Healthy Families Arizona Annual Evaluation Report

October 2023 – September 2024

January 2025

LeCroy & Milligan
ASSOCIATES, INC.

Healthy Families Arizona Annual Evaluation Report: October 2023 - September 2024

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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 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.

About LeCroy & Milligan Associates:

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 housed at the Arizona Department of Child Safety (DCS) and, in its 33rd year, served 4,190 families, reaching all 15 counties. The HFAz program is accredited by Prevent Child Abuse America and received re-accreditation in 2023 that is valid through 9/30/2028. HFAz is modeled after the Healthy Families America (HFA) initiative, which is an approved evidence-based early childhood home visiting service delivery model.

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 and referrals to participating families. By providing services to under-resourced and stressed families, the HFAz program fits into a continuum of services to support Arizona families.

Funding for HFAz in FY24 totaled $22,370,719. The largest source of funding in FY24 was the DCS/Lottery funds and Governor's Office/General Fund (GF). Two thirds of families were funded by the DCS/GF. First Things First, MIECHV, and State Opioid Response continued to be other sources of funding for 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 10/1/2023 to 9/30/2024 (FY24).** 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. **HFAz has committed to making intentional efforts to promote equity in all facets of operations with families, staff, and community.** To inform equity strategies, this report examines characteristics of families who were retained and exited the program in FY24, so the program may tailor program retention strategies to families.

Families Served

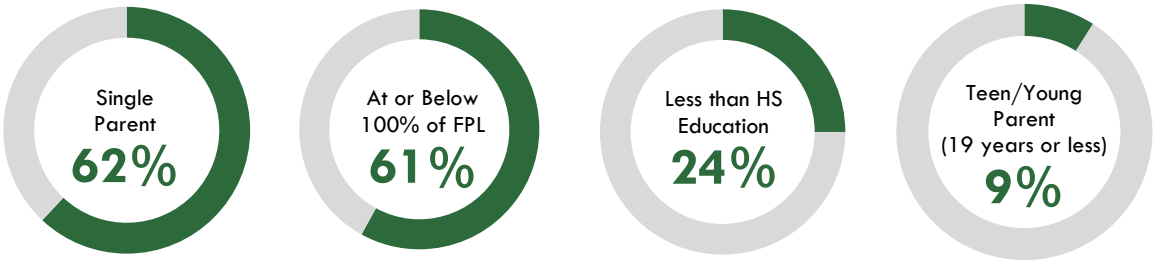
With increased funding and program expansion, **HFAz served a total of 4,190 families in FY24, which is an 11% increase from the number of families served in FY23.** HFAz serves families living in all 15 Arizona counties. Sites have between one and 14 home visitor teams, for a total of 52 Family Support Specialist (FSS) teams, which is an increase from 49 teams in FY23. Three new program sites were funded as of January 1, 2024. These programs expanded HFAz services to families in parts of Maricopa and Pinal Counties and the Gila River area.

Characteristics of 4,190 Families Served in FY24

- Community referrals accounted for 47% of families and systematic screenings referred 39% of families.
- 98% of primary caregivers are the birth mothers of children.
- Caregiver age at enrollment ranged widely from 13 to 61 years (average of 28 years).
- 56% of caregivers identified as Hispanic/Latinx and 74% identified their race as White/Caucasian. Broken down further, 47% identified as White, Hispanic/Latinx, and 28% identified as White, non-Hispanic.
- 74% speak English as their primary language, 22% primarily speak Spanish, 2% are bilingual, and 2% primarily speak another language.

Key Child Well-Being Indicators – Maternal Risk Factors

Mothers enrolled in the HFAz program have higher rates of risk factors for poor child well-being compared to mothers in Arizona. This data suggests the program is targeting families who can benefit the most from the services provided.



Family Participation

- Families participated for a **median of 9 months**. **38% of families have been active in the program for <u>five or fewer months</u>**, reflecting the program's expansion and increased enrollment in families.
- **21% have participated in the program for <u>more than two years</u>**.
- A total of **65,136 visits** were conducted statewide, with **97% occurring in person.**

Program Retention and Family Characteristics

Statewide, HFAz had a **55% retention rate** of families who remained active in the program going into FY25. The program was significantly more likely to retain families with the following characteristics:

- Hispanic/Latinx families
- Spanish is primary language
- Older (average age of 28 years)/not a young parent
- Above the FPL
- Have a high school diploma or more education

Program Exit and Family Characteristics

Statewide, HFAz had a **family closure rate of 45%** in FY24. Of the 1,871 families that closed in FY24, 17% received 24 months or more of services. However, **there continued to be a notable increase (23%)** in the percentage of families who **exited the program with less than three months of service** in both FY24 and FY23, compared to previous years.

- Significant differences were observed for **length of time families spent in the program**. **Hispanic/Latinx families** spent a significantly longer time in the program (average of 15.9 months) compared to non-Hispanic families (average of 14.1 months). **African American families** and **Native American families** spent significantly less time in the program (average of 10.0 months) compared to families of all other races (average of 14.0 months).
- Exiting the program with **less than 3 months of HFAz services** was significantly related to **speaking a language other than English or Spanish** and **African American families.**
- Exiting the program after **24 months or more of HFAz services** was significantly related to **primarily speaking Spanish and racial groups other than Native American.**

Exit Reasons and Family Characteristics

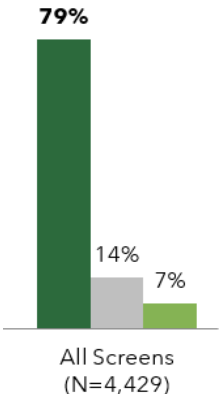
The top three exit reasons were examined to better understand the characteristics of caregivers who left HFAz for these reasons. This data indicates which families HFAz tends to serve more successfully than others and provides insights into where retention improvements can be made.

Family was not responsive to FSS follow-up and/or not able to be reached by FSS for further services (n=377)	• Hispanic/Latinx families • Native American families • At or below 100% FPL • Less than a high school education • Has older children (6-17 years) • Single parents
Family refused further services, including a worker change and families who felt they reached self-sufficiency (n=506)	• Above the FPL • Older parents (average age of 29 years) • Completed high school or more education • In a partnered relationship/married • Speak a language other than English or Spanish
Family completed the program, per FSS determination (n=230)	• Hispanic/Latinx families • Racial groups other than African American or Native American • Primarily speak Spanish • Older parents (average age of 29 years) • In a partnered relationship/married

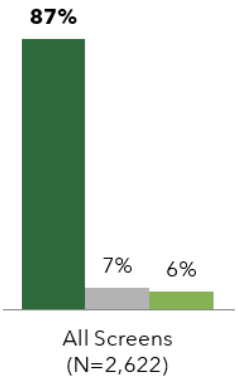
Outcomes for Families and Children

Child Development Screening and Referrals

A total of **4,429 Ages and Stages Questionnaire 3rd Edition (ASQ-3) screenings were conducted in FY24 for 2,449 children**. Children received between one and seven screenings, depending on the outcome of their initial and subsequent screenings. For all screening time points, **79% screened in the typical range for physical and social development, 14% were questionable, and 7% were identified as delayed.** Of the 327 total cases that were screened as delayed in FY24, all but 2% (n=8) had a follow-up action recorded in ETO, which is an improvement from 10% that did not have a referral recorded in ETO in FY23.

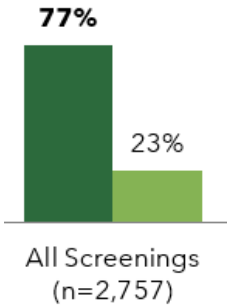


A total of **2,622 ASQ Social Emotional, 2nd Edition (ASQ: SE-2) were completed in FY24 with 1,978 children across six points**. Most children (87%) showed no concern in social-emotional areas, 7% needed additional monitoring, and 6% needed a referral to services. Of children needing a referral, 59% were referred to services, 14% were already receiving services, and 29% did not have a referral documented in ETO.



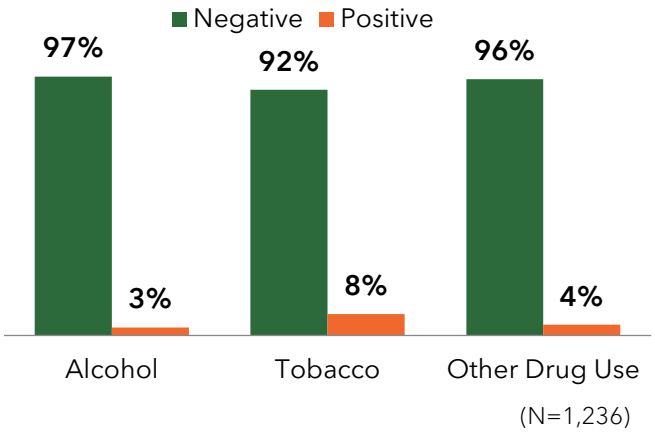
Postnatal Depression Screening and Referrals

A total of **2,757 Edinburgh Postnatal Depression Screens** were completed in FY24 with **2,088 parents**. Across all time points, **77% of screens were negative for depression and 23% were positive.** Of the 624 parents who screened positive, 66% received a referral that was accepted by the parent, 24% were already receiving services, and 10% did not have a referral documented in ETO. **Of adults referred to services, 51% engaged in the service and 29% had services that were pending or soon to start.** In 10% of cases the adult refused services or did not take action on the referral, and in 2% of cases the service was full or not accessible (e.g., cost prohibitive, lack of insurance). 9% of records did not have a referral outcome documented in ETO.



Substance Abuse Screening and Referrals

1,236 Past 30-day Alcohol, Tobacco, and Other Drug (ATOD) screenings were completed with newly enrolled parents. **Most ATODs resulted in a negative screen.** The highest positive screen rate was for **tobacco use at 8%.** Of positive tobacco screens, 83% received a referral for tobacco cessation services and 17% did not have a referral recorded into ETO. Of the adults who discussed substance use with their home visitor at program intake, 11% received a referral for substance use services.



Change in Parenting Behaviors and Family Outcomes

A total of **942 baseline HFPI surveys were completed by parents in FY24**.

The top three HFPI areas with the highest rates of concern at baseline, which were consistent over time, include:

- Personal Care
- Parenting Efficacy
- Role Satisfaction

These areas may need more attention by home visitors in working with families, especially those whose HFPI results show a concern in these areas.

6-8 Month Follow-up - 363 HFAz parents and caregivers completed a baseline and a 6–8-month follow-up HFPI (from FY18 to FY24). From baseline to 6-8 months post, statistically significant improvements were observed for **Home Environment, Mobilizing Resources, Parent-Child Interaction,** and **Problem Solving.** Non-significant improvements were observed for all other subscales.

12-14 Month Follow-up - 1,684 HFAz parents and caregivers completed a baseline and a 12–14-month follow-up HFPI (FY18 to FY24). Significant improvements occurred for **Home Environment, Mobilizing Resources,** and **Problem Solving.** Statistically significant decreases occurred in **Parent-Child Interaction** and **Role Satisfaction**, indicating that some parents were struggling in these areas.

Safety Practices in the Home - In FY24, a total of **2,716 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 are **supervised near water**, age-appropriate **car seats are correctly installed**, **tobacco products and sharp objects** are out of reach, and **weapons and ammunition** are locked.

Safety areas that could potentially be improved include:

- **Home has at least one working smoke detector**
- **Poisonous household chemicals are kept out of reach**
- **Unused electrical outlets are covered**.

Child Maltreatment Prevention – Families that received at least 6 months of HFAz services were included in a matching process with DCS administrative data on child maltreatment. **Overall, 98.5% of families served in FY24 who received at least 6 months of services did not have a substantiated child maltreatment report from 6 months post enrollment to the program.** A total of **1.5% of families** served in FY24 had a substantiated report at some point after they had received at least 6 months of HFAz services.

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.

Service Recommendations

- **Supporting Families in HFPI Areas** – HFPI data on concern areas shows that home visitors could provide more support to families in areas of personal care and developing a sense of self-efficacy as a parent, as well as role satisfaction and parent-child interaction, especially as their child grows. Families showed significant improvements over time from baseline to 12-14 months in the areas of setting up a home environment for raising a child and their ability to mobilize resources. This finding suggests that the program is especially effective in supporting families in these areas and these practices should be continued.
- **Strengthen Referrals to Services** - Since a portion of families are not retained in the program (23% closed in less than 3 months), referring them to existing community services during their first few months of service is important. This would provide more support for families who exit the program prematurely, so they have access to other community resources available.
- **Identify ways to better retain and serve African American, Native American, single caregivers, and young caregivers** – These families have lower retention and completion rates than their counterparts, warranting additional attention to what could be contributing to these disparate effects. Retrospectively or going forward, a small group of staff could conduct a case review of early program exits for families with these characteristics, documenting stressor or service factors that contributed, and identifying ways to mitigate these in the future.
- **Promote Greater 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, and are interested in opportunities to meet other families who participate in HFAz. Families would like more information and resources particular to their child's needs. Some families requested additional or longer home visits.

Program Administration Recommendations

- **Promote Equity Planning and Implementation** – HFAz Central Administration could continue to gather staff feedback on the equity planning process and implementation. The evaluation team could conduct focus groups with staff on equity plan implementation. The FY24 Equity Plans emphasized promoting equity through supportive supervision, staff development, team building, and family engagement.

Supervisors are encouraged to provide tailored guidance, reflective practices, and collaborative time management planning to meet diverse staff needs. Staff development focuses on offering personalized training opportunities, recognizing contributions, and establishing mentorship programs to support professional growth. Team-building efforts promote inclusivity through open conversations, cultural sharing, and activities that strengthen cohesion and morale. Family engagement strategies prioritize flexibility with virtual visits, accessible events, language support, and targeted outreach to marginalized communities, ensuring equitable access and meaningful connections for all families.

- **Strengthen Data Entry and Quality Checks** – Overall, data entry and documentation of referrals made for services in FY24 showed notable improvement from FY23. However, the Central Administration and ETO Administrators could continue to provide training and technical assistance for staff in entering data into ETO, data cleaning, and performing quality checks.
- **Strengthen Referrals from DCS/SENSE to HFAz** - The ADHS 2024 Child Fatality Review Team's recommendations to prevent child abuse and neglect related deaths include increasing home visiting programs throughout the state. HFAz and DCS programs could collaborate to determine ways to increase referrals of families involved in DCS to HFAz. Examining how these families may be different can assist the program in providing services that better match the needs of the specific population.
- **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. These include enhancing staff support by addressing workload management, reducing redundancies in paperwork, fostering professional growth, offering targeted training, promoting team building and appreciation, expanding cultural sensitivity and tailoring curricula for diverse families, and ensuring competitive salaries and benefits.

Recommendations for Evaluation

LMA puts forth the following recommended focus areas for the FY25 evaluation of HFAz. LMA will continue to monitor changes in evaluation data as the program expands and serves new families, such as outcomes from newer populations served and changes in demographics of families served. As the program implements equity plans, LMA can evaluate and provide feedback on plan implementation and suggest ways to improve subsequent equity plans. LMA can continue to examine caregiver characteristics by service utilization, retention, and exit reasons to inform equity strategies and strengthen tailoring of retention efforts to family needs. HFAz Central Administration could consider clarifying the existing definition of "program graduation" with staff, when documenting reasons for exiting the program.

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 33rd year, served a total of 4,190 families, reaching all 15 counties. The HFAz program is accredited by Prevent Child Abuse America and received re-accreditation in 2023 that is valid through 9/30/2028. HFAz is modeled after the Healthy Families America (HFA) initiative, which is an approved evidence-based early childhood home visiting service delivery model by the US Department of Health and Human Services. HFA has been designated as "well-supported" (the highest rating) by the Title IV-E Prevention Services Clearinghouse. In the HFA model, families are screened and participate voluntarily in the program. Trained staff provide home visits 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. The HFAz logic model for prenatal and postnatal families is shown in Appendix A and B.

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 10/1/2023 to 9/30/2024 (FY24). 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. HFAz has committed to making intentional efforts to promote equity in all facets of operations with families, staff, and community. To inform equity strategies, this report examines characteristics of families who were retained and exited the program in FY24, so the program may tailor program retention strategies to families.

Statewide System and Funding

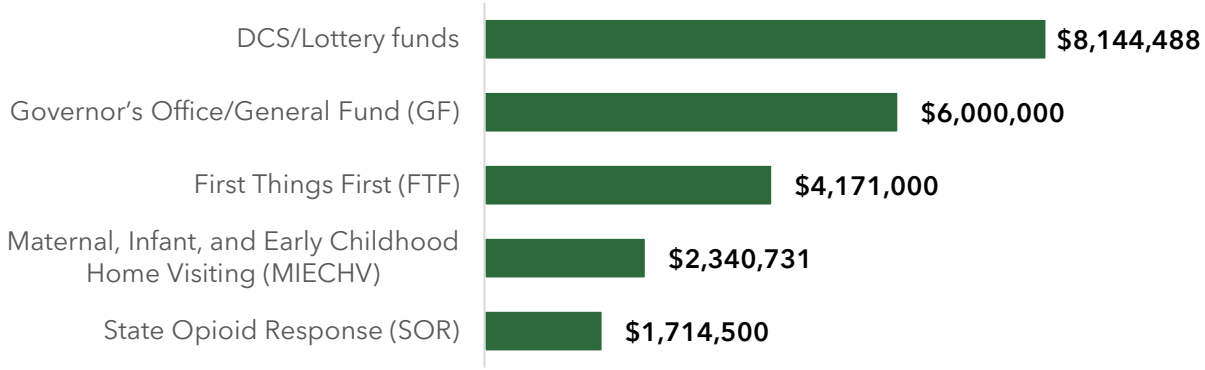
HFAz is an affiliate of the HFA State/Multi-Site system. Central Administration for HFAz is housed within the Office of Fidelity and Compliance under the Arizona DCS. There are five core functions of Central Administration that guide operations at the state and program level (Exhibit 1).

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

Program Funding

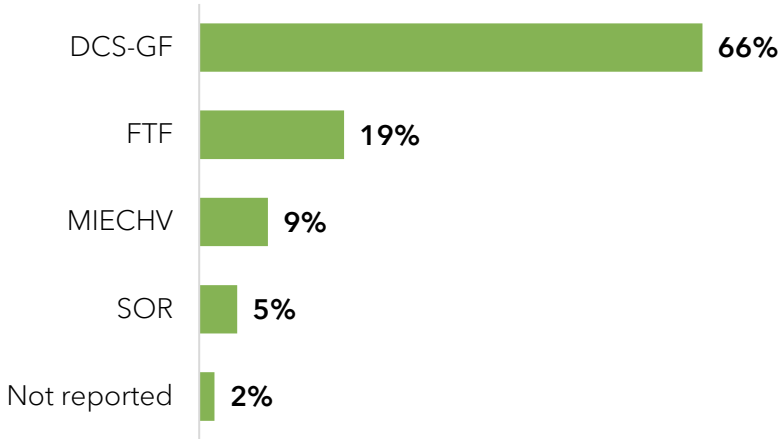
Funding for HFAz in FY24 totaled $22,370,719. The largest source of funding in FY24 was the DCS/Lottery funds and Governor's Office/General Fund (GF). Funding sources and amounts are shown in Exhibit 2.

Exhibit 2. Funding Sources for Healthy Families Arizona, FY24



HFAz served a total of 4,190 families in FY24 from October 1, 2023 through September 30, 2024 and funding sources for families are shown in Exhibit 3. Two thirds of families (66%, n=2,769) are funded by the DCS General Fund, which combines the DCS/Lottery and GF. FTF, MIECHV, and SOR continue to be other sources of funding for families.

Exhibit 3. Funding Sources for Families, FY24



(N=4,190 families)

HFAz Program Expansion

With increased funding and program expansion, **HFAz served a total of 4,190 families in FY24, which is an 11% increase in the number of families served in FY23 (N=3,785)**. HFAz serves families living in all 15 Arizona counties. The map below (Exhibit 4) shows the number of families served in each county, with lighter shades indicating a lower number of families and darker shades indicating a higher number of families served.

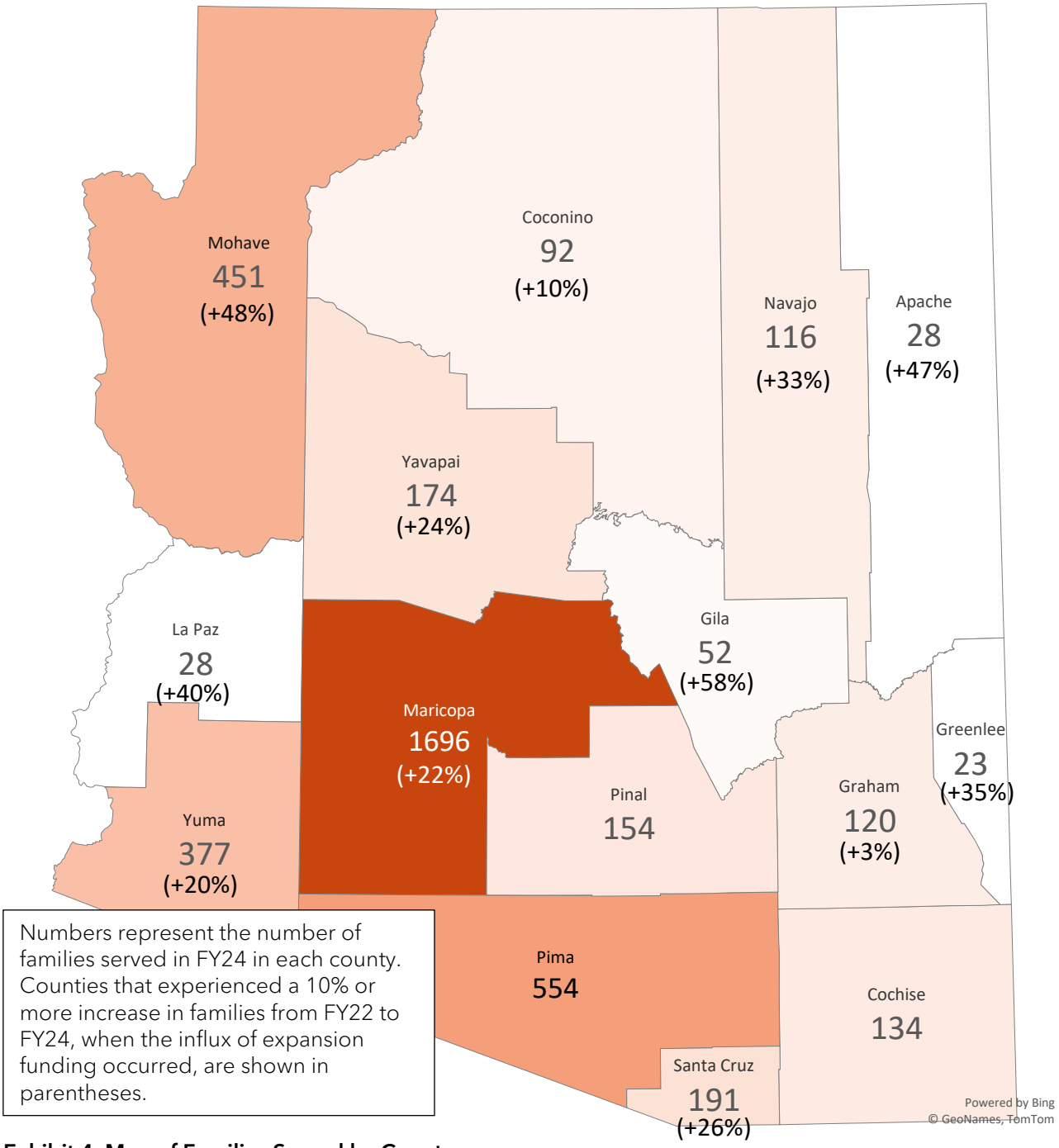
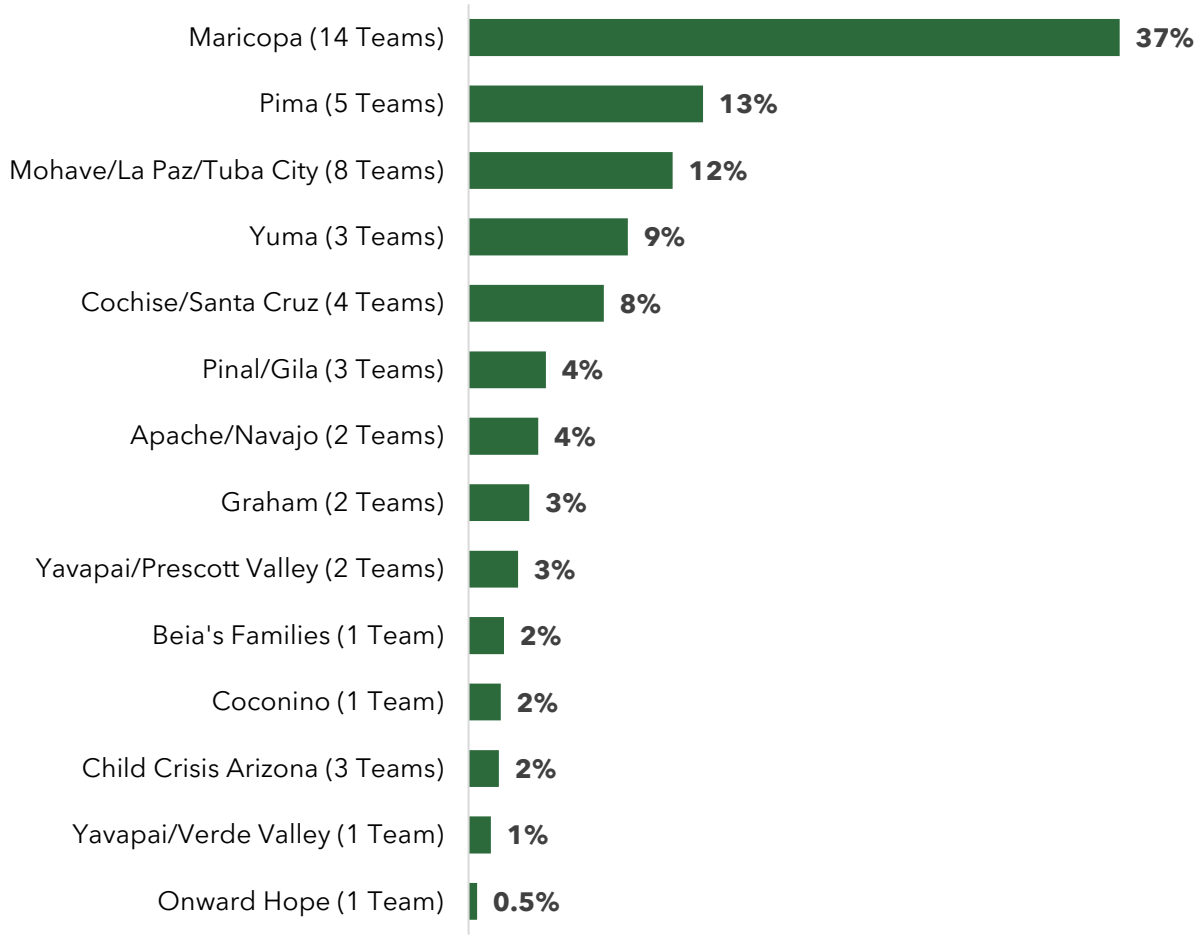


Exhibit 4. Map of Families Served by County

Exhibit 5 shows the proportion of families enrolled statewide that are served by the 14 HFAz program sites. Sites have between one and 14 home visitor teams, for a total of 52 Family Support Specialist (FSS) teams, which is an increase from 49 teams in FY23. Three new program sites were funded as of January 1, 2024, including Beia's Families, Child Crisis Arizona, and Onward Hope. These programs expanded HFAz services to families in parts of Maricopa and Pinal Counties and the Gila River area.

Exhibit 5. Proportion of Families Served by HFAz Program Sites and Teams



The statewide Central Administration team maintained its expanded six person staff team in FY24, to accommodate program expansion and continue to provide a high quality of service to the network, ensuring program fidelity and best practices.

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 *2024 KIDS COUNT Data Book* and state level report.

Updates on Equity Home Visiting

A review of recent literature on home visitation.

Program Participation and Family Characteristics

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

Program Outcomes

Results from key child and adult screening and prevention services. Changes in parenting and family outcomes from baseline to 6 and 12 month follow-up, measured by the Healthy Families Parenting Inventory; home safety practices; immunizations; and child maltreatment data from Arizona DCS.

Program Implementation

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

Recommendations

Recommendations are provided for program improvement and evaluation focus areas in FY25.

EVALUATION DESIGN

The FY24 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 the Efforts to Outcomes (ETO) enterprise database platform. Program implementation data is collected by staff and entered into ETO. Process evaluation data is also collected by the evaluation team from program staff, supervisors, managers, and HFAz Central Administration through discussions at meetings and survey data. Process data is used for program monitoring and improvement. The table below shows the key process areas assessed in this report.

Process Evaluation Component	Data Sources
Families served: characteristics, referral processes, service equity, and service delivery details	Family characteristics and services, collected in ETO.
Equity plans and implementation	Equity plan development and implementation, as reported by Central Administration and Supervisors.
Participant satisfaction	Family satisfaction and perspectives on diversity, equity, inclusion, and belonging, collected by the Caregiver Survey. Family exit reasons, documented in ETO.
Program implementation fidelity and challenges	Performance management information (e.g., rates of screening), collected in ETO.
Staff satisfaction	Staff Satisfaction and Cultural Survey and Staff Exit Survey.
Training and technical assistance for staff	Training session data and TA/QA Survey.

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?
- ✓ To what extent are families and staff satisfied with the HFAz Program? What are staff and families' perspectives on HFAz? What are the reasons that families exit the program before completion? How are family characteristics related to program exit and retention? How is equity addressed by the program?

Data Analysis

In addition to descriptive statistics, the evaluation team performed bi-variate analyses to explore relationships between caregiver characteristics and program retention and exit reasons. Binary variables (e.g., 1=retained in the program/0=exited the program) were compared by caregiver characteristics using a 2 x 2 contingency table and *Pearson's chi-square* (x^2) statistical test to evaluate how likely it is that any observed difference between the two groups was due to chance. *Independent samples t-tests* were performed when comparing binary variables with continuous variables, such as program retention/exit by caregiver age. The alpha level used for all statistical tests in this study is $p < 0.05$. Differences between caregiver characteristics and retention and exit reasons with p values less than 0.10 are also highlighted, which are considered to be marginally significant.

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. Outcome data presented in this report, shown in the table below, were collected by home visitors and entered into ETO. The guiding questions for the outcome evaluation include:

- ✓ What impact does HFAz have on parenting outcomes?
- ✓ What impact does HFAz have on the care and protection of children?
- ✓ To what extent does the HFAz program achieve the objectives outlined in the legislation and the program's logic model (see Appendix A and B)?

Outcome Evaluation Component	Data Sources
Percent of children screened for developmental delays and referrals made.	Ages and Stages Questionnaire, 3rd Edition (ASQ-3), Ages & Stages Questionnaire: Social-Emotional (ASQ: SE-2)
Percent of caregivers screened for substance abuse and postnatal depression and referrals made.	Edinburgh Postnatal Depression Screen (EPDS), Past 30-Day Alcohol, Tobacco, and Other Drug (ATOD)
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.	Healthy Families Parenting Inventory (HFPI)
Percent of families implementing safety practices by age of child.	Safety Checklist
Percent of families with a substantiated incidence of child maltreatment since entering the program.	Arizona Department of Child Safety Guardian data.

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 ***2024 KIDS COUNT® Data Book*** (2024a) and state level reports (2024b). 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 42nd out of 50 states in child well-being (with 50 being the worst ranking), which is a decline from 39th in 2023.

Arizona's rankings in 2019 to 2024 for each domain and overall are shown in Exhibit 6. The *2024 KIDS COUNT® Data Book* ranked Arizona overall as 42nd in the nation, which is a decline in Arizona's overall ranking compared to two of the previous five years (Arizona's overall ranking was higher only in 2021 and 2023). Additionally, two of the four areas declined for Arizona, while one stayed the same and one improved. **Family and Community declined** (41st in 2024 compared to 40th in 2023), as well as **Health Rank** (34th in 2024 compared to 32nd in 2023). **Economic Well-Being stayed the same** (33rd in 2024 and 2023), and **Education improved** (44th in 2024 compared to 47th in 2023).

Exhibit 6. KIDS COUNT Child Well-Being Rankings for Arizona, 2019 to 2024

Domain	2019	2020	2021	2022	2023	2024	Change in Arizona's National Rankings Over Time
Overall Rank	46	42	40	44	39	42	Worse
Economic Well-Being Rank	43	36	35	41	33	33	Same
Family and Community Rank	46	46	46	44	40	41	Worse
Education Rank	46	46	47	47	45	44	Improved
Health Rank	35	33	28	29	32	34	Worse

Data from the national *KIDS COUNT Data Book* (2024a) and Arizona's state profile (2024b) for the four domains and indicators are shown in Exhibit 7.

Exhibit 7. KIDS COUNT Profile for the United States and Arizona

Arizona's Overall Rank = 42	United States		Arizona		Change in Arizona Over Time
	2019	2022	2019	2022	
Economic Well-Being Rank = 33 (Same as 2023 ranking)					
Children in poverty	17%	16%	19%	16%	**Improved**
Children whose parents lack secure employment	26%	26%	27%	25%	**Improved**
Children living in households with a high housing cost burden	30%	30%	28%	29%	**Worse**
Teens not in school and not working	6%	7%	8%	8%	**Same**
Family and Community Rank = 41 (Worsened from ranking of 40th in 2023)					
Teen births per 1,000 births	17	14	18	15	**Improved**
Children living in high-poverty areas	13% (2012-16)	8% (2018-22)	20% (2013-17)	8% (2018-22)	**Improved**
Children in families where the household head lacks a high school diploma	12%	11%	15%	14%	**Improved**
Children in single-parent families	34%	34%	37%	37%	**Same**
Education Rank = 44 (Improved from ranking of 45th in 2023)					
Young children (ages 3 and 4) not in school	53% (2013-17)	54% (2018-22)	62% (2013-17)	65% (2018-22)	**Worse**
Fourth graders not proficient in reading	66%	68%	69%	69%	**Same**
Eighth graders not proficient in math	67%	74%	69%	76%	**Worse**
High school students not graduating on time	14% (2018-19)	14% (2020-21)	22% (2018-19)	24% (2020-21)	**Worse**
Health Rank = 34 (Worsened from ranking of 32nd in 2023)					
Children without health insurance	6%	5%	9%	8%	**Improved**
Children and teens (ages 10 to 17) who are overweight or obese	31% (2018-19)	33% (2021-22)	25% (2018-19)	31% (2021-22)	**Worse**
Low-birthweight babies*	8.3%	8.6%	7.4%	7.8%	**Worse**
Child and teen death rate per 100,000**	25	30	30	35	**Worse**

Source: Annie E. Casey Foundation, 2023a, 2023b. *Percentages for low-birthweight babies are reported with one decimal place for accuracy purposes. **Child and teen death rates per 100,000 are actual numbers of children and teens, not percentages.

TRAUMA-INFORMED APPROACH TO HOME VISITING

This review examines the impact of stressors—such as trauma and anxiety—on families and the importance of adopting trauma-informed approaches in home visiting programs. The review also highlights the role of Tribal Home Visiting programs in providing culturally responsive support to Native American populations.

Impact of Stressors on Families

Families face various challenges when migrating to the United States, which can vary based on their unique circumstances and the stage their family is in. Whether it is a new pregnancy, the arrival of the first baby, or changes in family composition, each stage of family life presents its own set of challenges. It is crucial for home visitors to consider these factors, as understanding the family's specific stage allows them to address the family's needs more effectively. By doing so, home visitors can ensure that families feel supported and achieve the goals of the home visit.

> Most often, the home visitors were found to be helpful because they offered emotional support, concrete assistance through advocacy and case management, translation, friendship, and education (Paris, 2008).

These stressors can have significant impact on the socio-emotional and cognitive development of children in these families (Park & Katsiaficas, 2019). Families may migrate due to poverty, violence, or other circumstances, which are difficult to navigate and can cause trauma (Park, 2019). Families may also face language barriers, financial instability, and cultural displacement, all of which may lead to depression and anxiety. However, these families have remarkable strength. Many possess incredible resilience (Paris, 2008). Their hopes for the future, determination to build new lives, and traditions are powerful assets that can be nurtured within home visiting programs (Shea & Wong, 2022). This fresh perspective can enrich society and contribute to a deeper sense of community and shared responsibility. By focusing on the challenges and stressors they may be experiencing and their aspirations and strengths, home visiting programs can foster a more balanced and empowering engagement with families.

Trauma-Informed Approaches in Home Visiting Programs

Effective home visiting programs rely on trauma-informed, culturally responsive methodologies to address the needs of families. By adopting a family-centered approach, home visiting programs can help reduce intergenerational trauma and promote resilience (Park & Katsiaficas, 2019). This approach includes dyadic interventions, which involve both parents and children in the healing process, as well as culturally responsive models that ensure services are accessible and relevant (Park & Katsiaficas, 2019).

Having dyadic interventions where both parents and children participate strengthens parent-child relationships and addresses the effects of trauma collectively. Research shows these interventions improve socioemotional outcomes for children and reduce parent stress and trauma symptoms (Park, 2019). Central to these approaches is the emphasis on building trusting relationships between home visitors and families and providing emotional support, which creates a safe environment for discussing trauma-related issues (Paris, 2008). Relationship-based based approaches help reduce barriers and fosters engagement (Katsiaficas, 2020). Additionally, employing bilingual and bicultural paraprofessional home visitors is another trauma-informed strategy (Paris, 2008). Community input can also play a key role in shaping services, which may include locating programs within trusted community organizations to further improve accessibility (Katsiaficas, 2020).

Programs such as Baby TALK and Parent Child Home Program are examples of initiatives designed to support diverse families. These models integrate culturally sensitive practices to address the unique needs of these populations (Park & Katsiaficas, 2019). In Los Angeles, the Welcome Baby program builds trust by employing multilingual staff, offering optional data reporting, and partnering with local nonprofits to address families' fears of legal repercussions (Sandstrom et al., 2022). Michigan's home visiting initiative engages parent leaders from immigrant communities to help shape program policies, fostering a sense of ownership and trust among participants (Katsiaficas, 2020). These strategies demonstrate how home visiting programs can alleviate fears while fostering engagement and trust. Lessons learned from existing programs provide a robust foundation for policy and practice advancements in this critical area (Katsiaficas, 2020).

Tribal Home Visiting Programs

Tribal Home Visiting initiatives working with Native American populations utilize culturally responsive practices that can be applied effectively to immigrant families, acknowledging the unique cultural identities, histories, and values that families bring with them. It is important to take into consideration the incorporation of tribal knowledge, involving tribal leaders, elders, and community members. As representatives of their community, they can contribute to the development and implementation of program strategies (Singleton et al., 2022). This practice of community engagement can be adapted to other communities, recognizing that community

input is essential for developing programs that serve the needs of the population. In addition, peer collaboration and sharing, and programs encouraging peer-to-peer learning among Tribal programs contribute to exchange in knowledge about successful culturally specific practices. Singleton et al. also noted how programs provided flexibility for communities to adapt evidence-based models and practices to local cultural contexts. By incorporating tribal knowledge and engaging the community in program design, these initiatives help ensure that services are culturally relevant and address the strengths and concerns of Native American families.

In home visiting programs, trauma-informed and culturally responsive practices can enhance service delivery and ensure that families receive the support they need while recognizing the strengths and hopes they carry forward. Home visiting programs offer a promising pathway to support families facing trauma, isolation, and systemic barriers. By adopting trauma-informed strategies, these programs can help mitigate fears while fostering resilience among families.

PROGRAM PARTICIPATION AND FAMILY CHARACTERISTICS

A total of 4,190 families were served by HFAz in FY24 (Exhibit 8). The program had a 55% (n=2,319) statewide retention rate of families who remained active in the program going into FY25. The program had a statewide family closure rate of 45% (n=1,871) in FY24.

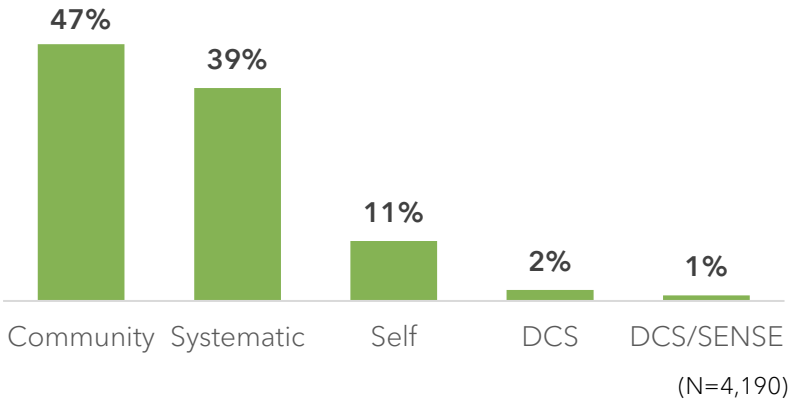
Exhibit 8. Number of Families Served and Closure/Retention Rates in FY24

Program Name	Total Families Served in FY24	Family Retention Rate	Family Closure Rate
Statewide	4,190	55%	45%
Apache/Navajo/White Mountains	165	49%	52%
Beia's Families (Maricopa and Gila River)	84	55%	45%
Child Crisis Arizona (Maricopa and Pinal)	72	72%	28%
Cochise/Santa Cruz Counties	320	57%	43%
Coconino County	76	53%	47%
Graham County	144	50%	50%
Maricopa County	1,541	55%	45%
Mohave/La Paz Counties and Tuba City, AZ	483	58%	42%
Onward Hope (Maricopa)	20	55%	45%
Pima County	555	49%	51%
Pinal/Gila Counties	183	56%	44%
Yavapai County/Prescott Valley	117	49%	51%
Yavapai County/Verde Valley	53	74%	26%
Yuma County	377	63%	37%

Referral Sources

Families are offered HFAz services through various referral sources (Exhibit 9). Community referrals account for 47% (n=1,951) of families active in FY24. Community organizations include non-profits, referral hotlines, and medical providers, such as pediatricians and behavioral health. Over a third (39%, n=1,620) of referrals came from systematic screenings. These screenings occur at hospitals and clinics through contractual agreements and an onsite HFAz Family Assessment Worker (FAW) screens pregnant and postpartum women for services. A smaller portion of families came to HFAz through self-referral (11%, n=476), referral from DCS (2%, n=91), and referral from the DCS Substance Exposed Newborn Safe Environment (SENSE) program (1%, n=52).

Exhibit 9. Referral Sources of Families Served in FY24



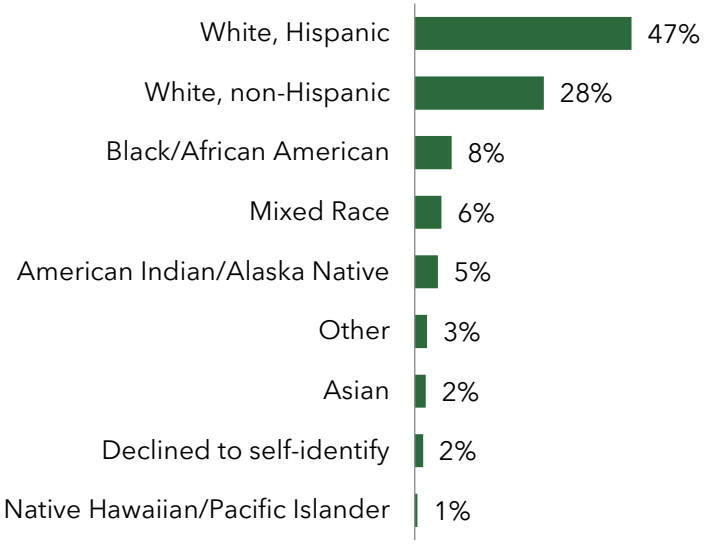
Caregiver Demographics

Demographics shown in this section are for the primary caregiver.

- **Relationship to child**. 98% (n=4,107) are the birth mothers of children. Fathers (n=59), grandmothers (n=8), other relatives (n=7), and non-relatives (n=2) are primary caregivers in approximately 2% of families.
- **Age**. The average and median age of caregivers is 28 years, ranging from 13 to 61 years (for whom a valid date of birth was available, n=4,162). 9% (n=374) are 19 years old or younger and n=8 caregivers are 50+.
- **Relationship status**. 37% (n=1,519) reported being married, 33% (n=1,353) live with a partner, and 29% (n=1,188) reported being single, including widowed, divorced, or separated.
- **Other children**. 40% (n=1,605) have older children at home between 6-17 years; 60% (n=2,449) only have children who are less than six years old at home (n=4,054).
- **Health Insurance and Housing**. Of families for whom information was reported, most had health insurance at program enrollment (97%, n=4,034) and most had stable housing (98%, n=3,968).

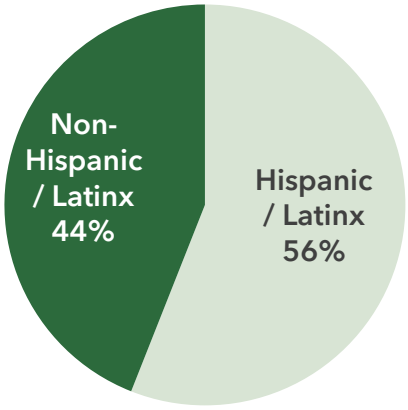
Race and Ethnicity. Over half (56%, n=2,321) of caregivers identified as Hispanic/Latinx and 74% (n=3,119) identified their race as White/Caucasian (Exhibits 10 and 11). Broken down further, 47% (n=1,949) identified as White, Hispanic/Latinx and 28% (n=1,170) identified as White, non-Hispanic.

Exhibit 10. Race of Caregivers Served by HFAz



(N=4,190)

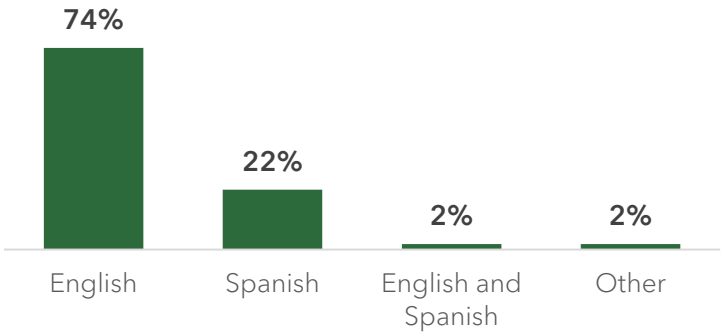
Exhibit 11. Ethnicity of Caregivers Served by HFAz



(n=4,162)

Language. Almost three-quarters of caregivers speak English as their primary language (74%, n=3,086), 22% (n=913) speak Spanish, 2% (n=81) are bilingual, and 2% (n=95) speak another language (Exhibit 12). Other languages spoken are Apache, Arabic, Bengali, Bisaya, Burmese, Chinese/Mandarin, Croatian, Dari, Farsi, Filipino, French, Greek, Haitian/Creole, Hebrew, Igbo, Japanese, Karen, Kinyarwanda, Lingali, Malay, Navajo, Nepalese, Pashto, Persian, Portuguese, Punjabi, Rohingya, Russian, Somali, Swahili, Tagalog, Ukrainian, Urdu Brave, Vietnamese, and American Sign Language.

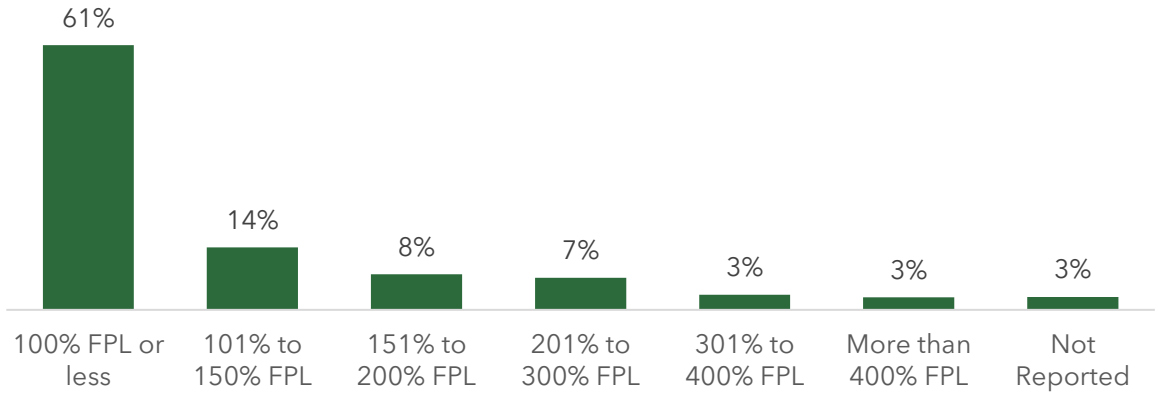
Exhibit 12. Primary Language Spoken by HFAz Caregivers



(n=4,177)

Poverty Status. Exhibit 13 shows the breakdown of families by percentage below or above the Federal Poverty Level (FPL) (in 2024). This data was calculated based on self-reported number of household members and annual household income. Sixty-one percent (n=2,548) of families are at or below 100% of the FPL, which is the level used by the American Community Survey to determine persons in the U.S. who are living in poverty. However, living wage calculations indicate that Arizona families need to earn a little over four times (more than 400%) the poverty rate to adequately support a decent standard of living[1]. Thus, nearly all families served by the program face some level of economic stress.

Exhibit 13. Federal Poverty Level Status of HFAz Families in FY24



(N=4,190)

Child Well-Being Indicators

Several indicators, identified by the Annie E. Casey Foundation's 2024 KIDS COUNT Data book (2024a, 2024b), are risk factors for poor child well-being that HFAz gathers at intake. Mothers enrolled in the HFAz program have higher rates of these risk factors compared to mothers in Arizona (Exhibit 14). This data suggests the program is targeting families who can benefit the most from the services provided.

Exhibit 14. Selected Risk Factors for Poor Child Well-Being, HFAz Families and Arizona

Risk Factors	HFAz	Arizona
Teen Births (age 19 years or less)	9.0% (n=375)	4.6%*
Births to Single Mothers	62.5% (n=2,541)	44.9%*
Less Than a High School Education	24.4% (n=990)	13.4%**
Participating in Labor Force	34.3% (n=1,356)	65.2%***
Median income in past 12 months	$25,000 (n=4,064)	$44,148***
At or below 100% of the Federal Poverty Level	60.8% (n=2,548)	28.3%***

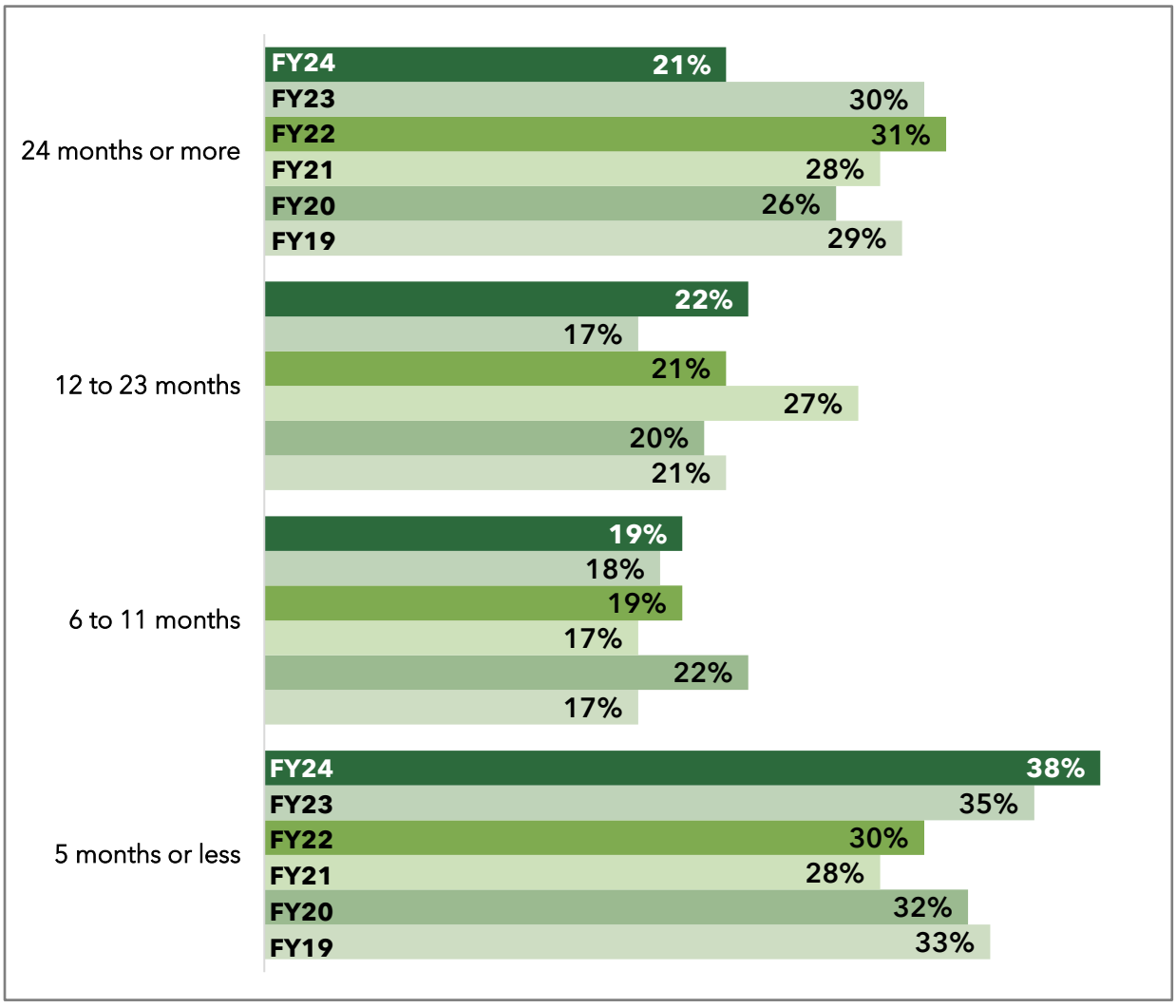
Sources: *ADHS, 2023; **CDC, 2024a; ***U.S. Census Bureau, 2023a, 2023b, 2023c.

[1] https://livingwage.mit.edu/states/04

Length of Time in Program

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. **Families served in FY24 participated in the program for a range of less than one month to 131 months (10 years) and a median of 9 months** (compared to 11 months in FY23, 13 months in FY22, 10 months in FY21 and FY20, and 12 months in FY19). Exhibit 15 shows the length of time that families participated in the program from FY19 to FY24, broken into four categories. It is noteworthy that **38% of families have been active in the program for five or fewer months**, which is the highest rate compared to the past five years, reflecting the program's expansion and increased enrollment in families in the past year.

Exhibit 15. Families' Length of Time in HFAz, FY19 to FY24



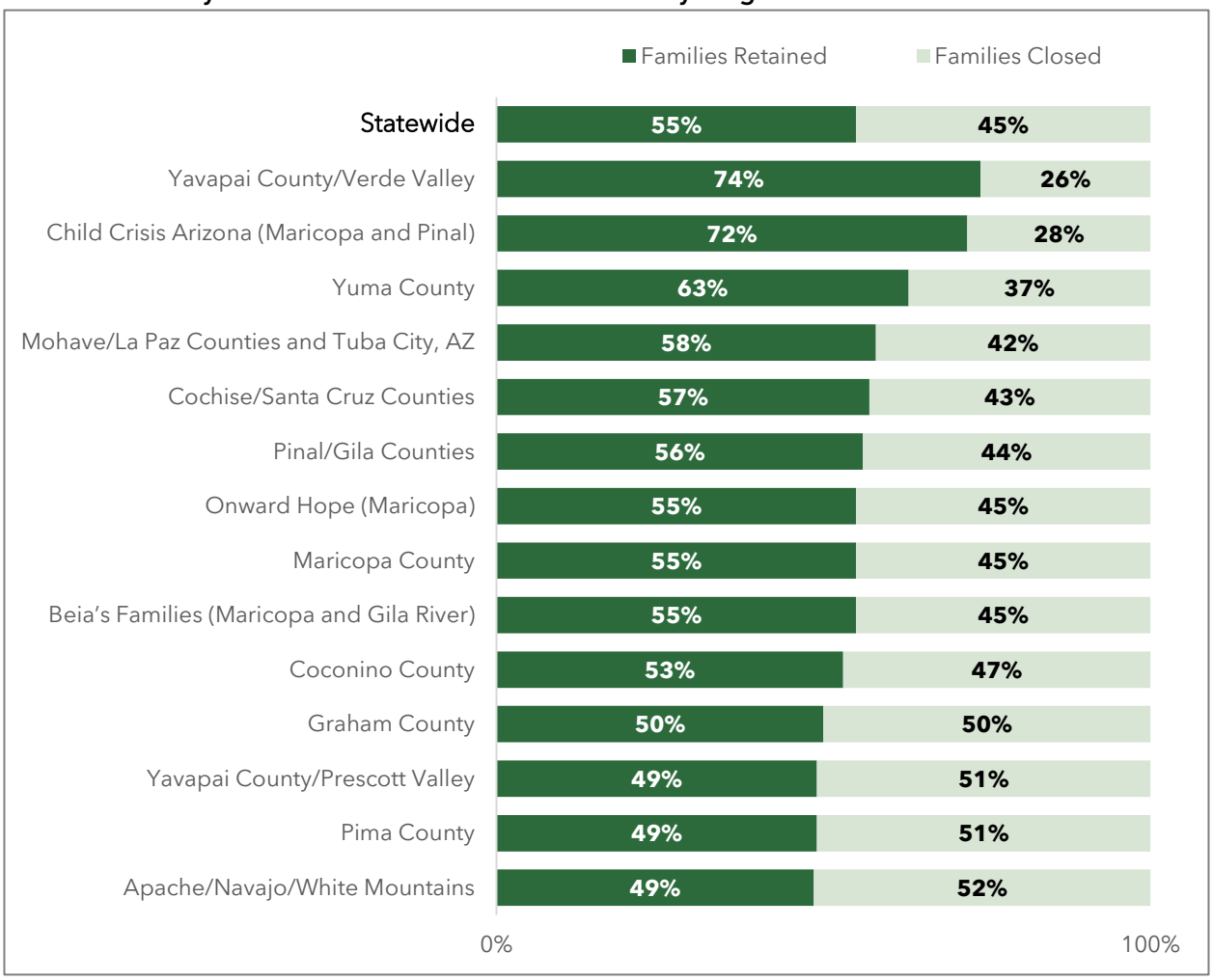
Home Visits

In FY24, a total of 65,136 visits were conducted statewide, as reported in the data system, ETO. Most visits (97%) were completed in person, either in the family's home or at a community location.

Family Retention and Closure

Exhibit 16 shows the family retention and closure rates for HFAz statewide and by program site. **HFAz had a statewide retention rate of 55% in FY24.** The program's retention rate has somewhat fluctuated over time (63% in FY23, 60% in FY22, 62% in FY21, 70% in FY20, and 58% in FY19). Conversely, **45% of families statewide exited the program in FY24.** Family closure rates statewide have also fluctuated over time (37% in FY23, 40% in FY22, 45% in FY21, 35% in FY20, 50% in FY19).

Exhibit 16. Family Retention and Closure Rates in FY24 by Program and Statewide



(N=4,190)

Program Retention and Family Characteristics

The evaluation team compared various caregiver characteristics with whether the family remained active/were retained or closed at the end of FY24.

HFAz was significantly more likely to retain families with the following characteristics in FY24:

- Hispanic/Latinx
- Spanish is primary language
- Older (average age of 28 years)/not a young parent
- Above the FPL

- Families who identified as **Hispanic/Latinx** were significantly more likely to still be active in the program at the end of FY24 (57%, n=1,324) compared to families who identified as non-Hispanic/Latinx (53%, n=1,841) (x^2=5.53, p=.02).

- **Hispanic/Latinx** families also spent a significantly longer time in the program (an average of 15.9 months) compared to non-Hispanic families who spent an average of 14.1 months in the program (t=3.752, p=.00). Significant differences were not observed when factoring in caregiver race.

- Families who speak **Spanish** had the highest retention rates (61%, n=560), followed by families whose primary language is something **other than English or Spanish** (59%, n=57). Families who primarily spoke **English** (54%, n=1,660) had the lowest rate of retention (x^2=16.651, p=.00). In FY23, families who spoke a language other than English or Spanish had the lowest retention rate, so this finding suggests and improvement in the past year.

- Parents who are **older than 19 years** had higher retention rates (56%, n=2,122) compared to parents who are 19 years or younger (51%, n=189) (x^2=4.15, p=.04). Being a single parent, a first time parent, and having older children (ages 6-17) in the household did not show a relationship to program retention.

- Families whose household size and annual income (self-reported) placed them **above the FPL** had higher rates of remaining active in the program at the end of FY24 (58%, n=875) compared to families at or below the FPL (55%, n=1,392). This finding was marginally significant (x^2=3.583, p=.06).

- Caregivers with a **high school diploma or more education** also had higher retention rates (57%, n=1,739) than those with less than a high school education (53%, n=528). This finding was marginally significant (x^2=3.147, p=.07). Caregiver employment status did not show a relationship to program retention.

Length of Time to Closure

Exhibit 17 (on the next page) shows the length of time that closed families stayed in the program, compared over time. Of the 1,871 families that closed in FY24, 17% (n=326) received 24 months or more of services, which is the lowest rate over the past six years. **There continued to be a notable increase - 23% (n=434) - in the percentage of families who exited the program with less than three months of service in FY24 compared to previous years.** Families who closed in less than three months had higher rates of declining services as their reason for closure. Of families who closed in FY24 the following significant differences were observed:

- **African American families** spent significantly less time in the program (average of 10.1 months) compared to families of all other races (average of 14.0 months) (t=3.187, p=.00).
- **Native American families** spent significantly less time in the program (average of 10.0 months) compared to families of all other races (average of 13.9 months) (t=2.858, p=.00).

Exiting with Less Than Three Months of Service

The evaluation team compared caregiver characteristics of closed families (n=1,871) by those who exited after receiving less than three months of service (23%, n=434) and those who closed after three or more months of service (77%, n=1,437).

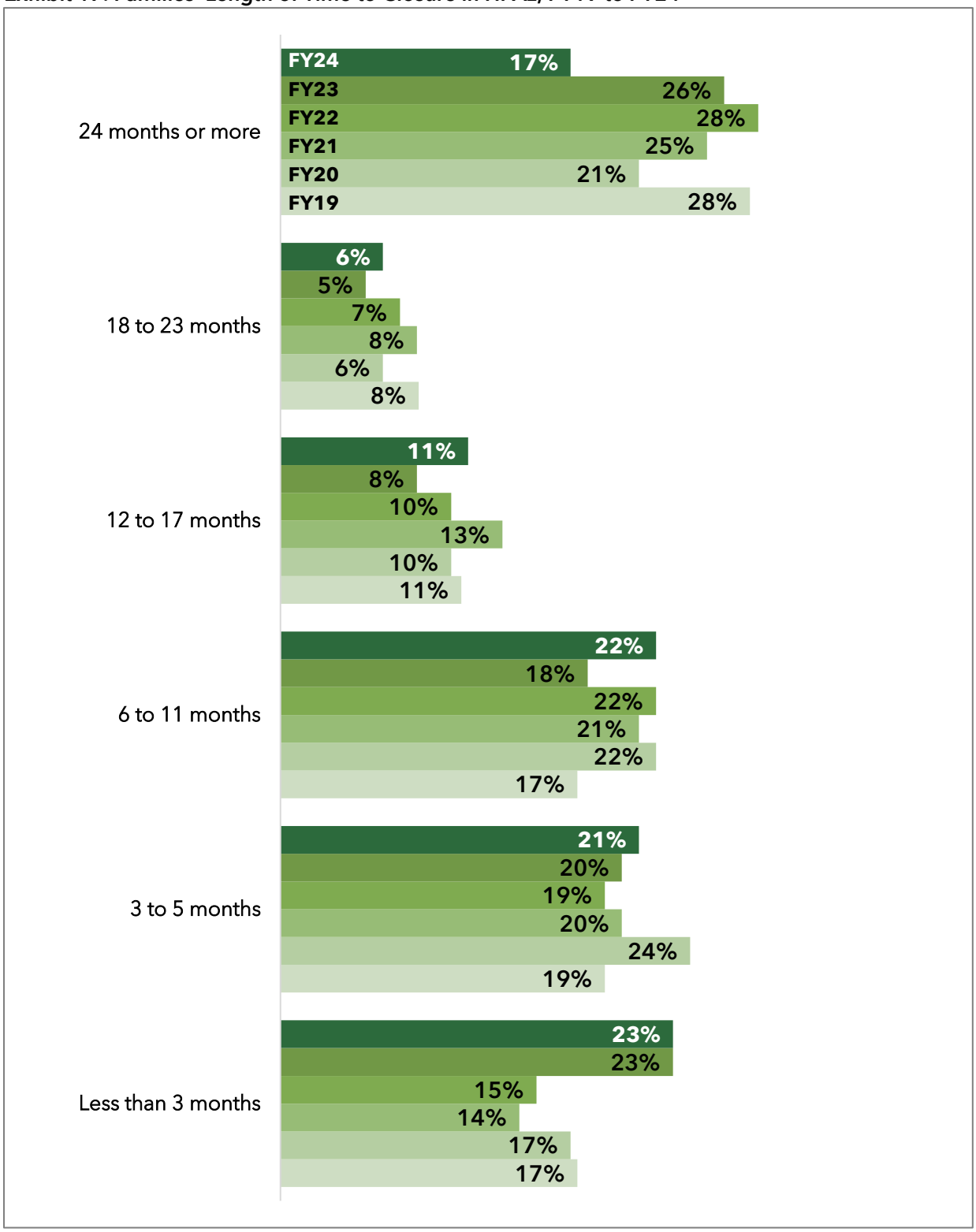
Characteristics of families who left HFAz with less than three months of service:

- Primarily speak a language other than English or Spanish
- African American families

- Caregivers whose **primary language is something other than English and Spanish** were significantly more likely to leave the program with less than three months of service (38%, n=15), compared to those who primarily spoke English (23%, n=333) or Spanish (20%, n=69) (x^2=7.236, p=.03).
- **African American families** had higher rates of leaving the program after less than three months of service (37%, n=56), compared to families of any other race (22%, n=378) (x^2=18.294, p=.00).

Leaving the program with less than three months of service was not related to ethnicity, other racial groups, being a first-time parent, single parent, or young parent, age of children living in the home, poverty status, education, and employment.

Exhibit 17. Families' Length of Time to Closure in HFAz, FY19 to FY24



Exiting after 24 Months or More of Service

The evaluation team also examined caregiver characteristics of closed families (n=1,871) by those who exited after 24 months or more of service (17%, n=326) compared to families who exited with less than 24 months of services (83%, n=1,545).

Characteristics of families who left HFAz after 24 months or more of service:

- Primarily speak Spanish
- Racial groups other than Native American

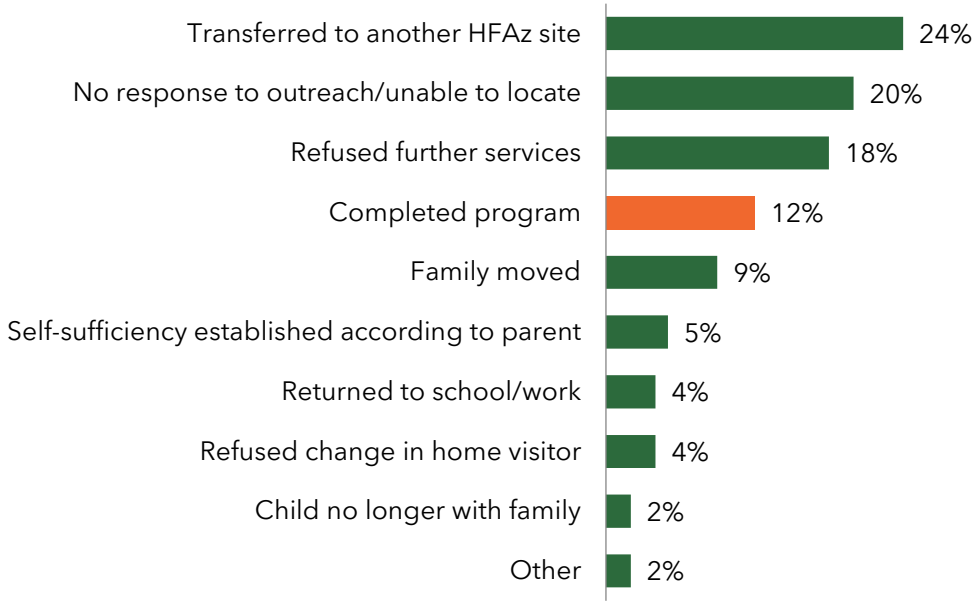
- Caregiver language showed a significant relationship with exiting the program after having completed 24 months or more of service, with **primarily Spanish speaking families** (25%, n=87) exiting at a higher rate after longer-term engagement than English speaking (16%, n=223) or families who speak another language (10%, n=4) (x^2= 17.585, p=.00).
- **Native American** caregivers were significantly less likely to exit the program after having completed 24 months or more of service, with 10% (n=10) of Native Americans exiting after reaching the 24 month service mark compared to 18% (n=316) of families of any other racial group (10%, n=4) (x^2= 17.585, p=.00).

Leaving the program after 24 months or more of service was not influenced by ethnicity, being a first-time parent, single parent, or young parent, age of children living in the home, poverty status, education, and employment.

Reasons for Family Closure

Exhibit 18 (on the next page) shows the reasons families closed in FY24. There are many reasons that families leave the program and they may not be negative reasons. Of the 1,871 families that exited the program in FY24, the top closure reasons were that 24% (n=456) **transferred to another HFAz team**, 20% (n=377) **did not respond to outreach efforts or were not able to be located by staff,** and 18% (n=338) **refused further services**. However, 12% (n=230) closed because they **completed the program** (e.g., completed at least three years of service with the target child), as recorded in ETO by their home visitor. The program's 12% completion rate is lower than previous years (15% in FY23, 16% in FY22, 14% in FY21, 12% in FY20, and 16% in FY19). **Families who completed the program spent a significantly longer amount of time – an average of 44 months (about three and a half years) – in HFAz**, compared to families who exited after an average of 9 months for a non-completion reason (t=29.739, p=.00).

Exhibit 18. Reasons Families Exited HFAz in FY24



(n=1,871)

Exit Reasons and Family Characteristics

The top three exit reasons (see Exhibit 18 above) were examined individually to better understand the characteristics of caregivers who left HFAz for these reasons. Exhibit 19 shows a summary of findings and further information is provided below.

Exhibit 19. Exit Reasons and Family Characteristics

Exit Reason	Characteristics of Families Significantly Related to Exit Reason
Family was not responsive to FSS follow-up and/or not able to be reached by FSS for further services (n=377)	• Hispanic/Latinx families • Native American families • At or below 100% FPL • Less than a high school education • Has older children (6-17 years) • Single parent
Family refused further services, including a worker change and families who felt they reached self-sufficiency (n=506)	• Above the FPL • Older parents (average age of 29 years) • Completed high school or more education • In a partnered relationship/married • Primarily speak a language other than English or Spanish
Family completed program, per FSS determination (n=230)	• Hispanic/Latinx families • Racial groups other than African American or Native American • Primarily speak Spanish • Older parents (average age of 29 years) • In a partnered relationship/married

No Response to Follow-up/Unable to be Reached

A total of 1,185 families left the HFAz program for reasons other than graduating or being transferred to another HFAz program in FY24. Looking at all other exit reasons, 32% (n=377) did not respond to follow-up efforts or were unable to be reached by their FSS and 68% (n=808) closed for another reason (other than program completion or being transferred).

- Families who identified as **Hispanic/Latinx** were significantly more likely to exit due to not responding to outreach efforts in FY24 (35%, n=214) compared to families who identified as non-Hispanic/Latinx (28%, n=154) (x^2=7.246, p=.01).

- **Native American families** were more likely to exit due to not responding to outreach efforts (42%, n=30) compared to families of all other races (31%, n=347), however these results were marginally significant (t=3.430, p=.06).

- Socio-economic status showed a significant relationship, with families who are **at or below 100% of the FPL** (36%, n=264) being significantly more likely to not respond to FSS follow-up or not able to be reached by their FSS for additional services than families above the FPL (24%, n=99) (x^2= 16.112, p=.00).

- Caregivers with **less than a high school education** were significantly more likely to not respond to follow-up/not able to be reached (38%, n=118) compared to caregivers who completed high school or more education (29%, n=246) (x^2= 7.786, p=.01).

- Caregivers with **older children at home (6-17 years)** were significantly more likely to not respond to follow-up/could not be reached (36%, n=161) compared to caregivers who had younger children under 6 years at home (29%, n=202) (x^2= 4.911, p=.03).

- **Single parents (not married, divorced, separate, or widowed)**, at a rate of 40% (n=140), were significantly more likely than married/partnered parents (28%, n=224) to not respond to follow-up or could not be reached to continue services (x^2= 15.561, p=.00).

No other caregiver characteristics showed a significant relationship to not responding to follow-up/unable to be reached as an exit reason.

Refused Further Services

Of the 1,185 families left HFAz in FY24 for reasons other than graduating or being transferred to another HFAz program, 42% (n=506) refused further services (this category combines families who declined a worker change, were documented in ETO as family "refused further services" or "declined services," and families who felt they had reached self-sufficiency). The remaining 57% (n=679) closed for another reason, other than program completion or being transferred.

- Families who are **above the FPL** (50%, n=204) were significantly more likely than families at or below the FPL (39%, n=287) to refuse further services (x^2= 13.653, p=.00).

- Caregivers who completed **high school or more education** were significantly more likely to refuse further services (45%, n=375) compared to caregivers with less than a high school education (37%, n=116) (x^2= 5.108, p=.02).

- **Older caregivers (average age of 29 years)** (44%, n=456) were significantly more likely than young caregivers (19 years or less) (31%, n=41) to refuse further services (x^2= 8.038, p=.01).

- Caregivers in a **married or partnered relationship** (47%, n=376) were significantly more to have refused further services than single parents (32%, n=113) (x^2= 22.540, p=.00).

- Primary language of caregiver was marginally significant (p=.08) as a notably higher rate of families who primarily spoke a language **other than English or Spanish** (50%, n=13) refused further services, compared to English speaking (44%, n=416) and Spanish speaking families (36%, n=66).

No other caregiver characteristics showed a significant relationship to refusal of further services as their exit reason.

Completed the Program

Excluding families who were transferred to another HFAz program, 16% (n=230) completed the program and 84% (n=1,185) closed for a reason that was not completion. Several family characteristics showed a significant relationship with program completion.

- **Hispanic/Latinx families** had significantly higher rates of completing HFAz (19%, n=144) compared to non-Hispanic families (13%, n=86) (x^2= 8.148, p=.00).

- Families who identified as **any racial category other than African American and Native American** had significantly higher rates of completing HFAz (18%, n=212) compared to Native American (9%, n=7) and African American (9%, n=11) families (x^2= 10.180, p=.01).

- Caregivers who primarily **speak Spanish** (27%, n=70) were significantly more likely to complete HFAz compared to those who spoke English (13%, n=142) and those who spoke another language (13%, n=4) (x^2= 32.160, p=.00).

- Being an **older parent (average age of 29 years)** was significantly related to completing HFAz compared to younger parents (average age of 27 years) (t=2.869, p=.00).

- Families in a **married or partnered relationship** (18%, n=172) were significantly more likely to complete HFAz than single parent families (13%, n=52) (x^2= 4.485, p=.03).

No other caregiver characteristics showed a significant relationship to completing the HFAz program.

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 in the ETO data management system, 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 areas: 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.

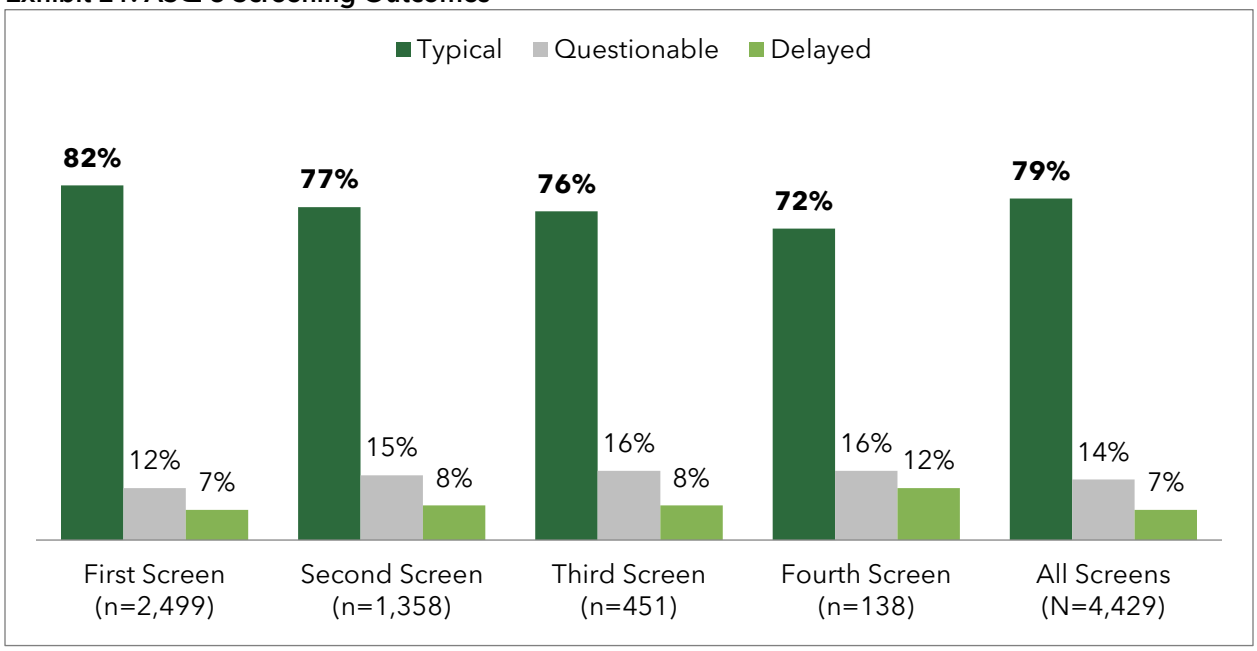
A total of 4,429 screenings were conducted in FY24 for 2,449 children served by HFAz. Children received between one and seven screenings, depending on the outcome of their initial and subsequent screenings. Most children, (99%) received between one and four screenings. Screenings were not completed when the family was not currently active in the program/on outreach, the child was enrolled in AZEIP, and/or some other reason. Exhibit 20 shows the number of ASQ-3 screenings completed in FY24.

Exhibit 20. ASQ-3 Screenings Completed in FY24

Screening Periodicity in FY24	Screenings Completed
1st Screening	2449
2nd Screening	1358
3rd Screening	451
4th Screening	138
5th Screening	24
6th Screening	8
7th Screening	1
Total	4,429

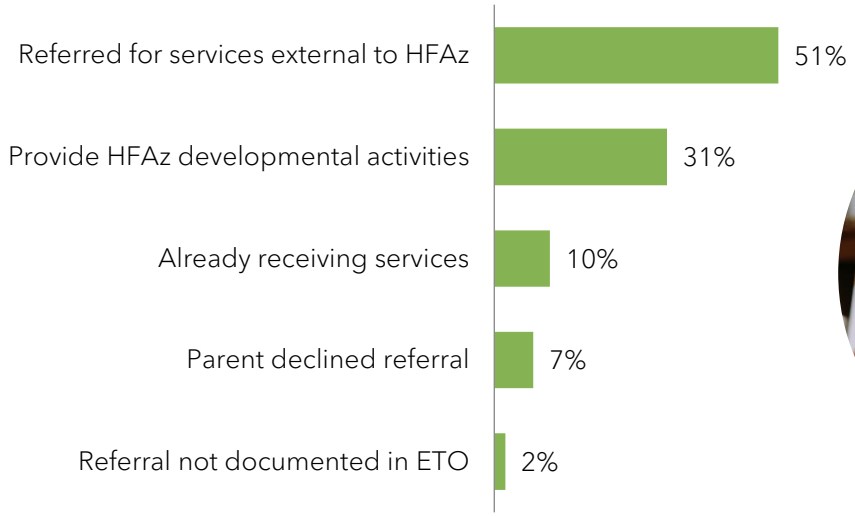
Exhibit 21 reports on the outcomes of screenings at the first through fourth timepoint and overall. For all time points, 79% (n=3,496) screened in the typical range, 14% (n=606) were questionable, and 7% (n=327) were identified as delayed.

Exhibit 21. ASQ-3 Screening Outcomes



Of the 327 total cases that were screened as delayed in FY24, all but 2% (n=8) had a follow-up action recorded in ETO, which is an improvement from 10% that did not have a referral recorded in ETO in FY23. Exhibit 22 shows the follow-up outcome categories recorded in ETO. In over half of cases (51%, n=165), the family was referred to external services, such as AZEIP, the school district, a primary care doctor, and/or community resources. Almost a third of delayed cases (31%, n=100) were documented that the FSS would provide HFAz developmental activities to work with the child on improving their developmental progress, but no external referrals were documented. In 10% (n=32) of cases the child was already receiving services and in 7% (n=22) of cases a referral was made but the family declined the referral.

Exhibit 22. Outcomes of ASQ-3 Screening Referrals



(n=327 screened as delayed)

Ages and Stages Questionnaire: Social-Emotional

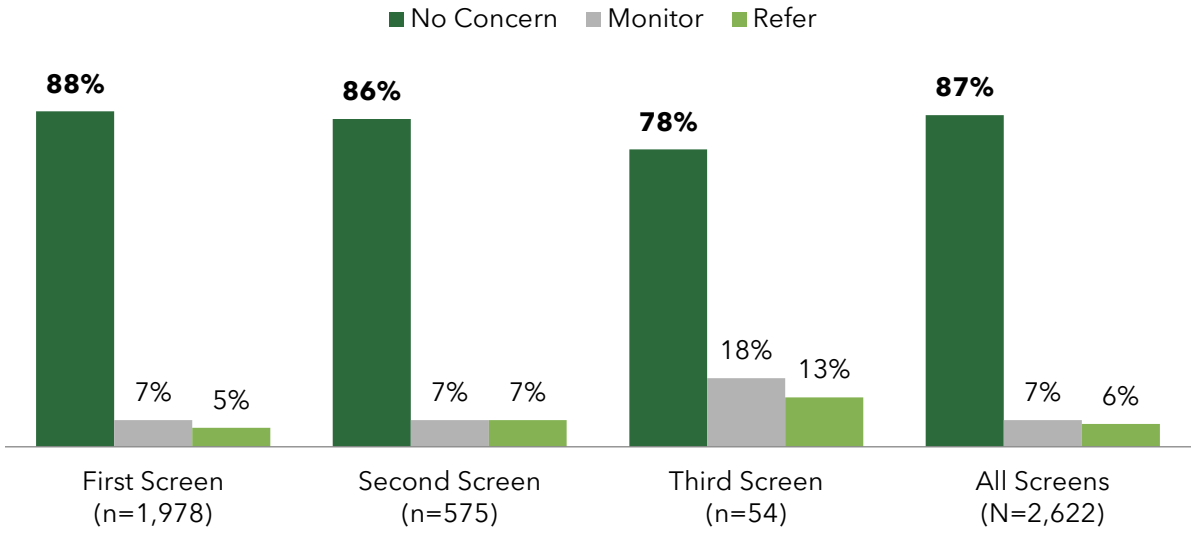
Another measure of childhood development is the Ages & Stages Questionnaire: Social-Emotional (ASQ: SE-2), which screens for social and emotional behaviors in the areas of: self-regulation, compliance, social-communication, adaptive functioning, autonomy, affect, and interaction with people. In FY24, a total of 2,622 ASQ: SE-2 screenings were completed with 1,978 children (Exhibit 23). While 99% of children received between one and three screenings, some children received up to six screenings.

Screening in FY24	Screenings Completed
1st Screening	1,978
2nd Screening	575
3rd Screening	54
4th Screening	11
5th Screening	3
6th Screening	1
Total	2,622

Exhibit 23. ASQ:SE-2 Screenings Completed in FY24

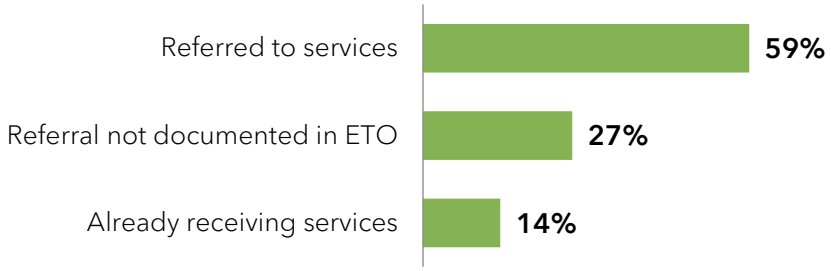
ASQ:SE-2 scoring results in outcomes of No Concern, Monitor and Refer. For all screenings (n=2,622), 87% (n=2,290) of children screened as having no concern, 7% (n=179) needed additional monitoring, and 6% (n=153) needed a referral. Exhibit 24 presents the results for the first three screening periods and overall.

Exhibit 24. Outcomes of ASQ: SE-2 Screenings



A total of 153 screenings resulted in "Refer" and referral outcomes are shown in Exhibit 25. Of these screenings, 59% (n=90) were documented in ETO as "yes" – a referral to services was noted as made (including cases where the parent refused the referral), 14% (n=22) were documented as already receiving services, and 27% (n=41) were documented in ETO as "no" – no referral to services. The percentage of cases documented as not having a referral or a notation has decreased from 39% in FY23, which is an improvement in staff documentation efforts. However, because a notable percentage of cases in FY24 did not have a note as to why there was not a referral to services, the referral and data entry process should be clarified by program staff to ensure that appropriate referrals are made and recorded into ETO. Anecdotally, HFAz Central Administration commented that in some areas there is a lack of resources available for infant mental health services, which may reflect a lack of referrals made.

Exhibit 25. ASQ: SE-2 Screening Referrals Made

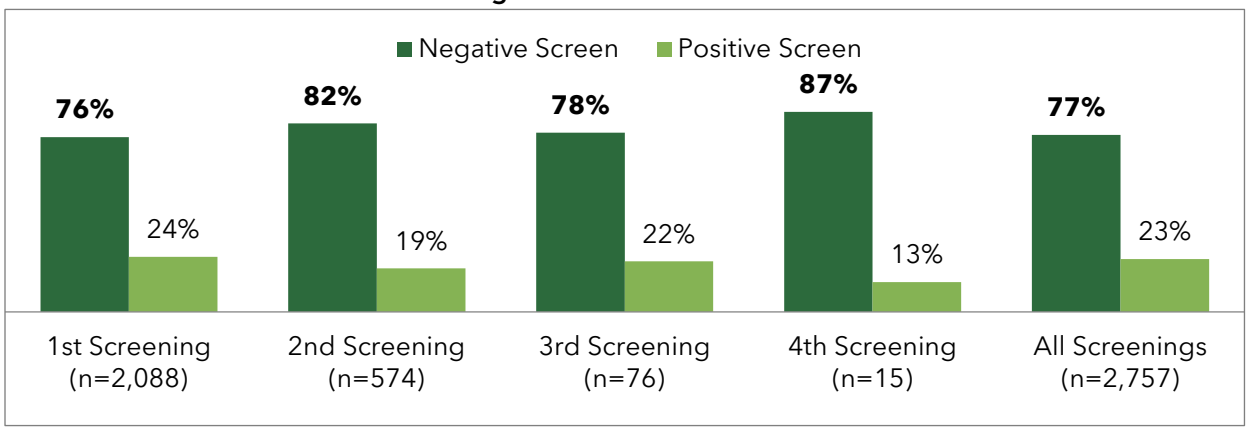


(n=153 children who screened as "Refer")

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 considered a positive screen for depression, which requires a referral to external therapeutic services unless they are already receiving such services. A total of 2,757 EPDSs were recorded in ETO between October 1, 2023 and September 30, 2024 for 2,088 parents (Exhibit 26). Parents received between one and five screens, with most receiving only one screening (note: due to the low number of parents, n=4, who received a 5th screen, this time point is not shown in Exhibit 26). Of all screenings completed, 77% (n=2,133) were negative for depression and 23% (n=624) were positive.

Exhibit 26. Outcomes of EPDS Screenings in FY24



Of the 624 parents who screened positive on the EPDS, 66% (n=414) received a referral from their FSS, 24% (n=151) were already receiving services, and 10% (n=59) did not have a referral documented in ETO (Exhibit 27). It is notable that the percentage of positive screens without documentation of a referral has decreased from 11% in FY23 to 10% in FY24, suggesting that documentation has improved. However, the referral process and ETO documentation is an area that could continue to be reviewed by HFAz leadership to ensure staff are making and documenting referrals appropriately.

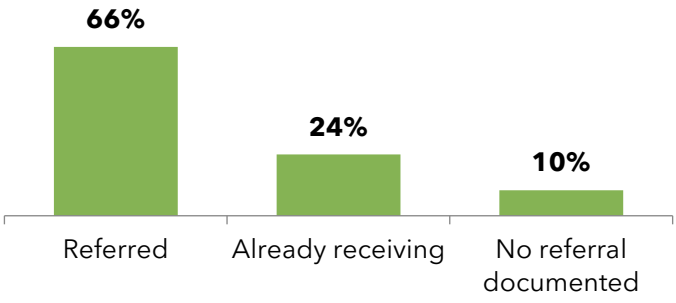
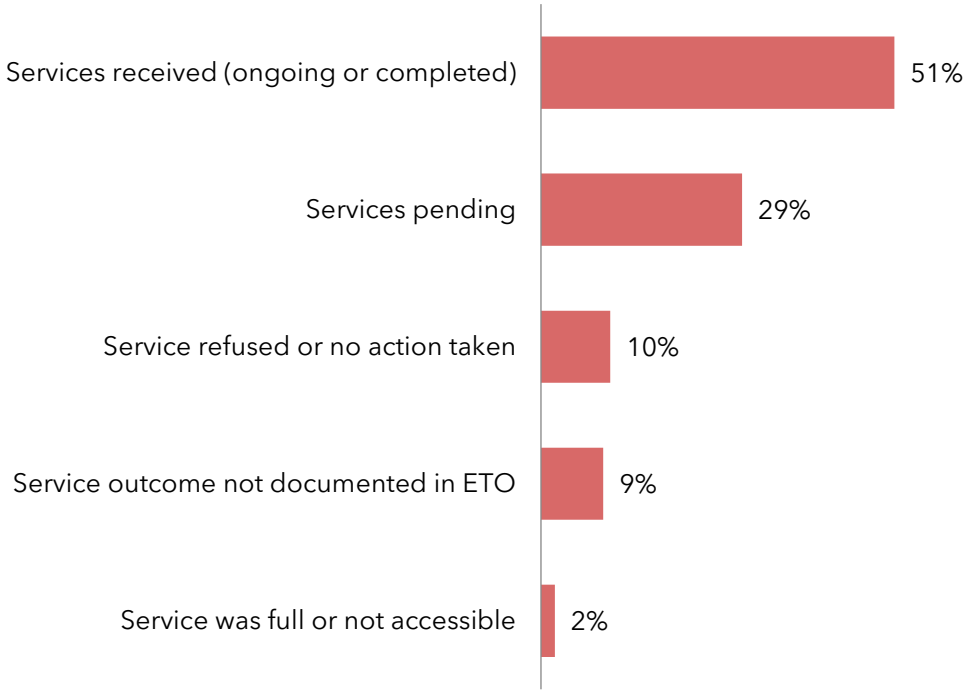


Exhibit 27. EPDS Positive Screenings and Referrals Made (n=624)

Of the 624 positive screens, 51% (n=316) of adults had received services (including ongoing and completed) and 29% (n=179) had services pending (Exhibit 28). In 10% of cases (n=61) the adult refused services or did not act on the referral, and in 2% of cases (n=10) the service was full or not accessible (e.g., lack of transportation, cost prohibitive, lack of insurance). Additionally, 9% (n=58) of records did not have a referral outcome documented in ETO (which is a decrease from 11% of records that lacked documentation in FY23).

Exhibit 28. Status of Mental Health Services After Positive EPDS Screen

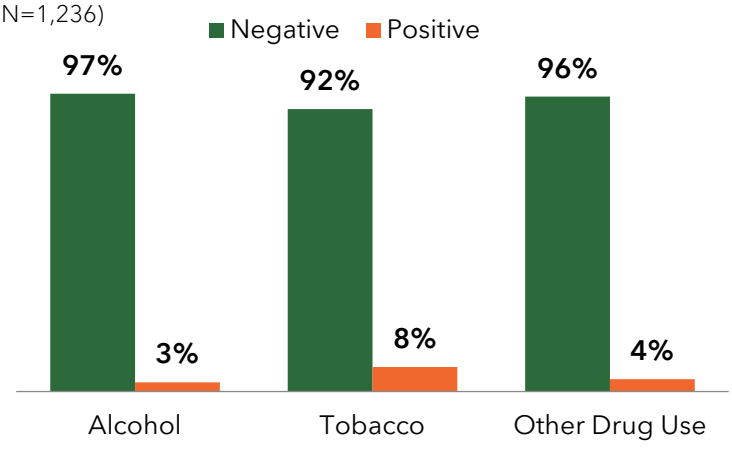


(n=624)

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, 2024) shows that substance use (i.e., marijuana, opioids, alcohol, and methamphetamine) was a contributing factor in fatalities of children in 38% of preventable deaths in 2023. Because of these risk factors, HFAz completes the Past 30-Day Alcohol, Tobacco, and Other Drug (ATOD) screening with caregivers shortly after enrollment into the program. From October 1, 2023 to September 30, 2024, a total of 1,236 ATOD screenings were completed with 1,204 caregivers (some caregivers received a subsequent screening). Most caregivers screened negative for alcohol, tobacco, and drug use (Exhibit 29).

Exhibit 29. Outcomes of Past 30-Day ATOD Screenings
(N=1,236)



A higher percentage of caregivers screened positive for tobacco use (8%, n=98) than alcohol or other drugs, which is a consistent finding compared to previous years. Of those who screened positive for tobacco use, 83% (n=81) received a referral for tobacco cessation services and 17% (n=17) did not have a referral recorded in ETO (this percentage is notably less than the 29% with no referral documentation in FY23). 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 66% (n=2,778) of caregivers, 27% (n=1,110) did not discuss substance use, and 7% (n=302) 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, 11% (n=300) of discussions resulted in 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).

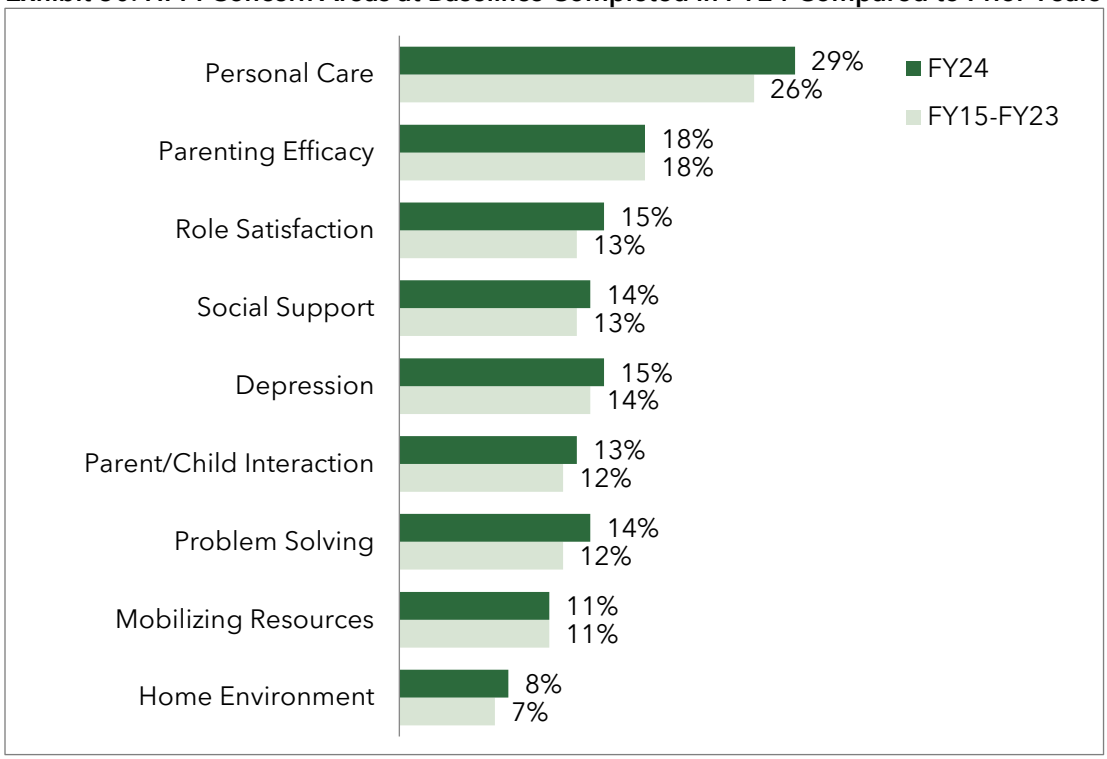
Healthy Families Parenting Inventory

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, & Milligan, 2017). 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.

HFPI Concern Areas at Baseline in FY24 Compared to Prior Years

Exhibit 30 shows the percentage of families whose baseline HFPI subscale score indicated an area of concern, comparing caregivers who completed a baseline in FY24 (n=942) and caregivers who completed a baseline from FY15-FY23 (n=3,224). The top three HFPI areas with the highest rates of concern at baseline, which have been consistent over time, include **Personal Care, Parenting Efficacy,** and **Role Satisfaction**. These three areas may need more attention from home visitors in working with families, especially those whose HFPI results show concern in these areas. No significant differences were noted between the two time frames.

Exhibit 30. HFPI Concern Areas at Baselines Completed in FY24 Compared to Prior Years



(FY24 n=942. 2015-2023 n=3,226)

Change in HFPI from Baseline to 6-8 Month Follow-Up

A total of 363 HFAz parents and caregivers completed a baseline and a 6-8 month follow-up HFPI, based on ETO data downloaded from FY18 to FY24. The evaluation team conducted *paired sample t-tests* for HFPI subscales with baseline and 6 month data to assess changes observed at this timepoint. Average scores at baseline and follow-up, significance levels (*p*-value), and effect sizes (Cohen's *d*) are shown in Exhibit 31. N-values vary if a participant did not fully complete a subscale, as their total score for that subscale was excluded from the analysis.

From baseline to 6-8 months follow-up, statistically significant improvements (i.e., increased average score) were observed for the HFPI subscales of **Home Environment, Mobilizing Resources, Parent-Child Interaction,** and **Problem Solving** (Exhibit 31). Non-significant improvements were observed from baseline to 6-8 months for all other subscales. Home visitors should continue to collect HFPI data at 6 months post baseline to assess meaningful changes that may occur in families within the first 6-8 months of services.

Exhibit 31. Change in HFPI Subscales from Baseline to 6-8 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
Home Environment	50	42.2	43.3	**.00**	**.20**	362
Mobilizing Resources	30	24.2	25.3	**.01**	**.18**	362
Parent-Child Interaction	50	45.3	45.9	**.01**	**.14**	363
Problem Solving	30	24.1	24.6	**.01**	**.14**	363
Depression	45	39.3	39.7	.09	.09	362
Role Satisfaction	30	25.5	25.9	.09	.09	362
Parent Self-Efficacy	30	25.9	26.0	.37	.05	361
Personal Care	25	18.9	19.1	.37	.05	362
Social Support	25	21.7	21.9	.29	.06	363

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

Change in HFPI from Baseline to 12-14 Month Follow-Up

A total of 1,684 HFAz parents and caregivers completed a baseline and a 12-14 month follow-up HFPI, based on ETO data downloaded from FY18 to FY24. The evaluation team conducted *paired sample t-tests* for each HFPI subscale 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 32. N-values vary if a participant did not fully complete a subscale, as their total score for that subscale was excluded from the analysis.

From baseline to approximately 12-14 months follow-up, statistically significant improvements (i.e., increased average score) were observed for the HFPI subscales of **Home Environment, Mobilizing Resources,** and **Problem Solving** (Exhibit 32). Statistically significant decreases in average score were observed for **Role Satisfaction** and **Parent-Child Interaction**, indicating that some parents were struggling in these areas at their 12-14 month follow-up**.** As the child ages, it is not uncommon for these scales to shift towards a less favorable direction. Average baseline and 12-14 month follow-up scores that showed negligible change over time include Personal Care, Social Support, Depression, and Parent Self-Efficacy. Home visitors should continue to support families in these areas as their child ages and their roles and interactions continue to change.

Exhibit 32. Change in HFPI Subscales from Baseline to 12-14 Months Post Enrollment

HFPI Subscale	Total Possible Score	Average Score at Baseline	Average Score at Follow-up	Direction of Change	P-Value (Two-Sided)	Cohen's d (Effect Size)	N
Home Environment	50	42.6	45.4	↑	.00	.25	1,679
Mobilizing Resources	30	24.6	25.3	↑	.00	.15	1,681
Problem Solving	30	24.4	24.6	↑	.02	.06	1,683
Role Satisfaction	30	26.0	25.7	↓	.00	.07	1,680
Parent-Child Interaction	50	45.6	45.4	↓	.05	.05	1,680
Personal Care	25	18.8	18.9		.17	.03	1,683
Social Support	25	21.9	21.8		.31	.03	1,683
Depression	45	39.5	39.5		.77	.01	1,682
Parent Self-Efficacy	30	25.8	25.8		.87	.00	1,679

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.

Safety Practices in the Home

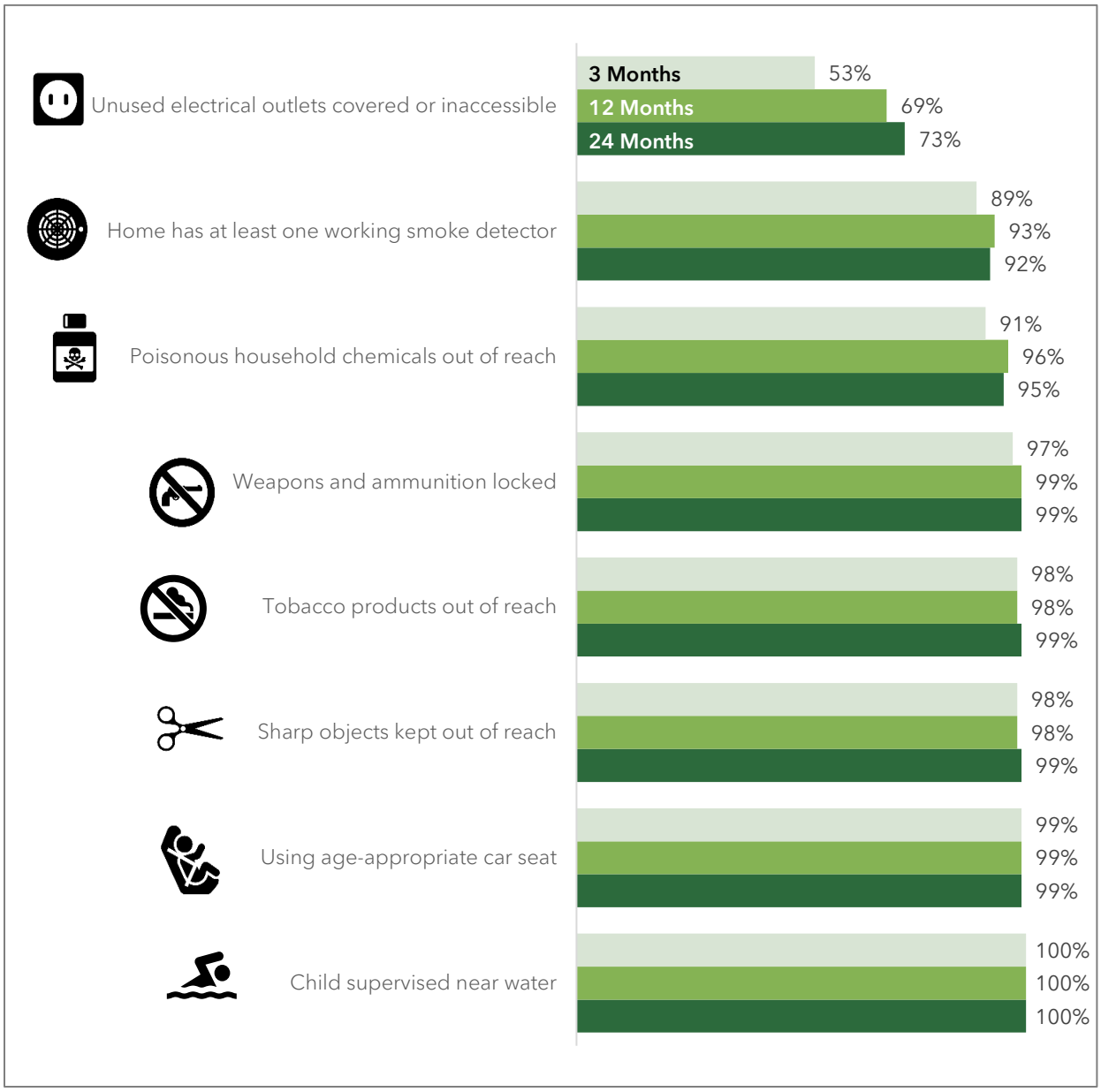
According to the CDC, accidents and unintentional injuries are the leading cause of death for children and youth aged 1-4 years and the fourth leading cause of death for infants under the age of one year (CDC, 2024b). The *Arizona Child Fatality Review* Report (ADHS, 2024) states that **"A child's death 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, 2024, p. 30). Risk factors for preventable deaths in infants and children include: poverty, unsafe sleep environment, substance use, DCS history with the family, and lack of supervision.

ADHS (2024) reported that 49% of child deaths in Arizona in 2023 were preventable. Preventable death rates were higher among male children ages one to four years and disproportionately higher among Black and American Indian children. An unsafe sleep environment was the leading risk factor in 81% of preventable deaths among infants 28 days to less than 1 year of age. In line with the ADHS infant 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 a common cause of death in children under 5 years of age, with 71% of drowning deaths occurring in this age group. The majority (47%) of neglect/abuse deaths among children were due to accidental injuries, such as suffocation, drowning, and poisoning. The HFAz home visitors assess and provide education to families about safe home environments for children by completing the Safety Checklist.

In FY24, a total of 2,716 Safety Checklists were completed with 2,462 families based on the child's age, with most checklists completed at three months postnatal (42%, n=1,155), 12 months (23%, n=635), and 24 months (12%, n=331). Exhibit 33 shows the various safety practices reported as "always" being followed, based on the child's age.

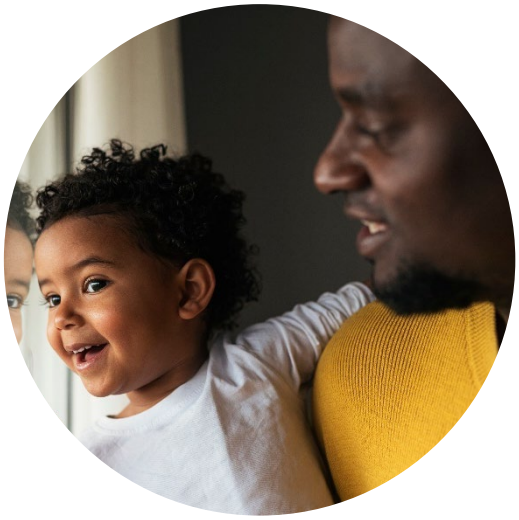
- **Safety areas that most families implement regardless of child age include**: children being supervised near water, age-appropriate car seats are correctly installed, tobacco products and related items (matches and lighters) are kept out of reach, weapons and ammunition are locked, and sharp objects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

Exhibit 33. Percentage of Families "Always" Implementing Safety Practices by Child Age



(Note: 3 months n=1,155, 12 months n=635, and 24 months n=331)

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, 2024) states that Arizona saw a 22% decrease in the child abuse/neglect death rate from 2022 (8.9 deaths per 100,000 children) to 2023 (7.0 deaths per 100,000 children). Nearly two-thirds (60%) of abuse/neglect deaths occurred in infants (less than one year of age), followed by children ages 1-4 years (22%). Male children, Black children, and American Indian children were disproportionately affected.

Almost half (47%) of abuse/neglect deaths were due to accidental injuries. Parental substance use was the most commonly identified risk factor in 71% of child maltreatment deaths, 63% 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 FY24 who reported information about prior DCS involvement (n=4,064), 14% (n=554) self-reported having been involved with Arizona DCS in the six months prior to their enrollment to the program (Exhibit 34). This rate continues to show a downward trend compared to previous years (16% in FY23, 18% in FY22, 19% in FY21, 20% in FY20, and 25% in FY19).

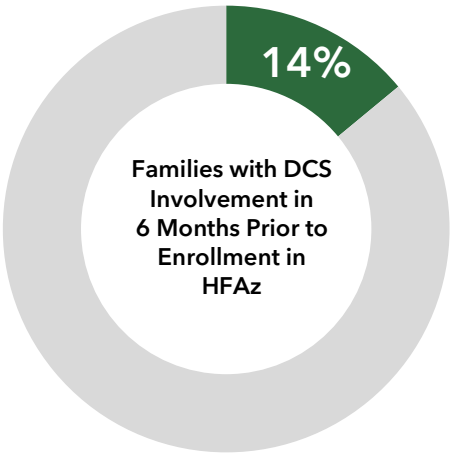


Exhibit 34. Families with DCS Involvement in Six Months Prior to Enrollment to HFAz

(n=4,064)

This decreased trend in families with prior DCS involvement reflects a decrease in referrals of families to HFAz from Arizona DCS workers and the DCS SENSE program. In FY24, 3% (n=143) were referred from DCS (2%, n=91) and the SENSE program (1%, n=52). These rates are lower than 5% in FY23, and 7% in FY22. 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.

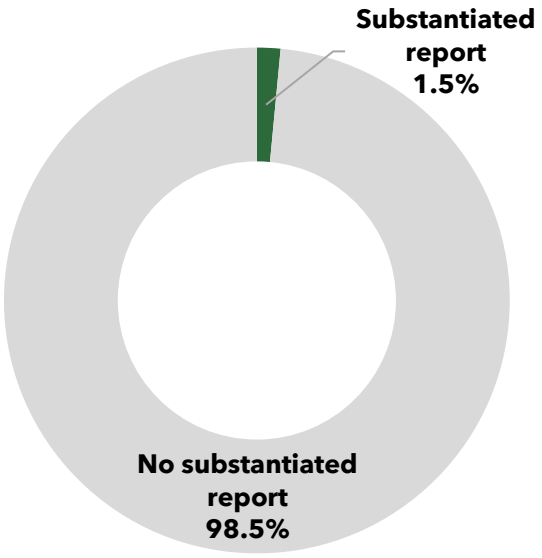
Data from the Arizona DCS data system was requested through a data sharing agreement to determine the rates of substantiated child maltreatment for HFAz participants. It is important to acknowledge that using official child abuse and neglect data as an indicator of program success is complex and is unlikely 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 a high 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 following information describes the involvement of families in DCS child welfare services for families who have been active in HFAz during FY24 and received at least six months of services. The evaluation team performed a matching process of the HFAz enrollment data (N=4,190) with DCS child welfare intake data using HFAz caregiver/parent first name, last name, and date of birth. The DCS intake file included records of investigations of maltreatment and substantiated findings from 7/3/2021 through 9/30/2024[2]. 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). Of the families that had received six months or more of HFAz services (n=2,579) during FY24, only 13% (n=333) had a DCS investigation that occurred after enrollment to the HFAz program and 1.5% (n=38) had a substantiated finding for maltreatment (Exhibit 35). Past program substantiation rates have been slightly higher (4.8% in FY23, 3.1% in FY22, 3.7% in FY20, and 3.6% in FY19 and FY18 (DCS data was not available for the FY21 report). The evaluation team will continue to monitor this data to assess changes over time.

Exhibit 35. Substantiated Child Maltreatment Report Rate of Families Served by HFAz in FY24 with at Least Six Months of Services



(n=2,579)

[2] The DCS Intake data file was deduplicated to include only the most recent finding date for maltreatment for each case or primary caregiver. This resulted in N=92,099 unduplicated cases for the time period of 7/1/2021 to 9/30/2024, of which 81% (n=74,408) resulted in an unsubstantiated finding for maltreatment.

PROGRAM IMPLEMENTATION

HFAz Equity Plan Development and Implementation

The HFAz program continues taking steps towards advancing health equity through their programming. 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. Equity Plans were initially developed by sites and statewide in November 2023 and were revised in December 2024 based on data collected in the past year. 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. Data utilized to inform Equity Plan opportunities and strategies include the annual Staff and Caregiver Surveys, discussions with staff during supervision, feedback from community partners and stakeholders, and other programmatic data and documentation. Exhibit 36 shows examples of opportunities for growth or improvement and strategies to address them that were excerpt from site Equity Plans. Areas of focus include supporting staff and providing them with additional training in areas of interest, enhancing supervision, team dynamics, and family engagement strategies.

Exhibit 36. HFAz Site Equity Plans - Examples of Improvement Areas and Strategies

Opportunities for Growth or Improvement	Strategies to Address
Staff expressed interest in receiving more support with organization and finding ways to manage time more effectively to help them be able to complete job duties on time.	• Provide support in supervision. • Complete time management plans with staff • Initiate and foster team conversations around time management and organization. • Address barriers and challenges as they come up.
Staff identified wanting more professional development with topics that address working with families who face risk factors and challenging issues and on how to honor family culture and diverse family structure.	• Discuss with staff training topics they are interested in. • Staff and supervisors will look for training opportunities that meet the training needs of staff.
Families identified they would like their home visitor to spend more time with than talking about goals and goal setting,	• Share results of caregiver survey with staff. • Identify challenges home visitors are having with facilitating these conversations. • Problem talk ways to incorporate more conversation about goals into home visits. • Follow up with staff in supervision on goal conversations with families.
Staff would like additional team building and appreciation efforts.	• Recognize staff for their efforts. • Organize team gatherings with team building activities. • Host pot lucks to celebrate birthdays and anniversaries. • Recognize seasoned staff by offering mentoring opportunities to new staff. Seasoned staff can facilitate team building activities.

Opportunities for Growth or Improvement	Strategies to Address
Families expressed a preference for scheduling and timing accommodations and more social gatherings with other families.	• Provide virtual visits as requested per family. Supervisors will work with staff during Reflective Supervision when families are cancelling either due to their schedules or time to accommodate the best they can to meet family needs. • Organize Parent Events at different times of the day and different areas. Offer more than one Parent Event per quarter. Offer survey to families after events to determine the best times for events.
Caregiver Survey data and FSS discussion with families showed that Spanish-speaking mothers would like opportunities for social connections in Spanish.	• Offer information in the family's native language whenever possible (books, referrals, tools, surveys, etc.). • Create a social connection, one time per month for Spanish-speaking families to come together and talk, share ideas about parenting and build relationships with each other.

Key Themes in Equity Plans

The following summarizes the key themes presented in 2024 Equity Plans. The evaluation team will continue to monitor changes in Equity Plan key themes and successes and challenges with implementation.

Supportive Supervision

- **Provide supervision support**: Ensure supervisors are accessible and offer guidance tailored to staff needs. Tailored support ensures staff with varying workloads or skill levels receive equitable guidance in managing their responsibilities. Regularly check in with staff during supervision about goal-setting conversations with families. Work proactively to identify and solve challenges staff face.
- **Time management planning**: Collaborate with staff to create time management plans and address organizational challenges.
- **Reflective supervision**: Use reflective practices to discuss challenges with families, including scheduling conflicts or goals discussions. By addressing challenges specific to individual staff members and families, supervision becomes a tool to promote equity in both staff development and family engagement.

Staff Development and Training

- **Provide training opportunities**: Support staff and supervisors in identifying and pursuing relevant training. Encourage staff to share topics they are interested in for professional development. Encouraging staff to identify training topics ensures diverse professional needs are met, recognizing the varying skills and experiences of the team.
- **Recognize staff efforts**: Celebrate achievements and highlight contributions to maintain morale. Celebrating contributions at all levels fosters a culture where every team member feels valued, regardless of their role.

- **Mentorship**: Offer seasoned staff opportunities to mentor new hires and lead team-building activities. Engaging seasoned staff as mentors uplifts team members with institutional knowledge while fostering an inclusive environment where newer staff can grow and succeed.

Team Building

- **Team conversations**: Encourage discussions around time management and organizational strategies. Use thematic team-building activities to align with staff and program goals (e.g., resilience, adaptability). Explore flexible scheduling for staff to balance supervision, training, and family visits effectively. Encouraging open discussions about organizational challenges ensures all voices are heard, promoting inclusivity in decision-making.
- **Team gatherings and recognition**: Host events like potlucks, birthday celebrations, or team-building activities. Implement a recognition system (certificates, shout-outs) to celebrate individual and team achievements. Team events and celebrations create opportunities for bonding across differences, building a stronger, more cohesive team.
- **Cultural sharing**: Invite staff to share their cultures and experiences through group lunches and activities. Inviting staff to share their cultural experiences enriches team understanding and respect, fostering a workplace that values diversity.

Family Engagement

- **Virtual visits**: Provide virtual options for families when scheduling conflicts arise. Providing flexible options for family visits reduces barriers for families with unique scheduling or accessibility needs.
- **Parent events**: Organize events at varied times and locations to increase accessibility, with surveys to gather feedback on preferences. This ensures that families with varied work schedules, transportation challenges, or caregiving needs can participate.
- **Language accessibility**: Offer materials (e.g., books, referrals, surveys) in families' native languages whenever possible. This directly addresses language barriers, ensuring all families can access resources and participate fully.
- **Social connections**: Host monthly gatherings for Spanish-speaking families to build community and share parenting ideas. Creating targeted opportunities for underrepresented groups fosters inclusivity and empowers marginalized communities to build supportive networks.

Healthy Families Arizona Program Staffing

A total of 203 FSS and 33 FAW provided HFAz program services to families in FY24. This number includes staff who have dual roles of being an FSS and FAW or an FSS/FAW and a Supervisor.

Staff Training and Professional Development

Many staff training and professional development activities occurred between October 1, 2023 and September 30, 2024. These include the following:

- Staff received training from the HFAz network in Partners for a Healthy Baby, Family Goal Planning, and Home Visit Note Training. The Family Goal Planning and Home Visit Note were developed by the DCS/CA team. Every new hire watches an ETO orientation training video developed by DCS ETO and Bonterra as part of their onboarding process.
- Staff received training and curriculum materials from Baby Talk or Portage. Most of the program curriculum used previously was designed primarily for children 0-3 so this was an identified need to enhance support for children 3-5 years for families who stay in program past 3 years as well as older siblings.
- LeCroy & Milligan Associates provided staff with monthly HFPI Core Trainings. Attendees of the HFPI Core Training received a copy of the HFPI Manual and laminated Tip Sheets. LMA conducted three HFPI Trainings that were specific to Supervisors and their use of the HFPI in supervision. LMA also conducted monthly training for staff in using the CHEERS Check-in tool. LMA developed and distributed handouts to support this assessment.
- Staff attended the Healthy Families Arizona Institute in October 2024, a 2 day conference providing training and networking sessions and opportunities specific to home visitation and the HFA Model.

Staff Perspectives on Healthy Families Arizona

As part of the Healthy Families America *Best Practice Standards (BPS), 8th Edition* (2022), program sites must gather information from staff to ensure that their voices are heard and feedback received is used to improve the program's ability to provide culturally respectful and responsive services. One strategy utilized by HFAz, as recommended in the BPS, is the annual Staff Survey. By providing statewide and site level reports of Staff Survey data, Central Administration and sites use this information to revise their equity plans.

The Staff Survey was launched on 4/1/2024 and closed on 5/10/2024. Staff were informed that the survey was voluntary and anonymous, provided them an opportunity to give their honest feedback about the program, and that it should take 10-15 minutes to complete. They were informed that all responses would be combined in statewide and site level reports, ensuring that staff would not be identifiable by their position and/or responses to questions. **A total of 237 staff completed this survey, representing 50 teams and 14 sites.** This section presents key statewide findings of the Staff Survey, comparing data from FY23 and FY24.

Staff Workload and Position

Compared to staff survey results from last year, a lower percentage of staff in FY24 feel that their workload is "too high," and a slightly higher percentage of staff feel that it is "just right" or "too low" (Exhibit 37). An increase was also observed in the percentage of staff who felt their workload is "very manageable" and a decrease was seen in staff feeling that their workload is "somewhat manageable."

Best Practice Standard 5 – Staff celebrate diversity and honor the dignity of families and colleagues by educating and encouraging self and others, continuously striving to improve relationships, identifying and addressing barriers, increasing access to services, and achieving greater equity in service delivery, especially for underrepresented groups in the community, confronting disparities caused by systemic oppression, institutional racism and discrimination.

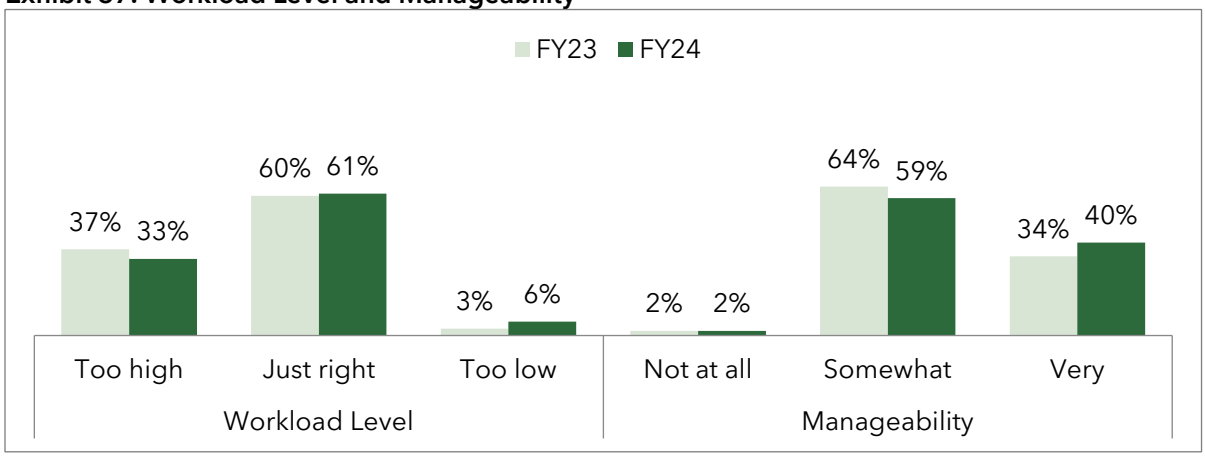
5-1 The site supports staff's ability to continually strengthen the skills required for authentic relationships, including self-awareness, self-regulation, self-reflection, skilled listening, and empathy.

5-2 The site supports development of a partnership with families that honors diverse family structures and the sources of strength derived from family cultures, values, beliefs, and parenting practices. Practice also recognizes the historic and current relevance of discrimination based on race, ethnicity, gender identity, sexual orientation, age, religion, and abilities and seeks inclusivity in all aspects of its work with families.

5-3 The site works at the community level, through policy and practice, and with guidance from its community advisory board, as a champion for families and children, advocating for just and equitable opportunities within the community, and increasing access to services and supports for those it serves and employs.

5-4 The site gathers information to reflect on and better understand issues impacting staff and families served and to examine the effectiveness of its equity strategies.

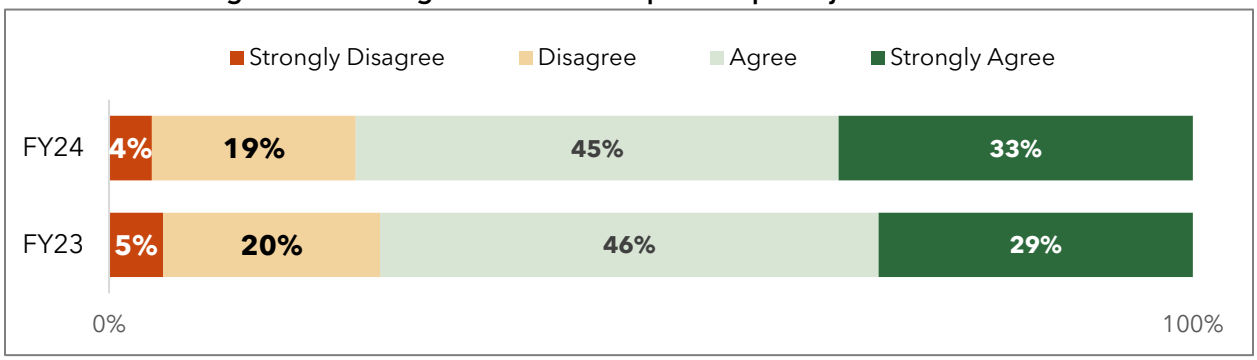
Exhibit 37. Workload Level and Manageability



(FY23 N=297, FY24 N=237)

Comparing data from the past two years, the overall percentage of staff who expressed agreement (i.e., "agreed" or "strongly agreed") with statements about their position increased or stayed the same over time. One statement that showed a positive shift in strong agreement ratings in FY24 was that **33% of staff strongly agreed that "I am able to complete all required job duties within their allotted work time,"** compared to 29% in FY23 (Exhibit 38).

Exhibit 38. Staff Agreement Rating - I'm able to complete required job duties within allotted work time

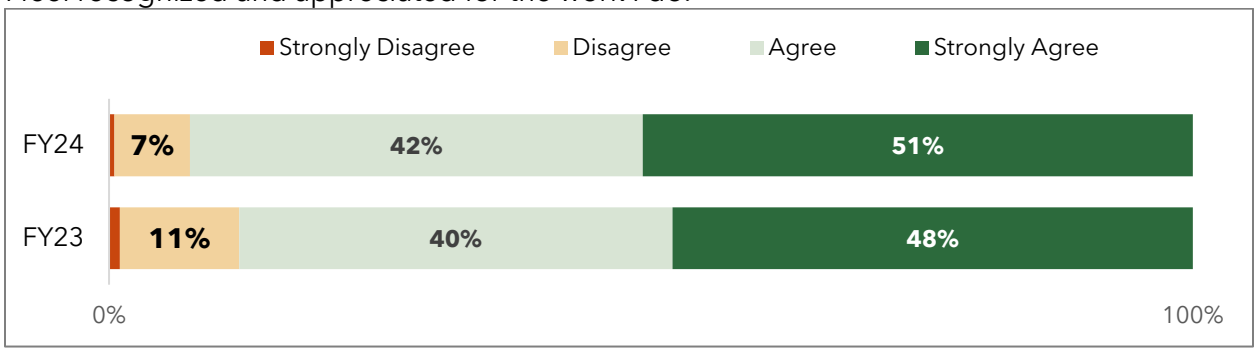


(FY23 N ranges from 296-297, FY24 N ranges from 236-237)

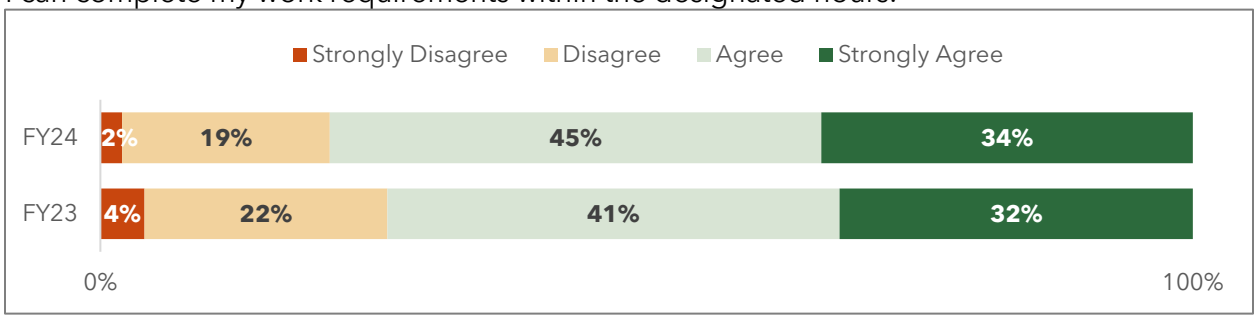
Looking at staff perception of their agency's support for their position, a positive shift noted is that a higher percentage of staff in FY24 expressed agreement (i.e. agreed or strongly agreed), compared to FY23, on statements that they can complete their work requirements within the designated hours and have appropriate time to complete their HFAz duties, the benefits they receive are good, they can use their paid time off, they feel recognized and appreciated for their work, and they are proud to work for their agency. Additionally, a higher percentage of staff strongly agreed in FY24 than in FY23 that they can complete their work in the designated time, they feel recognized and appreciated for their work, they can use their paid time off, and they recommend their agency as a great place to work (Exhibit 39). All statements about HFAz teams received high agreement ratings, which are consistent over time. Areas where nearly two-thirds or more of staff strongly agreed include: their co-workers treat each other with respect, they can go to co-workers for support and resources, and their team works well together.

Exhibit 39. Agreement with Key Statements on Agency Support
(FY23 N ranges from 286-297, FY24 N ranges from 224-233)

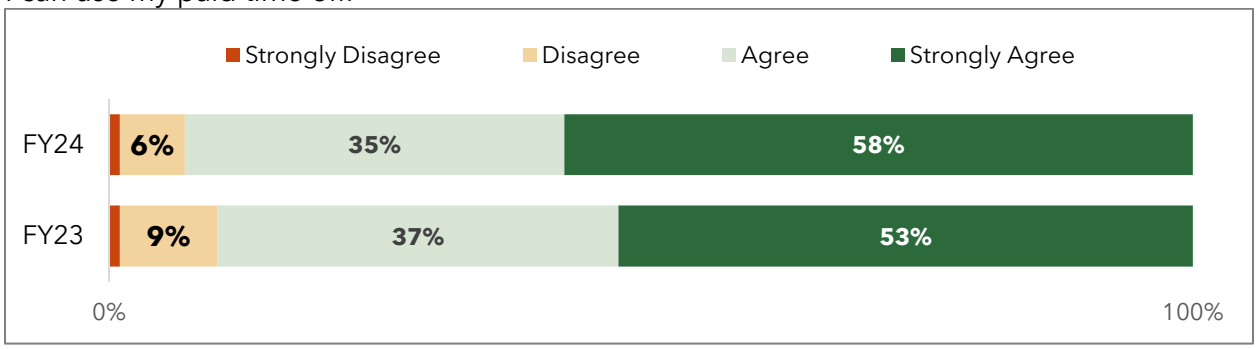
I feel recognized and appreciated for the work I do.



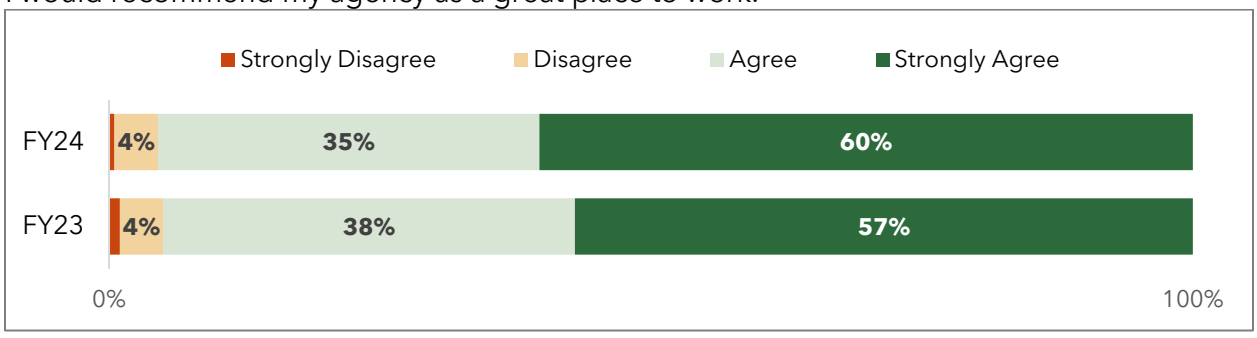
I can complete my work requirements within the designated hours.



I can use my paid time off.



I would recommend my agency as a great place to work.



Rating of Supervision

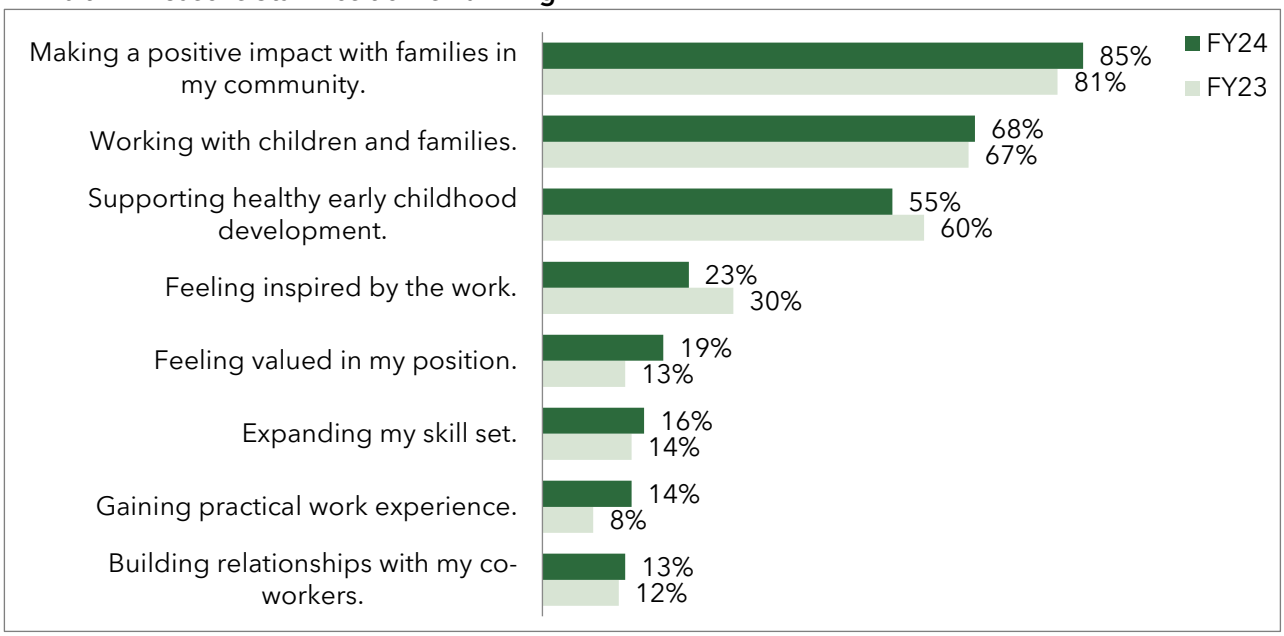
Staff were asked to rate their supervisor and supervision from 1 to 5 stars with 5 being the highest rating. All areas measured received an increase in average ratings from FY23 to FY24, which indicates that staff highly rate their supervision and supervisor even more in this past year (Exhibit 40). Average ratings in FY24 ranged from a high of 4.81 for the statement: "My supervisor communicates with me respectfully," to a low of 4.68 for the statement "My supervisor supports me in maintaining a healthy work/life balance."

Exhibit 40. Average Rating of Supervision and Supervisor from 1 to 5 Stars

Staff Retention

Staff were asked to select the top three reasons that make their job fulfilling (Exhibit 41). The leading reason over the past two years selected by over 80% of staff is that they feel they are making a positive impact with families in their community. Other primary reasons are working with children and families and supporting healthy early childhood development.

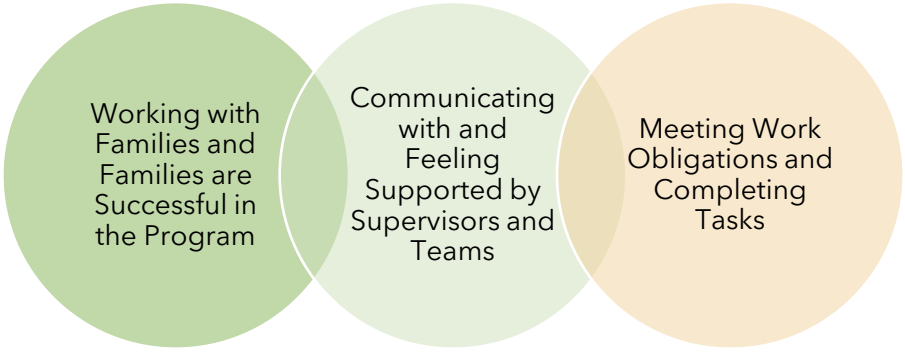
Exhibit 41. Reasons Staff Position is Fulfilling



(FY23 N=298, FY24 N=228)

Staff were asked "When do you feel successful in your work?" The three main themes that emerged from open-response comments are shown in Exhibit 42 and are consistent with results from FY23. Respondents feel successful when they work with families and families are successful in the program, they feel supported in supervision and working as a team, and meet work obligations while maintaining work/life balance.

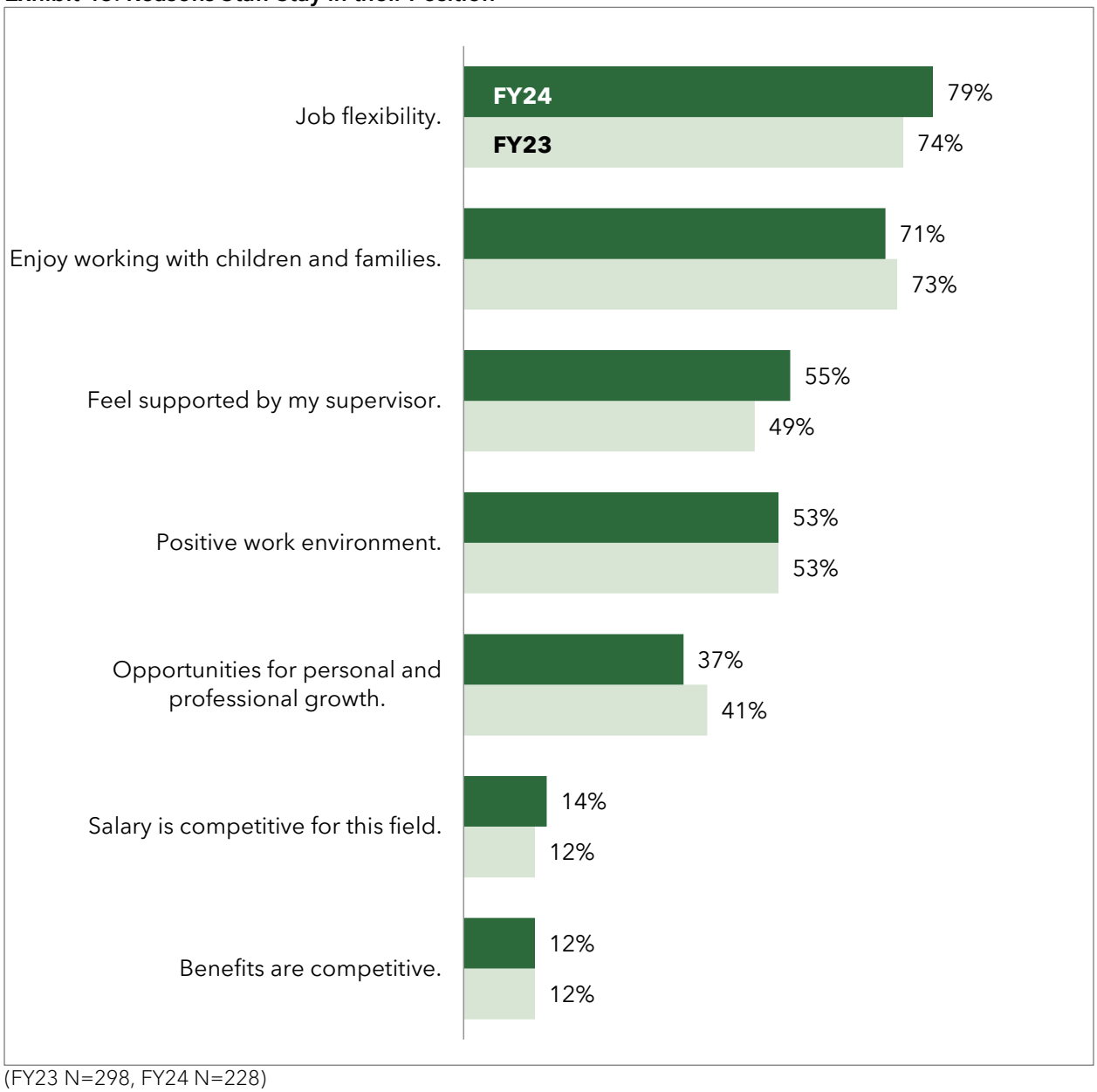
Exhibit 42. Ways Staff Feel Successful in Their Work – Main Themes



(n=205)

Reasons why staff stay in their position have been consistent over the past two years (Exhibit 43). Predominant reasons given by approximately three out of four staff include the flexibility of their job and that they enjoy working with children and families. Additionally, more than half stay in their position because they feel supported by their supervisor, which is an increase from 49% in FY23. More than half also stay because of the positive work environment.

Exhibit 43. Reasons Staff Stay in their Position

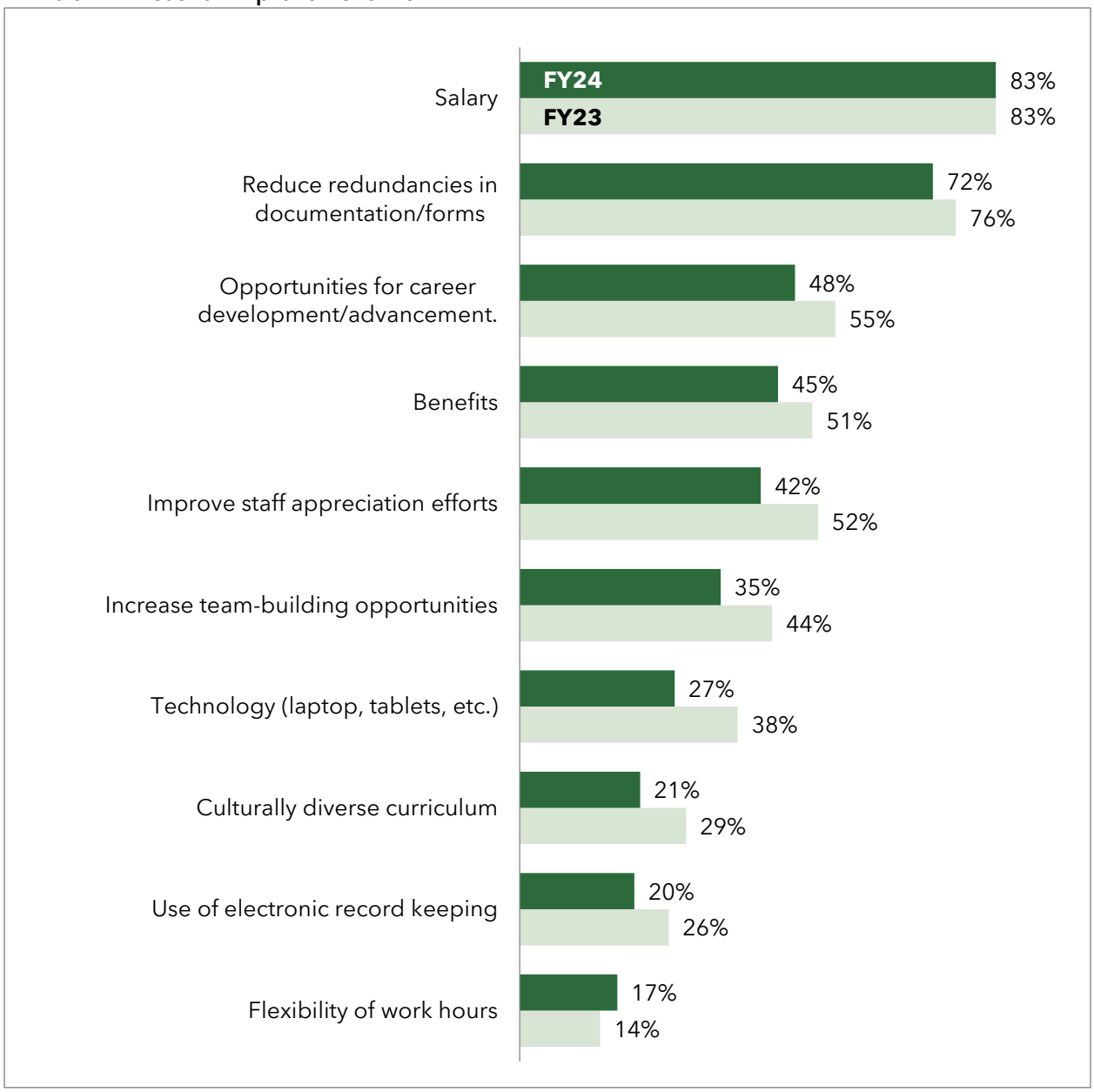


(FY23 N=298, FY24 N=228)

Areas for Improvement

Staff were asked to select their top five areas that they would like to see improved within the HFAz program. Results from FY23 and FY24 show a consistent trend in terms of prioritized areas selected by staff, however FY24 showed a general decrease in percentages in most areas (Exhibit 44). Over both years, 83% of staff surveyed would like to see an improvement in their salary. Staff would also like to see a reduction in paperwork redundancies and opportunities for career development and advancement.

Exhibit 44. Areas for Improvement within HFAz

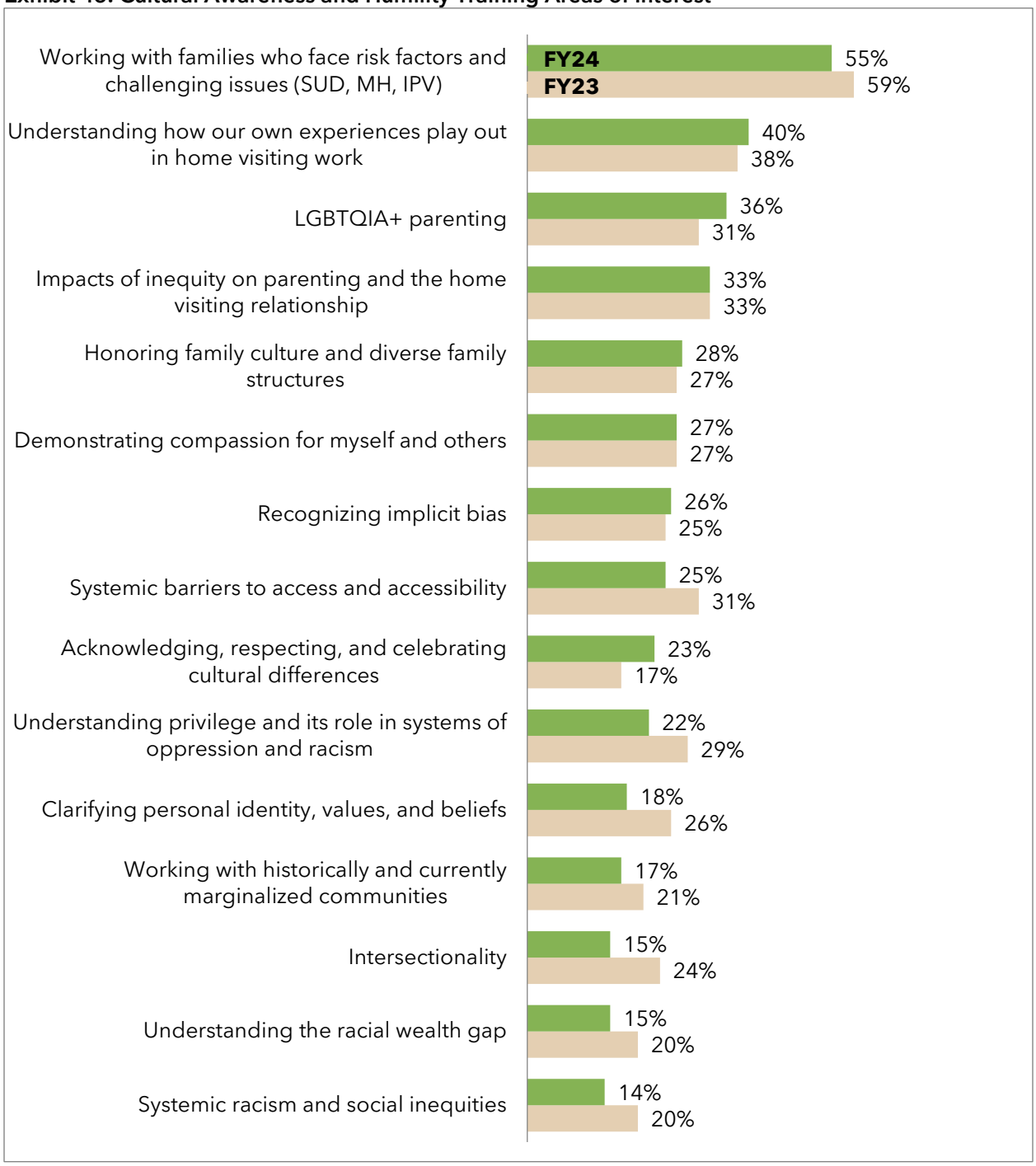


(FY23 N=298, FY24 N=228)

Cultural Awareness Training Needs

Training areas of interest to staff in FY24 trend similar to interests expressed in FY23 (Exhibit 45). Over half of staff continue to be interested in receiving training in working with families who face risk factors and challenging issues, such as substance abuse, mental health, intimate partner violence, and cognitive impairment.

Exhibit 45. Cultural Awareness and Humility Training Areas of Interest

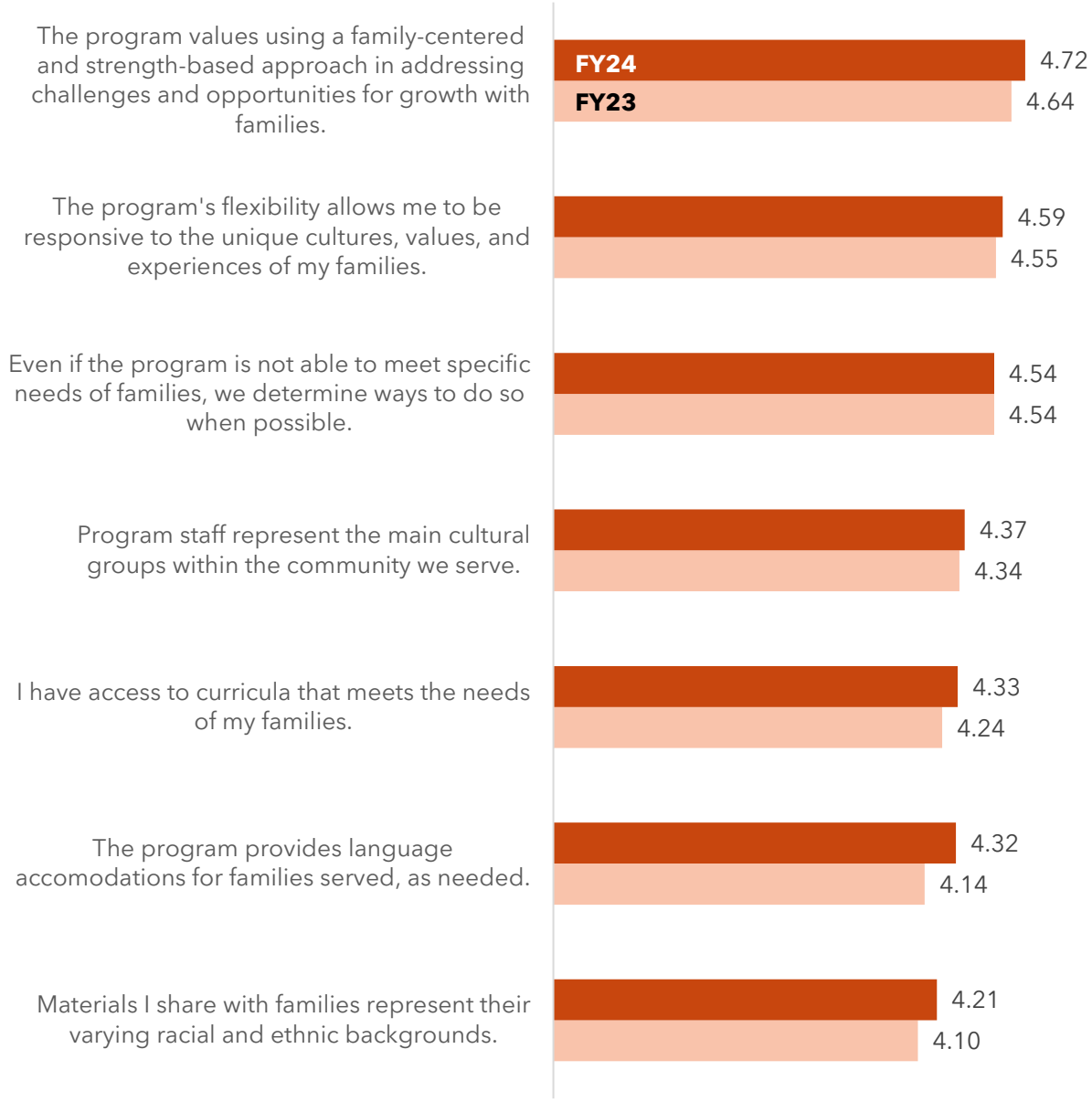


(FY23 N=298, FY24 N=228)

Rating of HFAz Cultural Awareness

Staff were asked to rate statements on cultural awareness areas from 1 to 5 stars, with 5 being the highest rating (Exhibit 46). Comparing average staff ratings from FY23 and FY24, all ratings increased in FY24. The three areas with the highest average rating were: the program values using a family-centered and strengths-based approach, the program's flexibility allows staff to be responsive to the unique needs of their families, and the program determines ways to meet unique family needs, when possible. The two areas that received the lowest average ratings continue to focus on language accommodation for families and materials being representative of varying racial and ethnic backgrounds of families served.

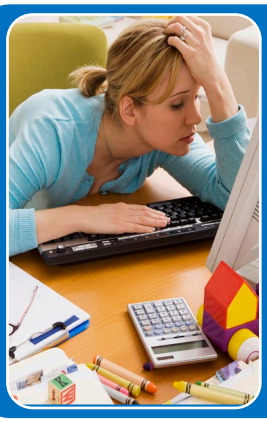
Exhibit 46. Average Rating of HFAz Cultural Awareness Areas



(FY23 N ranges from 271-274, FY24 N ranges from 218-221)

Recommendations from the Staff Survey

Staff survey data collected in FY23 and FY24 were compared to assess changes in perspectives over time. While responses to most questions were consistent over the past two years, notable improvements were observed with staff giving higher average ratings to all statements on their supervisors and supervision and the program's cultural awareness. The following are recommendations that HFAz site leadership and Central Administration should consider based on the results of the staff survey and two year comparison.



Identify ways to support staff struggling with managing their workload.

While data on staff workloads slightly improved this past year, 33% still feel their workload is "too high" and 59% feel their workload is "somewhat" manageable. Nearly a quarter (23%) of staff in FY24 disagreed that they can complete their required work in the allotted work time or designated hours. Between 24% and 28% of FSS and supervisors would like to improve their organizational and time management skills. Additionally, the area "My supervisor supports me in maintaining a healthy work/life balance" continued to receive the lowest average staff rating, compared to ratings of other supervisory areas. These findings suggest the need for program leadership to better support staff who are struggling with managing their workloads.

Identify ways to support staff in professional growth and development.

All staff positions expressed the desire to have more support during supervision in identifying and guiding their professional growth. Nearly half (48%) of staff prioritized opportunities for career development/advancement as one of the top five ways the program could improve and this area was selected by 37% as a reason staff stay in their position. Interestingly, only 27% of supervisors in FY24, compared to 42% in FY23, would like guidance on supporting and promoting staff professional development. It is possible that supervisors received training in this area in the past year, which lowered their interest. Program leadership should explore ways to better support staff at all levels in their professional growth and career development and ensure that supervisors know how to best support their supervisees in this way.

Support staff in improving areas of interest by staff position.

Almost half of data staff would like to better understand how to create and interpret ETO reports. The top priorities of FAWs are strengthening family pre-engagement and outreach strategies and using the FROG scale. FSS could benefit from more support and guidance on effectively using curriculum, educational materials, and reflective strategies with families and supporting families in goal planning. Almost half of supervisors would like to strengthen their reflective supervision strategies and 39% would like guidance in improving collaboration with FSS in supporting families.

Provide staff with training on working with high risk and diverse families.

The most requested training area continues to be "working with families who face risk factors and challenging issues," such as substance abuse, mental health, intimate partner violence, and cognitive impairment. Areas on diversity where a third to over half of staff would like additional training include: LGBTQIA+ parenting, understanding how personal experiences impact home visiting work, and the impacts of inequity on parenting and home visiting.

Continue to explore materials and resources that can expand the cultural sensitivity of HFAz.

All cultural awareness areas received higher average ratings from staff in FY24 compared to FY23, indicating that the program has improved in these areas. However, areas that continue to receive the lowest average staff ratings are around language accommodations for families and materials being representative of varying racial and ethnic backgrounds of families served. Additionally, 21% of staff feel that use of a culturally diverse curriculum is an area in which HFAz could improve.

Continue to explore ways to keep staff salaries and benefits competitive.

Even with salary increases in 2022 with the infusion of Governor's Office Funding, survey data showed that salary and benefits continue to be an area where staff would like to see improvements made. Most staff (83%) prioritized their salary and 45% prioritized benefits as one of the top five ways the program could improve. Comparatively, only 14% said that competitive salary and 12% said competitive benefits are reasons they stay in their position.

Continue to explore ways to support staff in data entry, using ETO reports, and reducing redundancies in documentation and forms.

Almost half of data management staff asked for additional support in creating and understanding ETO reports in FY24, which is a notable increase from 24% in FY23. Additionally, 26% of FAWs, 29% of supervisors, and 31% of FSS would like additional support in strengthening their data entry and documentation. Nearly 3 out of 4 staff surveyed across all staff positions feel the agency could improve by reducing redundancies in documentation and forms.

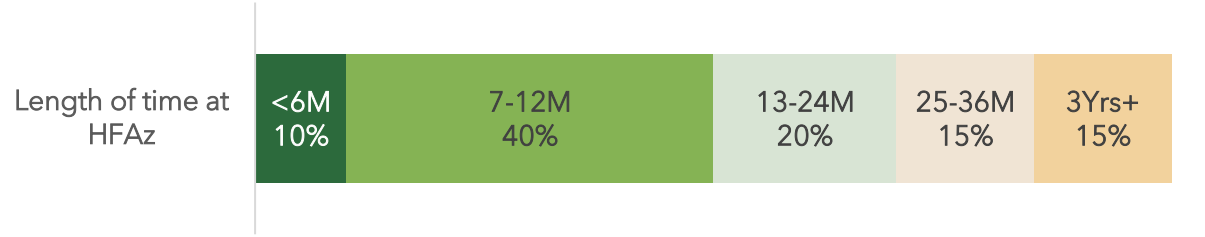
Continue staff appreciation and team building efforts.

Three out of four staff strongly agreed that they feel their position is important and 95% agree that team building supports better relationships and communication among team members. Additionally, 42% of staff prioritized improving staff appreciation efforts and 35% would like more team-building opportunities as ways the program could improve. These findings suggest the continued need for program leadership to offer staff appreciation and team building efforts.

Staff Exit Survey Results

When staff members leave HFAz, they are provided with an opportunity to submit feedback through an online Exit Survey that was available anonymously through a link or QR code. The evaluation team received 20 exit surveys in FY24. Most staff (90%) who submitted a survey reported that they worked directly with families as FSS or FAW (n=18). Ten percent (n=2) of respondents were employed with HFAz for less than 6 months; 40% (n=8) for 7-12 months; 35% (n=7) for 1-3 years; and 15% (n=5) for more than 3 years (Exhibit 47).

Exhibit 47. Length of Time at HFAz



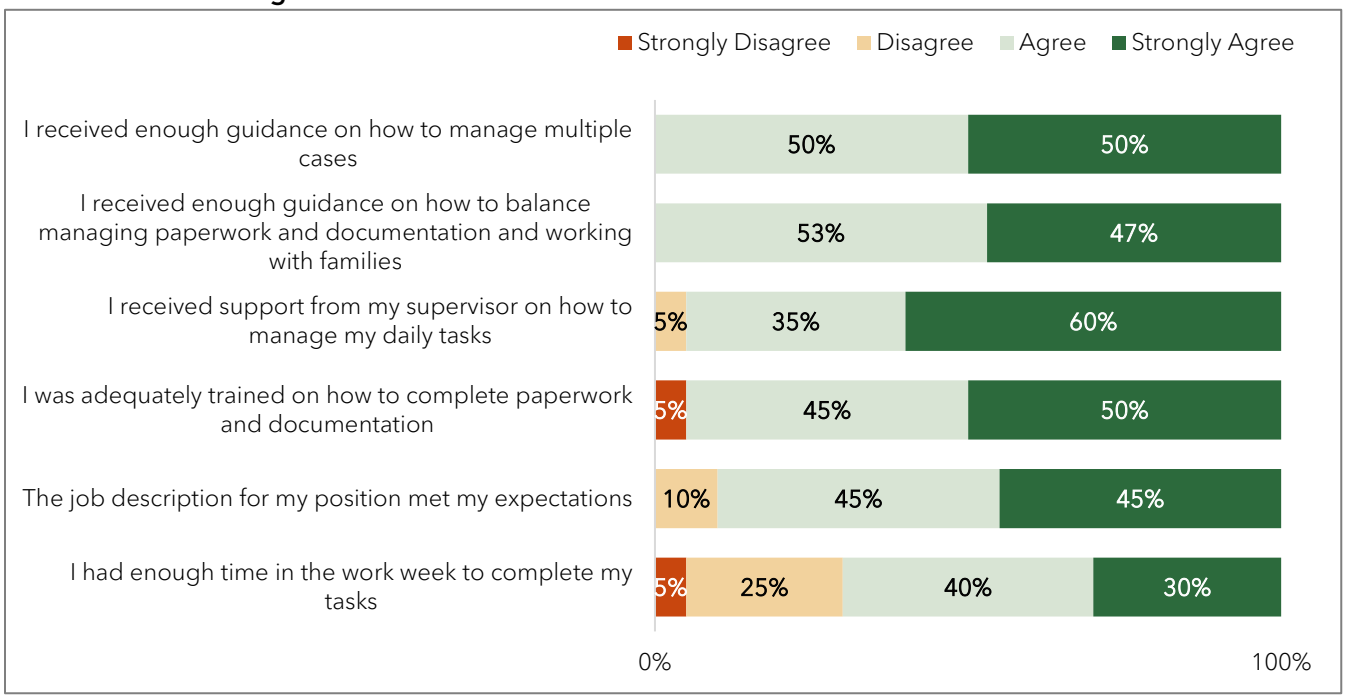
(N=20)

Staff were asked to indicate the reasons why they left their position with HFAz, with 45% (n=9) saying they wanted better pay and/or benefits. Twenty-five percent (n=5) left due to a health issue for themselves or a family member; 20% (n=4) reported that the caseload was too much; 15% (n=3) changed careers; 15% (n=3) said the position had limited growth opportunities; 15% (n=3) returned to school; 10% (n=2) did not intend for their position to be long-term; and 5% (n=1) said they left the workforce/retired.

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. The majority of respondents (65%, n=13) said "No", and 30% (n=6) said "Yes." Among those who answered yes, reasons given included a **better rate of pay** a more **flexible work schedule**, **shorter driving distances**, more **focus on quality care** rather than documentation, and having a **part-time position**.

Staff members were asked to rate their agreement or disagreement with a series of statements around their position and the level of support and guidance they received (Exhibit 48). All staff expressed agreement that they **received enough guidance on managing multiple cases and balancing paperwork/documentation and working with families**. Most staff agreed or strongly agreed that they received support from their supervisor on how to manage daily tasks, were adequately trained in how to complete paperwork and documentation, and the job description met their expectations, while a few respondents disagreed or strongly disagreed with these statements. The area that had the most variation in responses was the statement "I had enough time in the work week to complete my tasks." Seventy percent (n=14) agreed or strongly agreed, while 30% (n=6) disagreed or strongly disagreed.

Exhibit 48. Staff Rating of Statements on their Position and Guidance Received



(N ranges from 19-20)

Exiting staff were asked: **"What do you think the organization that you worked for did really well in regard to implementing the HFAz program?"** Multiple respondents mentioned beneficial training, strong and knowledgeable supervisors, and working in a safe and supportive environment. A few also highlighted the quality of support provided for families.

The survey also asked staff to **"Describe the three things you liked best about working with your supervisor and/or the agency."** Most respondents complimented their supervisor, saying that they were supportive, caring and helpful, and communicated well. Some also said that their training was thorough and helpful, and that scheduling of home visits was flexible. Another common response was that coworkers were supportive, shared resources, and cooperated well to accomplish tasks.

Conversely, staff were also asked to **"Describe the three most difficult things about working with your supervisor and/or the agency."** Common responses were the amount of paperwork required to do their job, fluctuating schedules, feeling overwhelmed, too much driving, and low rate of pay. Others felt that meetings were redundant or they experienced issues with technology. One person said that there were not enough supplies available for their families.

Exiting staff were asked **"What advice would you have for the next person in your position?"** Most respondents said that keeping up with paperwork and practicing organizational skills was critical. Many also mentioned that people should not be afraid to ask questions or for help from other team members if they needed it, and to take advantage of the training offered. Several highlighted the need of staff to practice self-care in their position.

Caregiver Perspectives on Healthy Families Arizona

As part of the Healthy Families America (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 Caregiver Survey was launched on 6/17/2024 and closed on 9/1/2024. A total of 1,167 families completed the Caregiver Survey representing 52 teams and 14 sites, which was a response rate of 43% of families enrolled as of 7/1/2024.

Caregiver Language and Equity

Exhibit 49 shows the language(s) that families speak at home and with their home visitor, with the majority speaking English or a combination of English and Spanish at home. Most caregivers (97%, n=1,118) reported that the language they speak at home is the same language that they speak with their home visitor during visits or that their home visitor utilizes translation services during the visit. Languages spoken through translation services include American Sign Language (ASL), Arabic, Créole/Haitian, Nepali, and Swahili. On the other hand, 3% (n=37) of caregivers speak a different language at home than what they speak with their home visitor. Other languages reported, in addition to translated languages, include Baluchi, Burmese, Chinese/Mandarin, Dari, Farsi, French, Igbo, Ilokano, Vietnamese, Kinyarwanda, Tamil, and Tagalog.

Healthy Families America (2022)

Best Practice Standard 5

Staff celebrate diversity and honor the dignity of families and colleagues by educating and encouraging self and others; continuously striving to improve relationships; identifying and addressing barriers; increasing greater equity in service delivery, especially for underrepresented groups in the community, by confronting disparities caused by systemic oppression, institutional racism, and discrimination.

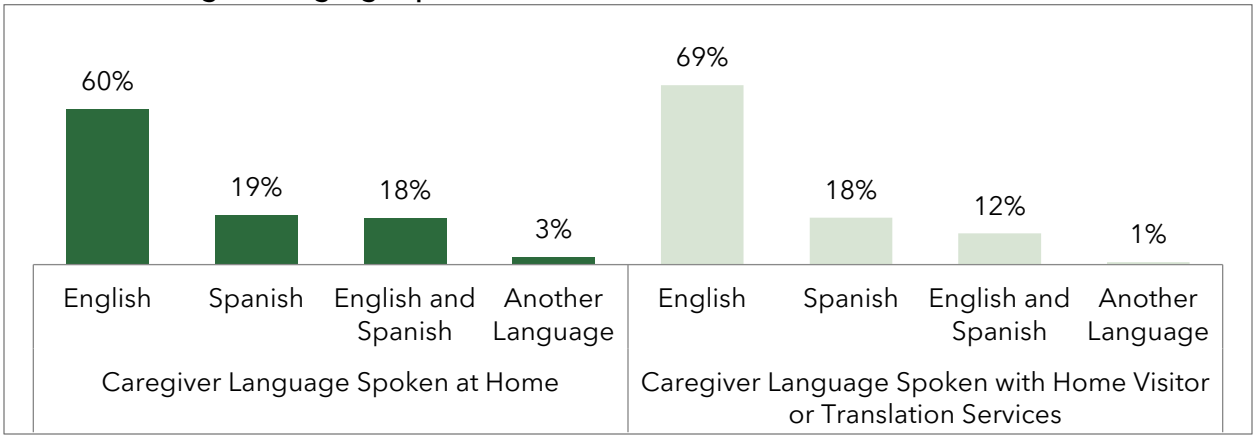
Staff strengthen skills required for authentic relationships, including self-awareness, self-regulation, self-reflection, skilled listening, and empathy (5-1).

Sites honor diverse family structures and the sources of strength derived from **family cultures, values, beliefs, and parenting practices** (5-2).

Sites advocate for just and equitable opportunities within the community, **increasing access to services and supports for those it serves** (5-3).

Sites **gather information** to reflect on and better understand **issues impacting families served** and to examine the **effectiveness of its equity strategies** (5-4).

Exhibit 49. Caregiver Language Spoken at Home and with their Home Visitor



(N=1,158)

Key Findings from the Caregiver Survey

- Nearly all families (99%) affirmed that the **program is as helpful as they thought it should be**. 98% of families "usually" or "always" feel like they **have enough time with their home visitor**.
- 94% of respondents said that **child development** is addressed during most visits. 85% strongly agreed that their home visitor helps them understand their **child's development** and 54% ranked **"learning about my child's development"** as the best thing they like about the program.
- 83% of families said their home visitor addressed **activities to do with their child** during most visits. Over 50% of caregivers ranked **"learning about activities that my child and I can do together"** as the best or second best thing they like about the program. A recommendation from families was to have more activities during visits.
- 82% of families said their home visitor addressed **parenting skills** during most visits. For 64% of caregivers, "**having another adult who listens and supports me**" was one of the top three best things they like about the program.
- Most caregivers thought highly of the program's **materials and resources**, agreeing or strongly agreeing that materials are in their language, reflect their values, support their family's traditions, and are interesting and helpful. Families would like additional materials and resources, especially those that are specific to a child's age, the family's language and culture, and the family's structure.
- 82% or more caregivers strongly agreed with statements regarding their experience with their **home visitor.** 89% strongly agreed that their home visitor **makes them feel like their concerns are important.**
- Home visitors received an **average recommendation rating of 9.8 out of 10,** suggesting 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, several recommendations emerged from the data (Exhibit 50).

Exhibit 50. Recommendations for Program Improvement from the Caregiver Survey

Home Visiting Logistics:

- Families would like the program to offer more frequent home visits and/or extend the duration of each visit to enhance the quality of interactions. Home visitors should strive to meet the BPS standard of holding visits 60 minutes or longer.
- The program could explore providing more flexible scheduling options, such as having visits during evenings and weekends, and allowing for virtual visits, when needed.
- The program should strive to maintain consistent and more permanent home visitors to build stronger relationships with each family.

Expanded Activities and Materials:

- Consider introducing more age-appropriate and multilingual developmental activities, including sensory activities and educational games.
- Strengthen training for staff on working with families from different cultures.
- Ensure activities are engaging and that families receive guidance during visits. Create opportunities for extended family members to participate in activities.
- Home visitors should strive to complete each of the five home visit discussion areas with families regularly and at least once a month.

More Information and Resources:

- Continue to foster relationships with community partners to provide families with concrete resources. Identify resources to distribute diapers, baby items, toys, books, and vouchers for essentials. Consider providing or referring families to resources such as transportation assistance and financial assistance for expenses, bills, and emergencies.
- Identify and refer parents to credible and reliable online resources with printable materials, community events, and other parent resources.
- Increase resources related to mental health and emotional support.
- Offer continued guidance on child development milestones and practical advice for addressing developmental stages.
- Continue to facilitate discussions on how families can set and achieve goals.

Foster Community and Connection:

- Organize more group events, socials, and meetups to build community among parents.
- Offer virtual meetups for working parents to discuss parenting and share experiences, potentially on a monthly basis.

RECOMMENDATIONS

This report covers the FY24 timeframe from October 1, 2023 through September 30, 2024. LMA respectfully puts forth the following programmatic recommendations for HFAz Central Administration's consideration, based on evaluation data reported this year.

Recommendations for Program Implementation

Service Recommendations

- **Supporting Families in HFPI Areas** – HFPI data on concern areas over the past five years show that home visitors could provide more support to families in areas of **personal care and developing a sense of self-efficacy as a parent, as well as role satisfaction and parent-child interaction**, especially as their child grows. Families showed significant improvements over time from baseline to 12-14 months in the areas of setting up a home environment for raising a child and their ability to mobilize resources. This finding suggests that the program is especially effective in supporting families in these areas and these practices should be continued.
- **Strengthen Referrals to Services** - Since a portion of families are not retained in the program (23% closed in less than 3 months), referring them to existing community services during their first few months of service is important. This would provide more support for families who exit the program prematurely, so they have access to other community resources available.
- **Identify ways to better retain and serve African American, Native American, single caregivers, and young caregivers** – These families have lower retention and completion rates than their counterparts, warranting additional attention to what could be contributing to these disparate effects. Retrospectively or going forward, a small group of staff could conduct a case review of early program exits for families with these characteristics, documenting stressor or service factors that contributed, and identifying ways to mitigate these in the future.
- **Promote Greater 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, and are interested in opportunities to meet other families who participate in HFAz. Families would like more information and resources particular to their child's needs. Some families requested additional or longer home visits.

Program Administration Recommendations

- **Promote Equity Planning and Implementation** – HFAz Central Administration could continue to gather staff feedback on the equity planning process and implementation. The evaluation team could conduct focus groups with staff on equity plan implementation. The FY24 Equity Plans emphasize fostering equity through supportive supervision, staff development, team building, and family engagement. Supervisors are encouraged to provide tailored guidance, reflective practices, and collaborative time management planning to meet diverse staff needs. Staff development focuses on offering personalized training opportunities, recognizing contributions, and establishing mentorship programs to support professional growth. Team-building efforts promote inclusivity through open conversations, cultural sharing, and activities that strengthen cohesion and morale. Family engagement strategies prioritize flexibility with virtual visits, accessible events, language support, and targeted outreach to marginalized communities, ensuring equitable access and meaningful connections for all families.
- **Strengthen Data Entry and Quality Checks** – Overall, data entry and documentation of referrals made for services in FY24 showed notable improvement from FY23. However, Central Administration and ETO Administrators could continue to provide training and technical assistance for staff in entering data into ETO, data cleaning, and performing quality checks.
- **Strengthen Referrals from DCS/SENSE to HFAz** - The ADHS 2024 Child Fatality Review Team's recommendations to prevent child abuse and neglect related deaths include increasing home visiting programs throughout the state. HFAz and DCS programs could collaborate to determine ways to increase referrals of families involved in DCS to HFAz. Examining how these families may be different can assist the program in providing services that better match the needs of the specific population.
- **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. The following areas are important for staff retention:
  - Supporting staff who are struggling with managing their workload and reducing redundancies in documentation and forms.
  - Identifying ways to support staff in professional growth and development, especially in areas of interest by staff position.
  - Increasing staff appreciation and team building efforts and providing staff with training in working with high risk and diverse families.
  - Exploring materials and resources that can expand the cultural sensitivity of HFAz and providing staff with training.
  - Keeping staff salaries and benefits competitive.

Recommendations for Evaluation

LMA puts forth the following recommended focus areas for the FY25 evaluation of HFAz.

- Monitor change in evaluation data as the program continues to expand and serve new families, such as outcomes from newer populations served and change in demographics of families served through program expansion.
- As the HFAz program (statewide and site level) implements annual equity plans, LMA can evaluate this implementation as part of the process evaluation to provide feedback to Central Administration on implementation progress and suggest ways to improve subsequent equity plans. LMA can continue to examine caregiver characteristics by service utilization, retention, and exit reasons to inform equity strategies and strengthen tailoring of retention efforts to family needs.
- HFAz Central Administration and the evaluation team will continue to review strategies to improve the Staff Exit Survey data collection. Increasing this response rate could provide the program with more feedback from exiting staff.
- HFAz Central Administration should consider clarifying with staff the existing definition of program completion as a reason for exiting the program. The program could add instructions to forms and include program completion as a discussion topic at Supervisors' meetings and Program Manager meetings. In general, the program could provide staff with more explanation and guidance around closure reasons and which option to select for each family's unique circumstances, especially when new staff are hired. Monitoring who is more likely to complete the program can help inform strategies to better support those who are less likely to complete it.

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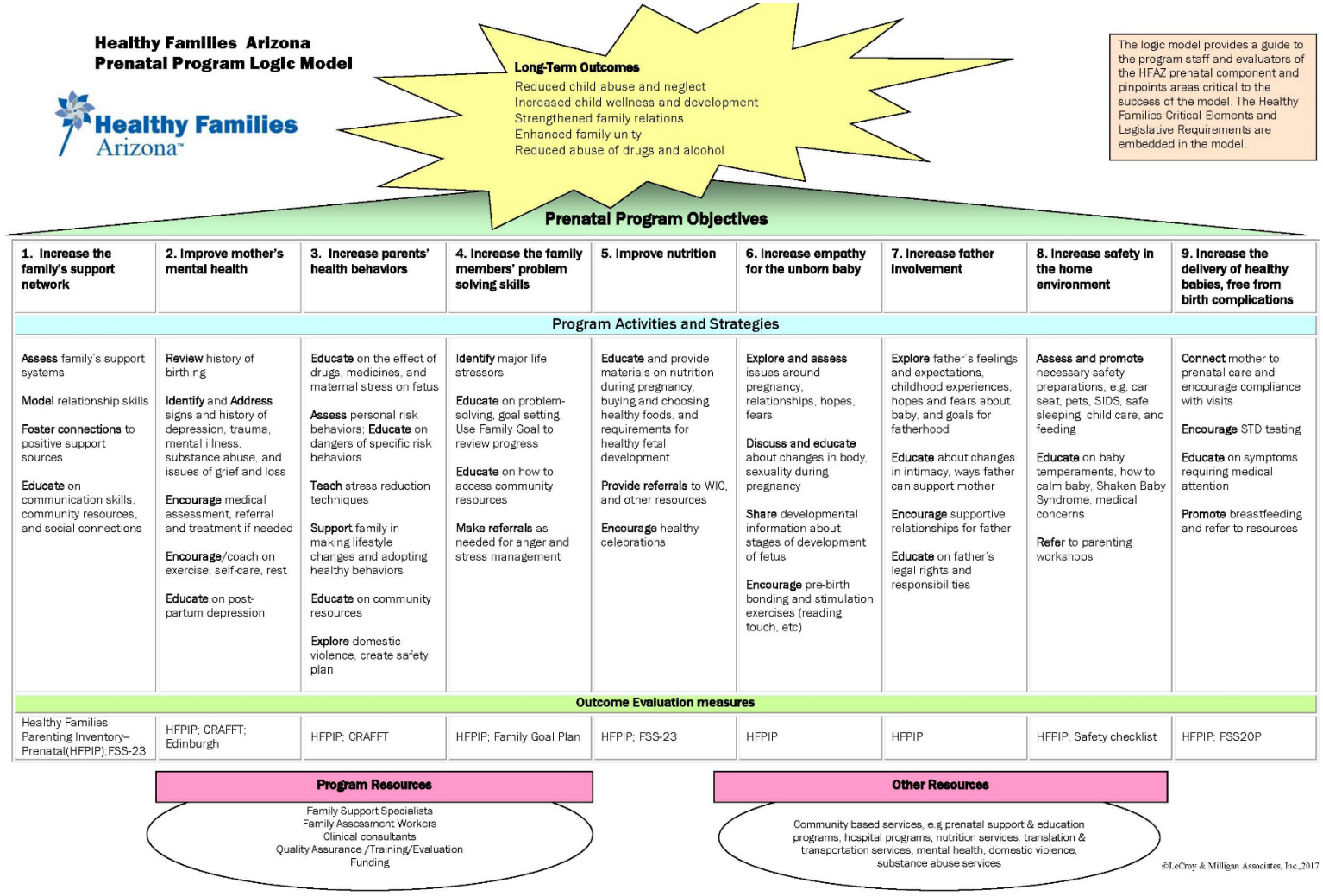
APPENDIX A. HEALTHY FAMILIES ARIZONA PRENATAL LOGIC MODEL



APPENDIX B. HEALTHY FAMILIES ARIZONA POSTNATAL LOGIC MODEL