Healthy Families America (HFA)

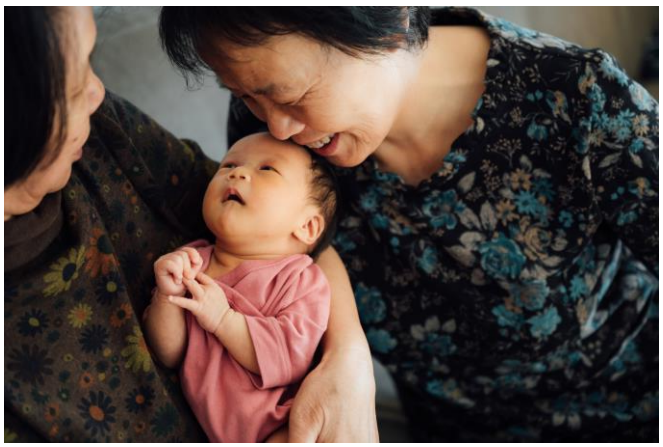
Key Continuous Quality Improvement (CQI) Considerations

CQI BRIEF FOR CALIFORNIA COUNTIES AND EBP PROVIDERS

INTRODUCTION

As California continues to strive for excellence in child welfare, the implementation of evidence-based programs (EBPs) is a fundamental component of the Family First Prevention Services (FFPS) prevention plan. **This policy brief is designed to provide counties and providers with a comprehensive framework for implementing Healthy Families America (HFA)**, a well-supported evidence-based program approved by the Family First Prevention Services Clearinghouse to meet the diverse needs of at-risk youth and their families.

As you review this information, consider how you will measure the success of HFA within your county and how you can develop or refine your implementation to ensure eligibility for IV-E reimbursement, as well as improved outcomes for children and families.



Counties and providers can utilize this Brief to facilitate discussions at the county, agency, and community levels, aimed at identifying best practices for tracking and sharing data. These discussions should also focus on reviewing the CQI prompts to assess program delivery and implementation, making necessary adjustments as needed. Additionally, counties and providers should use these Briefs to establish feedback loops for sharing qualitative data on family-specific needs, ensuring that future efforts to serve and support families are informed and responsive.

The information presented in this resource, including service descriptions, target populations, program or service delivery, and implementation details, is informed by several key sources. These include meetings with California's Family First Prevention Services CQI Subcommittee, Family First Prevention Services Advisory Committee, Community Pathway Subcommittee, IV-E Subcommittee, and Healthy Families America.

Key Terms

Developer/Purveyor: The entity responsible for creating and supporting the implementation of the EBP. They provide training, resources, and guidance to ensure fidelity and effective implementation.

Provider: The individual or organization delivering the EBP services directly to children and families.

HEALTHY FAMILIES AMERICA PROGRAM OVERVIEW

Healthy Families America (HFA) is a home visiting program for new and expectant families with children who are at-risk for maltreatment or adverse childhood experiences. HFA is a nationally accredited program that was developed by Prevent Child Abuse America. The overall goals of the program are to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term, and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed.

Who is Eligible?

Expectant families and families with a child up to 5 years old who are at-risk for child abuse and neglect. HFA excludes families if the child is beyond the program's age limit.

Program Goals

Build and sustain community partnerships to systematically engage overburdened families in home visiting services

Cultivate and strengthen nurturing parent-child relationships

Promote healthy childhood growth and development

Enhance family functioning by reducing risk and building protective factors

Families Need to Know

Services begin as early as prenatally and continue for a minimum of 3 years

HFA is an intensive program with weekly home visits lasting approximately 1 hour in duration.

Over time, families may move to less frequent visits (biweekly and then monthly). Movement to less frequent visits depends on the needs and progress of the family and, in times of crisis, visit frequency can increase.

HFA is usually delivered in the family's home

Cultural Relevance

HFA has been shown to have positive outcomes for American Indian or Alaskan Native, Asian, Biracial or Multiracial, Black, Latinx, and Native Hawaiian or Pacific Islander children and families

HFA has materials available in English and Spanish

MEASURING PROGRAM SUCCESS

Measuring the capacity, reach, fidelity, and outcome data outlined below can greatly enhance the implementation and effectiveness of HFA. Regular quality assurance monitoring ensures this adherence.

Data Collection for Federal IV-E Reimbursement

Under the Family First Prevention Services Act (FFPSA), federal IV-E reimbursement for evidence-based programs (EBPs) is contingent upon several requirements described on pages 27, 39, and 52 of the federally approved California Prevention Plan. To meet these requirements and ensure accurate cost tracking:

- **The HFA developer/purveyor currently does not provide reports on capacity, reach, outcomes, or fidelity measures.** Therefore, providers must establish and maintain internal systems to monitor key metrics, including service capacity, reach, fidelity, and outcomes.
- **HFA providers will enter reach and capacity data into the CARES provider portal on a monthly basis.**
- Tracking both outcome and fidelity data is required for IV-E reimbursement.
- **Outcome and fidelity data will be reported by the HFA providers and submitted to CARES using the designed provider template provided in Appendix A.**

The **CDSS FFPS Program** will:

- **Upload outcome and fidelity data** into the backend of CARES.
- **Translate the reach, capacity, outcome and fidelity data into Tableau reports for use in state- and county-level FFPS CQI processes.**

Key Metrics for Continuous Quality Improvement (CQI)

To measure the success of HFA, it's important to regularly review data in four key areas:

1. ***Capacity –*** *staff requirements*
2. ***Reach –*** *the extent to which children and families are being served*
3. ***Fidelity –*** *adherence to model implementation requirements*
4. ***Outcomes –*** *impact of services on children and families*

These metrics provide a comprehensive view of program effectiveness. More information on this framework can be found here: Measurement Framework for Implementing and Evaluation Preventive Services.

HFA MEASUREMENT FRAMEWORK

The **HFA Measurement Framework** provides standardized metrics for California counties and EBP providers to evaluate **capacity**, **reach**, **fidelity**, and **outcomes**, supporting continuous quality improvement (CQI) and compliance with the Family First Prevention Services Act (FFPSA) for federal IV-E reimbursement. The following data tables outline these measures and expectations for tracking critical program components. **It is recommended that all stakeholders review and familiarize themselves with this information to clearly understand the expectations for tracking and assessing critical components of program implementation.** CQI prompts are included to guide discussions, identify successes, address barriers, and support effective program implementation and oversight.

Capacity

Capacity refers to the resources dedicated by the agency or program to effectively deliver services to children and families, including staffing, infrastructure, and service availability. Adequate capacity is essential for successful implementation of HFA and influences the program's ability to meet community needs.

Table 1 outlines key capacity measures required to monitor program implementation. **HFA providers will submit capacity data for each provider site monthly through the CARES provider portal.** Counties should review capacity data and conduct CQI activities monthly.

Table 1. Description of HFA Capacity Data Elements

Measure	Indicator
Staffing	Total # of provider agency sites
	Total # of full-time model-trained or certified practitioners
	Total # of part-time model-trained or certified practitioners
	Total # of supervisors
Supervisor / Practitioner Ratio	1:6
Full-time / Part-time Caseload	15 families for full-time 7 families for part-time
Service Duration	156 weeks (3 years)

Capacity CQI Prompts:

- **Analyze Reach and Capacity Data: Combine reach, capacity, and waitlist data to determine if additional HFA clinicians or service slots are needed in specific communities.**
- **Address Staffing Challenges: If Supervisor/Clinician ratios, caseloads, or adherence to service duration are not meeting standards, collaborate with providers to identify barriers and develop solutions.**

Reach

Reach refers to the extent to which the program engages its target population by ensuring eligible children and families are identified, referred to, and actively enrolled in services. It measures how well HFA is serving those it is intended to reach and whether the service is accessible to those in need.

Table 2 lists the reach data elements to be tracked for effective outreach and engagement. **HFA providers will submit reach data monthly through the CARES provider portal.** Counties should review reach data and conduct CQI activities monthly.

Table 2. Description of Standardized Reach Data Elements

Measure	Indicator
Eligible Child Welfare & Probation Candidates *(This data will come from the Title IV-E agency)*	Total # of FM/VFM/602 youth who come to the attention of the agency*
	Total # identified as a Family First candidate • FM – Family Maintenance • VFM – Voluntary Family Maintenance • 602 WIC Petition**
	Total # identified as a Family First pregnant or parenting youth in care (PPY)
	Total # not identified as a candidate
Eligible Community Pathway Candidates *(This data will come from the Title IV-E agency)*	Total # of community pathway children granted IV-E agency candidacy approval

	Total # of community pathway children denied IV-E agency candidacy approval
	• Reason for denial
	  ○ MH, SA, or PS imminent risk/need not identified
	  ○ Child outside of age range of the recommended EBP

EBP Referrals to Providers	Total # candidates referred to an EBP provider
EBP Service Uptake	Total # candidates who started the EBP

	Total # candidates who did not start the EBP
	• Reason did not start the EBP
	  ○ No action taken; referral still in process
	  ○ Placed on waitlist; median days on waitlist
	  ○ Provider rejected referral
	  ○ Provider unable to contact or engage with the family
	  ○ Family did not consent, etc.
	  ○ Other

EBP Service Completion	Total # candidates who completed the full EBP

	Total # candidates who did not complete the full EBP
	• Reason did not complete the full EBP
	  ○ Provider unable to contact or engage with family
	  ○ Family withdrew
	  ○ Family no longer eligible
	  ○ Provider capacity issues
	  ○ Other

**Total number of referrals to Probation (inclusive of citations and arrests)*

***Youth referred to Probation by a Law Enforcement Agency for alleged involvement in delinquent behavior that could result in a WIC 602 petition*

Reach CQI Prompts:

Look at eligible child welfare and probation candidates and compare with the number referred to HFA, started HFA, and completed HFA. Discuss strategies to address:

- **Service Flow: Compare eligible candidates to those referred, enrolled, and completed.**
- **Waitlists: Identify causes and reduce delays.**
- **Referral Rejections: Address common reasons for declined referrals.**
- **Family Contact: Improve provider outcome and engagement.**
- **Consent Issues: Increase family consent rates.**
- **Withdrawals: Identify strategies to reduce early terminations.**
- **Eligibility Changes: Minimize service disruptions.**
- **Provider Capacity: Align staffing and resources to demand.**

Outcomes

Outcomes refer to the measurable impacts of the program on children and families, demonstrating whether HFA is achieving its intended goals. These metrics help assess program effectiveness and inform continuous quality improvement efforts.

Table 3 outlines the key outcome measures needed to monitor and evaluate program success. **HFA providers will use a standardized template to submit outcome data to CDSS biannually. The CDSS FFPS team will upload provider outcome data into the CARES backend for county CQI activities.** Counties should review outcome data and conduct CQI activities quarterly.

Table 3. Description of HFA Outcome Data Elements

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Increased Positive Parenting Practices	% of primary caregivers with children in the target age range whose caregiver-child interaction was assessed using a validated tool.	90%	CHEERS Check-In or another validated tool.	Collected based on child's age.	None; provider-specific
Improved Pregnancy Outcomes	% of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) who are born preterm following program enrollment.	<15%	HFA Spreadsheet or site's custom report	Collected once at end of pregnancy.	
Improved Child Health & Development	% of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool.	90%	ASQ-3	Collected twice a year from birth to age 3, then annually.	
	% of children enrolled in home visiting referred for services for a positive screen for developmental delays (measured using a validated tool) who receive services in a timely manner.	90%	HFA Spreadsheet or site's custom report	Collected after positive screen.	
Improved Caregiver Health	% of primary caregivers enrolled in home visiting for at least three months who were screened for depression within 3 months of enrollment OR 3 months of delivery (for those enrolled prenatally).	80%	None specified; providers may use the PHQ-9 or EPDS	If enrolled prenatally, collected during pregnancy and within 3 months after birth; if enrolled postnatally, collected at the time of enrollment.	

	% of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts.	80%	HFA Spreadsheet or site's custom report	Collected after a positive screen.

Outcomes CQI Prompts:

- **Establish Data Tracking Plan: Develop a plan to regularly track and monitor outcome data, discussing successes and identifying challenges that may impact outcomes. Encourage providers to share successful strategies.**
- **Assess Population Impact: Compare reach data to identify which candidacy groups (e.g. probation vs. child welfare, FM vs. VFM) are benefitting most, considering factors like race, ethnicity, gender, and age.**

Fidelity

Fidelity refers to how closely the program follows the prescribed HFA model to ensure services are delivered as intended. Maintaining high fidelity is crucial for achieving positive outcomes and ensuring program integrity.

Table 4 outlines the fidelity measures required to assess program adherence. Reporting on fidelity data will be divided between the provider and the developer/purveyor. **HFA providers will use a standardized template to submit outcome data to CDSS biannually. The CDSS FFPS team will upload provider outcome data into the CARES backend for county CQI activities.** Counties should review fidelity data and conduct CQI activities quarterly.

Table 4. Description of HFA Fidelity Data Elements

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	% of staff (including direct services staff, supervisors, and program managers) who have received intensive HFA Core Foundations training by an HFA certified training within 65 months of date of hire.	100%	HFA Spreadsheet or site's custom report	Collected as training occurs.	None; provider-specific
	% of staff (including direct service staff, supervisors, and program managers) hired more than 12 months ago wo have received ongoing, annual training.	100%			
Meets Staffing Qualification Requirements	% of program managers who have required qualifications.	100%		Collected during hiring process.	
	% of supervisors who have required qualifications.	100%			
	% of direct service staff who have required qualifications.	100%			
Meets Supervision Frequency Requirements	% of direct service staff who receive weekly supervision.	100%		Collected as needed.	
	Ratio of supervisors to direct service staff is 1:6.	N/A			
Timely Completion of Home Visits	% of families using the HFA Standard Model who receive their first home visit within 3 months after the birth of the baby.	80%			

	% of families referred by child welfare using the Child Welfare Protocol who receive their first home visit by the time their child is 24 months of age.	80%

Fidelity CQI Prompts:

- **Establish Fidelity Monitoring Plan: Counties and providers should develop a plan to regularly track and monitor fidelity data to ensure adherence.**
- **Address Implementation Challenges: If challenges are identified, contract holders should collaborate with providers and the model developer to develop solutions.**

RESOURCES

To ensure the successful implementation of HFA, it is crucial to establish a strong relationship between the HFA provider, the HFA developer/purveyor, and the county. Here are the steps to initiate this process:

Providers Contact HFA: Reach out to Healthy Families America, the official developer/purveyor of HFA. Contact information can be found on their website: https://www.healthyfamiliesamerica.org/about/. Initiate a conversation to discuss your interest in implementing HFA and to seek guidance on the next steps.

Providers and County Leaders Contact Your Local CPP Lead: Providers or counties looking to implement HFA for IV-E reimbursement should contact their local Comprehensive Prevention Planning Lead to ensure their implementation plans align with state and federal requirements, including IV-E reimbursement guidelines. Follow this link to determine your point of contact: https://cdss.ca.gov/Portals/9/CCR/FFPSA/ffps-title-iv-eagency-county-contact-list.pdf

You can also submit additional questions to the FFPS Inbox at FFPSAPreventionServices@dss.ca.gov

STAY TUNED!

In the coming months, the CQI Subcommittee and statewide advisory committees (see Page 1) will be drafting a comprehensive California Continuous Quality Improvement Plan. The content will include governance structure recommendations, CQI focused resources/policies, data analysis, and feedback loops. Stay tuned for these updates as we enhance our statewide CQI practices for Family First Prevention Services.

REFERENCES

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Hyland, S. T., & O'Brien, J. (2023). Evidence-based programs desk guide 2023. Chapin Hall at the University of Chicago.

U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (n.d.). Title IV-E prevention services clearinghouse. https://preventionservices.abtsites

APPENDIX A: PROVIDER OUTCOME & FIDELITY TEMPLATE

HFA Outcome Measures

Healthy Families America (HFA)						
Provider sends the percentage for each location in a data file.						
Measure	**Increased positive parenting practices**	**Improved pregnancy outcomes**	**Improved child health and development**		**Improved caregiver health**	
Indicator	*% of primary caregivers with children in the target level age range whose caregiver-child interaction was assessed using a validated tool.*	*% of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) who are born preterm following program enrollment.*	*% of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool.*	*% of children enrolled in home visiting referred for services for a positive screen for developmental delays (measured using a validated tool) who receive services in a timely manner.*	*% of primary caregivers enrolled in home visiting for at least three months who were screened for depression within 3 months of enrollment OR 3 months of delivery (for those enrolled prenatally).*	*% of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts.*
Target Level	90%	15%	90%	90%	80%	80%
Site 1						
Site 2						
Site 3						

HFA Fidelity Measures

Healthy Families America (HFA)									
Provider sends the percentage for each location in a data file.									
Measure	**Provider received and maintained required training**		**Meets staffing qualification requirements**			**Meets supervision frequency requirements**		**Timely completion of home visits**	
Indicator	*% staff (including direct service staff, supervisors, and program managers) who have received intensive HFA Core Foundations training by an HFA certified training within 6 months of date of hire.*	*% of staff (including direct service staff, supervisors, and program managers) hired more than 12 months ago who have received ongoing, annual*	*% of program managers who have required qualifications.*	*% of supervisors who have required qualifications.*	*% of direct service staff who have required qualifications.*	*% of direct service staff who receive weekly supervision .*	*Ratio of supervisors to direct service staff is 1:6.*	*% of families using the HFA Standard Model who receive their first home visit within 3 months after the birth of the baby.*	*% of families referred by child welfare using the Child Welfare Protocol who receive their first home visit by the time their child is 24 months of age.*
Target Level	100%	100%	100%	100%	100%	100%	Yes / No	80%	80%
Site 1									
Site 2									