NEW YORK STATE | Office of Children and Family Services

healthy families new york
*Home Visiting Program*

# 2016 Triennial Report

**Andrew M. Cuomo,** ***Governor***
**Sheila J. Poole,** ***Acting OCFS Commissioner***

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*Home Visiting Program*

**Healthy Families New York: A Home Visiting Program that Works!**

In accordance with section 429 (7) of the Social Services Law (SSL) (Chapter 141, Laws of New York, 2000), the New York State Office of Children and Family Services (OCFS) is required to submit a report to the Governor and Legislature every three years regarding all of the home visiting programs in New York State, collectively known as Healthy Families New York (HFNY) that are funded under section 429 of the SSL. This report is being submitted on behalf of OCFS and its partners: Prevent Child Abuse New York (PCANY), the Center for Human Services Research (CHSR) and the 37 programs that promote safety and well-being for children and families in high risk areas of New York State.

HFNY started in 1995 and now operates 37 programs throughout New York State. From its inception through June of 2016, HFNY has provided nearly 1,500,000 home visits to more than 37,800 families. Approximately 6,300 families are served each year, at an average annual cost of $4,500 (upstate) to $5,000 (New York City) per family. The HFNY program is managed by OCFS, which contracts with community-based agencies to provide home visitation services. HFNY supports OCFS's commitment to promoting services that are developmentally appropriate, family-centered, responsive to local needs, community-based and demonstrated to be effective in achieving desired outcomes. HFNY has received a number of national distinctions, including a designation from the RAND Corporation's Promising Practices Network as a "Proven Program," indicating the program has demonstrated effectiveness using extremely rigorous scientific standards. We look forward to the continuation of HFNY for many more years, given its track record of success.

In New York State, 184,168[1] reports of suspected child abuse or maltreatment were called in to the Statewide Central Register of Child Abuse and Maltreatment in 2015. Nationally, four to five children die from child abuse and neglect each day. Children under the age of six have the highest victimization rates, yet evidence confirms that these years lay the foundation for all that follows.

According to National Children's Alliance 2013 National Abuse Statistics[2]:

- Approximately 3.1 million children received preventative services from Child Protective Services agencies in the United States
- Children under the age of one had the highest rate of victimization (23.1 per 1,000 children).
- Almost 80 percent of reported child fatalities resulting from abuse and maltreatment were caused by one or more of the child's parents.

In 2014, more than two-thirds of U.S. children under the age of 18 were exposed to violence at some

[1] New York State Office of Children and Family Services Statewide Central Register of Child Abuse and Maltreatment Data

[2] http://www.nationalchildrensalliance.org/media-room/media-kit/national-statistics-child-abuse

point within the past year, either as victims or witnesses.[3] Repetitive and significant encounters with trauma and stress have real consequences for the physical, social, and emotional well-being of children. The Adverse Childhood Experiences (ACE) study, the largest epidemiological study ever done in the United States, has documented the strong relationship between adverse childhood trauma exposures and a range of consequences in adulthood, including an increased risk of health and mental health conditions, substance abuse disorders, and a higher risk of experiencing abuse in adulthood, including domestic violence. Fortunately, the presence of protective factors, such as a person's own innate characteristics, the presence of safe, stable, and nurturing relationships, and communities and systems that are supportive of health and development, can help to mitigate these effects.

Programs that begin working with parents during the prenatal period and right after birth stand the greatest chance of reducing the risk of child abuse and promoting positive childhood outcomes. Home visiting programs provide a forum for encouraging healthy prenatal behaviors and parenting attitudes, engaging infants in play, modeling a positive adult-child bond, promoting self-sufficiency skills and facilitating linkages to supportive services.

HFNY, a national Healthy Families America (HFA)-accredited program, is an evidence-based prevention program that seeks to improve the health and well-being of children by providing intensive home visiting services to expectant and new parents living in targeted high-risk communities. Participation in the program is voluntary. The goals of the program are to:

- promote positive parent-child bonding and relationships;
- prevent child abuse and neglect;
- promote optimal child and family health, development, and safety; and
- enhance family self-sufficiency.

**Eligibility for the Program**

Screening is used to target expectant parents and parents with an infant less than three months of age who are deemed to be at risk for child abuse or neglect and live in targeted communities that have high rates of teen pregnancy, infant mortality, welfare receipt, and late or no prenatal care. Parents who screen positive are referred to the HFNY program and a Family Assessment Worker (FAW) assesses parents for risk of child abuse and neglect using the Kempe Family Stress Checklist (FSC)[4]. If parents score above a certain threshold on the checklist indicating the presence of substantial risk, they are eligible to receive intensive home visiting services. If parents score under the threshold, they are referred to other needed community services.

[3] Finkelhor, D, Turner, H.A. Shattuck. A & Hamby, S.L.(2015). *Prevalence of childhood exposure to violence crime and abuse*: Results from the national survey of children's exposure to violence. JAMA Pediatrics, 169(8), 746-754.

[4] Kempe, C.H. (1976). Approaches to preventing child abuse, the health visitor concept. *American Journal of Diseases of Children* 130. 9. 941-947

**Statewide Program Participant Demographics**

Below is a snapshot of participants at the time of enrollment for July 1, 2015 through June 30, 2016. As these figures show, HFNY provides services to a diverse group of families.

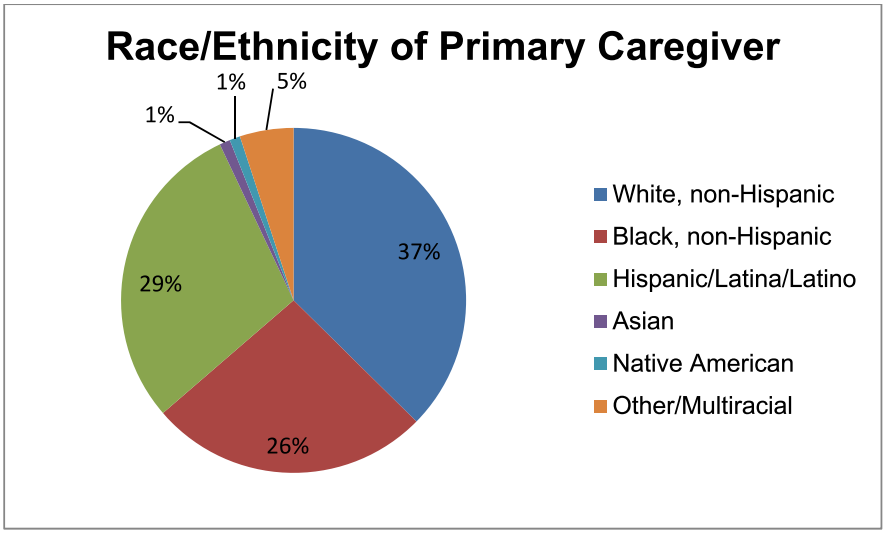



**Figure 1:** Healthy Families New York Participant Race/Ethnicity

Although the teenage pregnancy rate is declining, 18 percent of HFNY participants were 19 years of age or younger at the time of enrollment, while the majority of participants were between the ages of 20 and 30 at the time of enrollment.

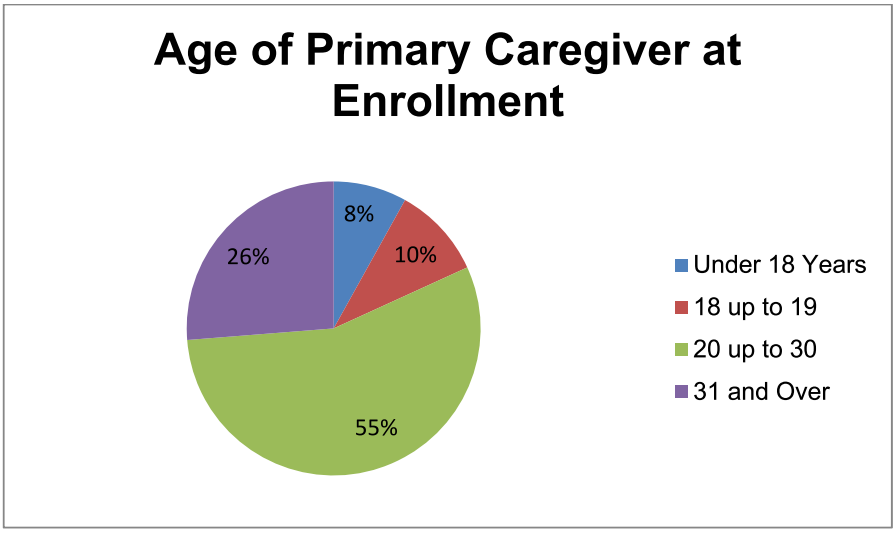



**Figure 2:** Healthy Families New York Age of Primary Caregiver at Enrollment

Many HFNY participants have less than a high school degree and need assistance to re-enroll in school or to enter a job training program.

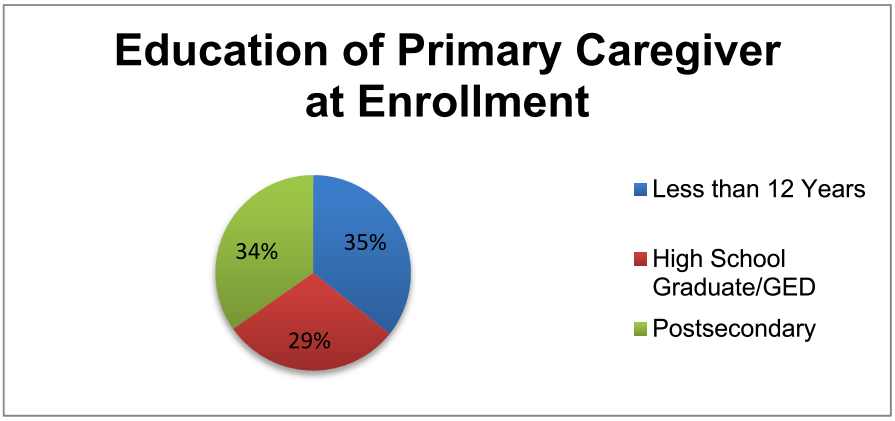



**Figure 3:** Healthy Families New York Education of Primary Caregiver at Enrollment

Many HFNY families come to the program with low or very low income. At the time of enrollment, 21 percent of families were receiving Temporary Assistance for Needy Families (TANF), and 54 percent were receiving Food Stamps. Home visitors work with families on budgeting, nutrition, and job readiness skills.

HFNY reaches many families at the optimum time, prior to poor parenting practices being developed. At enrollment, 64 percent of participants were first time mothers, and 68 percent of families enrolled before the baby was born. Home visitors assist families in obtaining prenatal care, support good self-care for mothers, assist families in preparing for a baby's arrival, and provide education and information on pregnancy, childbirth, and child development.

**Staff Characteristics and Training**

HFNY home visiting program staff are highly-trained individuals who live in the targeted communities and share the same language and cultural backgrounds as program participants. Many HFNY program staff speak languages other than English, including American Sign Language. Home visitors are selected primarily based on personal attributes such as warmth, fondness for children, non-judgmental attitude and belief in non-physical methods of disciplining children. Home visitors are often able to reach families who might not go to an office-based setting to receive services. Most (71 percent) home visitors are parents themselves and 58 percent reside in the target area in which they provide services. Although home visitors are not required to have any post-secondary education, currently about 24 percent have taken courses at the post-secondary level and just under half of HFNY program staff are college graduates.

They are oriented and prepared by the HFNY training team for their roles through trainings for Family Assessment Workers (FAW), Family Support Workers (FSW), Supervisors, and Program Managers. The skills and knowledge of staff are further developed through prenatal training, family goal plan training, and other introductory and advanced training events.

The goal of the HFNY trainings is to teach the home visiting program staff the skills needed to perform home visits and assessments, including training on parent-child interaction, child development, and strength-based service delivery for home visitors; and training for supervisors and managers on their role in promoting quality services. Core training is facilitated by a team of approved HFA trainers from PCANY. The training team utilizes reflective training practices to support relationship-based work in the field.

The FAW core training (Parent Survey for Community Outreach Training), a comprehensive four-day training, is designed for staff whose primary role is to conduct initial assessments in the home in order to identify strengths and challenges unique to the family. It is also ideal for home visitors who want to advance their communication skills to more confidently address difficult situations with families. Topics include, but are not limited to: identifying overburdened families, interviewing skills, conducting risk assessments, completing necessary paperwork and documentation, family-centered support services, and communication skills.

The FSW core training (Integrated Strategies for Home Visiting), also a comprehensive four-day training, guides home visitors to build on families' strengths, supports them in identifying and achieving goals, and assists families in maintaining a healthy environment for babies. Topics include, but are not limited to: establishing and maintaining trust with families, goal setting, completing necessary paperwork, the role of the home visitor, communication skills, and intervention strategies.

HFNY program supervisors and managers also attend trainings and receive resources and support related to: administrative, clinical and reflective supervision, quality assurance, crisis management, case management and reflective practice. In addition, supervisors and managers attend all trainings required for the roles they supervise.

**Services**

Home visits are scheduled bi-weekly during pregnancy and increase to once a week after the mother gives birth, remaining at this level until the child is at least six months old. As families progress through the service levels, home visits occur on a diminishing schedule. The home visiting program usually continues until the target child is five years old or enrolls in kindergarten or Head Start. Home visitors typically carry a caseload of 15 cases when the home visitor is seeing families weekly and up to 25 cases as the families progress through service levels. The content of the visits is intended to be individualized and culturally appropriate. Home visitors use information gathered in the Family Stress Checklist to customize services to support specific family needs. During the prenatal period, home visits focus on promoting healthy behaviors, discouraging risky behaviors, coping with stress and encouraging compliance with prenatal care. During subsequent visits, activities focus on supporting parents, improving the parent-child relationship, helping parents understand child development and age-appropriate behaviors, encouraging optimal growth, providing assistance with access to health care, working with parents to address family challenges and developing individual family support plans to improve self-sufficiency and family functioning. Home visitors utilize curricula approved by HFNY Central Administration as well as standardized instruments to assess children

for developmental delays. Referrals to local early intervention programs or other community services are provided as needed.

### Administration of the Program

HFNY is guided by the system's Central Administration partners that include OCFS, which provides funding, oversight, and evaluation; PCANY, which provides training and staff development; and the CHSR, which provides assistance with evaluation and management information system (MIS) management. The multi-site system provides support to new and developing programs, data collection and analysis, staff training and professional development opportunities, informational and networking support, assistance with HFA accreditation, access to educational resources, quality assurance and technical assistance.

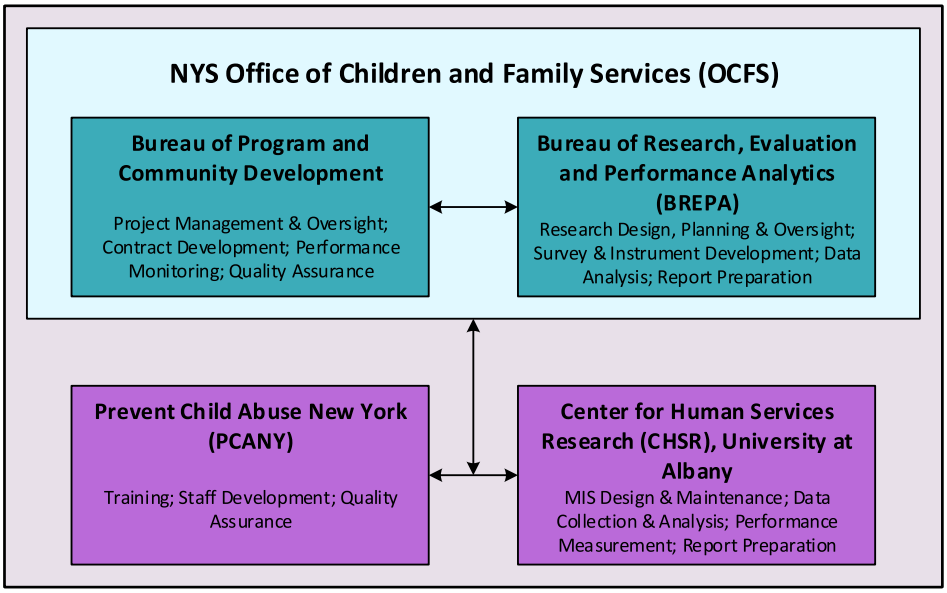



**Figure 4:** Healthy Families New York Central Administration Organizational Chart

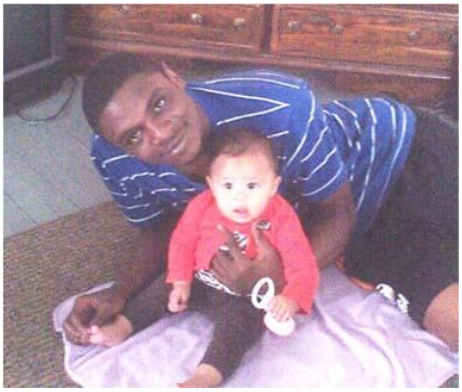
### Accreditation

HFNY is an HFA-accredited multi-site system which allows all of HFNY's 37 program sites and the Central Administration team to achieve accreditation status. The HFA accreditation is valid for five years. HFA is currently scheduling accreditation visits for the fall of 2017 with Central Administration with program visits to follow in hopes that all HFNY program sites will receive full accreditation by the fall of 2018.

HFNY has been recognized by the national governing body as a leader in the HFA movement. Several members of the Central Administration team sit on national committees providing technical assistance to the national system on matters of evaluation, accreditation, policy development and system enhancement.

**Special Projects**

**Fatherhood Initiative**



HFNY continues to recognize the essential role of fathers in supporting the growth and development of children. The mission of the HFNY Father Involvement Initiative is to actively and consistently engage fathers in HFNY programs by supporting their role in promoting positive child development outcomes and long-term family success. The program strives to: (a) encourage fathers to participate in every level of service, from initial outreach attempts to long-term home visiting; (b) send strong and positive messages to communicate to families and communities that HFNY values and encourages fathers' involvement; and (c) continue to assess, evaluate and enhance programs' effectiveness of efforts made to engage fathers.

Research suggests that when fathers take a more active role in their child's life the child has better academic, social, and behavioral outcomes. To encourage father involvement, the HFNY program staff provides information on parenting skills and child development; focuses on the relationship with the parent(s) of the child; and provides information on the importance of father involvement in families. Program staff meet the needs of fathers by utilizing several modes of service delivery, including tandem home visits where the Family Support Worker (FSW) and dedicated fatherhood staff work with the mother and father together; one-on-one sessions where dedicated fatherhood staff works with the father and child; fathers' groups where the dedicated Fatherhood Support Specialist provides information on parenting skills and child development; and home visits where an FSW works with the entire family to provide information.

OCFS has sponsored annual Fatherhood Summits since 2012. These events have provided HFNY Fatherhood Support Specialists and other community partners with the opportunity to gain practical knowledge to utilize in the field, share lessons learned, network with others who are engaging fathers and provide input regarding the future of this important initiative. Participants from HFNY programs and staff from PCANY, CHSR, OCFS, Local Departments of Social Services and representatives from state not-for profit agencies attended the summits.

HFNY's Central Administration also supports a series of fatherhood conference calls dedicated to discussions about father involvement in home visits. Over the last three years, more than 15 calls were held. These calls allowed program representatives throughout the state to receive and share information, discuss best practices, and provide feedback to help shape the strategic plan for this work. Staff presented at several local and national conferences, and provided valuable information and strategies on how to engage fathers.

**Support to Unfunded Programs**

OCFS has received several inquiries from communities wishing to begin a HFNY program utilizing local funds. OCFS staff have met and have had several technical assistance visits and conference calls with interested parties wishing to adopt the HFNY model of services. OCFS, along with its Central

Administration partners, continues to work with these communities and provide training, management information systems capability, technical assistance, networking opportunities, and use of policy and procedures. Communities currently working with OCFS are; Schuyler County, Oswego County, and Columbia County. Schuyler County is currently providing services to a small number of families, Oswego County anticipates serving families early in 2017, while it is anticipated that Columbia County will begin to provide home visiting services in the spring of 2017.

**Research & Evaluation Activities**

OCFS currently uses two mechanisms to evaluate the quality, performance, and effectiveness of HFNY: a comprehensive, ongoing assessment of program quality and service delivery and a longitudinal randomized controlled trial (RCT). HFNY is also participating in various quality improvement efforts related to Maternal Infant and Early Childhood Home Visiting (MIECHV) funding. These activities are described in greater detail below.

**Assessing Program Quality**

OCFS uses data collected from the individual HFNY programs to (1) monitor program performance; (2) assess whether the program is being implemented with fidelity to the model (e.g., delivering core program components according to the prescribed schedule and dosage); and (3) improve the quality of services provided. This allows OCFS to track programs' progress in achieving performance targets related to the goals of HFNY, to develop protocols for program policy and quality improvement activities, and develop and pilot projects to evaluate the effectiveness of or improve program practice.

<u>Monitoring Program Performance</u>

To achieve expected outcomes, HFNY programs work toward 21 goals (performance targets) in three domains:

- Health and Development: These performance targets include assisting mother and baby to get connected to medical providers for prenatal and general medical care, well-baby care, developmental assessments, lead assessment and scheduled immunizations.
- Parent-Child Interaction: These performance targets focus on parents' early bonding with the baby through activities that celebrate parent-baby interactions, thereby developing positive parenting skills. The mother is encouraged to breastfeed the baby since this practice has proven to have strong outcomes for health and development of the baby, as well as health benefits to the mother. Attention is focused on reducing parental stress during the critical periods between six months and one year after the baby is born, as stress is an indicator of child abuse and neglect. Stress is measured by an assessment tool, the Parental Stress Index, so that reduction of stress can also be measured.
- Family Life-Course: These performance targets address family self-sufficiency. Family goals focus on employment, education and training. If a family enrolls in the HFNY program relying on federally-funded TANF benefits, the program will follow-up to see if they are no longer relying on public assistance for their primary financial support and support them in obtaining employment or involvement in a training program. Other family life-course targets measure referrals to other services, most importantly for mental health, substance abuse and domestic violence as well as services for concrete health and safety needs, such as cribs, car seats and other baby equipment, housing, food and other immediate needs.

All of the performance targets are tracked through data that is entered into the MIS. Reports are

generated from the system and analyzed to determine progress.

The following percentages represent performance on select targets for all HFNY programs (calendar year 2015):

- 97 percent of infants received required immunizations at one year of age; 93 percent of infants received required immunizations at two years of age.
- 100 percent of children were assessed for the risk of lead in their environment at the appropriate age.
- 100 percent of children had a medical provider.
- 97 percent of target children had at least five well-baby visits by 15 months of age and another 94 percent had the required visits between 15 and 27 months of age.
- 100 percent of target children were screened for appropriate developmental milestones and were referred for further evaluations if delays were detected.
- 99 percent of primary caregivers had a medical provider.
- 47 percent of mother's breast fed their children for at least three months from birth.
- 81 percent of primary care givers had a reduction in stress by the target child's first birthday.
- 78 percent of families enrolled in an education program, job training, job placement program or obtained employment by the child's first birthday.
- 47 percent of families who were receiving TANF benefits at enrollment no longer need to receive benefits on the target child's first birthday.
- 56 percent of primary care givers under the age of 21 years at intake and without a high school degree or General Education Degree enrolled in a degree program or received a high school degree or certificate by the target child's first birthday.
- 86 percent of families with identified domestic violence, mental health or substance abuse issues were referred for the appropriate services within six months of enrollment.

## Adherence to HFA Model Fidelity

HFNY programs are also expected to deliver services with fidelity to HFA model requirements. Model fidelity is assessed in a variety of different ways, such as through quarterly and annual program reports, site self-assessments, technical assistance and quality assurance conversations with HFNY administrators, and HFA model accreditation activities. HFNY model fidelity is also assessed biannually using a set of 13 indicators (performance indicators) calculated using data collected in the HFNY MIS. These indicators focus primarily on structural indicators of model fidelity, such as family retention rate, program capacity, home visit rate, and adherence to training requirements. Each indicator has a target that programs must meet to be considered as operating with fidelity to the HFA model.

### Evaluation/Practice Improvement Projects

HFNY engages in a variety of evaluation projects designed to better understand and improve the services offered to families. These projects are often developed as a result of information learned from conversations with HFNY program staff and families or from results generated by the performance monitoring system. Data are collected from participating families and program staff, often through surveys or program data already collected.

The results are then discussed with HFNY administrators and program staff and are used as the

foundation for developing and implementing practices and policies to improve service delivery. Several of HFNY's recent evaluation/practice improvement projects are highlighted below.

*Breastfeeding*

Promoting optimal child and family health and development is one of HFNY's primary goals. Encouraging breastfeeding is one of the ways that HFNY works to achieve this goal, since breastfeeding is associated with many positive outcomes for infants and mothers. In 2013, OCFS examined data from the MIS to better understand how HFNY encouraged breastfeeding. The results showed that both the number of home visits a family received and the percentage of home visits in which breastfeeding was discussed, were associated with a greater likelihood of a mother initiating breastfeeding and continuing to breastfeed for at least six months.

These findings suggest that frequent discussions about breastfeeding, both pre- and postnatal, are important for encouraging breastfeeding initiation and continuation. It also underscores the importance of reinforcing the breastfeeding message through ongoing discussions between home visitors and new and expectant families during home visits. Programs may want to consider developing a set of breastfeeding promotion activities that home visitors can complete with families. Ideally, these activities would facilitate conversations that address family members' attitudes about breastfeeding and other concerns, describe the benefits of breastfeeding for the mother and the baby, and explore the various breastfeeding resources available in the community. Developing and implementing creative strategies to help families receive the HFNY recommended frequency and duration of visits should also be considered.

*Father Involvement*

Research shows the important role that fathers play in promoting healthy child development. In 2007, HFNY began a focused effort to promote the development of a father-inclusive culture and increase involvement of fathers in all aspects of home visiting. Initial exploration of HFNY MIS data determined that HFNY was not adequately capturing fathers' participation in home visits. This led to a revision to HFNY data collection forms and the HFNY MIS.

In 2015, OCFS conducted a new series of analyses to learn more about how fathers are involved in HFNY. These analyses showed a slight increase in father participation in home visits since the beginning of our Fatherhood Initiative. In 2007, a father was present in 13 percent of visits, compared to 19 percent of visits in 2015. We learned that when fathers were present from the very beginning of services, they participated more frequently. Families where fathers attended visits also remained enrolled in the program longer than families with fathers who did not attend any visits. Additionally, father involvement in visits influenced family stability, with participating fathers being more likely to remain in or move into the home by the time the child was six months old.

These findings suggest that programs should focus their efforts on locating and engaging fathers from the very beginning of services and should specifically request their presence during the assessment process and at initial visits. Family support workers should be educated as to the benefits of father presence on family retention and stability, and on how to balance engaging fathers against concerns they may have about issues like domestic violence.

These analyses also revealed some important limitations in our current data collection system. Almost 40 percent of families were missing some information about fathers' participation. We also determined that programs did not have the tools they needed to understand how fathers were participating in and being served by the program. To address these issues, OCFS initiated a project to use the data collected in the MIS to provide information on missing data and father participation in services to programs. Over the course of the next year, these reports will be compiled and shared with HFNY administration and the programs to inform the development of policy and practice guidelines related to engaging fathers. These conversations will also inform the development of an automated report that will allow programs to monitor their own progress in improving the collection of information about fathers and increasing father involvement in home visits.

*Family Support Worker Survey*

Family Support Workers (FSWs) are the backbone of HFNY programs. As such, HFNY has made an effort to assess their experiences in order to develop policies and practices to improve their work environment. Analyses conducted on data collected from 2002 to 2006 indicated that family support workers who perceived their work climates to be more positive (i.e. lower work pressure and higher emphasis on planning, efficiency and getting the job done) experienced lower levels of burnout. This was due, in part, to workers feeling like they had greater control over their jobs, suggesting that both work climate and worker empowerment are important factors to assess and address when attempting to reduce worker burnout and staff turnover.

In 2014, HFNY began a new round of inquiry, surveying FSWs in every HFNY program across the state. The study was designed to gain a better understanding of workers' experiences and to identify areas for improvement. The survey included items to assess areas of training need, identify program objectives, and understand the influence of organizational factors on worker performance. Approximately 85 percent of HFNY's FSWs responded to the survey.

In general, FSWs seemed to have positive perceptions of their jobs and the HFNY program. FSWs felt that their programs were very supportive of the program objectives and believed that they had the skills and knowledge necessary to work effectively with families. While FSWs expressed dissatisfaction with their pay and the lack of promotional opportunities available to them, they were generally satisfied with most aspects of their jobs (i.e., supervision, nature of work, coworkers, communication, contingent rewards, and operating conditions).

The information obtained from this survey is currently being used by HFNY administrators to target areas where programs are in need of additional support or technical assistance and to prioritize training needs. OCFS plans to survey home visitors across the state again in 2018.

*Combined Enrollment*

HFNY research has shown the positive impact of early prenatal enrollment on birth outcomes and parenting behaviors. More detailed analyses of program data indicated that decreasing the amount of time between the various screening, assessment and enrollment contact points led to fewer families being lost to follow-up and more families enrolled in services prenatally.

Building on those results, in 2015, we began the process of developing and evaluating a strategy to

further increase prenatal enrollments — moving from a two-step assessment and enrollment process to a one-step process.

Under the current two-step process, HFNY program sites receive referrals from community partners. Then, a specially trained HFNY Family Assessment Worker (FAW) contacts the family to explore their strengths and stressors and assess their eligibility and service needs. Eligible families are then referred to the Family Support Worker who enrolls the client and delivers intensive home visiting services. A few Healthy Families America sites in other states have moved to a one-step enrollment process, where the same worker enrolls, conducts the assessment and provides intensive home visits to the family; however little information is available about the impact that this has had on those programs or the families receiving services.

Anecdotal evidence suggests that the one-step process allows families to enroll earlier in pregnancy and may promote greater family engagement by having only one worker connect with the family. However, there is some debate in the field about the feasibility of this approach. Some argue that outreach and assessment and intensive service delivery each require a specialized skill set that not all workers possess. Others argue that community outreach is diminished when the assessment role is combined with intensive service delivery.

To date, HFNY has been in contact with several of the states who have implemented the one-step process of enrollment to learn more about their processes and the impact that the change has had on their systems. HFNY has used this information, as well as information on best practices and our own state needs, to develop a one-step enrollment process for HFNY. We are currently identifying sites to participate in the pilot project. Over the next two years, we plan to implement this process in three HFNY program sites, and will collect data from program staff and the HFNY management information system to determine its impact on the state system.

**Healthy Families New York Randomized Controlled Trial (RCT):**
OCFS's Bureau of Research, Evaluation, and Performance Analytics, in collaboration with the Center for Human Services Research, initiated a longitudinal randomized controlled trial of HFNY in 2000. Women who met the assessment criteria for HFNY were randomly assigned to either an intervention group that was offered HFNY services or a control group that was given information and referrals to appropriate services. Baseline and follow-up data were collected for the 1,173 women in the HFNY program and control groups at the time of the child's birth, and first, second, third, and seventh birthdays (with various levels of retention) from in-depth interviews with mothers, child welfare and public assistance administrative records, the HFNY data management system, and videotaped observations of parent-child interactions. The target children were also interviewed for the first time when they were approximately seven years old and their first grade school records were requested directly from their schools.

To date, the RCT has demonstrated that HFNY is effective in improving birth outcomes, reducing child abuse and neglect, supporting positive parenting, and improving children's educational outcomes. Detailed findings from the HFNY RCT can be found at:
http://www.healthyfamiliesnewyork.org/Research/publications.htm.

A 15-year follow-up study is currently under way. In-depth interviews with mothers and their now-adolescent children will assess outcomes such as maternal life course, child abuse and neglect, parenting practices, family conflict, educational experiences, youth behaviors, delinquent/criminal activity, and health and access to health care. Administrative database searches will be conducted to obtain child maltreatment reports, foster care services use; food stamps and public assistance benefits; birth records; juvenile justice experiences; school records; and criminal justice system involvement. Data collection and preliminary analyses are expected to be completed in 2019.

**Maternal, Infant and Early Childhood Home Visiting Program**

The federal Patient Protection and Affordable Care Act (ACA) of 2010 authorized the creation of the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) to promote and improve the health, development and well-being of at-risk children and families through evidence-based home visiting programs. The New York State Department of Health (DOH) was designated as the lead entity to accept and administer New York State's MIECHV funds ($9.2 million annually). In New York State, MIECHV funding is used to support Healthy Families New York (HFNY) and Nurse-Family Partnership (NFP) only. OCFS, as the co-applicant, receives a portion of these funds to support MIECHV implementation through an MOU with DOH, providing administrative oversight of HFNY MIECHV-funded programs statewide, and serving as the co-lead of the MIECHV evaluation team with DOH.

Competitive Award: Client Retention Evaluation

New York State (NYS) was awarded an additional $9.4 million in federal MIECHV competitive grant program funds in March 2015, to support six additional evidence-based home visiting sites through 2017. The expansion made possible by the MIECHV Competitive Grant Program funding will address unmet needs in New York State, and will move the state closer to its vision of a statewide home visiting system that achieves meaningful, positive impacts not just for individual families, but for entire communities and ultimately the state as a whole. As part of this expanded initiative, New York State is evaluating program-level strategies to increase client retention and engagement. To maximize the effectiveness and learning potential, all 17 MIECHV-funded sites are participating in the evaluation, regardless of federal MIECHV formula or competitive funding source. The findings of this evaluation will help support our programs to implement services with fidelity, promote that clients are receiving adequate amounts of services, and achieve anticipated outcomes. This project is expected to conclude in 2017.

Mother and Infant Home Visiting Program Evaluation-Strong Start

The Mother and Infant Home Visiting Program Evaluation-Strong Start (MIHOPE-Strong Start) is a randomized controlled trial designed to evaluate the effectiveness of two evidence-based home visiting models (HFA and Nurse-Family Partnership) at improving birth outcomes. It is a large-scale evaluation conducted at the national level, and funded by the U.S. Department of Health and Human Services. The study was designed to investigate the features of local programs and of home visitation that lead to improved birth outcomes and reduced health care costs in 20 different states. In 2015, six HFNY program sites participated in this national study, recruiting a total of 257 participants. A final report detailing the study’s impacts is not yet available.

**Table 1: MIECHV-Funded Local Implementing Agencies**

| County | Local Implementing Agency | Model | Agency Type | Community Setting |
|---|---|---|---|---|
| Bronx | Catholic Guardian Society and Home Bureau | HFNY | CBO | Urban |
| Bronx | Bronx Lebanon Hospital | HFNY | Hospital | Urban |
| Bronx | Morris Heights Health Center | HFNY | FQHC | Urban |
| Bronx | NYC Department of Health and Mental Hygiene | NFP | Local health department | Urban |
| Erie | Buffalo Prenatal – Perinatal Network | HFNY | CBO | Urban |
| Kings | SCO Family of Services | NFP | Family Service Agency | Urban |
| Kings | CAMBA Inc. | HFNY | CBO | Urban |
| Monroe (2 grants) | Monroe County Department of Public Health (has expansion grant, too) | NFP | Local health department | Urban |
| Nassau | Visiting Nurse Service of New York | NFP | Family Service | Urban |
| Onondaga | Onondaga County Health Department | NFP | Local health department | Urban |
| Bronx | Montefiore Home Care | NFP | Hospital | Urban |
| Chemung | Comprehensive Interdisciplinary Developmental Services Inc. | NFP | Family Service | Rural |
| Dutchess | The Institutes for Family Health | HFNY | FQHC | Urban |
| Kings | Brookdale University Hospital | HFNY | Hospital | Urban |
| Kings | Sunset Park Health Council/dba Lutheran Family Health Centers | HFNY | FQHC | Urban |
| Schenectady | Schenectady County Public Health Services | HFNY | Local health department | Urban |

**Funding Source**

The majority of funding for the HFNY program comes from state appropriations, which for the last three years has totaled $23,288,200 annually. These state funds support 37 programs throughout the state, as well as the contract with PCANY for training and staff development, and the contract with CHSR for the maintenance of the MIS and evaluation of program services. Each HFNY program is required to provide a minimum 10 percent local share toward the program in the form of cash, in-kind services or private donations.

OCFS receives $4,216,995 annually in MIECHV funds from New York State Department of Health (DOH). Receipt of these federal funds requires maintenance of the state's investment in home visiting from when the initial MIECHV funds were awarded in FY 2010. A total of $3,738,725 is for contractual services provided by the local implementing agencies and $478,270 remains with OCFS to support the program administration. The initial funding directed at OCFS was used to enhance and expand four existing HFNY programs in the Bronx and Erie counties. Additional funds have since been awarded to

New York State through the increase in the federal formula-based MIECHV grant and the awarding of the MIECHV competitive based grant. These additional funds have resulted in the expansion into and/or increased capacity to provide home visiting services in Schenectady, Dutchess, Bronx, and Kings counties.

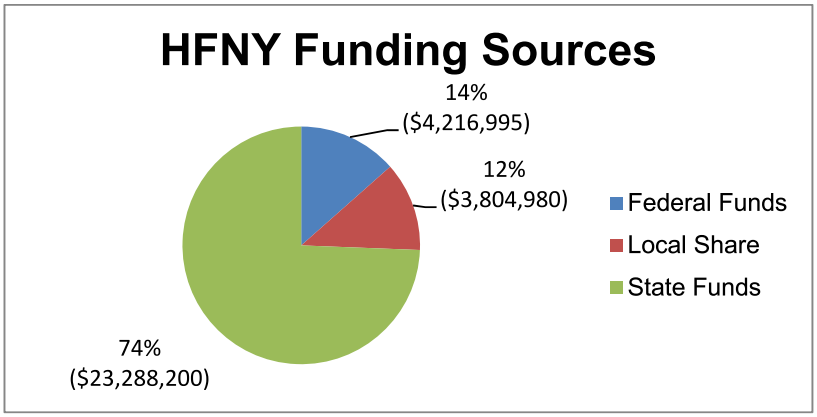


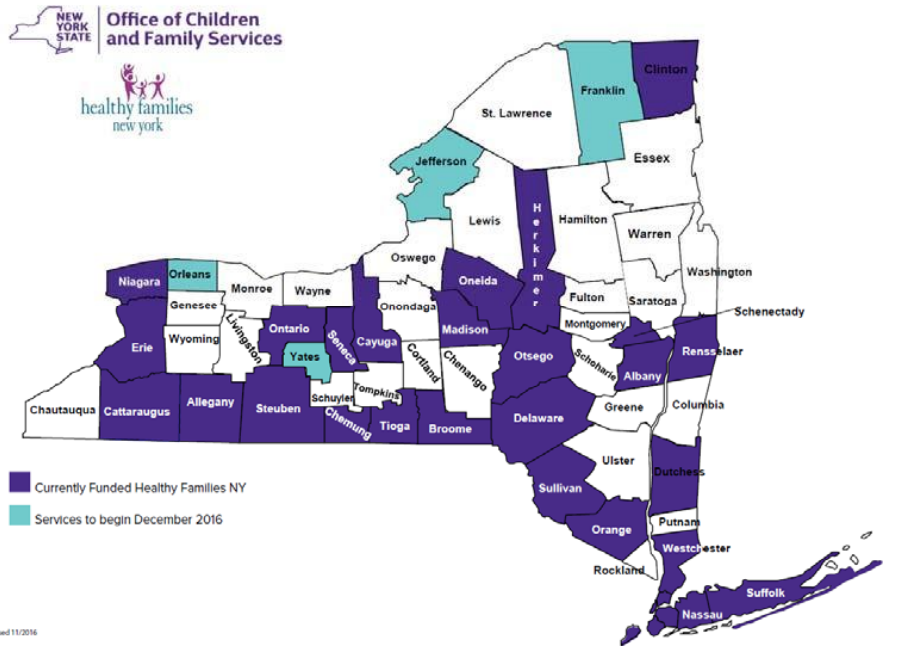

**Figure 5:** HFNY Funding Sources

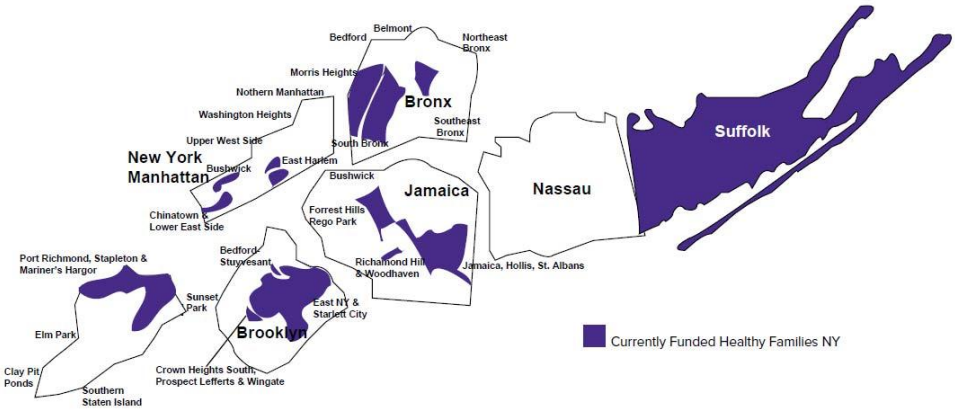
**Additional Funding**

As a result of savings in Title IV-E adoption assistance delinking, approximately $1 million was re-allocated to support HFNY home visiting programs. In June 2016, a Request for Proposals (RFP) was released by OCFS to begin new or expand existing HFNY home visiting programs in high-need and underserved communities. Twenty-nine applications for funding were received in response to the RFP. Of these, five proposals were selected for awards to expand four current programs and begin one new program. Contracts are currently under development with an anticipated start date of December 1, 2016. An approved but not funded list was also established from the RFP for future funding consideration in the event that additional funds become available

**Table 2: Anticipated New or Expanding HFNY Programs**

| Program | County | Region | Award Amount |
|---|---|---|---|
| Behavioral Health Services North | Franklin County and St. Regis Mohawk Tribe | North Country | $200,000 |
| Children and Family Resources | Yates County | Finger Lakes | $90,000 |
| Family and Children Services of Niagara | Niagara and parts of Orleans counties | Western | $180,000 |
| Family Service League, Inc. | High need areas in Suffolk County | Long Island | $170,000 |
| New Program | | | |
| North Country Prenatal/Perinatal Council, Inc. | Jefferson County | North Country | $360,000 |


NEW YORK STATE
Office of Children and Family Services
healthy families new york
Clinton
Franklin
St. Lawrence
Essex
Jefferson
Lewis
Herkimer
Hamilton
Warren
Washington
Oswego
Oneida
Fulton
Saratoga
Schenectady
Niagara
Orleans
Monroe
Wayne
Onondaga
Montgomery
Genesee
Livingston
Ontario
Madison
Rensselaer
Erie
Wyoming
Seneca
Cayuga
Cortland
Chenango
Otsego
Albany
Yates
Tompkins
Schuyler
Greene
Columbia
Chautauqua
Cattaraugus
Allegany
Steuben
Chemung
Tioga
Broome
Delaware
Ulster
Dutchess
Sullivan
Orange
Putnam
Westchester
Rockland
Suffolk
Nassau
Currently Funded Healthy Families NY
Services to begin December 2016
Revised 11/2016


Bedford
Belmont
Northeast Bronx
Morris Heights
Nothern Manhattan
Bronx
Washington Heights
Southeast Bronx
Upper West Side
South Bronx
New York Manhattan
East Harlem
Bushwick
Bushwick
Jamaica
Nassau
Suffolk
Chinatown & Lower East Side
Forrest Hills Rego Park
Port Richmond, Stapleton & Mariner's Hargor
Bedford Stuyvesant
Richmond Hill & Woodhaven
Jamaica, Hollis, St. Albans
Sunset Park
East NY & Starlett City
Elm Park
Brooklyn
Clay Pit Ponds
Crown Heights South, Prospect Lefferts & Wingate
Southern Staten Island
Currently Funded Healthy Families NY

**County**
Agency Funding[5]

## Albany County

Albany County Department for Children, Youth and Families $1,054,242

Albany County Healthy Families provides services to approximately 227 families a year. This program is a unique partnership between Albany County's Local Department of Social Services and Parson's Child and Family Center, a local private not-for-profit agency. The target population covers the urban areas of Albany County, serving primarily low income families and recent immigrants many of whom do not speak English and require the use of interpreter services. Albany County Healthy Families is part of the Albany County Single Point of Entry System (SPOE), which provides a centralized referral system for women's health, child development and supports available through the county and community. This collaboration between the Albany County Department for Children Youth and Families and the Albany County Health Department was created to improve maternal and child health outcomes in Albany County.

Many families struggle with one or more barriers to achieving their parenting goals, including homelessness, mental health issues, domestic violence developmental delays and substance abuse issues. In addition to the support services offered by the program, Albany County Healthy Families contracts with Parsons Child and Family Center to offer short term clinical services to families whose children may be at risk for placement.

### Allegany and Cattaraugus County

Parent Education Program $700,000

This program serves approximately 154 families combined in Allegany and Cattaraugus counties annually. Both Allegany and Cattaraugus Counties are very large and predominantly rural, and most families live in outlying areas. Enrollment includes 10 percent teen mothers and 82 percent unmarried mothers, with 49 percent of families having the biological father in the household and 20 percent with another supportive caregiver in the household. As a result of the lack of transportation, education and training, there is a high unemployment/underemployment rate, resulting in 63 percent of families receiving food stamps. Families face particular challenges with mental health and substance abuse issues. Five out of the 12 home visitors are males; the majority of all staff have been with the program for over five years. There is a Certified Lactation Counselor on staff. The program is collaborating with the Seneca Nation of Indians to serve their families who live off the reservation.

### Bronx County

Bronx Lebanon Hospital Center ($638,829 State, $217,985 MIECHV) $856,814

[5] Amount listed is state funds unless otherwise broken down.

South Bronx Healthy Families provides services to an average of 173 families a year in the South Bronx community target areas. The community served, known by the residents as Morrisania, has over 30 percent foreign-born residents from a variety of regions, including Mexico, Central and South America, the Caribbean and a variety of countries in Africa. The population speaks languages such as Spanish, French, Garifuna, Mandingo, Fulani and Wolof, among others. A large percentage of the population lives below the poverty level. The program was able to secure another source of funding to expand their work with fathers and teen parents.

Catholic Guardian Services ($496,310 State, $164,960 MIECHV) $661,270

Healthy Families Parkchester provides services to an average of 141 families a year in their Bronx community target area, described as Crotona Park and West Farm in the Bronx. The community is an area of high service needs, as indicated by high rates of child abuse, teen pregnancy, infant mortality and poverty, including a large population of teen and single mothers.

Morris Heights Health Center ($615,784 State, $831,203 MIECHV) $1,446,987

Healthy Families Morris Heights provides services to an average of 182 families a year in the Bronx community target area. Healthy Families Morris Heights' service area is greatly affected by poverty. The target area is a densely populated, urban area geographically located in the northwest section of the Bronx, well known as the Kingsbridge Heights, Mt. Eden, Morris Heights, and Bedford neighborhoods. The population is racially diverse, young, and headed by a mostly by single head of household. Morris Heights was awarded a MIECHV competitive grant to further expand services into the 10467 zip code community of Williamsbridge in 2015.

**Broome County**

Broome County Health Department $541,449

Healthy Families Broome (HFB) provides services to approximately 145 families a year in Broome County. HFB supports families with children from pregnancy until the child enters school, emphasizing that parents are their child's first and most important teachers. HFB Home Visiting Program provides an innovative fatherhood program to families offering tandem home visits by a Fatherhood Advocate and Family Support Worker. The relationship between the home visitors and the family serves as the foundation for developing the family's parenting skills and confidence. During home visits, families learn child development information and participate in parent child activities which promote school readiness and early literacy. By encouraging bonding, attachment and teaching age appropriate expectations, HFB strives to prevent child abuse and neglect.

**Cayuga and Seneca County**

Cayuga/Seneca Community Action Agency $460,661

This program serves approximately 177 families annually. Cayuga and Seneca Counties are rural areas

in Central New York with challenges of isolation and lack of transportation. The program serves the following areas in Cayuga County: Auburn, Port Byron, Cato, Martville, Scipio Center, Cayuga and Weedsport; and the following areas in Seneca County: Seneca Falls, Waterloo and Ovid. These areas have been identified as "high-risk" for low birth weight babies, out-of-wedlock mothers, Medicaid/self-pay for health care, late or no prenatal care, infant mortality, teen births and teen pregnancy rates. Following their initial assessment and after they have made a connection with their home visitor, either the Program Manager or another supervisor will do an introductory visit to welcome the family and express their appreciation for allowing them into their home, to assess how they feel about the program and assure them that they want the family to get the most from the program.

**Chemung County**

Comprehensive Interdisciplinary Development Services, Inc. $621,710

Healthy Families Chemung provides services to approximately 169 families a year. The program serves Chemung County, a rural area located in south central New York. The target population is primarily first- and second-time parents. According to data, 50 percent of the counties' newborn population is Medicaid eligible. There is a 14 percent poverty rate and eight percent unemployment rate. Healthy Families Chemung receives funds through Eaton Corp and Child Care Council each year to provide new books to enrolled families to promote early literacy. Given the loss of other services available to families in Chemung County, Healthy Families Chemung provides necessary services to those in need.

**Clinton County**

Behavioral Health Services North $348,543

The Early Advantages Program provides home visiting services to an average of 97 expectant and newly parenting individuals and families a year in Clinton County. The majority of parents that the program serves are single mothers. Early Advantages' target area is the most northeastern county in New York, located on interstate 87 to the Canadian border and on the western shore of Lake Champlain. Clinton County is a primarily rural county, covering an area of 1,059 square miles, which has the only city in a three-county area (Clinton, Franklin and Essex).

**Delaware County**

Delaware Opportunities, Inc. $218,108

Healthy Families Delaware County provides services to an average of 76 families a year. Delaware County is a geographically large, sparsely populated rural county, encompassing 1,460 square miles, located in the southern tier of New York State. There is no city in the county and no population center exceeding 5,000 people. Families served by Healthy Families Delaware County are subject to high rates of poverty, infant mortality and teen pregnancy. There are no birthing centers and few doctors practicing obstetrics and gynecology in Delaware County. Therefore, networking and creative outreach by all staff members is pivotal to the success of the program.

**Dutchess County**

Institute for Family Health ($715,729 State, $295,059 MIECHV) $1,010,788

Dutchess County Healthy Families provides services to an average of 190 families a year in Dutchess County. The program serves new and expectant parents in the town and city of Poughkeepsie, as well as in Hyde Park and Beacon. In February 2015, Institute for Family Health was awarded MIECHV funds to allow the program to expand into Wappingers Falls, Fishkill, and East Fishkill/Hopewell. The program focuses on prenatal enrollment in order to capitalize on the impact that the program can have when beginning with families prenatally. The program is geared toward families with specific life factors that put them at a distinct risk for abuse and maltreatment of children, including stress for parents, such as single-parenting, divorce, a history of substance abuse, mental health issues or domestic violence, unemployment or lack of medical or prenatal care.

**Erie County**

Buffalo Prenatal-Perinatal Network ($1,411,219 State, $547,355 MIECHV) $1,958,574

The Buffalo Home Visiting Program provides services to an average of 610 families a year in the Erie County target areas. The target population is primarily African American and Latino families, and those families displaying racial and ethnic disparities associated with birth outcomes in the target area. These families have low income, and are without health insurance, and who, on average, attend fewer prenatal visits and have experienced poor pregnancy outcomes. Many of these residents also exhibit other characteristics of living an impoverished life, including unstable residence with addresses that change regularly, intermittent availability of telephone services, which make it difficult to make health appointments, and to receive reminder calls for keeping appointments, and lack of adequate transportation and child care that impedes accessing needed services. Erie County has one of the highest percentages of single mother households. Buffalo has been cited as the third poorest city in the United States, with 26.6 percent of its residents living in poverty.[6]

**Herkimer County**

Herkimer County Public Health $284,434

Herkimer County Healthy Families provides services to approximately 100 families annually in their service area. The residents of Herkimer County are faced with many stressors which make them more prone to child abuse and/or neglect including: isolation, poverty, single parenthood, mental health issues and a lack of resources. The Herkimer County Healthy Families Program assists these overburdened families by providing them with a solid support system, parenting education, and child development information.

[6] The Buffalo News, by Jay Rey, Published October 1,2016 taken from A Picture of Poverty from 2015 Census Data published September 30,2016 by Mark Mulville/Buffalo News.

**Kings County (Brooklyn)**

Bedford Stuyvesant Family Health Center $397,174

The Successful Start program serves approximately 85 families annually residing in the Bedford Stuyvesant section of Brooklyn. Roughly 70 percent of the population is below 200 percent of the poverty level. Health status indicators show this community to have great health needs and high infant and maternal health risks, with limited resources. Drug abuse, homelessness, crime and poor health are pervasive. The Bedford Stuyvesant community is culturally diverse, where most households tend to be multi-generational, living in multi-family residences. An increasing number of the participants served are immigrants from the Caribbean. The program received some outside funding to serve homeless teen mothers in shelters.

Brookdale Hospital Medical Center ($496,310 State, $382,162 MIECHV) $878,472

The program serves approximately 219 families annually, primarily minority women (African American and Hispanic) of child-bearing age and their families who are of low socioeconomic status and exhibit high-risk factors for poor birth outcomes. The program serves populations who often delay entry into the health care system for a variety of reasons: lack of health insurance, lack of transportation, non-English-speaking, teen pregnancy, immigrant status or lack of child care, resulting in inadequate nutrition and late or no prenatal care. In February 2015, Brookdale Hospital Medical Center was awarded MIECHV funds to expand the program into additional zip codes in the target area.

CAMBA ($666,804 State, $200,000 MIECHV) $866,804

CAMBA's Healthy Families Program provides services to an average of 238 families a year in their Brooklyn target area of Flatbush. The program serves a large Haitian immigrant population. Most have few, if any, support systems in place. Due to cultural barriers, a n d isolation, these families often fail to avail themselves of vital support programs and services. As a result, they face major challenges and barriers to receiving health and supportive services. CAMBA was awarded a MIECHV grant to serve 50 additional families in 2013.

Public Health Solutions $731,849

Bushwick Healthy Families provides services to approximately 136 families annually in their service area. The program serves Community District #4 - Bushwick which is a largely Latino community. A third of the adult population is foreign-born and nearly 14 percent of children aged 0-13 years live in linguistically isolated households. The residents of Bushwick face many economic difficulties. The median household income is significantly lower than the New York City-wide average. A larger percentage of adults in Bushwick face unemployment (14.7 percent) than adults in New York City (11.2 percent). The vulnerability of Bushwick residents to violence, substance abuse and environmental toxins, as well as their lack of proper access to medical care, has detrimental effects on the health outcomes in this community, particularly with regards to maternal, infant, and children's health. All staff are bi-cultural-bilingual and familiar with working with immigrant populations. They are trained as Certified Lactation Counselors, and able to provide strong Home-Based Breastfeeding Support and

education to families about lactation. The staff are also trained in the use of the Baby Basics Curriculum, which is geared to families with low literacy. The staff use the colorful Curriculum Book, which is framed as a gift to the families. A number of family events are held every year that support family networking and reduction of isolation.

The multicultural event at the end of the year in December brings together approximately 200 – 300 family members and other community members. Community Baby Showers help outreach to new families. The program's partnership with Wyckoff Hospital provides us access to the Labor & Delivery unit to offer our families a tour of the facility at the end of each baby shower. Several staff are also trained as Childbirth Educators and support families in developing Birth Plans and support Preparation for Labor and Delivery.

Sunset Park Health Council, Inc. $700,000

Healthy Families Sunset Park is serving 140 high-risk families in the 11220 and 11232 zip codes. The lead agency is well established in the community as a provider of medical and community-based programs. Sunset Park's families struggle with growing food insecurity, high rates of teen pregnancy, and unstable housing, among many other challenges. The community struggles with limited English proficiency and low educational attainment among both children and adults. Sunset Park's target communities have 79 percent of residents that speak a primary language other than English at home. Most are of either Hispanic or Chinese descent.

**Madison County**

Community Action Program for Madison County, Inc. $695,414

Healthy Families Madison serves approximately 219 families annually. The program serves Madison County, a very rural county with limited services and transportation. The service population is vulnerable and highly stressed pregnant or newly parenting families. Healthy Families Madison is one of the few services providers in the area and offers a wide range of services to families in need. The program offers families the necessary support to prevent child abuse and neglect, referrals to needed services and has a strong fatherhood component.

**New York County (Manhattan)**

Dominican Women's Development Center, Inc. $550,000

Program staff represents six different cultures and countries. The multicultural strength-based approach allows the program to reach the diverse community in the Inwood and Washington Heights community that is comprised predominantly of immigrants from Mexico, Dominican Republic, Puerto Rico and Israel. According to the 2011 Community Snapshot, the community of Washington Heights/Inwood had a 34.7 percent rate of child abuse and neglect. Healthy Families Washington Heights provides the community with an evidence and strength-based program that addresses needs that will impact generations to come.

Northern Manhattan Perinatal Partnership, Inc. $592,468

Healthy Families Central Harlem provides services to approximately 132 families annually in Central Harlem. The program serves a diverse population that resides in Central Harlem, many who do not speak English and have limited services available. The area continues to be ranked one of the poorest neighborhoods; many of the residents live in poverty with a median household income nearly half that of families in the United States.

One third of the adults living in Central Harlem did not graduate from high school. Families in Central Harlem are very receptive to the Healthy Families New York model of home visitation. They are interested in resources that ensure the best outcomes for the growth and development of their children.

University Settlement $496,310

University Settlement Healthy Families Program (USHF) serves approximately 78 families in East Harlem and sections of the Lower East Side of Manhattan. The program's target community has a rich history of immigration and University Settlement is well-connected to this community through its other programs and has the language capacity, cultural competence, and HFNY experience and expertise to expand the program to the Chinese immigrant community, while continuing to serve the English and Spanish speakers the program has been serving since USHF's inception. The program serves immigrants who are predominately low-income. Most families are living on the economic margins and challenged with poverty, unemployment, language barriers, housing issues and the struggle to provide for their children. Specifically, the two most common issues that families struggle with are affordable housing and challenges associated with the families' immigration to the United States.

**Niagara County**

Niagara County Department of Social Services $481,710

Healthy Families Niagara serves approximately 126 families annually that reside in Niagara Falls and Lockport. The residents in the rural areas struggle with issues of poverty, unemployment and lack of transportation. Residents experience numerous psychosocial stressors, and there is a lack of accessible services to address these issues. Niagara Falls has the fourth highest poverty rate for female-headed households with children among the 26 upstate New York cities. The City of Niagara Falls residents have lower incomes, less education and a higher rate of chronic medical conditions than the rest of the state; 28.4 percent of the city's children live in poverty. Healthy Families Niagara has successfully embedded a Fatherhood Component into the core program for the last several years. The Fatherhood Component of the program utilizes the Fatherhood Advocate either as part of the home visiting team with a Family Support Worker or as the only home visitor. Curriculum specific to parenting and life issues is shared and includes information on topics such as discipline, communication styles, anger management, and character development, making toys, cooking, tantrums, father/child activities and nutrition. This component also offers a support group just for fathers to educate men about their role in parenting and to help fathers navigate the ups and downs of parenting. Being under the umbrella of a multi service agency of Family & Children's service of Niagara, the program has the unique advantage to be able to offer services to families that help address domestic violence and mental health. Having programs with

the agency that can coordinate the necessary treatment and /or activities with the experts in those fields allows the Healthy Family Niagara workers to focus on the expertise – providing parenting education and support. The program is in the process of developing a mechanism to form a single point of entry for maternal and child health through the Healthy Moms/Healthy Babies coalition.

**Oneida County**

Kids Oneida, Inc. $585,710

Healthy Families Oneida County services approximately 150 families annually within the county of Oneida. Oneida County is diverse and includes urban and rural communities. Despite this diversity, the struggles that families face in Oneida County seem to be similar – substance abuse, mental health issues, poverty, domestic violence, teen pregnancy and child protective services involvement. As Oneida County is rich in services, the program encourages families to seek out and actively engage in their community resources to help overcome their struggles, therefore allowing Healthy Families to focus on strengthening the parent-child relationship.

**Ontario County**

Ontario County Department of Social Services $200,008

Healthy Families Ontario, delivered through sub-contracted agency Child & Family Resources, Inc. provides services to approximately 63 families annually. The program serves a portion of Ontario County. The target population is parents that live in a diverse community, including many ethnic backgrounds, histories and traditions as well as very rural areas of the county. The community faces several challenges due to the lack of transportation, limited services, low income and the lack of affordable housing. One initiative that Healthy Families Ontario has integrated into their approach is the introduction of Baby Café, a community support for breastfeeding mothers. Baby Café is facilitated by the Family Support Workers and other service providers trained as Certified Lactation Counselors.

**Orange County**

Access: Supports for Living, Inc. $943,109

Healthy Families Orange serves 219 families annually in the communities of Newburgh, New Windsor, Middletown and Wallkill. Newburgh has a long history of difficult economic circumstances: high rates of unemployment and poverty; large numbers of individuals receiving Temporary Assistance to Needy Families and Home Relief; and high rates of both juvenile and adult crime and violence. Participants are impacted by gangs, drug activity and physical assaults. The influx of undocumented immigrants with language barriers, lack of appropriate services to meet their needs, and their immigration status presents additional challenges to the program. Maternal-Infant data shows significant rates of no or late prenatal care, low birth weight babies, out-of-wedlock births, infant/neonatal death rates, teen pregnancies and Medicaid self-pay. Language barriers and lack of appropriate services to meet their specific needs have also impacted this population.

**Otsego County**

Opportunities for Otsego, Inc. $254,956

Building Healthy Families Otsego serves approximately 92 families annually. The target population is a mostly rural community that includes a large number of unskilled workers who work seasonal tourism jobs. Over the past few years there has been an increase in reported substance abuse during pregnancy and an increase in the poverty rate. Building Healthy Families provides support, referrals and promotes parent-child interaction in this community. Building Healthy Families collaborates with medical practitioners, services providers and early childhood professionals to offer the Annual Building Healthy Families Community Baby Shower that provides resources, family fun and education about pregnancy, childbirth breastfeeding, child development and fatherhood.

**Queens County**

Safe Space, Inc. $535,108

This past year the program served approximately 111 families of a diverse ethnic background residing in the Jamaica area of Queens. Approximately 73 percent originate from 15 other countries, predominantly the Caribbean, South America, Mexico and Spain. The people in this area speak Spanish, English and Haitian Creole. The majority of enrolled families are households led by single mothers, while 40 percent have a biological father in the household. This area has the highest poverty rates in Queens, and similarly high rates for crime, drug abuse, child abuse, unemployment and teen pregnancy. The program has a memorandum of understanding with the Queens Public Library to conduct prenatal workshops in the community. Two staff are Certified Lactation Counselors and the rest of staff are trained in this practice. The agency offers stress management groups for participants. The program is creating a “Prematurity Education Packet” with information provided by the March of Dimes to give to pregnant women they assess or enroll to educate them on strategies to reduce their risk of pre-term birth.

**Rensselaer County**

Samaritan Hospital of Troy $789,866

Healthy Families of Rensselaer County has the capacity to serve 210 families annually. The county is diverse and includes urban, suburban and rural areas; residents are from various socio-economic backgrounds. According to the most recent New York State Department of Health data, revised in October 2014, 11.6 percent of Rensselaer County residents were living in poverty. Many Rensselaer county residents suffer from mental health and intellectual disabilities issues which results in over one-third of enrolled families involved with mental health services or cognitive-intellectual disabilities services. In recognizing the importance of breast feeding to the health of the infant and bonding with moms, a supervisor was trained as a Certified Lactation Consultant and is available to go to the hospital to speak with our new parents and has attended home visits to help educate expecting parents on breast feeding.

**Richmond County (Staten Island)**

Vincent J. Fontana Center for Child Protection $583,824

Healthy Families Staten Island provides services to approximately 115 families annually. The service population for Healthy Families Staten Island is primarily made up of Medicaid-eligible pregnant women, including teens and their partners, single fathers and grandparents caring for a young child. There are a high percentage of child abuse and neglect investigations within Staten Island.

**Schenectady County**

Schenectady County Public Health ($564,220 State, $400,000 MIECHV) $964,220

Healthy Schenectady Families target area of Schenectady County is the second smallest county in area in New York State. The program serves an average of approximately 227 families. A major indicator of poor birth outcomes is poverty; there is a significant disparity in the number of children living in poverty in the City of Schenectady. In February 2015, Schenectady County Public Health was awarded MIECHV funding to put emphasis on the target areas within the City of Schenectady. Healthy Schenectady Families focuses much of its outreach on enrolling these city residents for HFNY services.

**Steuben County**

Institute for Human Services $777,398

Healthy Families Steuben serves approximately 244 families annually. Steuben County is a geographically large, rural community covering 1,409 square miles with an estimated population of 98,990. Challenges for these families are poverty, isolation and lack of transportation to outlying areas, which is especially difficult for pregnant mothers with toddlers. Home visiting services offers these families access to parenting support so they can learn about their baby's developmental stages, activities to enhance their child's development, and where to find access to adequate medical care for themselves and their children. The program is working in collaboration with their local community action agency and Steuben County Public Health Department to develop strategies to ensure every new or expectant family in the county receives some form of early childhood education home visiting services and early developmental screenings. The program emphasizes early literacy and provides new books to families at least once a quarter. They also have staff that are trained car seat technicians, lactation counselors, Itsy Bitsy Yoga instructors and a Certified Trainer who teaches parents infant massage to support their families.

**Suffolk County**

Family Service League of Suffolk $456,351

The service population is approximately 86 families who reside in the Brentwood, Bay Shore, and Central Islip communities. Families in the target area struggle to overcome many social and economic disadvantages that limit their ability to provide appropriate care to their children, including low wages or

dependence upon public assistance, limited educational attainment, inability to speak English or limited English proficiency; illiteracy or limited reading ability, single, teen parenthood, social isolation, crowded and substandard housing, high rates of substance abuse and violence in their neighborhoods, and childhood and marital histories of violence and neglect. The program manager and supervisor of this HFNY program are Certified Lactation Counselors who have shared this education with all staff to be able to share this information with families to encourage breastfeeding.

**Sullivan County**

Sullivan County Public Health Services $245,512

Healthy Families of Sullivan serves approximately 126 families annually. Sullivan is a rural county, consisting of 1,011 square miles of woods and farmland, with two urban pockets in Liberty and Monticello. Risk factors are above the state average for unemployment, indicated reports of child abuse/maltreatment, premature births, infant mortality, and the number of babies with low birth weights, teen pregnancy and mothers with no prenatal care. In 2013, countyhealthrankings.org deemed Sullivan County the second-worst ranking county in New York for health risks, including premature deaths, smoking, adult obesity and lack of insurance. The program has staff that are trained as car seat technicians, crib safety trainers and a Spanish-speaking Certified Breastfeeding Peer Counselor.

**Tioga County**

Our Lady of Lourdes Memorial Hospital, Inc. $404,190

Tioga Families Healthy Families provides services to approximately 125 families annually. The Lourdes Tioga PACT Healthy Families Home Visiting Program promotes the importance of fathers in the lives of children, which produce healthier outcomes for families. There is no other intensive home visiting program available in the county. Tioga County is a rural community with limited services for families. Many families do not have reliable transportation to access needed services. The program conducts in–person outreach in the community to decrease barriers for families in accessing the program.

**Ulster County**

Institute for Family Health $1,012,057

Ulster County Healthy Families provides services to an average of 223 families a year in their target area. Located in the Mid-Hudson Valley, Ulster County is a large, sparsely populated rural area with Kingston as its one urban center. Healthy Families' service population has a high percentage of minority participants, recent immigrants, non-English speaking parents, single parents and teen parents.

**Westchester County**

Julia Dyckman Andrus Memorial, Inc. $473,280

Westchester Healthy Families serves approximately 112 families annually. The families are

predominately from Spanish-speaking countries, prenatal and parenting families of children younger than three months of age who reside in Yonkers. Families face a variety of issues ranging from poverty to health-related issues such as low birth weight babies, childhood obesity, asthma, poor oral health and trauma.