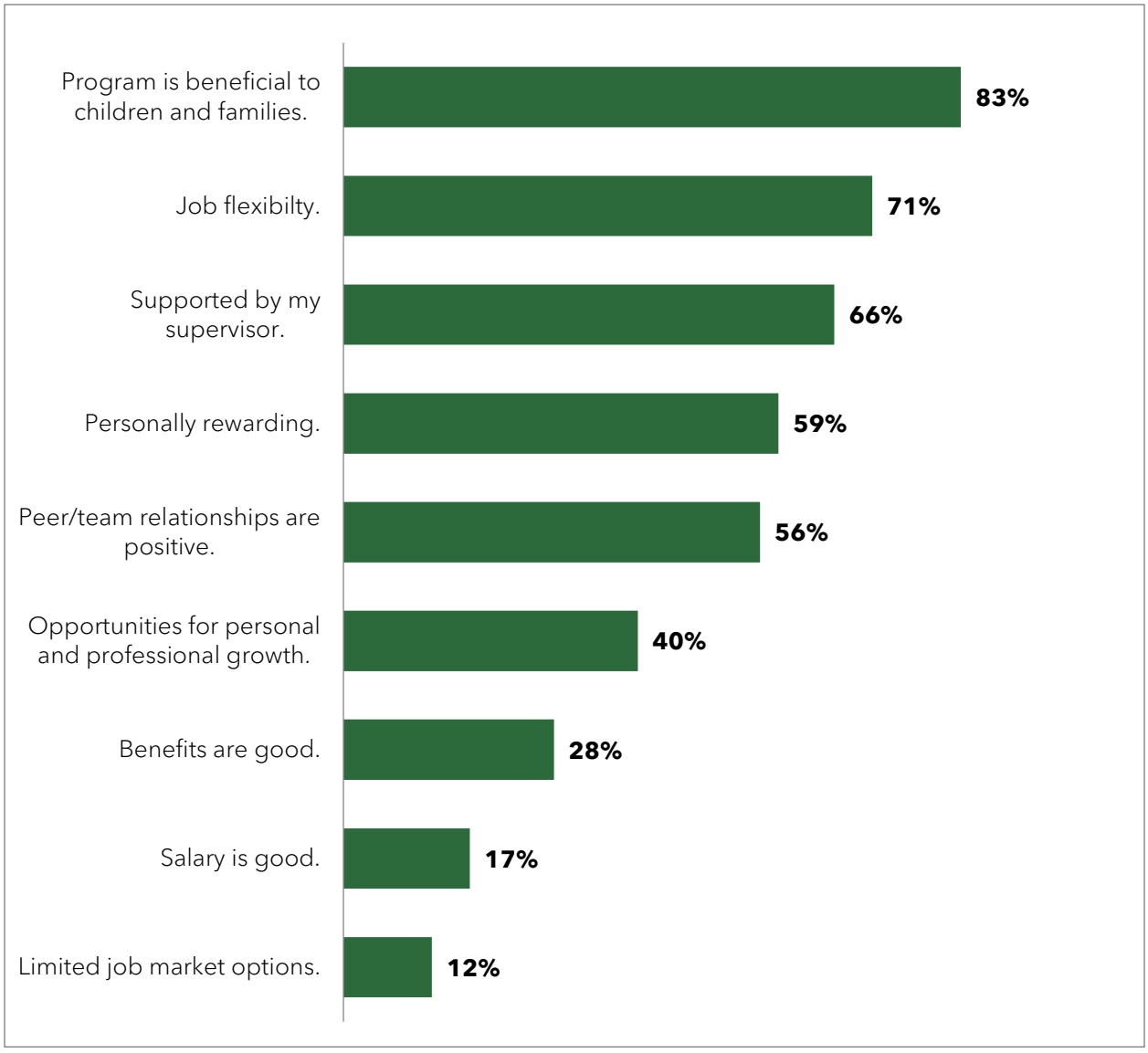
Exhibit 33. Opportunities for Staff Survey Respondents to Provide Input into Work Areas



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

Feeling that the program is beneficial to children and families was the reason the largest proportion of staff (83%) indicated motivates them to stay with HFAz (Exhibit 34). Job flexibility and being supported by one's supervisor were also major reasons cited by 71% and 66% of the staff, respectively.

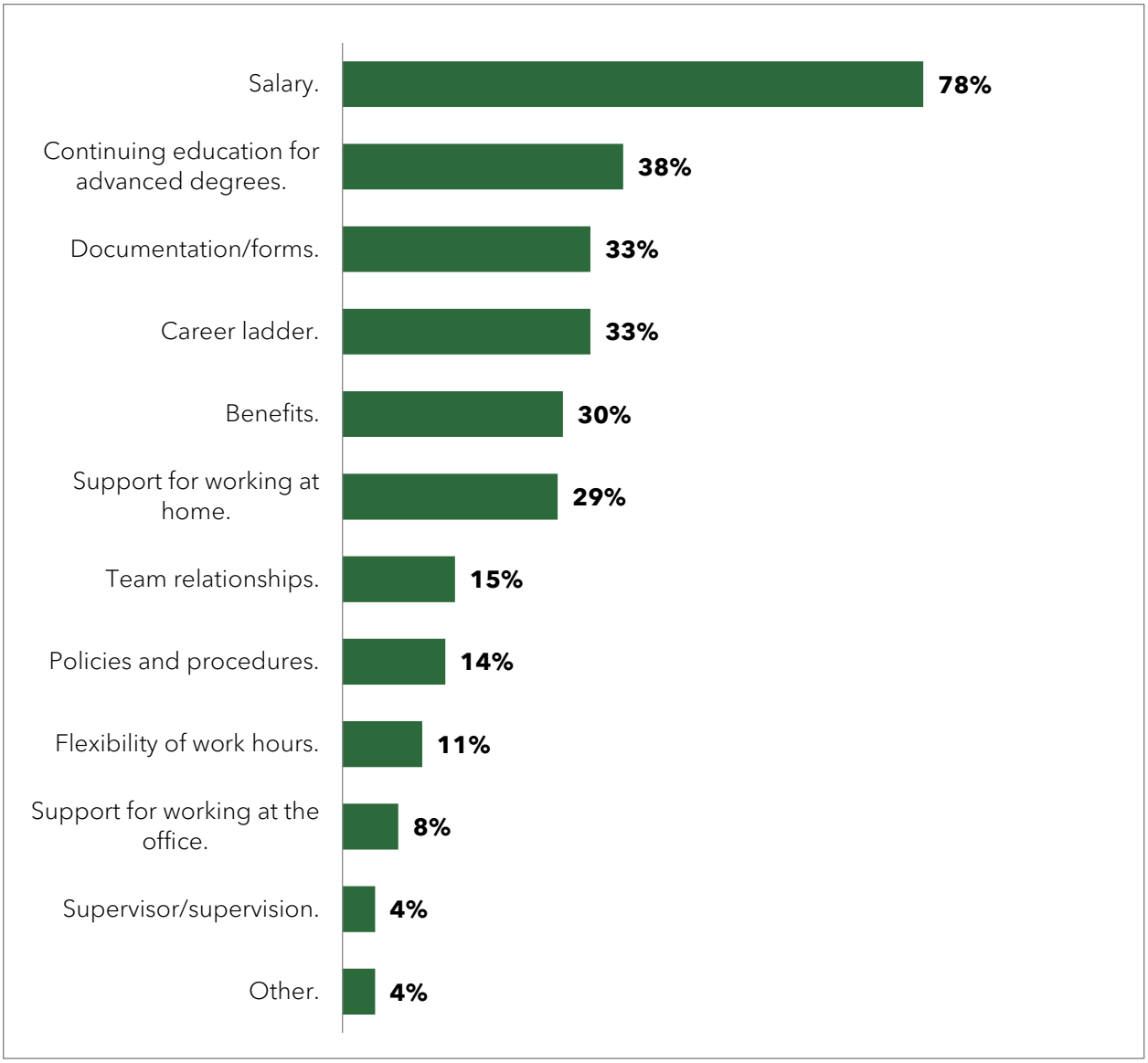
Exhibit 34. Reasons Staff Survey Respondents Stay with HFAz



(N=159)

Salary was the aspect of work most identified by staff (78%) as needing improvement (Exhibit 35). The next most commonly reported aspects of work that staff felt needed improvement included continuing education (38%), documentation/forms (33%), and career ladder (33%).

Exhibit 35. Staff Survey Respondents Perspectives on Aspects of HFAz Work Needing Improvement

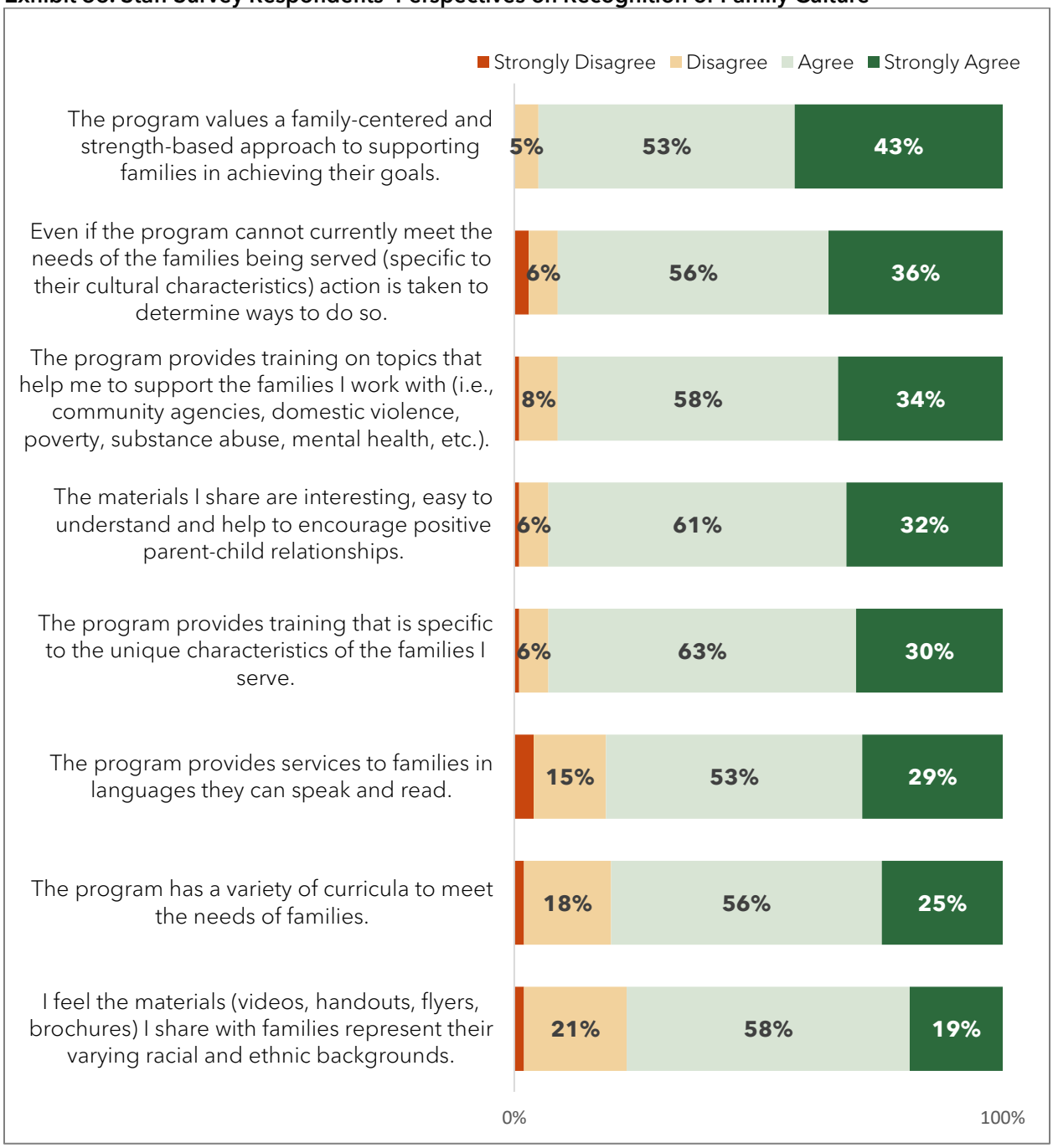


(N=159)

Diversity, Equity, Inclusion and Belonging Areas

Most staff agreed with statements on diversity, inclusion, equity, and belonging (DEIB) regarding the families served (Exhibit 36). A few areas that a portion of staff disagreed with include: the program provides services to families in languages they can speak and read, the program has a variety of curricula to meet the needs of families, and materials shared with families represent their varying racial and ethnic backgrounds.

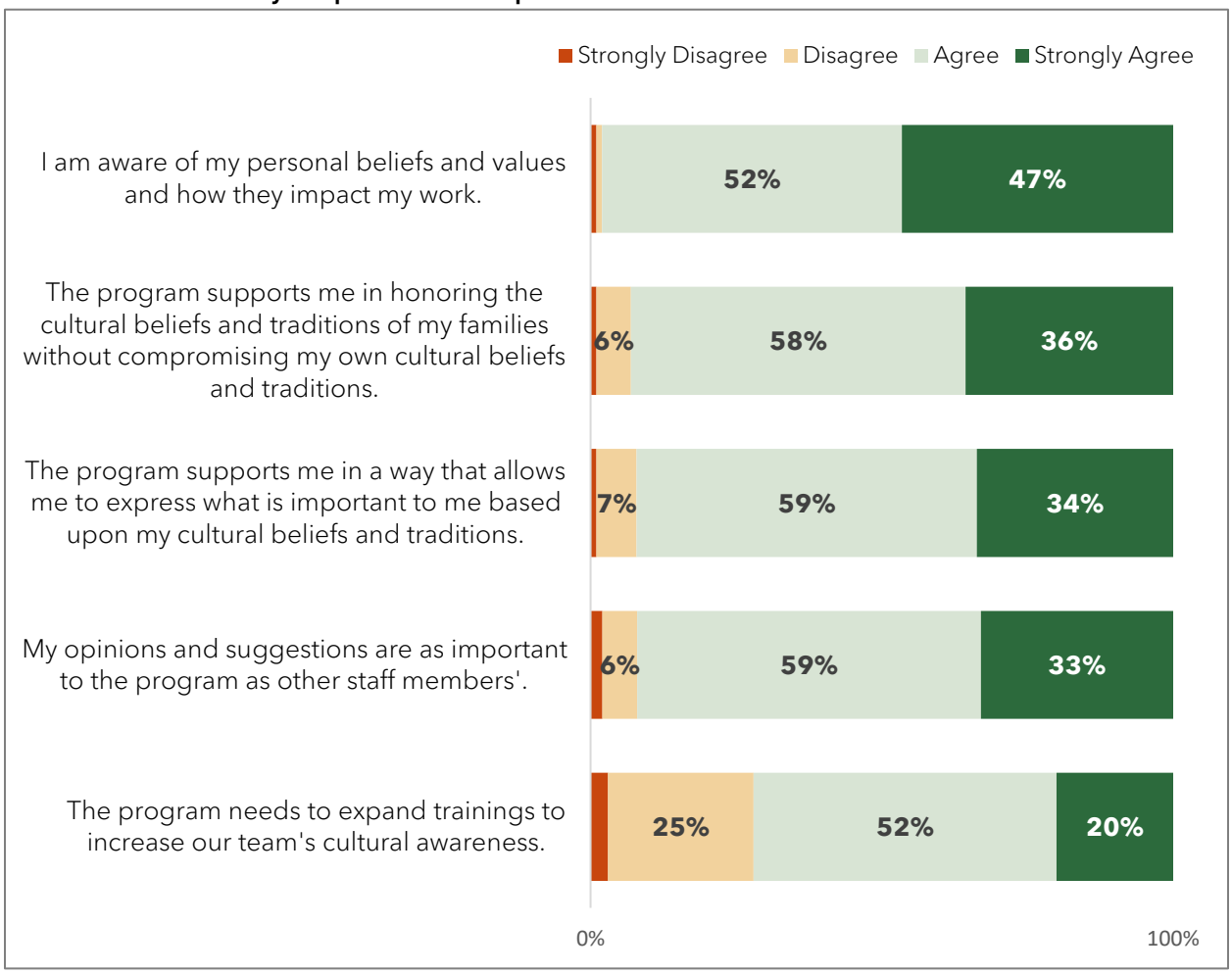
Exhibit 36. Staff Survey Respondents' Perspectives on Recognition of Family Culture



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

The largest proportion (99%) of staff agreed/strongly agreed that they were aware of their personal beliefs and how they impact their work (Exhibit 37). Seventy-two percent of staff indicated that HFAz needed to expand training to increase their team's cultural awareness.

Exhibit 37. Staff Survey Respondents' Perspectives on Their Personal Culture and Biases



The survey included several open-ended questions. Common themes and staff quotes 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 38). Another mentioned by a few staff was that curricula lacked sufficient activities.

Exhibit 38. Curriculum Issues Experienced by Staff Survey Respondents

Themes	
General Comments	• Not written from a strengths-based perspective. • Need activities specific to certain populations (i.e., teen moms). • Not enough developmentally appropriate activities (i.e., no lessons available for children over 36 months).
Cultural Relevancy/Appropriateness	• Provide activities and worksheets in languages other than English and Spanish to account for refugee populations and others. • Provide activities that are more relevant to indigenous families
Ease of Access	• Have activities available in a digital format.

Staff were asked to provide comments on the curriculum they use with families. A few themes emerged on the content of the curriculum itself, the availability of activities in other languages for families who do not speak English or Spanish, and digital options for tech-savvy families. Staff quotes include:

> *"The 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."*
>
> *"Sometimes too basic, too brief, not interesting to all families. Not meeting all families' needs. Difficult to search for information. Limited developmentally appropriate activities."*
>
> *"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."*
>
> *"We need more staff that speak diverse languages such as sign language, Arabic, African languages etc."*

Staff were asked to comment on some of the recent challenges they have experienced when working with families (Exhibit 39). Most of the responses centered around COVID, content and delivery of virtual visits, and requirements on frequency of visits.

Exhibit 39. Challenges Experienced with Home Visits by Staff Survey Respondents

Themes	
Frequency & Content of Visits	• Requirements for a family to receive services 1x/week: sometimes difficult for busy parents or single mothers. • Some parents use the visit as a counseling session.
Virtual Visits	• Families use virtual visits out of convenience, not due to illness. • Families are not as engaged.
COVID-19 Concerns	• Families may lack needed technology to successfully complete a visit. • Wearing a mask can affect rapport-building with families when they can't see the FSS' facial expressions. • Some families take no precautions and live in very small spaces, which is concerning for staff with higher COVID-related risks.

Quotes from staff responses include:

> *"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."*

Staff responses regarding visit modality were mixed, though more FSS staff reported that their families preferred in-person visits for the sake of better engagement with the child. The FSS who reported a family preference for virtual visits commented that it was the flexibility that families seemed to like (Exhibit 40).

Exhibit 40. Staff Survey Respondents' Observations of Families and Virtual vs. In-Person Home Visits

Themes	
In-Person Preference	• Kids are more engaged during in-person sessions; easier to complete activities together • Enjoy having someone come to the house to interact with kids
Virtual Preference	• Only good when there is illness in the family • Nice to have the option when a family is very busy and doesn't have time to complete in-person

Quotes from staff responses include:

> *"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 have enjoyed more in person visits as kids were not as engaged when it came to doing activities through video chat."*
>
> *"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."*

Staff were also asked to comment on their supervision and how well they thought it was going. This is an important aspect of the job since many FSS's made a switch to working remotely at least part of the time during the previous years. Most staff reported that their supervision was going well and that their immediate supervisor was available when they needed to talk to them or just get advice or feedback. One person felt like the frequency of supervision sessions was too much. Some of the following comments were made by staff:

> *"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 as monthly MHC. It would be ideal to consider supervision every other week."

At the end of the survey, staff were asked to provide any other comments/feedback, and the responses were overwhelmingly related to wage increases and ways that HFAz can show staff appreciation for their hard work. Some staff comments are below:

"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 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 an increase in 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."

"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."

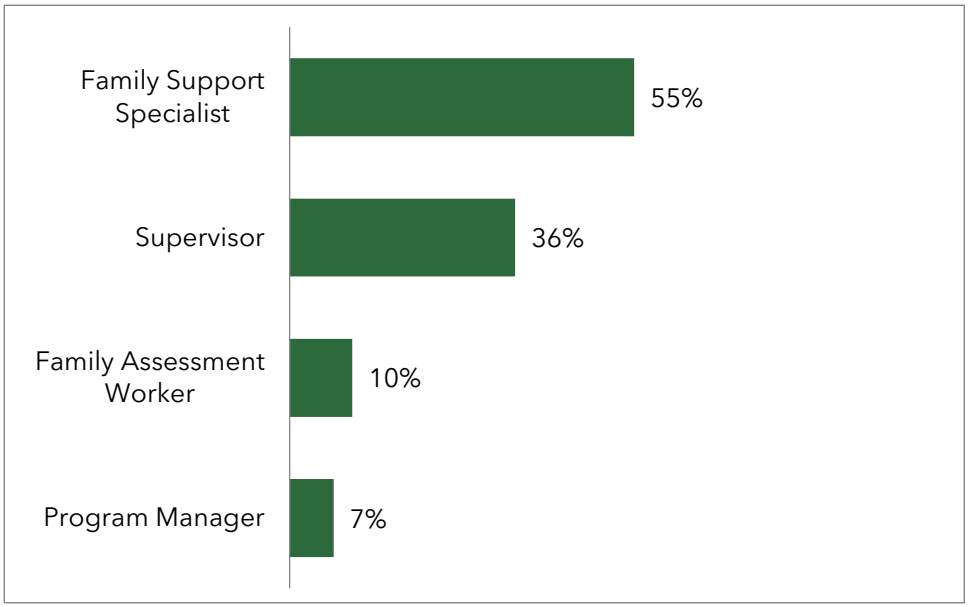
"I understand being nonprofit and following budget and funding guidelines is essential and important. I do wish that there were more opportunities for raises, especially for job performance. It's difficult knowing and seeing different levels of work being put into the same position and yet everyone is compensated the same."

Central Administration Site Visit Survey Results

As part of the HFA *Best Practice Standards (BPS), 8th Edition* (2022), program sites participate in a site visit by HFAz Central Administration. The Site Visit Survey was developed to gather feedback from staff who participated in the process. LeCroy & Milligan Associates uploaded the Site Visit Survey to a Qualtrics survey collector. The survey link was distributed to staff by HFAz Central Administration on 10/11/2022 and the collector was closed on 10/31/2022. The survey was voluntary and collected anonymously.

A total of 31 HFAz staff completed the online survey, representing 11 teams. A range of 1 to 6 staff from each team completed the survey. The total N varies by question depending on the number of people who responded to the question. Exhibit 41 shows that most of responding staff were FSS and Site Supervisors.

Exhibit 41. HFAz Staff Role of Site Visit Survey Respondents

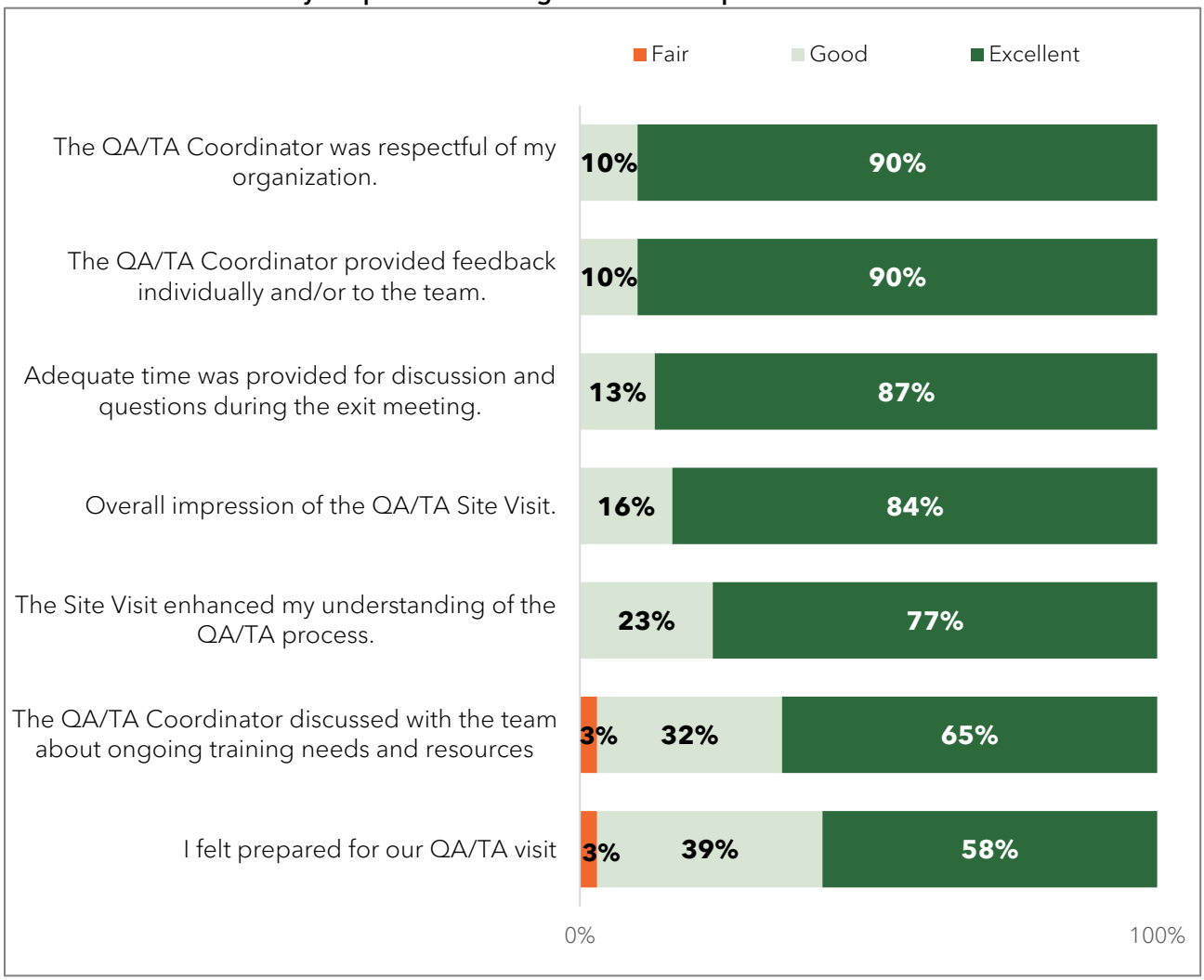


(N=31) Note: Some FSS also reported being an FAW, so the percentages do not total to 100%.

Staff Rating of the Site Visit Experience

HFAz staff were asked to rate their experience with the site visit on a scale from fair, good, and excellent. The majority of staff rated all areas measured as good or excellent (Exhibit 42). The two areas that 90% (n=28) of respondents rated as excellent were that the coordinator was respectful of their organization and provided feedback individually and/or to the team. Most staff also felt that there was adequate time for discussion and questions during the exit meeting and they had an overall positive impression of the Site Visit. Almost all staff (97%, n=29) said they were likely or very likely to tell their peers about their experience with this Site Visit.

Exhibit 42. Site Visit Survey Respondents Rating of Site Visit Experience



(N=31)

Positive Aspects of the Site Visit

Staff were asked an open-response question to indicate what they liked most about the Site Visit. A total of 28 staff responded. Overall, the site visits were well-received by respondents. They appreciated the helpfulness of feedback, the opportunity to learn and improve, and the general site visit process. Common themes and select quotes are shown in Exhibit 43.

Exhibit 43. Aspects Site Visit Survey Respondents Liked Most about the Site Visit

Themes	Quotes
Received helpful feedback from site visit - Staff appreciate receiving feedback that was: • Strengths-based • Concrete, thorough, and constructive • Individual/personal • From experienced QA/TA staff	"I appreciated the opportunity to have facetime with Central Administration. This allowed time for questions that were related and unrelated to the site visit. I valued their insights particularly about opportunities the site could explore for site enhancement. The feedback she provided was very constructive and framed in a comfortable and safe setting. Our team felt at ease." "I enjoyed the thoroughness of feedback - I felt we were acknowledged for our strengths and the opportunities for growth were given in such a way that excited and motivated the team." "The way that all feedback was presented. Areas of growth were discussed in an open and positive manner."
Site visits provided an opportunity for learning and improvement – Staff commented on the various learning opportunities that were presented during site visits: • Explore options for site enhancement • File review process • Learn program standards • Enhance reflective strategies • How to better support staff	"I liked that the meeting was an opportunity to learn and ask questions rather than it being a meeting that is serious and given in a more negative light." "Site visits help me and my staff to be aware of different standards to provide better visits and be more intentional with each family." "The QA team is very friendly and knowledgeable making it very easy to ask questions."
Site visit process was overall helpful and supportive - Staff felt supported in the following ways from the site visit: • Staff knew what to expect from the visit because of preparation work • Site visitors used good communication strategies • Time was well-utilized • Discussions eased staff concerns over accreditation • Staff questions were answered	"The QA/TA feedback was well presented, strength based. The QA/TA was engaging throughout and set up the visit to know what to expect." "The site visit made me feel very supported and eased my concerns about the upcoming accreditation process." "I was glad to see that they stayed in town for a few days and not be so rushed about it." "I liked the communication I had with site visitor prior to and during the site visit. She showed interest and responded within appropriate time."

Recommended Changes to Site Visits

Staff were asked in an open-response question "Are there any changes that would improve this Site Visit?" A total of 25 people provided a comment, of which 76% (n=19) indicated that they had no recommended changes. Of the six respondents who recommended a change, common recommendations and quotes are shown in Exhibit 44.

Exhibit 44. Site Visit Survey Respondents' Recommendations to Improve Site Visits

Recommendation	Quotes
Provide feedback from a neutral person who is not a site/team member	• "My team appreciates when they receive individual feedback. I provided feedback this time around. I feel they benefit the most when they hear it from a neutral person."
Provide feedback in person	• "I think sometimes, them being in person for the individual feedback would be beneficial." • "Having an exit meeting in person, and the report sent to supervisor after site visit."
Clarify the file review process	• "I would like to better understand how files are reviewed for certain aspects. For instance, I found some items in my chart that were stated as missing so I would just like to better understand to support this next time."
Incorporate food into Site Visits	• "I wish we could have our visitors in person and we could all go out to lunch." • "Perhaps, some snacks.'

Other Staff Comments

Staff were provided with space on the survey to comment on specific topics or anything else they wanted to convey about their Site Visit experience. Six people gave the following positive comments about their experience, which focused on the helpfulness of recommendations received, feeling assurance about the accreditation process, and having the opportunity to learn and grow in their position with support from HFAz Central Administration.

- *Lots of recommendations on new strategies and standards.*
- *It's great to have one on one time with Central Administration.*
- *It made me feel safe and secure with the upcoming accreditation. We felt seen and understood.*
- *I love the whole process and always am able to use it to support my own skill building and to support staff.*
- *I like the feedback in file review.*
- *I enjoyed receiving feedback that is helping me grow in my role.*

Staff Exit Survey Results

Staff members who leave HFAz have an opportunity to provide feedback via an online Staff 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 25 completed surveys from staff who exited between October 2021 and September 2022. Staff were asked about their role in the HFAz program, most of whom worked directly with families (Exhibit 45). Staff who left HFAz in FY22 varied greatly in their work tenure, ranging from less than one month to 17 years. All respondents (100%, n=25) worked full-time.

Exhibit 45. Roles of Staff Exit Survey Respondents

Role	n	%
I mostly worked directly with families.	24	96%
I mostly worked as a supervisor, manager of employees.	1	4%

Staff were asked to indicate the main reason why they left their position with HFAz (Exhibit 46). Over a third of respondents left because they wanted better pay and benefits. Slightly less than a third gave the reason "other" with more information given below Exhibit 46. Several staff left their position with HFAz to pursue educational goals.

Exhibit 46. Reasons Staff Exit Survey Respondents Left Their Position with HFAz

Reason	n	%
Wanted better pay and benefits	9	36%
Other (see comments below)	7	28%
Returned to school	4	16%
Position in Healthy Families was not a good fit for me	2	8%
Moved away from the area	1	4%
Left the workforce/ retired	1	4%
Left due to a health issue/family member health issue	1	4%

Staff who responded "other" provided further explanation as to why they left HFAz. Common themes were related to a general dissatisfaction with the number of responsibilities that were placed upon employees, fewer options for virtual visits when families were dealing with illness from COVID-19, a perceived lack of stability and continuity among management, and a feeling of being unheard and not valued by the organization's leadership staff. One respondent also felt that there was not a good backup system in place when an employee had to take time off due to illness or vacation, saying they had to work twice as hard before leaving and upon their return in order to catch up.

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. Almost two-thirds (64%, n=16) said that "yes," something could have been changed, while 36% (n=9) said "no." The most common responses of those who answered yes was around wanting a higher salary, better management, gradually increasing new staff caseloads, and providing staff with additional support around local program outreach and family recruitment. Select staff comments include:

- *Better pay may have allowed me to stay in the area. Need to move out of state since my income does not meet the basic rent in the area.*
- *I think that Family Support Specialists play a crucial role in this program so that they should be paid more. The pay should be transparent and equal. In addition to that Family Support Specialists are being asked to do outreach in the community without any additional compensation nor proper training for it.*
- *While my manager was extremely helpful in helping navigate all of the paperwork and scheduling, I frequently found myself not knowing what I even needed help with. The job was so new and I feel like I just got thrown into handling 20+ families too quickly. If there had been a max amount of families that gradually increased over the span of the first 6 months (or 3 months at the least), my experience working for Healthy Families would have been exponentially better.*
- *Not feeling like my ability to sell the program can make or break my value to the agency or the value of my position.*
- *Being provided with more time off, better compensation, and more opportunity for career growth.*
- *Support furthering education incentives for additional job responsibilities/ pay increase employee appreciation activities employee self-care support and guidance*
- *Teleworking for trainings and having families closer to my home area.*
- *The agency could have shown some respect/flexibility/sensitivity when employees ask for some reciprocated flexibility within the FSS' role. They could have shown that my dedication to working for the program for 8 years meant anything and listened when I had concerns regarding my position and the direction that HF was going given the current national concerns (i.e., gas prices, etc.).*

Staff were asked to write in their top three favorite things about working with the agency. Common answers were having supportive supervisors, reflective supervision, thorough training sessions that helped employees develop new skills, and helping families in need. Staff were also asked to respond with their top three least favorite things about working with the agency. The most common responses were low pay/low reimbursement rates when using a personal vehicle for work, large caseload sizes, and feeling undervalued in their role.

Staff members were asked to rate their agreement or disagreement with the statement, **"Most employees I knew and worked with at the Healthy Families program felt positive about their working situation."** The majority (80%, n=20) said they were either neutral, disagreed, or strongly disagreed with this statement (Exhibit 47).

Exhibit 47. Staff Exit Survey Respondents Perceptions on Colleagues Feeling Positive About Their Work Situation at HFAz

Rating	n	%
Strongly Agree	3	12%
Agree	2	8%
Neutral	11	44%
Disagree	4	16%
Strongly Disagree	5	20%
Total	**25**	**100%**

- Staff who responded with "strongly agree" or "agree" with other employees feeling position about their position mentioned the flexibility to work from home as well as the positive impact that HFAz has on families.
- Staff who responded with "neutral" brought up insufficient pay (though there was a pay increase for the FSS position after this survey was administered), perceived lack of support from management, feeling emotionally drained and lacking a strong sense of "community" in the workplace.
- Staff who responded with "disagree" or "strongly disagree" felt like they were under-appreciated in their role, said the rate of pay was unsustainable, and that leadership was unapproachable.

Finally, staff were asked: **"What do you think the organization that you worked for did well regarding implementing the HFAz program?"** Responses varied but most commented on the passion of employees and managers to provide compassionate care to families as something their organization did well. Many respondents liked having the option to attend trainings in-person and virtually and that there were numerous opportunities for personal and professional development for staff.

Caregiver Survey Results

As part of the HFA *Best Practice Standards (BPS), 8th Edition* (2022), program sites must gather information from parents and caregivers to ensure that their voices are heard, and that feedback received is used to improve the program's ability to provide culturally respectful and responsive services. The strategy employed this year by HFAz, as recommended in the *Best Practice Standards*, is the revision of the annual Caregiver Survey to include questions on diversity, equity, inclusion, and belonging (DEIB). By providing sites with this report of Caregiver Survey data, sites will use this information to develop an equity plan based on what the site learns about itself, from an equity perspective, in the way it supports its staff, the families it serves, and the community it works within. The equity plan sets a course for continuous improvement to achieve greater equity in all facets of its work.

The HFAz Caregiver Survey provided information for program staff and an opportunity for participants to reflect on their experiences in the program. The Caregiver Survey was launched on 7/15/2022 and closed on 8/31/2022. A total of 950 families completed the Caregiver Survey representing 40 teams and 11 sites, which was a response rate of 48% of families enrolled as of 7/1/2022. This section presents the statewide findings of the Caregiver Survey. Reports were developed for each site, which include a comparison of statewide data.

Methods

LeCroy & Milligan Associates collaborated with HFAz Central Administration to revise the annual Caregiver Survey to include questions on diversity, equity, inclusion, and belonging that will help sites develop their equity plans. The survey was uploaded to a Qualtrics survey collector and pilot tested by program staff. Once the survey was finalized, the evaluation team translated it into Spanish and created survey collector links and QR Codes for each HFAz team. Teams were provided with instructions on survey administration (with talking points in English and Spanish), a unique survey link and QR Code for families to access the survey, as well as electronic copies of the survey for sites to print and distribute paper copies, as needed. Caregivers were informed at the beginning of the survey and by their Home Visitor that:

- The survey was voluntary and an opportunity for you to give their honest feedback about the program.
- The survey should take about 7-10 minutes to complete.
- The survey was anonymous, meaning that no one would be able to identify them or their answers.
- Responses from all families would be combined in a report so that the program can make improvements.

Sample

A total of 950 caregivers completed this survey for a response rate of approximately 48% (after excluding any partially completed surveys), based on the 1,978 families enrolled as of 7/1/2022. This response rate exceeded the 35% response rate received for this survey in 2021. Exhibit 48 shows the number of survey respondents by site and the response rate based on the number of families enrolled as of 7/1/2022. On the initial page of the survey, families could choose to complete the survey in English or Spanish. Most surveys (85%, n=810) were completed in English and 15% (n=140) were completed in Spanish. The survey was open to all families served by HFAz, including current and former families. The survey included an initial question that asked if the family was a current participant or a past participant. If the caregiver was a past participant, this question triggered a skip pattern so that the remining questions were asked in past tense. Most respondents (99%, n=941) were current participants in the program, while 1% (n=9) were former participants. Unless otherwise noted, responses from current and former participants were combined as the same questions were asked, just in a different tense.

Exhibit 48. Number of Caregiver Survey Respondents and Response Rates by Site and Statewide

Site	Number of Respondents	Estimated Response Rate based on 7/1/2022 Program Enrollment
Apache County	28	68%
Cochise / Santa Cruz County	96	63%
Coconino County	14	38%
Graham County	47	57%
Maricopa County	290	36%
Mohave County	101	51%
Pima County	183	56%
Pinal County	54	100%
Yavapai County – Team 87	5	19%
Yavapai County – Team 21	28	46%
Yuma County	104	54%
Statewide	**950**	**48%**

Survey Incentives

To increase the response rate of families, upon completion of the survey families were invited to enter themselves into a raffle for a $100 gift card that would be drawn at the site level. Additionally, HFAz teams with the highest response rates would be offered professional development opportunities by HFAz Central Administration.

Measures

Exhibit 49 summarizes the measurement areas included in the Caregiver Survey.

Exhibit 49. Caregiver Survey Measurement Areas

Areas	Measures/Scales
Demographics	Caregiver race, ethnicity, age range, and language spoken in the home and with home visitor.
Experience with the Program	Time in program, frequency, and duration of home visits.
Home Visit Discussion Areas, Materials, and Resources	Frequency of home visitors talking with families about key areas during visits, rated on a 4-point scale (never, once in a while, about half the time, most visits).
Experiences with Home Visitor	Rating of materials, resources, and home visitor on DIEB statements and rating of home visitor helpfulness on a 4-point scale (strongly disagree, disagree, agree, strongly agree).
Ranking of Home Visitation Areas	Ranking of six home visiting areas on a scale from 1 to 6 with 1 = what families like the most.
Helpfulness of Home Visiting	Rating of home visiting support overall on a 4-point scale (yes, definitely; yes, pretty much; no, not really; no, definitely not). Open response item on how home visiting could be more helpful for families.
Recommendations to Improve	Rating of likelihood to recommend home visitor to others. 0 = I would not recommend and 10 = I would strongly recommend.

Data Analysis

Frequencies were calculated for each question and the total N varies by question depending on the number of people who responded to the question. Open-response questions were analyzed by coding for common themes. Bi-variate analyses were performed to explore the relationship between two variables. Statistical tests were determined to be significant if the p-value was less than or equal to 0.05.

Results

Caregiver Demographics

Of the respondents who reported their race (N=912), the majority of caregivers in the program statewide identified as Latino/a/x (50%) or White (45%) (Exhibit 50). Respondents could select all of the options that applied to them. For comparative purposes, the three sites that had the highest percentage of respondents from each racial group are shown below.

Exhibit 50. Race of Caregiver Survey Respondents

Race	% (n)	Sites with High Percentage of Respondents From Racial Group
Latino/a/x	50% (455)	Yuma County - 70% Cochise/Santa Cruz County - 60% Maricopa County - 56%
White	45% (414)	Yavapai County (#21) - 96% Graham County - 74% Mohave County - 72%
Black	6% (51)	Pinal County - 12% Pima County - 8% Maricopa County - 8%
Native American (or American Indian or Alaska Native)	4% (40)	Coconino County - 31% Apache County - 19% Pima County - 7%
Asian	3% (32)	Coconino County - 23% Yavapai County (#21) - 8% Pima County - 5%
Native Hawaiian or other Pacific Islander	1% (8)	Maricopa County - 2% Mohave County - 1% Yuma County - 1%
Total N	912	

Note: Respondents could select all the categories that applied to them.

Of the caregivers who reported their ethnicity (N=877), 63% identified as Hispanic and 37% identified as non-Hispanic (Exhibit 51). For comparative purposes, the three sites that had the highest percentage of respondents from each group are shown below.

Exhibit 51. Ethnicity of Caregiver Survey Respondents

Ethnicity	% (n)	Sites with High Percentage of Respondents From Group
Hispanic	63% (550)	Yuma County – 88% Cochise Santa Cruz County – 80% Pima County – 69%
Non-Hispanic	37% (327)	Apache County – 69% Graham County – 66% Mohave County – 65%
Total N	877	

Most caregivers who reported their age range (N=923) were between the **ages of 18 and 49 years** (Exhibit 52).

Exhibit 52. Age Range of Caregiver Survey Respondents

Age Categories	% (n)
Less than 17 years	2% (17)
18-29 years	50% (457)
30-49 years	48% (442)
50-64 years	1% (7)
65+ years	0% (0)
Total N	923

Regarding caregiver language, 98% (n=906) reported that the language they speak at home is the same language that they speak with their home visitor during visits, while 2% (n=16) speak a different language at home than what they speak with their home visitor. Over half (58%) of survey respondents speak English as their primary language at home and 68% speak English with their home visitor (Exhibit 53). A portion of respondents primarily speak Spanish (20%) at home or are bilingual speaking English and Spanish at home (22%). When working with their home visitor, 18% of caregivers reported speaking Spanish only and 14% speak English and Spanish. A few families reported speaking a language other than English or Spanish including: Navajo, Arabic, Bengali, Chinese, Bisaya, Kinyarwanda, Mandarin, Nepali, Tagalog, Visayan, and American Sign Language.

Exhibit 53. Caregiver Survey Respondents' Language Spoken at Home and with Home Visitor

Language	Language Spoken at Home % (n)	Language Spoken with Home Visitor % (n)
English	58% (532)	68% (625)
Spanish	20% (180)	18% (165)
English and Spanish	22% (198)	14% (132)
Another Language	1% (12)	0% (0)
Total N	922	922

Caregiver Experience with the Program

Of the current participants who responded to this survey, over half (58%) were enrolled in the program for over a year, just under a quarter (22%) were enrolled from six months to one year, and 20% were enrolled for less than six months (Exhibit 54).

Exhibit 54. Caregiver Survey Respondents' Length of Time in HFAz

Time	% (n)
Less than six months	20% (191)
Six months to one year	22% (205)
One year or more	58% (544)
Total N	940

Most families (86%) who are currently in the program have contact with their home visitor once a week or twice a month (Exhibit 55). A few caregivers reported "other" commenting that they have more frequent contact with their home visitor through text messages or phone calls that occur on a daily basis or two to three times a week.

Exhibit 55. Caregiver Survey Respondents' Frequency of Contact with Home Visitor

Frequency	% (n)
Once a week	47% (440)
Twice a month	39% (368)
Once a month	12% (110)
Other	2% (23)
Total N	941

The BPS revised in 2022 indicates that home visits should be 45 minutes or longer. Of all families surveyed, current and former, approximately three quarters (73%) of respondents indicated that their visits are on average 46 minutes or longer (Exhibit 56). Additionally, 97% of caregivers felt that their home visitor spent enough time with them during visits "usually" or "always" (Exhibit 57). Caregivers who reported a shorter average visit length (45 minutes or less) were significantly more likely than those who had longer visits (46 minutes or more) to have felt that their home visitor "sometimes" or "never" spent enough time with them during visits (x^2=12.834, p=.00).

Exhibit 56. Caregiver Survey Respondents' Average Duration of Home Visits

Frequency	% (n)
Longer than 60 minutes	10% (94)
46-60 minutes	63% (596)
30-45 minutes	21% (203)
15-29 minutes	6% (52)
Less than 15 minutes	.5% (5)
Total N	950

Exhibit 57. Caregiver Survey Respondents' Rating that Home Visitor Spends Enough Time with Family During Visits

Frequency	% (n)
Always	89% (844)
Usually	8% (77)
Sometimes	1% (12)
Never	2% (16)
Total N	949

Home Visit Discussion Areas

The majority of current and former caregivers reported that their home visitor addressed the five home visit discussion areas during "most visits" (Exhibit 58). The highest proportion of respondents (94%) said that **child development** is addressed during most of their visits. Additionally, 85% of families said their home visitor addressed **parenting skills** and **activities to do with their child** during most visits. The areas of **health and wellness** and **goal setting** are addressed during most visits for 82% and 77% of respondents, respectively, and during half of their visits by 13% and 17% of respondents, respectively.

Exhibit 58. Frequency that Home Visitor Discusses Areas with Caregiver Survey Respondents During Visits

Areas	Never	Once in a while	About half the time	Most visits	N
Child development	.2%	1%	5%	94%	948
Parenting skills	.3%	4%	11%	85%	942
Activities to do with my child	.6%	3%	11%	85%	942
Health and wellness information	.2%	5%	13%	82%	937
Goal setting for me and my family	.2%	6%	17%	77%	942

Note: Percentages may exceed 100% due to rounding.

Diversity, Equity, Inclusion, and Belonging Statements on Materials and Resources

The majority of both current and former caregivers expressed agreement (i.e., agreed or strongly agreed) with diversity statements on materials and resources (Exhibit 59). Areas that received the highest percentage of "strongly agree" ratings are that **materials and resources are in their language** and are **helpful for the specific needs of their family**.

Exhibit 59. Caregiver Survey Respondents' Perspectives on DEIB Statements and HFAz Materials and Resources

Materials and Resources	Strongly Disagree	Disagree	Agree	Strongly Agree	N
Are in my language	1%	.5%	12%	86%	948
Are helpful for the specific needs of my family	1%	.4%	19%	80%	941
Support my family's traditions	.5%	.5%	21%	79%	943
Reflect my family's values	.5%	.5%	21%	79%	939
Are what I am interested in	1%	.2%	22%	77%	943

Although the number of caregivers who disagreed with materials and resources statements is low, because of the *Best Practice Standard's* emphasis on equity, the evaluators examined how perspectives were related to race, ethnicity, language, and age. The following relationships were observed:

- Caregivers whose family **spoke a language at home that was different** than what they speak with their home visitor, specifically a language that is other than English and Spanish, were significantly more likely to disagree that **materials and resources were in their language** (x^2=25.682, p=.00) and that **materials and resources were helpful for the specific needs of their family** (x^2=16.271, p=.00).
- **Black caregivers** were significantly more likely than caregivers of all other races to disagree that **materials and resources supported their family's traditions** (x^2=3.924, p=.05).

Diversity, Equity, Inclusion and Belonging Statements regarding Home Visitors

Caregivers were asked to rate their agreement or disagreement with diversity statements regarding their experience with their home visitor (Exhibit 60). Areas that received the highest percentage of "strongly agree" ratings are that their home visitor:

- Carefully listens to and answers my questions.
- Accepts me for who I am.
- Makes me feel like my concerns are important.
- Explains things in a way that is easy for me to understand.

Exhibit 60. Caregiver Survey Respondents' Perspectives on Diversity Statements and Home Visitors

My Home Visitor	Strongly Disagree	Disagree	Agree	Strongly Agree	N
Carefully listens to and answers my questions.	.6%	.1%	14%	85%	933
Accepts me for who I am.	1%	0%	15%	84%	934
Makes me feel like my concerns are important.	.6%	.4%	15%	84%	935
Explains things in a way that is easy for me to understand.	.6%	.1%	15%	84%	937
Is respectful of my culture and beliefs.	1%	.1%	18%	81%	932
Is responsive to my family's specific needs.	.6%	.5%	18%	81%	934
Tries to understand how I see things before suggesting a new way to do things.	.7%	.1%	18%	81%	936
Does not make assumptions about me and my family because of our culture.	1%	.6%	19%	80%	932
Takes the time to understand my family's culture and beliefs.	1%	.4	21%	78%	936

Home Visitor Helpfulness

Most current and former caregivers expressed agreement with statements on the helpfulness of their home visitor (Exhibit 61). Areas that received the highest percentage of "strongly agree" ratings are that their home visitor helps them **understand their child's development** and **feel more confident as a parent**.

Exhibit 61. Caregiver Survey Respondents' Agreement with Statements on Home Visitor Helpfulness

My home visitor helps me	Strongly Disagree	Disagree	Agree	Strongly Agree	N
Understand my child's development.	.7%	.3%	16%	83%	941
Feel more confident as a parent.	.7%	.4%	17%	81%	937
Support my family's health and wellbeing.	.7%	.4%	19%	80%	938
Set and achieve goals for me and family.	.6%	.1%	21%	79%	939

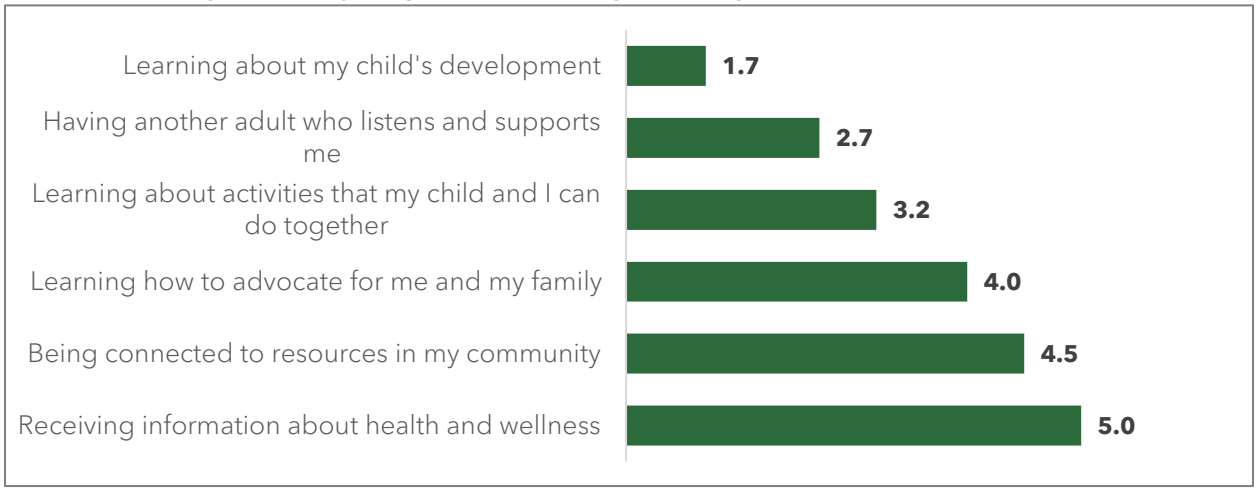
Although the number of caregivers who disagreed with diversity statements related to their home visitor is low, because of the *Best Practice Standards* emphasis on equity, the evaluators examined how agreement or disagreement was related to race, ethnicity, language, and age. The following relationships were observed:

- Caregivers whose family **spoke a language at home that was different** than what they speak with their home visitor, specifically a language that is other than English and Spanish, were significantly more likely to disagree that their **home visitor tries to understand how they see things before suggesting a new way to do things** (x^2=23.763, p=.00). Caregivers whose family **spoke a language at home that was different** were also significantly more likely to disagree that their home visitor helps them **feel more confident as a parent** (x^2=16.313, p=.00).
- A notably higher percentage of **black caregivers** (4%) compared to caregivers of all other races (1%) disagreed that their home visitor **takes the time to understand their family's culture and beliefs**, though no significant difference was observed. However, all black caregivers agreed that their **home visitor is respectful of their beliefs and culture**. A higher percentage of **black caregivers** (4%) compared to caregivers of all other races (1%) also disagreed that their home visitor helps them **feel more confident as a parent** (x^2=3.879, p=.05).
- A higher percentage of **Asian caregivers** (6%) compared to caregivers of all other races (1%) disagreed that their home visitor helps them **feel more confident as a parent** (x^2=7.962, p=.01).

Ranking of Home Visitation Areas

Caregivers were asked to rank a list of options to indicate what they liked most about the HFAz home visiting program. They were presented with six areas and were asked to them on a scale from 1 to 6, with 1 = what they like the best. Exhibit 62 shows the average ranking received by each home visitation area, with the lower average ranking indicating areas that families like the best. The top three areas rated by families include "learning about my child's development," "having another adult who listens and supports me," and "learning about activities that my child and I can do together."

Exhibit 62. Caregiver Survey Respondents' Average Ranking of Home Visitation Areas



Note: Caregivers ranked areas on a scale from 1-6 with 1 = what they liked the best about the program. Lower average rankings indicate areas families ranked as what they like the best compared to the other areas assessed.

Helpfulness of Home Visiting

Current families were asked "Has the home visiting support been as helpful as you thought it should be?" Almost all families (99%) affirmed "yes" that the program has been as helpful as they felt it should be. A few families indicated that it was not as helpful as they expected. Caregivers who indicated "no" were asked "How can we make the program better for you and your family?" Five of them provided suggestions including:

- Provide more up-to-date and in-depth parenting curriculum.
- Provide more ideas on activities caregivers can do with their baby outside of home visits.
- Focus more on the baby and less on talking about the home visitor's social life.
- Inform families about what resources are appropriate for them and how to access them. It is difficult when caregivers are given a resource list but do not know if they can use or are eligible for the resources.
- Match families with home visitors who have children of similar ages as the children in the program so that they have real-life experience.

Rating of Home Visitors

Current families were asked to rate on a scale from 0 to 10, how likely they are to recommend their home visitor to others, with 0 being "I would not recommend" and 10 being "I would recommend." A total of 915 caregivers responded to this question and 88% rated their home visitor as a 10 out of 10. While ratings ranged from 3 to 10, 99% of caregivers rated their home visitor as a 6 or higher, the median rating was 10, and the overall average rating was 9.8 (.76 SD).

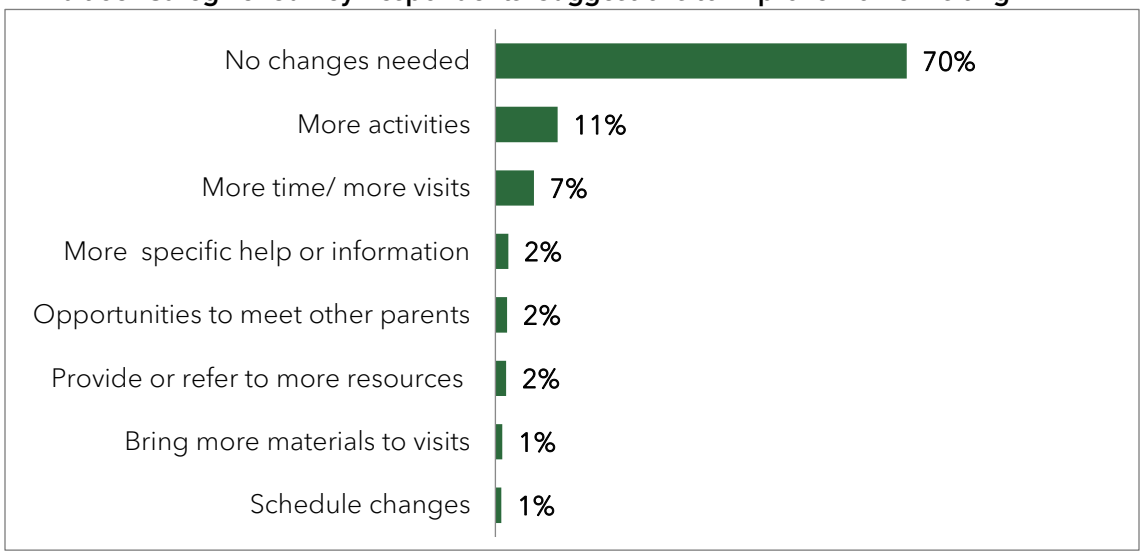
Reasons for Exiting the Program

Of the nine families who responded to the survey and were not currently participating in the program, three indicated reasons why they stopped participating. These reasons included: their family moved, they did not want to work with a new home visitor, and the pandemic made it difficult for them to participate. When asked "What could your home visitor have done differently to help you stay in Healthy Families?" two indicated that there was nothing the program could have done and one commented that they preferred working with their home visitor who left her position.

Recommendations to Improve Home Visiting

Current caregivers were asked, "What would make home visiting even better for you and your family?" Statewide, a total of 592 caregivers answered this open-ended question. Exhibit 63 shows the categories that were reported by at least 1% (n ≥ 6) of survey respondents. Responses were overwhelmingly positive.

Exhibit 63. Caregiver Survey Respondents' Suggestions to Improve Home Visiting



(N=592)

The most common response given by 70% (n=414) of caregivers was that **no changes were needed.** Respondents stated that they were satisfied with the way the program was run, and numerous added enthusiastic compliments to the program and/or their specific home visitor.

Satisfaction with Services	"[My home visitor] is perfect! She's very knowledgeable and patient. She knows how to have fun and gives me ways to encourage my son if I am stuck."
	"Home visits are great! Our home visitor always comes with new ideas and activities that we can do with the kids and informs us of our children's development stages. When I have questions or need help with an area, she always supplies me with the resources I need to answer my questions."
	"It's a great opportunity as it is to help be a great parent and understand my children's cues and their feelings and learning abilities I wouldn't change it."

Of those who requested some type of improvement, many requested **additional activities** (11%). This request included providing families with more hands-on activities during visits including arts and crafts, increasing home visitor interaction with their child during activities, providing resources to access activities and events in the community outside of visits, and providing ideas for activities that families can do on their own with their child.

More Activities and Community Resources	"Offer free passes/coupons/discounts for children's enriching activities that don't have free events, such as the zoo, museums, or county fair."
	"Offer more activity ideas for me to do with my child, and also interact more with my child with an activity that they bring."
	"More activities to do as a family. Example outdoor structured family building activities, scavenger hunts, or meeting other families in on outdoor setting (COVID safe). Activities that foster family fun time."
	"My daughter wants to do more fun crafts. Always having an activity and craft to do is helpful to keep my child entertained."
	"More interaction with my children by watching them do the skills instead of just asking if they can do something or not."

The third most common recommendation was for families to have **additional visits** with their home visitor and/or **longer visits** (7%). Some families who just joined the program and are completing assessments and paperwork asked if visits could be longer so that they had additional time for activities and to have fun with their child.

Additional and Longer Visits	"The visits should be allowed to be more than an hour."
	"If it were humanly possible to have more hours in the day because she's awesome and visits feel like they end way too fast."
	"If the visits were more frequent. My daughter enjoys everything she learns in every visit. I feel very comfortable talking about anything concerning the development of my child."
	"Have the program longer than 5 years."

The fourth category was more to provide families with additional **help or information (2%).** Some parents just stated "more help" without explanation. Others had specific requests, such as information particular to their child's needs, for more materials to be available in Spanish, and for materials to be more relevant to their family's culture.

More Information or Help	"Suggestions for toys, books, activities for age."
	"More time to better split between information and interacting with the development of the child."
	"More specific supports or resources geared towards fathers, perhaps presented by other males/fathers. Let's Talk Dads was great, but is now over."
	"More Spanish materials for my baby based on my families culture."
	"Provide a list of resources or discounted places I can take my children."

Several parents (2%) requested **opportunities to meet other families** who participate in HFAz, such as group meetings.

Engaging with Other Families	"Maybe setting up groups for moms in the area to meet and do fun activities together with our children."
	"I would love to see more playdates or opportunities to meet other families."
	"Talking to other moms."
	"More activities with other kids"
	"Maybe opportunities to meet with other families participating in the program? Opportunity to make friends?"

Key Findings from the Caregiver Survey

Overall, the Caregiver Survey results demonstrate that the HFAz program is meeting the needs of most families who responded to this survey.

- Almost all families (99%) affirmed that the program has been **as helpful as they felt it should be**.
- The highest proportion of respondents – 94% - said that **child development** is addressed during most of their visits. 83% of caregivers strongly agreed that their home visitor helps them understand their child's development and 57% ranked "learning about my child's development" as the best thing they like about the program.
- 85% of families said their home visitor addressed **parenting skills** and **activities to do with their child** during most visits. 41% of caregivers ranked "learning about activities that my child and I can do together" as the second best thing they like about the program.
- 56% of caregivers ranked "**having another adult who listens and supports me**" as the third best thing they like about the program.
- 88% rated their home visitor as a **10 out of 10 (highest rating)** and 99% rated their home visitor as a 6 or higher. The median rating was 10 and the overall average rating was 9.8 (.76 SD). This finding suggests that most families are satisfied with their home visitor and would recommend them to others.

Recommendations from the Caregiver Survey

While the overall findings from the Caregiver Survey are positive, a few findings that could indicate areas for improvement should be noted. It is important to acknowledge that while all families were invited to complete this survey through their home visitors, it is possible that some did not receive this invitation and some declined to participate. The results of this survey express the views, experiences, and opinions of the caregivers who responded to the survey. While some differences in experiences were observed based on caregiver demographics, these population groups were not sampled to be representative of all families. This information is intended for Central Administration, sites, and teams, to consider when developing their equity plan for the coming year.

- Open-response comments from caregivers on ways to improve the program suggest that some Hispanic/Spanish-speaking families would like more materials available in their language and have materials be more relevant to their family's culture. Also, while a low proportion of caregivers who responded to the survey speak a language other than English or Spanish, this difference seemed to lessen the relevancy of materials and resources, some interactions they had with their home visitor, and feeling confident as a parent. Other languages that families speak include: Navajo, Arabic, Bengali, Chinese, Bisaya, Kinyarwanda, Mandarin, Nepali, Tagalog, Visayan, and American Sign Language. When possible, the HFAz program should consider identifying and providing families with materials and resources that are in their native language to make the program more relevant for these families.

- Open ended comments suggest that families would like:
  - **More activities, access to community resources, and outdoor events.** More hands-on activities during visits including arts and crafts, more home visitor interaction with their child during activities, more resources to access activities and events in the community outside of visits, and more outdoor activities during home visits, and more ideas for activities that families can do on their own with their child.
  - **Opportunities to meet other families** who participate in HFAz, such as group meetings.
  - More **information and resources** particular to their child's needs.
  - **Offer additional visits** with their home visitor and/or **longer visits.**

- Caregivers who reported a shorter average visit length (45 minutes or less) were significantly more likely than those who had longer visits (46 minutes or more) to have felt that their home visitor "sometimes" or "never" spent enough time with them during visits. To optimize a family's experience, home visitors should strive to meet the BPS of holding visits that are 45 minutes or longer.

- A small proportion of black caregivers, when compared to caregivers who identified as any other race, expressed higher disagreement with a few diversity statements including: materials and resources to support their family's traditions, their home visitor takes the time to understand their family's culture and beliefs, and their home visitor helps them feel more confident as a parent. The program should consider providing home visitors with additional training on specific cultural values and norms of the families that they serve, especially if the family is of a different racial or ethnic background than the home visitor.

PROGRAM OUTCOMES

The outcome evaluation is designed to assess the impact of the HFAz program on families and children in terms of promoting child development and wellness, enhancing parent/child interactions, reducing the rates of child maltreatment, and promoting positive parental resiliency. Outcome data presented in this report were collected by home visitors and entered into ETO including:

- Child development screening and referrals
- Postnatal depression and substance abuse screening and referrals
- Parenting behaviors and family outcomes measured by the Healthy Families Parenting Inventory (HFPI) across nine domains: social support, problem-solving, depression, personal care, mobilizing resources, role satisfaction, parent/child interaction, home environment, and parenting efficacy
- Implementation of safety practices in the home
- Child maltreatment prevention

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.

Ages and Stages Questionnaire: 3rd Edition

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. HFAz home visitors administer the ASQ-3 at four and nine months in the first year of the child's life, with optional screenings conducted at six and 12 months. Then starting when the child is 18 months, the ASQ-3 is administered every six months until the child is three years of age, and then yearly at age four and five. Screenings can be scored as "typical" meaning that the child is developing on schedule, "questionable," which indicates that the child 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 addressed. Referrals are given to families when a child scores as delayed.

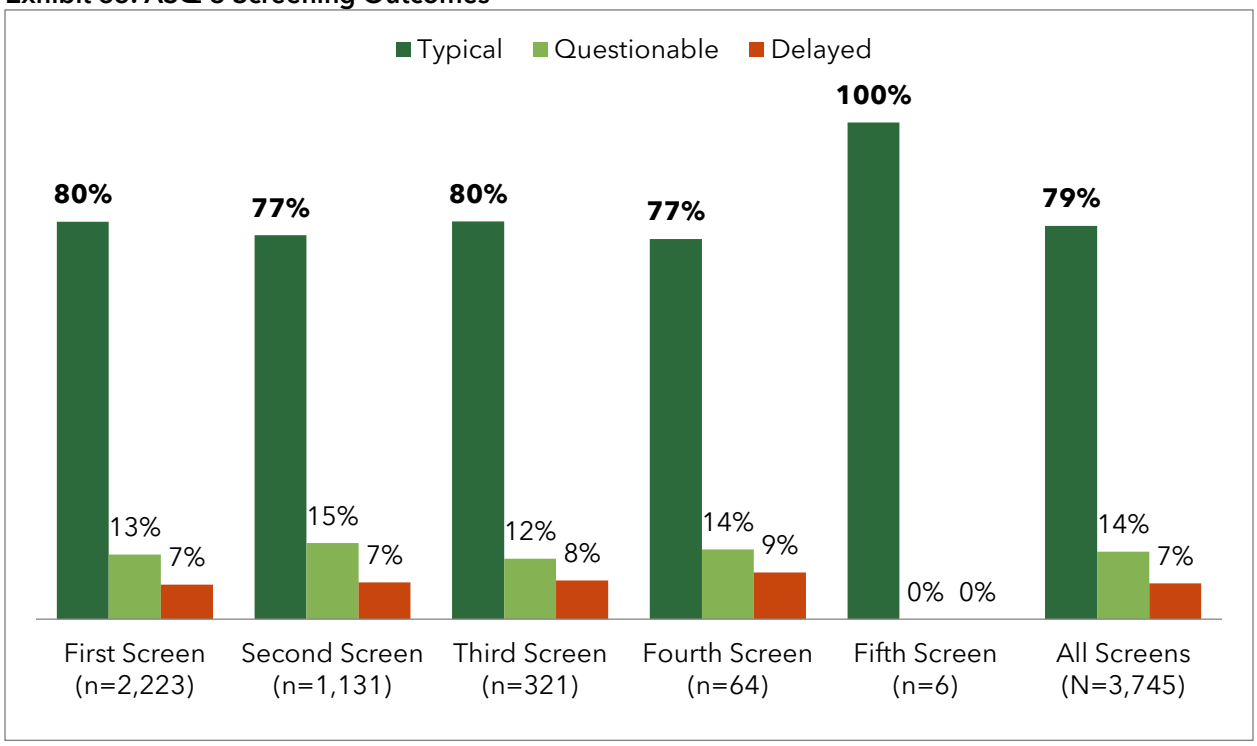
A total of 3,745 screenings were conducted in FY22 for 2,223 children, including the target child and subsequent children who are served by HFAz. Children received between one and five screenings, depending on the outcome of their initial and subsequent screenings. Screenings were not completed when the family was on outreach, the child was enrolled in AZEIP, and/or some other reason. Exhibit 64 shows the completion results of ASQ-3 screenings in FY22.

Exhibit 64. ASQ-3 Screenings Completed in FY22

Screening Periodicity in FY22	Screenings Completed
First Screening	2,223
Second Screening	1,131
Third Screening	321
Fourth Screening	64
Fifth Screening	6
Total	3,745

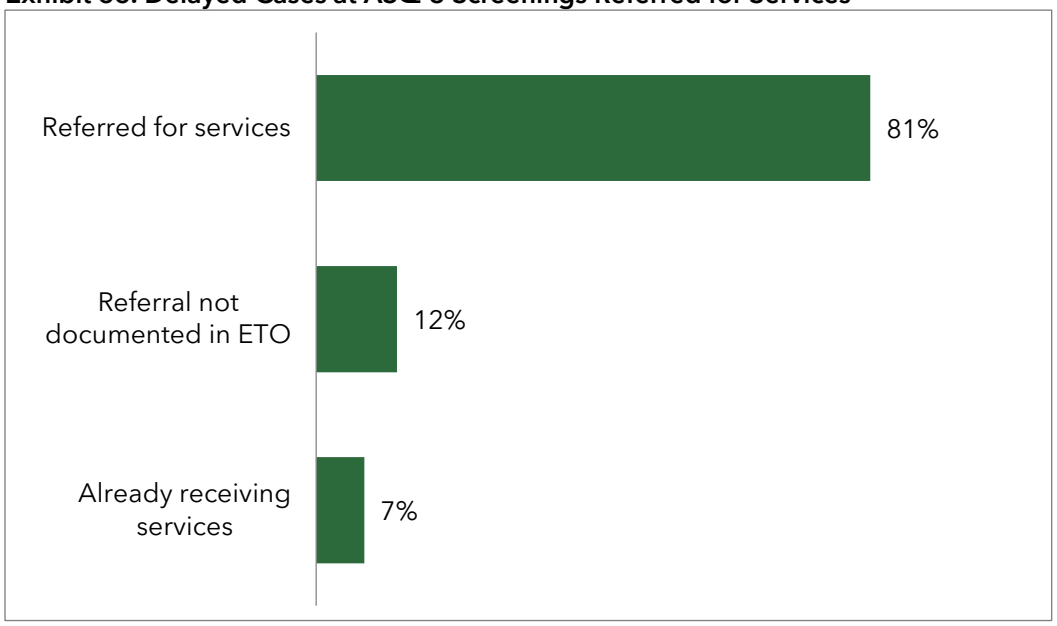
Exhibit 65 reports on the outcomes of screenings at each time point. For all time points, 79% (n=2,965) screened in the typical range, 14% (n=510) were questionable, and 7% (n=270) were identified as delayed.

Exhibit 65. ASQ-3 Screening Outcomes



Of the 270 total cases that were screened as delayed, 81% (n=219) were referred to services, 12% (n=32) did not have a referral recorded in ETO, and 7% (n=19) were already receiving services, thus a referral was not needed. Because of the critical importance of early screening, the referral and data entry process should be clarified by program staff to ensure that the appropriate referrals are made and recorded into ETO.

Exhibit 66. Delayed Cases at ASQ-3 Screenings Referred for Services



(N=270)

Ages and Stages Questionnaire: Social-Emotional

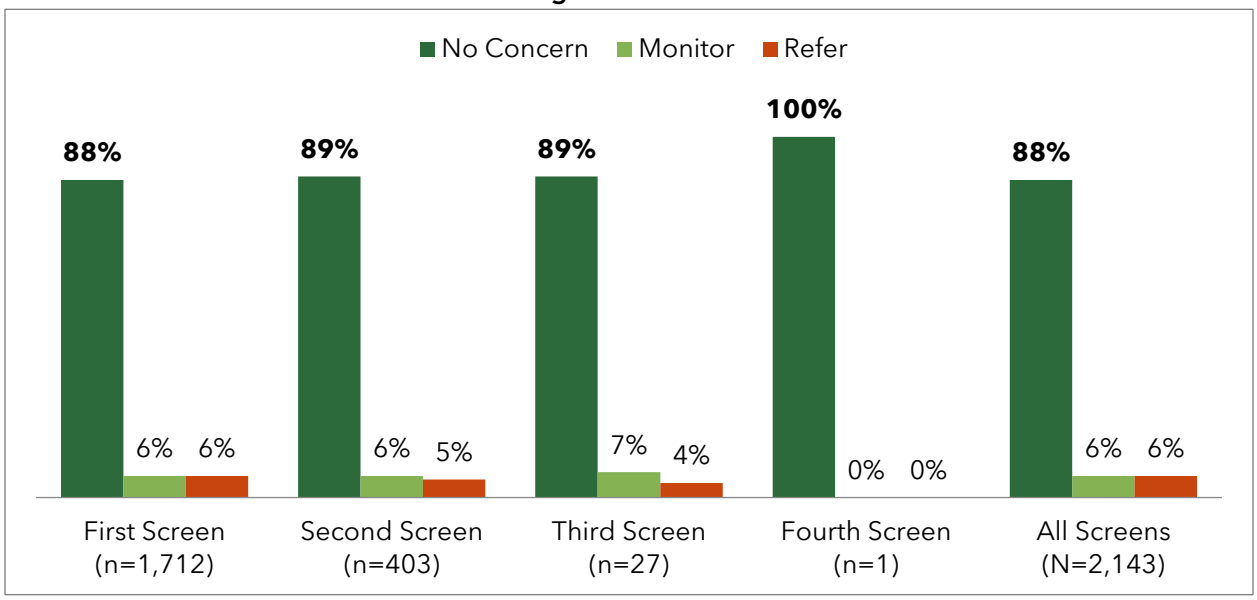
Another measure of childhood development is the Ages & Stages Questionnaire: Social-Emotional (ASQ: SE-2), which screens for social and emotional behaviors in the areas of: self-regulation, compliance, social-communication, adaptive functioning, autonomy, affect, and interaction with people. In FY22, a total of 2,143 ASQ: SE-2 screenings were completed with 1,712 children across four time points (Exhibit 67).

Exhibit 67. ASQ:SE-2 Screenings Completed in FY22

Screening Periodicity in FY22	Screenings Completed
First Screening	1,712
Second Screening	403
Third Screening	27
Fourth Screening	1
Total	2,143

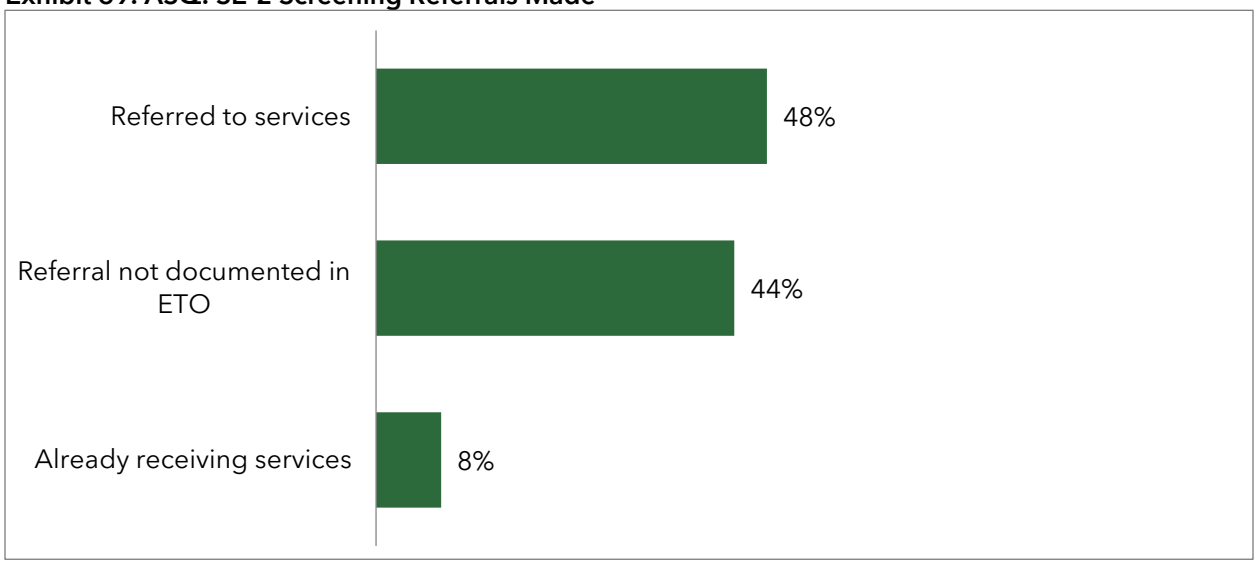
ASQ:SE-2 scoring results in outcomes of Refer, Monitor, and No Concern (Exhibit 68). Of all screenings completed, 88% of children screened as having no concern, 6% needed additional monitoring, and 6% were in need of a referral.

Exhibit 68. Outcomes of ASQ: SE-2 Screenings



A total of 117 screenings resulted in "Refer." Of these screenings, 48% (n=56) were documented in ETO as having been referred to additional services, 44% (n=52) were not documented in ETO as having been referred, and 8% (n=9) were already receiving services, thus a referral was not needed. The referral and data entry process should be clarified by program staff to ensure that the appropriate referrals are made and recorded into ETO.

Exhibit 69. ASQ: SE-2 Screening Referrals Made

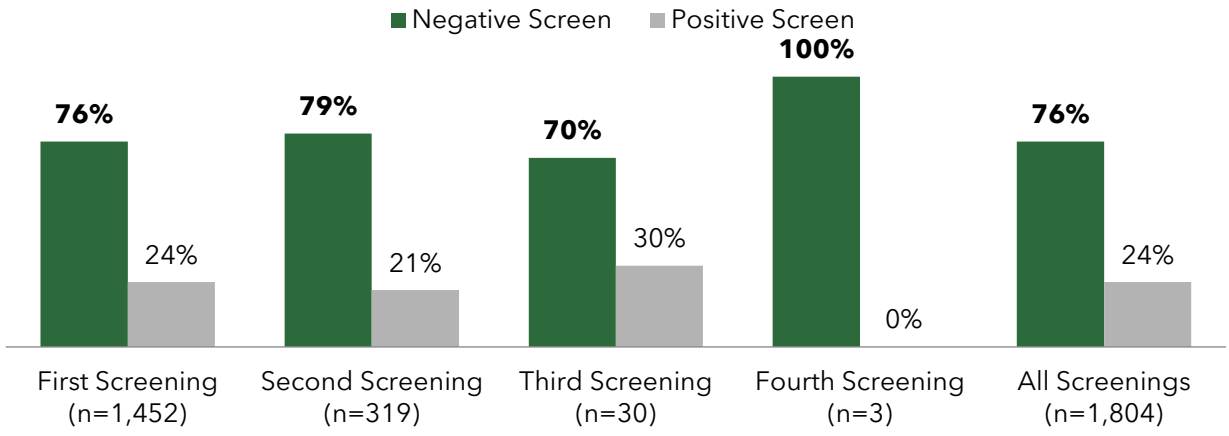


(N=117 children who screened as "Refer")

Postnatal Depression Screening and Referrals

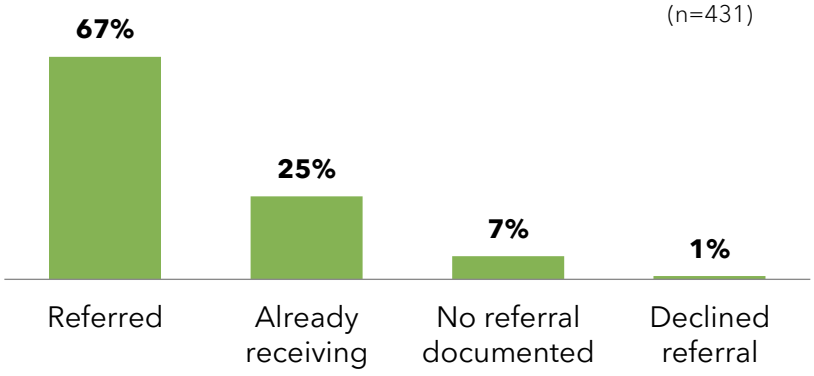
The Edinburgh Postnatal Depression Screen (EPDS) is required by HFAz to screen postpartum women within three months after the birth of a child. The EPDS consists of 10 questions scored by the parent from 0 to 3. The instrument is totaled and scores of 10 or higher are a positive screen for depression, which requires a referral to external therapeutic services, unless they are already receiving such services. A total of 1,804 EPDSs were recorded in ETO between October 1, 2021 and September 30, 2022 for 1,452 parents (Exhibit 70). Parents received between one and four screens, with most receiving only one screening. Across all time points, 76% (n=1,373) of screens were negative and 24% (n=431) were positive.

Exhibit 70. Outcomes of EPDS Screenings



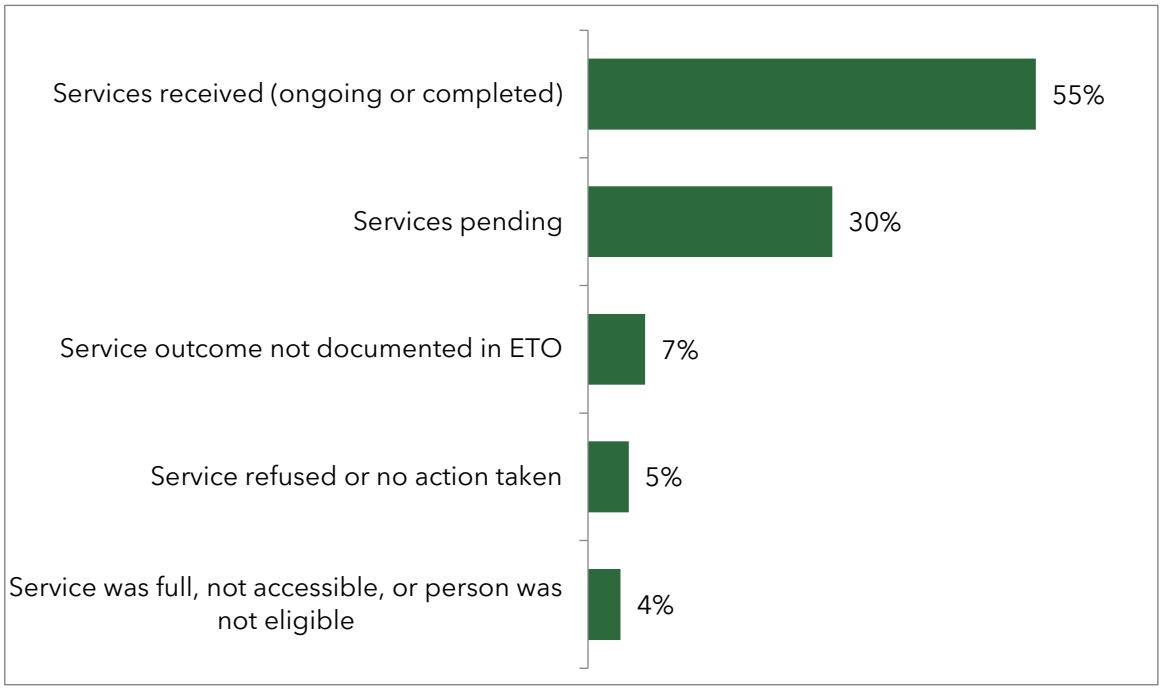
Of the 431 parents who screened positive on the EPDS, 67% (n=287) received a referral from their FSS that was accepted by the parent, 25% (n=110) were already receiving services, 7% (n=29) did not have a referral documented in ETO, and 1% (n=5) declined the referral given (Exhibit 71). It is unclear why a few records did not have a referral documented. The referral process and ETO documentation is an area that could be reviewed by HFAz leadership to ensure staff are making and documenting referrals appropriately.

Exhibit 71. EPDS Positive Screenings and Referrals Made
(n=431)



Of the 431 positive screens, 55% (n=237) of adults had received services (including ongoing and completed) and 30% (n=130) had services pending (Exhibit 72). In 5% of cases (n=20) the adult refused services or did not take action on the referral, and in 4% of cases (n=14) the service was full, not accessible (e.g., cost prohibitive, lack of insurance), or the person was not eligible for services (reason for ineligibility was not recorded in ETO. Additionally, 7% (n=30) of records did not have a referral outcome documented in ETO.

Exhibit 72. Status of Mental Health Services After Positive EPDS Screen



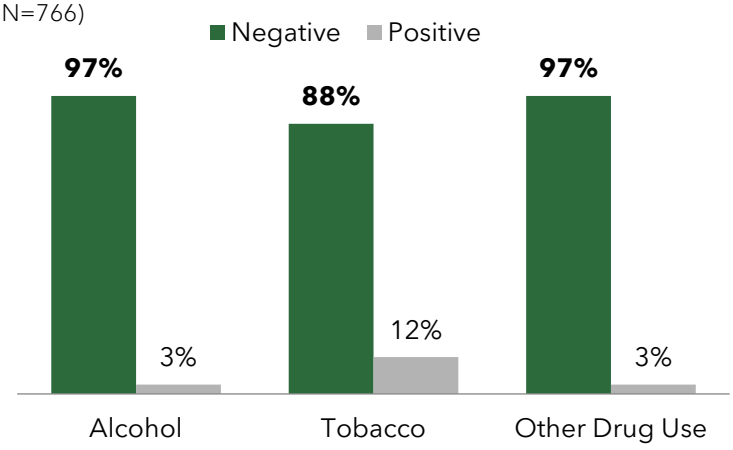
(n=431)

Substance Abuse Screening and Referrals

Caregiver substance abuse is a well-known risk factor for child maltreatment (Connelly et al., 2013; Dauber et al., 2017; Garner et al, 2014; Michalopoulos et al., 2019). When parents or caregivers 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 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 services. The Arizona Child Fatality Review Report (ADHS, 2021) shows that substance use was a contributing factor in one out of every five child fatalities in 2021. More specifically, 59% of child abuse and neglect deaths and 40% of preventable child deaths in Arizona involved substance use (i.e., Marijuana, Opiates, Alcohol, Methamphetamine). Because of these risk factors, HFAz completes the Past 30-Day Alcohol, Tobacco, and Other Drug (ATOD) screening with parents and caregivers shortly after enrollment into the program. From October 1, 2021 to September 30, 2022, a total of 766 ATOD screenings were completed with newly enrolled parents. Most families screened negative for alcohol, tobacco, and drug use (Exhibit 73).

Exhibit 73. Outcomes of Past 30-Day ATOD Screenings

(N=766)



A higher percentage of parents screened positive for tobacco use (12%, n=93) than alcohol or other drugs. Of those who screened positive for tobacco use, 59% (n=55) received a referral for tobacco cessation services, 3% (n=3) were already receiving these services, and 38% (n=35) did not have a referral recorded in ETO. Referrals for adults who screened positive for alcohol and/or other drug use were not documented as part of the ATOD data collection. Parent/Guardian Data collected at intake showed that home visitors discussed substance use with 61% (n=2,140) of caregivers, 18% (n=633) did not discuss substance use, and 22% (n=767) did not have data reported in this field (likely because this question was added after the family enrolled in the program). Of the adults who discussed substance use with their home visitor, 12% (n=261) of discussions warranted a referral to substance use services.

Parenting Behaviors and Family Outcomes

The HFAz program seeks to improve parenting behaviors and family outcomes that are key to protecting children from maltreatment: 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 (Jacobs, 2005). Research from randomized clinical trials of the HFAz program 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 (LeCroy & Krysik, 2011, LeCroy & Davis, 2016).

Healthy Families Parenting Inventory

The 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). An initial study validated the nine domains measured by the HFPI (Krysik & LeCroy, 2012). A recent validation study showed that pre-intervention HFPI scores demonstrated incremental predictive validity of a future official maltreatment report (Kelly & LeCroy, 2022). This study showed that the results of the HFPI can be successfully used by home visitors at a family's enrollment to services to suggest needs and services that will reduce the family's likelihood of child maltreatment.

Change in HFPI from Baseline to 12 Month Follow-Up

A total of 837 HFAz parents and caregivers completed a baseline HFPI after January 2019 and a follow-up HFPI (approximately 12 months post baseline) before October 2022. Baseline HFPI data was collected at three weeks or two months post enrollment into the program and follow-up HFPI data was collected approximately 12-months from the baseline data collection. The evaluation team conducted *paired sample t-tests* for each HFPI subscale and the total HFPI Score with pre and post data that was matched for individuals using a unique identifier from ETO. Average scores at baseline and follow-up, significance levels (*p*-value), and effect sizes (Cohen's *d*) are shown in Exhibit 74. N-values vary if a participant did not fully complete a subscale, as their total score for that subscale was excluded from the analysis.

Exhibit 74. Change in HFPI Subscales from Baseline to Follow-up (12 to 14 Months Post Enrollment)

HFPI Subscale	Total Possible Score	Average Score at Baseline	Average Score at Follow-up	P-Value (Two-Sided)	Cohen's d (Effect Size)	N
Total HFPI Score	315	269.8	272.9	**.00**	**.12**	834
Home Environment	50	42.8	44.5	**.00**	**.30**	834
Mobilizing Resources	30	24.5	25.4	**.00**	**.18**	834
Personal Care	25	18.9	19.2	**.01**	.09	835
Problem Solving	30	24.3	24.6	**.01**	.09	836
Depression	45	39.6	39.7	.63	.02	835
Parent Self-Efficacy	30	25.8	25.9	.32	.03	834
Role Satisfaction	30	26.2	25.9	.06	.07	834
Parent-Child Interaction	50	45.7	45.6	.36	.03	834
Social Support	25	22.0	22.0	.95	.00	836

*Statistical significance is observed when *p*-values are ≤ .05. Cohen's *d* values below .20 are considered small effect sizes and from .20 to .50 are considered medium effect sizes.

From baseline (collected at either 3 weeks post enrollment or 2 months post enrollment) to follow-up (collected at 12-months post enrollment or 14-months post baseline), statistically significant increases (improvements) were observed for the **total HFPI Score** and **four subscales**: **Home Environment, Mobilizing Resources, Personal Care,** and **Problem Solving.** Non-significant changes observed in average subscale scores from baseline to follow-up included a slight increase (improvement) for **Depression** and **Parent Self-efficacy**, a slight decrease (worsening) in **Role Satisfaction** and **Parent-Child Interaction,** and **Social Support** remained the same.

Prior to the pandemic, significant improvements had been consistently observed in most HFPI subscales. The evaluation team speculates that changes observed during the data collection time frame are likely related to factors impacted by the COVID-19 pandemic and pandemic recovery related issues. Families have faced unprecedented challenges in the data collection time frame that have likely impacted their mental health, socio-economic situation, satisfaction with being a caregiver, and relationship with their child. Another possible impact on HFPI scores could be the difference in HFPI administration from virtual to in person, which also occurred during the data collection time frame. 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 HFAz program is effective at improving the home environment, the family's ability to mobilize resources in the community, their personal care, and problem-solving skills. The evaluation team will continue to explore how the HFPI changes over time, as communities recover from the pandemic.

Safety Practices in the Home

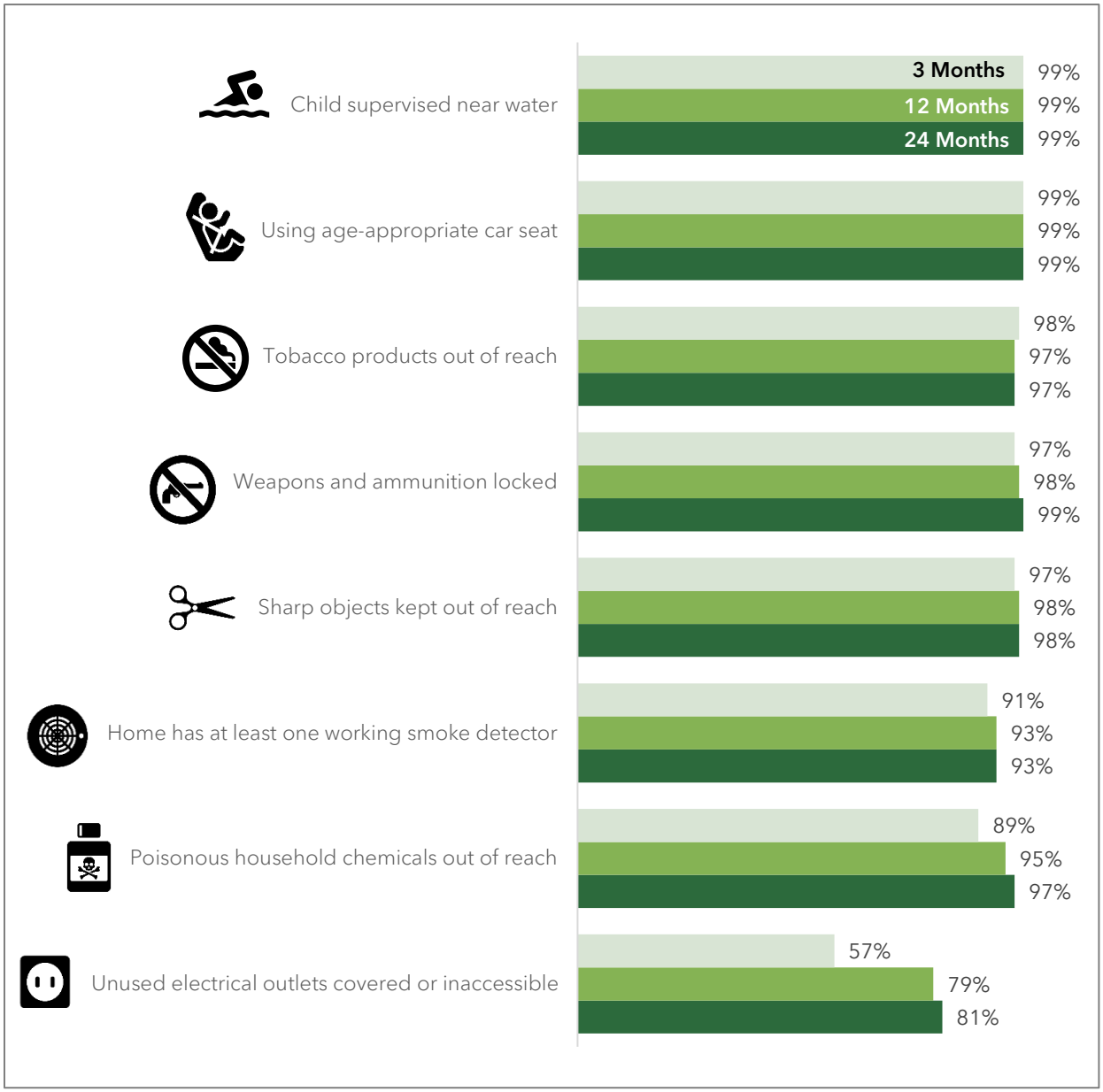
According to the CDC, unintentional injuries are the leading cause of death for children and youth aged 1-19 years and the third leading cause of death for infants under the age of one year (West et al., 2021). The Arizona Child Fatality Review Report (ADHS, 2022) states that **"A child's death is considered preventable if the community (education, legislation, etc.) or an individual could reasonably have done something that would have changed the circumstances that led to the child's death"** (ADHS, 2022, p. 22). Risk factors of preventable deaths in infants and children include: substance use, DCS history with the family, lack of supervision, lack of vehicle restraint, and parent/child relationship issues.

ADHS reported that 48% of child deaths in Arizona in 2021 were preventable. Preventable death rates were higher among male children ages four years or less and disproportionately higher among Black and American Indian children. Suffocation was the common cause of death among infants 28 days to less than 1 year of age and 95% of Sudden Unexpected Infant Deaths (SUIDs) occurred in an unsafe sleep environment. In line with the ADHS SUIDs mortality prevention recommendations, HFAz home visitors educate parents and caregivers on safe sleeping environments. All families receive this information within the first few visits and it continues to be a topic of discussion throughout their home visits. Additionally, drowning was the most common cause of death in toddlers aged 1-4 years, with 68% of drowning deaths – in pools or the bathtub - occurring in this age group. The drowning death rate doubled from 2020 to 2021. The HFAz home visitors assess and provide education to families about safe home environments for children by completing the Safety Checklist with them.

In FY22, a total of 2,036 had safety checklist information entered into ETO that were administered prenatally and postnatally at three months through 60 months, based on the child's age. Exhibit 75 shows the various safety practices reported as "always" being followed, based on the child's age of three months (n=718), 12 months (n=449), and 24 months (n=373).

- **Safety areas that most families implement regardless of child age include**: children being supervised near water, age-appropriate car seats are correctly installed, tobacco products and related items (matches and lighters) are kept out of reach, weapons and ammunition are locked, and sharp objects are kept out of reach.
- **Safety areas that could potentially be improved include**: the home has at least one working smoke detector, poisonous household chemicals are kept out of reach, and unused electrical outlets are covered.

Exhibit 75. Percentage of Families "Always" Implementing Safety Practices by Child Age



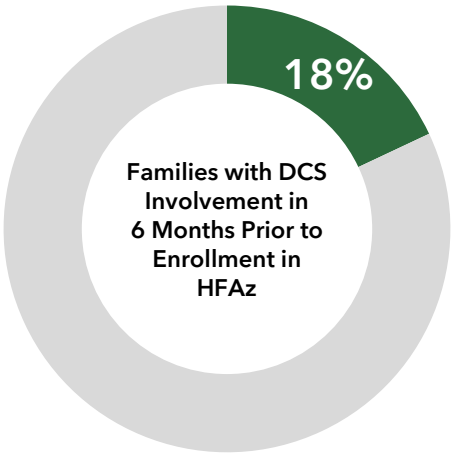
(Three months n=718, 12 months n=449, and 24 months n=373)

Child Maltreatment Prevention

A goal of HFAz is to reduce the incidence of child maltreatment, especially with families who are involved with or at risk of becoming involved with Arizona DCS. The Arizona Child Fatality Review Report (ADHS, 2022) states that the Arizona saw a 36% increase in the child abuse/neglect death rate from 2020 (5.8 deaths per 100,000 children) to 2021 (7.9 deaths per 100,000 children). Over half (52%) of abuse/neglect deaths occurred in infants (less than one year of age), followed by children ages 1-4 years (23%). Male children, Black children, and American Indian children were disproportionately affected. Over half (54%) of abuse/neglect deaths were due to accidental injuries. Substance use was the most commonly identified risk factor in 59% of child maltreatment deaths, 46% had a prior involvement with DCS, and 10% had an open DCS case at the time of death. **ADHS Child Fatality Review Team prevention recommendations include increasing home visiting programs throughout the state** and increasing awareness and support of prevention programs and services available in the state.

Of families served in FY22 who reported information about prior DCS involvement (n=3,246), 18% (n=580) self-reported having been involved with Arizona DCS in the six months prior to their enrollment to the program (Exhibit 76). This rate is slightly lower than previous years (19% in FY21, 20% in FY20, and 25% in FY19).

Exhibit 76. Families with DCS Involvement in Six Months Prior to Enrollment to HFAz



To facilitate recruitment of families with DCS involvement, HFAz receives referrals directly from Arizona DCS workers and the DCS SENSE program. In FY22, 7% (n=241) of families were referred from DCS (3%, n=103) and the SENSE program (4%, n=138). The SENSE program provides services to families after the birth of a substance exposed newborn. These families receive a coordinated Family Service Plan that includes HFAz home visitation as a supportive service. HFAz supportive services for families with current or prior DCS involvement 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.

Data from the Arizona DCS data system was requested through a data sharing agreement to determine the rates of substantiated child maltreatment for HFAz 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 HFAz 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).

There are several reasons the use of child abuse data is believed to have limitations. First, child abuse is an event that occurs infrequently and, therefore, changes are difficult to detect with statistical methods. Second, using official incidents of child abuse and neglect does not necessarily reflect actual behavior—there are many variations in what constitutes abuse and neglect and using only reported and substantiated incidents of abuse captures incidents that rise to that level of severity. Some incidents of child abuse or neglect are undetected or may not meet some definitional standard minimizing the accuracy of the count. Third, using official data requires a process whereby cases are "matched" on available information such as adult's first name, last name, and date of birth. When any of this information is missing or incorrect, the accuracy of the match decreases. Finally, because home visitors are trained in the warning signs of abuse and neglect and are required to report abuse or neglect when it is observed, there is a "surveillance" effect—what might have gone unreported had there been no home visitor show up in the official data.

Substantiated Child Maltreatment Reports Six Months Post Entry to HFAz

The evaluation team performed a matching process with DCS data using HFAz caregiver/parent first name, last name, and date of birth. Families that received at least six months of HFAz services (n=2,487) were included in the matching and analysis to determine if they had a substantiated report of child abuse or neglect. Overall, most families (96.9%, n=2,409) served in FY22 who had been in the program for at least six months, did not have a substantiated child maltreatment report from six months after they enrolled in the program. A low proportion of families served in FY22 (3.1%, n=78) had a substantiated report at some point after they had received at least six months of HFAz services. A substantiated finding means that "the Department of Child Safety has concluded that the evidence supports that an incident of abuse or neglect occurred based upon a probable cause standard" (see DCS substantiation guidelines for further detail). This substantiation rate of 3.1% is slightly lower but consistent with substantiation rates reported in FY20 at 3.7% and FY19 and FY18 at 3.6% (DCS data was not available for the FY21 report).

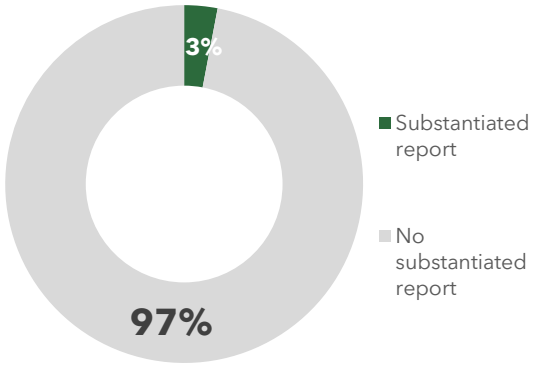


Exhibit 77. Substantiated Child Maltreatment Report Rate of Families Served by HFAz in FY22 With at Least Six Months of Services
(n=2,487)

RECOMMENDATIONS

This report covers the FY22 time frame from October 1, 2021 through September 30, 2022, which is the program's 31st year of service to families. The purpose of this annual evaluation report is to provide information on program process and implementation, performance measures, and family outcomes that demonstrate program success and can be used to guide program improvement.

Recommendations for Program Implementation

LMA respectfully puts forth the following programmatic recommendations for HFAz Central Administration's consideration, based on evaluation data reported this year.

- **Referrals to Services** - A portion of children and adults who screened positive in various areas seem to have not been referred to external services, based on data reported in ETO. It is unclear why referrals were not made. It is possible that the individual was already receiving services or that they refused services. It is also possible that a referral was made but the data was not recorded in ETO. Because of the critical importance of screenings and referrals to interventions external to HFAz, Central Administration and program leadership may want to explore this area to ensure that staff are clear on referral processes and are making and documenting referrals appropriately in ETO.
- **Data Entry and Quality Checks** – To support data entry of referrals made, Central Administration and ETO Administrators could continue to provide training and technical assistance for staff in entering data into ETO, data cleaning, and quality checks. Examples of data quality check needs observed by the evaluation team include ensuring assessment dates are accurate, that home visit notes and assessments are entered in a timely manner, and that referrals made are documented into ETO. LMA could collaborate with HFAz and ETO Administrators, as requested, to explore referral data and determine ways data collection and entry could improve the accuracy of results.
- **Measuring Family Outcomes in 6-Month Intervals** – Based on the recommended frequency of administration in the *HFPI User Manual* (LeCroy & Milligan, 2017), HFAz may want to consider collecting baseline HFPI data as close to program enrollment as possible to provide a "true" baseline of the participant without intervention. The program could also consider collecting HFPI data at six-months post baseline, which generally provides caregivers with enough time in program activities to assess meaningful change in subscale scores. Collecting data at this interval can also help home visitors to use HFPI data to identify family strengths, concerns, and solutions that can be incorporated into service plans. LMA will continue providing staff with additional training on the HFPI administration and use with families in FY23.

- **Supporting Families in Pandemic Recovery** – HFPI subscales where less or no improvement was observed could indicate areas where additional resources and support could help families navigate this critical, pandemic recovery environment. For example, in areas of Depression, Parent Self-Efficacy, Role Satisfaction, and Parent-Child Interaction more resources or referrals may be needed. Research shows that mental health needs have dramatically increased since the start of the pandemic, so HFAz could consider enhancing this referral process.

- **Strengthen Referrals from DCS/SENSE to HFAz** - The ADHS 2022 Child Fatality Review Team's recommendations to prevent child abuse and neglect related deaths include increasing home visiting programs throughout the state**.** In FY22, 7% of families were referred to HFAz directly from DCS (3%) and the SENSE program (4%). Given the recommendation of increasing home visiting, HFAz and DCS programs could collaborate to determine ways to increase referrals of families involved in DCS to HFAz.

- **Recognizing Family Language and Culture** – According to the annual Caregiver Survey, Hispanic/Spanish-speaking families and families who speak a language other than English or Spanish would like more materials available in their language and more relevant to their family's culture. Staff Survey respondents suggested the following equity areas as in need of improvement: the program could provide services to families in languages they can speak and read; the program may wish to utilize a variety of curricula to meet the needs of families; and materials shared with families could represent their varying racial and ethnic backgrounds. HFAz could also consider providing home visitors with additional training on specific cultural values and norms of families served. Improving staff awareness of family culture can help improve rapport building with families and their retention in the program.

- **Family Engagement in Services** - While the overall findings from the Caregiver Survey are positive, suggesting Caregivers appreciate the HFAz program, a few findings indicate areas for improvement. Families would like more activities, access to community resources, and outdoor events. Families are also interested in opportunities to meet other families who participate in HFAz, such as group meetings. In addition, there is interest in more information and resources particular to their child's needs. Some families requested additional or longer home visits. Caregivers who reported having a shorter average visit length on the survey (45 minutes or less) were significantly more likely than those with longer visits (46 minutes or more) to have felt that their home visitor "sometimes" or "never" spent enough time with them during visits. To optimize a family's experience, home visitors should continue to strive to meet the HFA Best Practice Standard of holding visits that are 45 minutes or longer.

- **Continue to Refine and Enhance the Site Visit Process** – Staff who completed the Site Visit Survey suggested several areas for continued enhancement of the site visit process. Recommendations include: providing feedback on the site visit to the site/team from a person who is not a supervisor or manager of that team; providing feedback in person; clarifying the file review process; and incorporating food into site visits.

- **Explore Recommendations Provided by Staff** – Data from the Staff Survey and Staff Exit Survey suggest areas that matter to staff and that HFAz may wish to explore, as feasible, to further enhance retention and program improvement efforts. For example, the following areas are important for staff retention: salary (which was enhanced with additional GOF/HFE funding), time off, self-care strategies, employee appreciation, team building, continuing education for advanced degrees, and opportunities for career growth. HFAz could continue to provide staff training in areas important to staff, including family engagement strategies, working with high needs families, and managing the balance between collecting paperwork and relationship-building with families. Data collected from staff also suggested areas where operational/process/leadership improvements could be helpful in their work. Staff recommendations reviewed in this report could be considered by HFAz Central Administration and leadership as ways to further improve staff retention and satisfaction.

Recommendations for Evaluation

LMA puts forth the following recommended focus areas for the FY23 evaluation of HFAz.

- As the HFAz program (statewide and site level) implements annual equity plans, LMA proposes to evaluate this implementation as part of the process evaluation to provide feedback to Central Administration on ways to improve subsequent equity plans.
- HFAz Central Administration and the evaluation team could collaborate to revise the annual Staff Survey to better inform annual equity plan updates and strategies for staff retention.
- HFAz Central Administration and the evaluation team could also review strategies to improve the Staff Exit Survey data collection. Increasing this response rate could provide the program with more feedback from exiting staff.
- LMA could explore additional analyses of family characteristics that predict retention and completion of the program.

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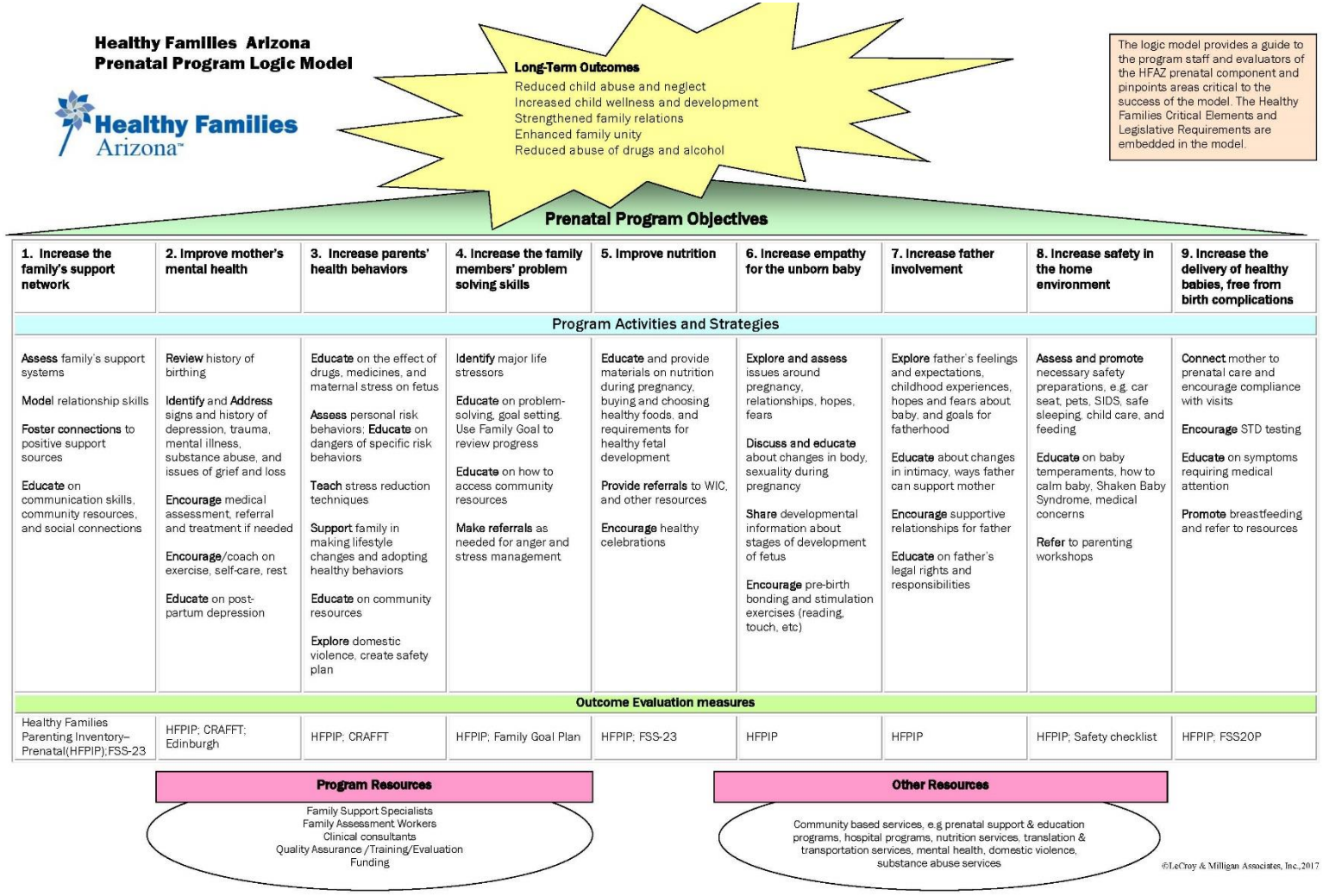
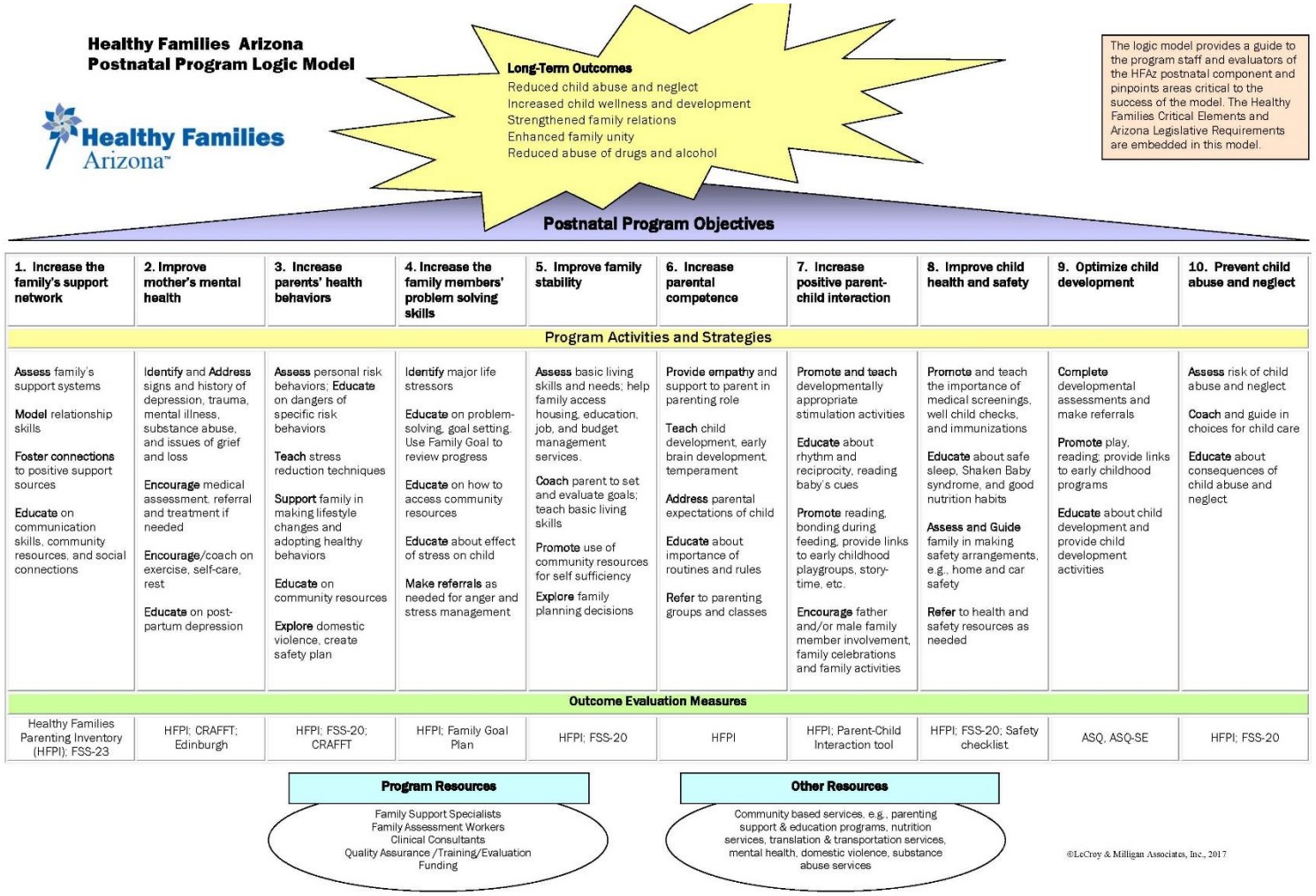
APPENDIX A. HEALTHY FAMILIES ARIZONA PRENATAL LOGIC MODEL



APPENDIX B. HEALTHY FAMILIES ARIZONA POSTNATAL LOGIC MODEL



APPENDIX C. CHILD WELL-BEING INDICATORS IN ARIZONA

Arizona ranked 44th out of 50 states (with 50th being the worst ranking) in overall child well-being, with our ranking fluctuating over time (46th in 2019, 42nd in 2020, and 40th in 2021) (The Annie E. Casey Foundation, 2021a, 2021b). 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 2022. These indicators demonstrate the strong need for HFAz, which provides additional support to families and helps mitigate the risk of experiencing poor outcomes in early childhood and in transitioning to adulthood.

Family and Community

Arizona's Family and Community ranking of **44th out of 50** improved in 2022 (the state ranked 46th from 2019 to 2021). Arizona saw improvements in three indicators and one remained the same. **Teen birth rates** dropped from 42 per 1000 births in 2010 to 17 per 1000 births in 2020. The percentage of **children living in high poverty areas** improved from 22% in 2008-12 to 12% in 2016-20. The percentage of **children in families where the household head lacks a high school diploma** decreased from 19% in 2010 to 15% in 2016-20. The percentage of **children living in a single parent household** has remained 37% over time.

Health

Arizona's Health ranking of **29th out of 50** is the state's best ranked domain and improved from 35th in 2019 to 33rd in 2020, but worsened compared to 28th in 2021. The percentage of **Arizona children without health insurance** has improved over time, from 13% in 2010 to 9% in 2016-20. The percentage of **children and teens (ages 10 to 17) who are overweight or obese** has slightly worsened in Arizona (26% in 2016-17 to 27% in 2019-2020). Two health indicators where Arizona also worsened over time include the percentage of **low-birthweight babies** (7.1% in 2010 and 7.4% in 2020) and the rate of **child and teen deaths per 100,000** (28 in 2010 and 36 in 2020).

Economic Well-Being

Arizona's **Economic Well-Being** ranking of **41st out of 50** is the state's second-best ranked domain and has fluctuated over time (43rd in 2019, 36th in 2020, and 35th in 2021). Arizona saw positive changes in all four areas. **Arizona children living in poverty** decreased from 24% in 2010 to 20% in 2016-20. **Children whose parents lack secure employment** dropped from 35% in 2010 to 29% in 2016-20. **Children living in households with a high housing cost burden** decreased from 43% in 2010 to 30% in 2016-20. The percentage of **teens who are not in school and not working** decreased from 12% in 2010 to 8% in 2016-20.

Education

Arizona's national ranking of **47th out of 50 for the 2022 Education domain** is the state's lowest ranked domain in comparison to other states and remained the same in 2021 (47th in 2021). However, Arizona saw improvements in three of the four indicators measured and one indicator remained the same. Arizona's rate of **young children not in school** dropped from 66% in 2010 to 61% in 2016-20. This rate is still higher than the national rate of 53%. 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.