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 practices (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 practice approved by the Family First Prevention Services Clearinghouse to meet the diverse needs of at-risk youth and their families.

This policy brief guides counties and providers in applying continuous quality improvement (CQI) activities to support the effective implementation of HFA under **California's Five-Year State Prevention Plan**. It outlines requirements for data collection, reporting, and review to meet both **federal CQI requirements under the Family First Prevention Services Act (FFPSA)** and **state expectations for CQI activities outlined in California's CQI Plan**. Together, these activities support real-time program monitoring, data-driven decision-making, and compliance with IV-E reimbursement standards.

Counties and agencies delivering HFA should use this brief as a guide for measuring the success of HFA in their local context, applying required CQI activities, and ensuring implementation meets federal IV-E reimbursement requirements. This brief supports local discussions, outlines the data tracking and sharing requirements established in the CQI Plan, and establishes feedback loops that inform program delivery and continuous improvement. The CQI prompts are designed to support reflection on program effectiveness, address implementation challenges, and guide data-driven decision-making to better meet the needs of children and families.

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

DATA REQUIREMENTS FOR CQI

CQI is a critical part of implementing EBPs as part of California's Family First Prevention Services (FFPS) Prevention Plan. The California CQI Plan outlines expectations for counties and EBP providers to collect, analyze, and use data to monitor program delivery and support continuous improvement.

To guide this work, the CQI Plan identifies four core categories of data collection, each essential to understanding implementation and driving progress.

Key Metrics for Continuous Quality Improvement (CQI)

To support continuous improvement and federal IV-E compliance, agencies delivering evidence-based programs (EBPs) must regularly collect and review data across four core categories:

1. ***Capacity –*** *Measures the staffing, infrastructure, and resources required to deliver services effectively. Capacity data tracks the number of trained staff, supervisors, and service sites, helping counties and providers assess whether programs are adequately resourced to meet the needs of families.*

2. ***Reach –*** *Tracks the extent to which eligible children, youth, and families are identified, referred, and engaged in services. Reach data helps ensure services are accessible and equitably distributed, identifying gaps in engagement or disparities in service delivery.*

3. ***Outcomes*** *– Captures the impact of services on children, youth, and families, including measures of engagement, behavior change, and safety outcomes. Outcome data helps counties and providers understand whether services are achieving their intended goals and where additional support or adjustments may be needed.*

4. ***Fidelity –*** *Monitors whether services are delivered as intended, using approved fidelity monitoring tools or guidelines. Fidelity data helps ensure staff are meeting competency standards and following model expectations, which is critical for achieving desired outcomes and maintaining IV-E compliance.*

These metrics provide a comprehensive view of program effectiveness and should be used to guide local CQI activities and inform state-level monitoring.

More information on this framework can be found here: Measurement Framework for Implementing and Evaluation Preventive Services.

Together, these categories form the foundation for EBP-related CQI activities. Regularly reviewing data across these areas helps counties and EBP providers assess performance, surface barriers, and make informed adjustments to better support children and families.

Detailed definitions, indicators, and reporting expectations for each category specific to HFA are provided in Appendix A.

HFA-SPECIFIC DATA REQUIREMENTS

The HFA Measurement Framework outlines how counties and EBP providers delivering HFA should collect and use data across the four CQI domains – capacity, reach, fidelity, and outcomes. **Counties and EBP providers are expected to track data regularly across all domains to ensure timely, complete, and accurate information is available to support both local and state-level CQI activities.**

The California CQI Plan emphasizes the importance of both local and state-level CQI processes to promote continuous learning and accountability. **At the county level, data is used to assess implementation progress, identify barriers, and inform continuous improvement.** Counties are encouraged to partner with providers—ideally through CQI teams—to review and apply data to local decision-making. County CQI Team leads will pull relevant reports from CARES on a regular basis: monthly for site-level capacity and individual-level reach data, quarterly for individual-level fidelity and outcomes data, and biannually for aggregate-level dashboards.

At the state level, the CDSS uses data submitted through the CARES Provider Portal, the standardized HFA template, and standardized provider templates to monitor program performance, generate Tableau dashboards, and fulfill Title IV-E reporting requirements under FFPSA. Federal reimbursement is contingent on meeting the requirements outlined in California's Five-Year Prevention Plan (see pages 27, 39, and 52).

Appendices A and B outline the required measures, data elements, and templates used for HFA data collection across all four domains.

Data Collection and Use

Child Welfare agencies and Community-Based Organizations (CBOs) delivering HFA should track utilization daily.

Site-Level Capacity Data

- ***Collection***: Entered into the CARES Provider Portal by HFA providers and CBOs for families receiving HFA services. Elements collected are listed in **Table 1** of Appendix A.
- ***Use***: CARES capacity reports will be pulled monthly by County CQI Team leads in preparation for their county CQI Teams and by the CDSS for statewide monitoring.

Individual-Level Reach Data

- ***Collection***: Entered into CARES for child welfare-involved families and into the CARES Provider Portal for Family First community pathway candidate families who are not involved with child welfare or probation. Elements collected are listed in **Table 2** of Appendix A.
- ***Use***: CARES reach reports will be pulled monthly by County CQI Team leads and by the CDSS for statewide monitoring.

Individual-Level Fidelity and Outcomes Data

- ***Collection****:* Collected by HFA providers and CBOs using a standardized provider template (Appendix B) or pulled from a site's own database management system or spreadsheets. Elements are listed in Appendix C.

- ***Use***: HFA providers and CBOs will prepare and share this data quarterly with the County CQI Team leads, using either the standardized template or exports from their own database management system or spreadsheets.

Aggregate-Level Fidelity and Outcomes Data

- ***Collection:*** HFA providers will upload aggregate fidelity and outcomes data biannually via the FFPSA portal in CARES.
- ***Use****:* County CQI Team leads will access aggregate-level fidelity and outcomes Tableau dashboards in CARES every six months for use in county CQI Teams.

For a full list of required HFA measures and indicators, see Appendix A.

CQI TRAINING

To support the implementation of California's FFPS CQI Plan and the HFA program, required training will be provided to county FFPS leads and HFA providers. This training will be delivered over the course of up to three days and is designed to build the knowledge and skills needed to effectively engage in CQI activities. Additional information about the required CQI training is available in the California Family First Prevention Services Continuous Quality Improvement Implementation Plan.

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 CONNECTED!

The California Family First Prevention Services Continuous Quality Improvement (CQI) Plan was developed with input from the CDSS leadership, counties, and advisory subcommittees across the state. It outlines core CQI structures, guidance, and tools to support counties and providers.

California will continue to build on this work through the CQI Implementation Plan and other prevention resources. Check for updates at Prevention Resources – Child and Family Policy Institute of California, and reach out to FFPSAPreventionServices@dss.ca.gov to share questions, experiences, or lessons learned.

REFERENCES

Chapin Hall at the University of Chicago. (n.d.). Measurement framework. https://www.chapinhall.org/research/measurement-framework

Healthy Families America. (n.d.). About Healthy Families America. https://www.healthyfamiliesamerica.org/about/.

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: HFA MEASUREMENT FRAMEWORK

This appendix outlines the data elements, indicators, reporting expectations, and CQI prompts for each of the four core measurement domains: capacity, reach, fidelity, and outcomes. **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	Data Collection & Submission Responsibility	Data Collection Frequency	Data Submission Level (Counties & CDSS)	Data Submission Format (Counties & CDSS)	Reporting Cadence	
						Counties	CDSS
Staffing	Total # of provider agency sites	CBO/EBP Provider	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
	Total # of full-time model-trained or certified practitioners	CBO/EBP Provider	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
	Total # of supervisors	CBO/EBP Provider	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
Supervisor / Practitioner Ratio	1:6	CBO/EBP Provider	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
Full-time Caseload	10-12 families for Family Support Specialists with less than 3 years of experience 15-20 families for Family Support Specialists with more than 3 years of experience	CBO/EBP Provider	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
Service Duration	156 weeks (3 years)	CBO/EBP Provider	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

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	Data Collection & Submission Responsibility	Data Collection Frequency	Data Submission Level (Counties & CDSS)	Data Submission Format (Counties & CDSS)	Reporting Cadence	
						Counties	CDSS
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[1]	County Title IV-E Agency	Monthly	Individual-level	CARES	Monthly	Monthly
	Total # identified as a Family First candidate • FM – Family Maintenance • VFM – Voluntary Family Maintenance • 602 WIC Petition[2]	County Title IV-E Agency	Monthly	Individual-level	CARES	Monthly	Monthly
	Total # identified as a Family First pregnant or parenting youth in care (PPY)	County Title IV-E Agency	Monthly	Individual-level	CARES	Monthly	Monthly
	Total # not identified as a candidate	County Title IV-E Agency	Monthly	Individual-level	CARES	Monthly	Monthly
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	County Title IV-E Agency	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

	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
		County Title IV-E Agency	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

EBP Referrals to Providers	Total # candidates referred to an EBP provider	EBP Provider/CBO	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

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

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

EBP Service Uptake	Total # candidates who started the EBP	EBP Provider/CBO	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

	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 Provider/CBO	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

EBP Service Completion	Total # candidates who completed the full EBP	EBP Provider/CBO	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

	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
		EBP Provider/CBO	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

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 upload outcome data biannually via the FFPSA portal in CARES.** 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	Data Collection Frequency	Data Submission Level		Data Submission Format		Data Reporting Cadence	
					Counties	CDSS	Counties	CDSS	Counties	CDSS
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.	Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
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.	Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
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.	Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
	% 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.	Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
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.	Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
	% 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.	Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually

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. **HFA providers will use a standardized template to upload fidelity data biannually via the FFPSA portal in CARES.** 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	Data Collection Frequency	Data Submission Level		Data Submission Format		Data Reporting Cadence	
					Counties	CDSS	Counties	CDSS	Counties	CDSS
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 trainer within 6 months of date of hire.	100%	HFA Spreadsheet or site's custom report	Collected as training occurs.	Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
	% of staff (including direct service staff, supervisors, and program managers) hired more than 12 months ago who have received ongoing, annual training.	100%			Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
Meets Staffing Qualification Requirements	% of program managers who have required qualifications.	100%		Collected during hiring process.	Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
	% of supervisors who have required qualifications.	100%			Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
	% of direct service staff who have required qualifications.	100%			Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
Meets Supervision Frequency Requirements	% of direct service staff who receive weekly supervision.	100%		Collected as needed.	Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
	Ratio of supervisors to direct service staff is 1:6.	N/A			Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
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%			Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
	% 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%			Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually

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.**

APPENDIX B: STANDARDIZED PROVIDER TEMPLATE

This template is optional. HFA providers will either pull all of the fidelity and outcome data fields depicted in the tables below from their own systems or spreadsheets on a quarterly basis for review during county CQI Team meetings, or complete the HFA Fidelity and Outcomes Report Template, which can be downloaded from the Child and Family Policy Institute of California (CFPIC) website at this link.
The standardized template can be used to examine differences in the indicators by gender, race, and ethnicity as defined in Technical Bulletin #1 which is necessary for identifying potential disparities in program outcomes and addressing them through the county CQI Team.

Below are sample screenshots of a portion of the outcome and fidelity data captured at the individual level in the standardized template.

Fidelity			
Agency Name:		Site Name:	
Staff Identifier	Provider Received and Maintained Required Training		
Staff Name	**How many months has this staff member been employed by this agency by the end of this quarter?**	**Did the staff member receive intensive HFA core foundations training by an HFA-certified trainer within 6 months of hire?**	**If the staff member was hired more than 12 months ago, have they received ongoing, annual training?**

Outcomes											
Agency Name:			Site Name:								
Child Identifier											
DCFS/Probation Unique Identifier	**HVP Model Child ID**	**Child Date of Birth**	**Child Sex**	**Child Hispanic or Latino Ethnicity**	**Child Race: White**	**Child Race: Black or African American**	**Child Race: Asian**	**Child Race: Native Hawaiian or Other Pacific Islander**	**Child Race: American Indian or Alaska Native**	**Child Race: Declined**	**Child Race: Unknown**

Outcomes		
Increased Positive Parenting Practices	Improved Pregnancy Outcomes	
Was the caregiver-child interaction assessed using a validated tool?	**Was the child's mother enrolled in the home visiting program prenatally before 37 weeks?**	**If "Yes", was the child born preterm following enrollment in the home visiting program?**

APPENDIX C: PROVIDER OUTCOME & FIDELITY TEMPLATES

Providers will complete the aggregate fidelity and outcome templates provided below. Providers are responsible for uploading their own model fidelity and outcomes documentation biannually via the FFPSA portal in CARES. Counties will be able to access this data in aggregate through Tableau dashboards.

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 caregivers 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						

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	*% of staff (including direct service staff, supervisors, and program managers) who have received intensive HFA Core Foundations training by an HFA certified trainer 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 training.*	*% of program managers who have the required qualifications.*	*% of supervisors who have the required qualifications.*	*% of direct service staff who have the 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 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									