



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

In accordance with the Home Visiting Law (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 the Healthy Families New York (HFNY) Home Visiting Programs. 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 36 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 36 programs throughout New York State. In March of 2015 the HFNY program will have been in existence for 20 years. Since its inception, HFNY has provided over 983,000 home visits to more than 31,400 families. Approximately 5,600 families are served annually, at an average annual cost of about \$4,000(upstate) to \$5,000(New York City) per family per year. The HFNY program is managed by the New York State Office of Children and Family Services, 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 another 20 years given its proven effectiveness.

In New York State between 2010 and 2012 an average of 164,097 reports of suspected child abuse or maltreatment were reported to the Statewide Central Register of Child Abuse and Maltreatment annually. Nationally, approximately three children die from child abuse and neglect each day. Children under the age of six have the highest victimization rates, yet new evidence confirms that these years lay the foundation for all that follows.

We know that:

- Most physical abuse and neglect occurs among children under the age of two.
- Forty-four percent of fatalities due to child maltreatment occur before the first birthday.
- The most critical brain development occurs during the first few years of life.

According to the 2012 Report of the Attorney General's National Task Force on Children Exposed to Violence, 46 million children living in the United States will have their lives affected by violence, crime, abuse or psychological trauma this year.<sup>1</sup> Repetitive and significant encounters with trauma and stress have real consequences for the physical, social, and emotional well-being of children. The

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<sup>1</sup> Nat'l Task Force on Children Exposed to Violence, U.S. Dep't of Justice, Report of the Attorney General's National Task Force on Children Exposed to Violence. (2012). Available at <http://www.justice.gov/defendingchildhood/cev-rpt-full.pdf>.

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:

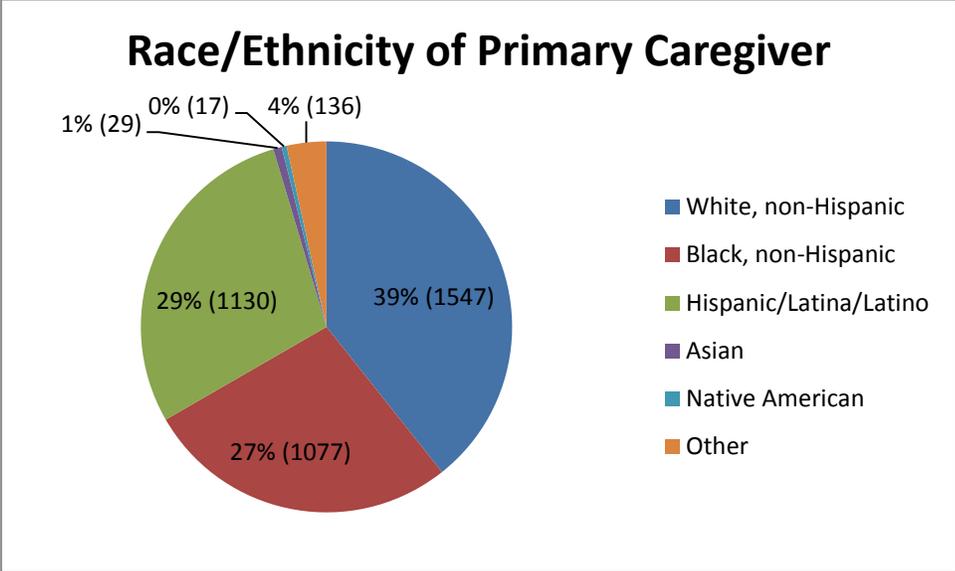
- promote positive parenting skills and parent-child interaction;
- prevent child abuse and neglect;
- promote optimal prenatal care and child health and development; and
- increase parents' self-sufficiency.

### **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) (Kempe, 1976). 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.

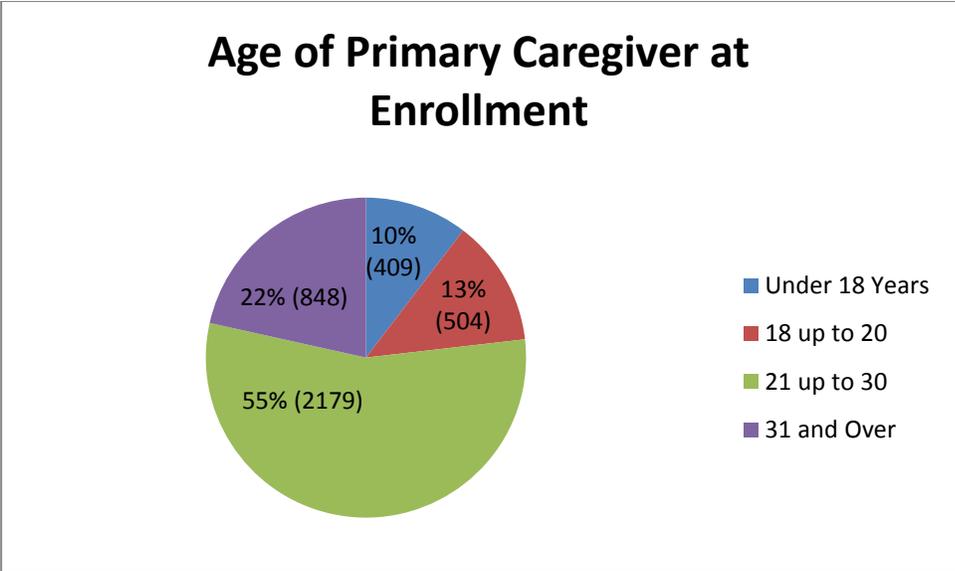
**Statewide Program Participant Demographics**

Below is a snapshot of participants at the time of enrollment for 2013. As these figures show, HFNY provides services to a diverse group of families. HFNY serves a variety of races and ethnicities; program staff reflects these same races and ethnicities and speak several languages and dialects.



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

Although the teenage pregnancy rate is declining, 23% of HFNY participants were under the age of 21 at the time of enrollment, while the majority of participants were between the ages of 21 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.

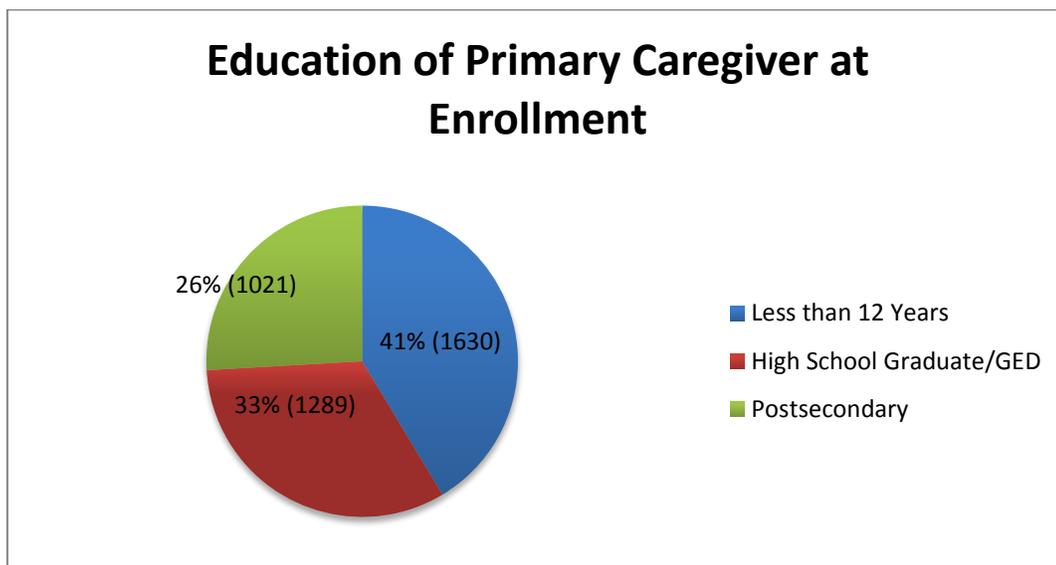


Figure 3: Healthy Families New York Education of Primary Caregiver at Enrollment

Many HFNY families come to the program with low or very low income. At the time of enrollment 25% of families were receiving Temporary Assistance for Needy Families (TANF), and 59% 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 59% of participants were first time mothers, and 69% 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 baby’s arrival, and provide education and information on pregnancy, childbirth, and child development.

### Staff Characteristics and Training

Home visitors are highly trained workers who live in the targeted communities and share the same language and cultural backgrounds as program participants. 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. Although home visitors are not required to have any post-secondary education, currently about 25% have taken courses at the post-secondary level and just over half of HFNY home visitors are college graduates.

All new HFNY staff members attend a one-week core training that is facilitated by a team of approved HFA trainers from PCANY. The goal of the core training is to teach the basic skills needed to perform home visits and assessments, including training on parent-child interaction, child development, and strength-based service delivery for home visitors; training in administering and scoring the FSC; and training for supervisors on their role in promoting quality services. Staff also receives intensive local “wraparound” training on a variety of topics such as domestic violence, abuse and neglect, well-baby

care and communication skills. Prior to visiting families, home visitors shadow an experienced home visitor.

Once in the field, home visitors meet with highly skilled supervisors for at least 1.5 hours each week and are observed on one home visit per quarter. Additional quality assurance measures include site visits, monitoring of quarterly performance targets, field observations and attendance at state-sponsored bi-monthly meetings for program managers.

## 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 program 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 when the families are visited less frequently. The content of the visits is intended to be individualized and culturally appropriate. Home visitors use information gathered in the FSC 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 from the OCFS who provide funding, oversight, and evaluation; PCANY who provide training and staff development; and the CHSR, who provide assistance with evaluation and data 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.

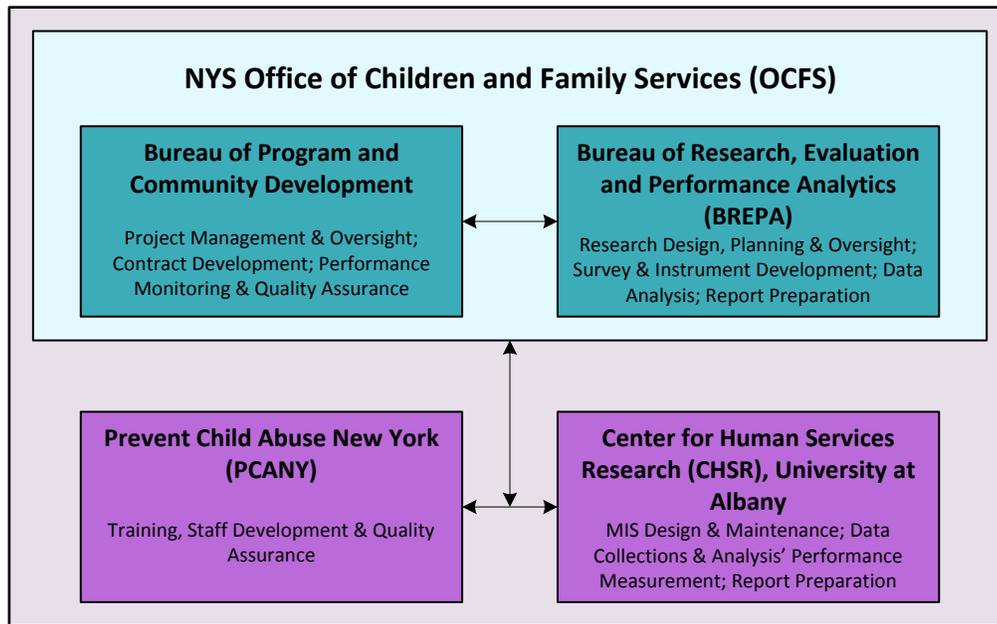


Figure 4: Healthy Families New York Central Administration Organizational Chart

## Accreditation

In 2013, Healthy Families New York Home Visiting Program was re-accredited by Healthy Families America. The purpose of Healthy Families America accreditation is to ensure that the Healthy Families America name, and programs using that name, represent a deep and abiding commitment to delivering the highest quality services possible and implement the program with fidelity to the national model.

The HFA model of service delivery is based upon 25 years of research regarding twelve Critical Elements and is committed to demonstrating consistent service implementation through the Quality Assurance process. HFNY began the accreditation process in the fall of 2011. The first step was for the Central Administration team to submit a self-study which included policies, data and various other elements of evidence. In early 2012, all 36 program sites were required to also submit a self-study regarding the 12 Critical Elements that drive service delivery.

Central Administration received a site visit from the national reviewers in March 2012 and was found to be in adherence to all of the required elements of governance, training, quality assurance and technical assistance. During the summer and fall of 2012, ten HFNY program sites were chosen to receive visits by the national reviewers. Five sites passed without requiring any response to the accreditation panel, two with perfect scores. Five sites were required to develop and implement a plan to address their deficiency. Of these five, three sites had to respond to only one of the Critical Elements.

The review and required responses were completed at the end of July 2013. HFNY is now an HFA-accredited multi-site system which allows all of our 36 program sites and the Central Administration team to achieve accreditation status. The accreditation is valid for five years.

HFNY has been recognized by the national governing body as a leader of 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.

### **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 randomized controlled trial (RCT).

#### **Assessing Program Quality:**

OCFS uses data collected from the individual HFNY programs to (1) assess whether the program is being implemented with fidelity to the model (e.g., delivering core program components according to the prescribed schedule and does); (2) monitor program performance, and (3) improve the quality of services provided. This data 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 improve program practice. Pilot projects include those to increase enrollment of families early in pregnancy, to increase the involvement of fathers in home visits, and to better understand barriers to discussing sensitive topics.

To achieve projected outcomes, HFNY programs work towards 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. 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 Temporary Assistance to Needy Families (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 Management Information System (MIS). Reports are generated from the system and analyzed to determine progress.

The following percentages depict performance on select targets for all HFNY programs (last quarter 2012):

- 96% of infants received required immunizations at one year of age; 91% of infants received required immunizations at two years of age.
- 96% of children were assessed for the risk of lead in their environment at the appropriate age.
- 99% of children had a medical provider.
- 95% of target children had at least five well baby visits by 15 months of age and another 88% had the required visits between 15 and 27 months of age.
- 99% of target children were screened for appropriate developmental milestones and were referred for further evaluations if delays were detected.
- 98% of primary caregivers had a medical provider.
- 52% of mothers breast fed their child for at least three months from the birth of the child.
- 79% of primary care givers had a reduction in stress by the target child's first birthday.
- 80% of families enrolled in an education program, job training, job placement program or obtained employment by the child's first birthday.
- 45% of families who were receiving Temporary Assistance for Needy Families at enrollment no longer received benefits on the target child's first birthday.
- 72% of primary care givers under the age of 21 at intake and without a high school degree or General Education Degree enrolled in a degree bearing program or received a high school degree or certificate by the target child's first birthday.
- 92% of families with identified domestic violence, mental health or substance abuse issues were referred for the appropriate services within six months of enrollment.

### **Healthy Families New York Randomized Controlled Trial (RCT):**

OCFS' Bureau of Research, Evaluation, and Performance Analytics, in collaboration with the Center for Human Services Research, instituted a longitudinal randomized controlled trial of HFNY beginning 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 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 7 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. The following sections present results from select analyses. Additional findings from the HFNY RCT can be found at [http://www.healthyfamiliesnewyork.org/research\\_reports\\_papers.cfm](http://www.healthyfamiliesnewyork.org/research_reports_papers.cfm)

### HFNY Prevents Low Birth Weight Babies

Promoting optimal child health, including preventing low birth weight, is a primary goal of HFNY. Indeed, low birth weight (defined as a birth weight of less than 2500 grams or 5 lb. 8 oz.) is associated

with many negative outcomes. Low birth weight babies face an elevated chance of early mortality, health problems, and developmental delays; they are twice as likely to be placed in foster care and to be maltreated as their normal weight peers. Pregnant women who are young, African American, and/or poor face a substantially higher risk of delivering low birth weight babies than other mothers.

Based on the analysis of 506 birth records, the RCT showed that home visited mothers (the HFNY group) were half as likely to have low birth weight babies than those who did not receive HFNY services (the control group). HFNY mothers were also less likely to have low birth weight babies than mothers in a Medicaid population.

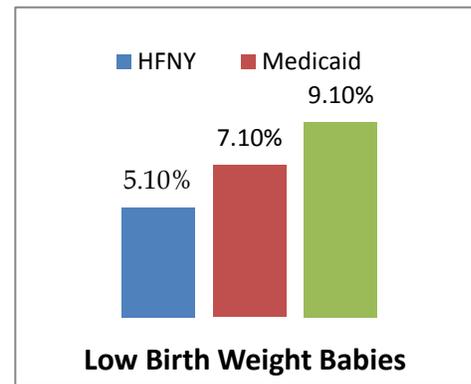


Figure 5: Low birth weight babies

While the mothers of the HFNY group were less likely than those of the control group to deliver low birth weight babies across all racial/ethnic groups, the program effects were particularly strong for African-American mothers. Only 3.1% of African American mothers in the HFNY group had low birth weight babies, while 10.2% of African American mothers in the control group had low birth weight babies. Findings indicated that the home visitors helped expectant mothers to achieve positive birth outcomes by improving linkages to medical providers, nutrition programs and social services. HFNY helped improve mothers’ access to primary care providers during the prenatal period while there was little change among mothers in the control group.

Program data also demonstrated that home visitors helped mothers to access resources such as WIC, Food Stamps, food pantries, nutritional counseling and housing assistance. It is possible that the social and tangible support provided by home visitors contributed to healthier and less stressful pregnancies and lowered the likelihood of low birth weight births, especially among African American mothers. Home visitors also provided instruction during the prenatal period and encourage participants to engage in healthy prenatal behavior.

HFNY Promotes School Success in the Early Years

Children in the home visited group were less likely to repeat first grade (3.5%) than those in the control group (7.1%, p=.03). In addition, a larger percentage of children in the home-visited group performed above grade level in first grade on all three behaviors that promote learning (BTPL): working or playing cooperatively with others, following directions or classroom rules, and completing home or class work on time (13.2% versus 7.7%, p=.03) than children in the control group.

First grade girls in the HFNY group were more likely to perform above grade level academically (on reading, math, and all 3 BTPL) (32.6% vs. 17.5%, p<.01) and less likely to perform below grade level academically (on reading, math or any of the 3 BTPL) (19.7% vs. 32.2%, p=.02) than girls in the control group.

The intensity of home visits was a significant predictor of children’s outcomes. Children who had a higher percentage of HFNY service levels where they received at least 75 percent of their expected visits were 2.28 times more likely to perform above grade level academically (p=.05) and 47.4 percent less likely to perform below grade level academically (p=.10).

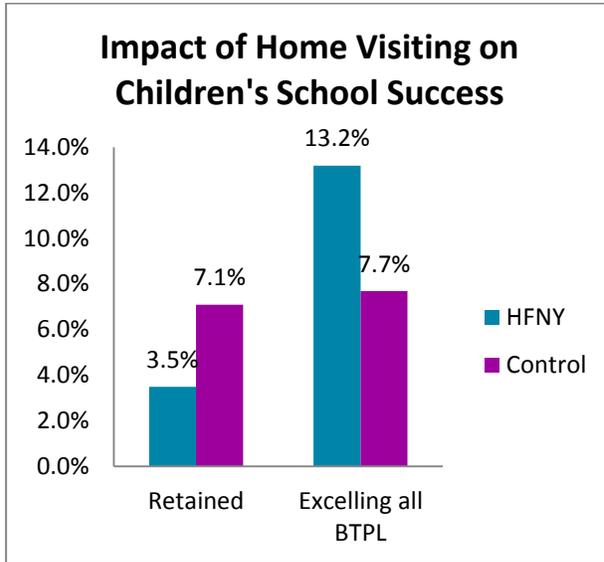


Figure 6: School Success by Treatment Arm (HFNY/Control)

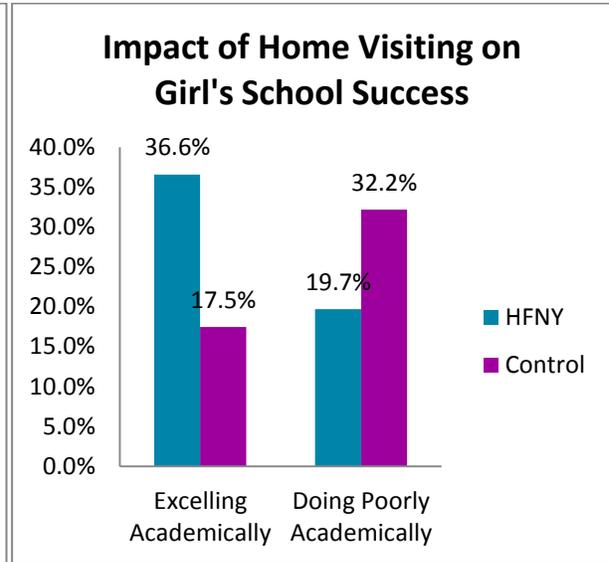


Figure 7: Girls' School Success by Treatment Arm (HFNY/Control)

HFNY Reduced Child Maltreatment

HFNY produced sustained effects on harmful parenting practices. Based on all mothers' reports of parenting practices, HFNY generated:

- An 88 percent reduction in the average number of acts of very serious physical abuse at age one.
- A 75 percent reduction in the average number of acts of serious physical abuse at age two.
- An 80 percent reduction in the average number of acts of serious physical abuse at age seven.

HFNY reduced rates of confirmed Child Protective Services (CPS) reports for neglect and physical abuse and for initiation of child welfare services through age seven for a subgroup of mothers with confirmed CPS involvement prior to being randomly assigned to the HFNY RCT ( $p \leq .05$ ).

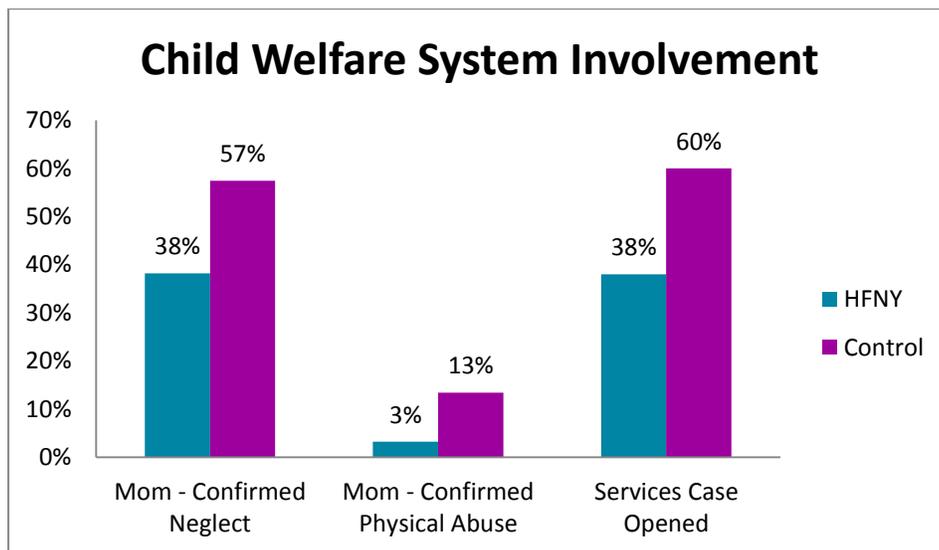


Figure 8: Child Welfare System Involvement by Treatment Arm (HFNY/Control)

Although there were no differences in the cumulative rate of confirmed CPS reports in the first four years of life, for a subgroup of children of young, first-time moms who enrolled in the study early in pregnancy, HFNY did reduce the rate at which these children were confirmed as victims in CPS reports between the fifth and seventh years of life ( $p \leq .10$ ).

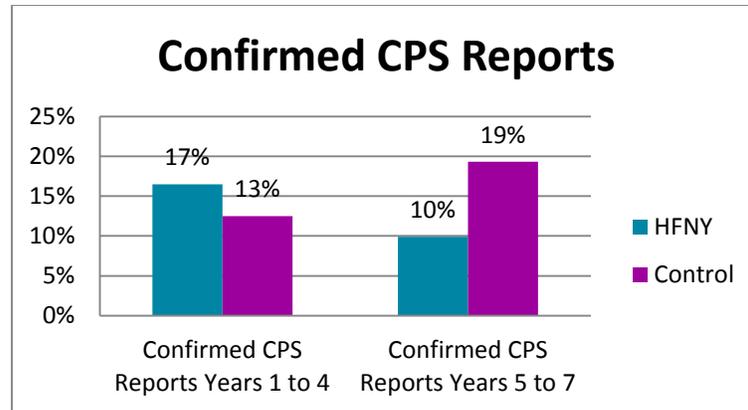


Figure 9: Confirmed CPS reports by year and Treatment Arm (HFNY/Control)

A 15-year follow-up study is currently in the start-up phase. 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 record requests; and criminal justice system involvement. Data collection and preliminary analyses are expected to be completed in 2019.

## 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 when fathers take a more active role in their child's life the child has better academic, social, and behavioral outcomes. In the past three years, HFNY has seen an increase in the number of home visits in which the father was involved. To help encourage father involvement, 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.

In both 2012 and 2013, Fatherhood Summits were held. These events provided the Fatherhood Support Specialists with the opportunity to gain practical knowledge to utilize in the field, share lessons learned, network with other Fatherhood Support Specialists and provide input regarding the future of this important initiative. Participants from HFNY programs and staff from PCANY, CHSR and OCFS also attended the summits. HFNY's Central Administration also supports and has also facilitated 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.

**Families with Intellectual Disabilities:**

Three HFNY programs, awarded a grant from the NYS Developmental Disabilities Planning Council (DDPC) in 2011, undertook a project to better serve participants with intellectual challenges. The goals of the project were to:

- 1) Establish new partnerships between the HFNY programs and the disability service delivery system in each program's respective target area(s) and
- 2) Enhance HFNY services to families who have a parent with developmental disabilities.

The local HFNY programs established many new partnerships with not-for-profit agencies that provided services to individuals with developmental challenges. Program staff educated their local partners on services that they offer to new and expecting parents. The community partners not only served as referral sources but were also valuable resources to help the programs make the modifications to policies, procedures, and curricula that were necessary to successfully provide services to families with intellectual challenges.

Positive outcomes for the families served included:

- 1) Families established a medical home and/or connected to specialized care providers, including mental health services.
- 2) Families learned to schedule and keep up with health care and social service appointments.
- 3) Families acquired and maintained appropriate financial support benefits (SSI, TANF, Medicaid and WIC).
- 4) Families selected and accessed other supportive resources.
- 5) Families became better able to communicate with county/court/medical officials and other service providers.
- 6) Families learned and began using nurturing skills and positive parenting techniques.

The programs that participated in this pilot have implemented the new policies, procedures and

curricula into their standard practice. The lessons learned from this project have also been incorporated into the statewide system. Additional training was determined to be necessary for home visitors to provide services to families in which there is a parent with an intellectual disability/delay. PCANY developed and implemented a training module on this topic in response to this need.

### Funding Source

The majority of funding for the HFNY program comes from State appropriations, which for the last three years has been in the amount of \$23,288,200 annually. These state funds support 36 programs throughout the state, as well as the contract with PCANY for training and staff development, and the contract with CHSR for the management information system and evaluation of program services. Each contractor is required to provide a minimum 10% local share towards the program in the form of cash, in-kind services or donations to the program.

The Patient Protection and Affordable Care Act (ACA) of 2010 authorized the creation of the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) to improve the health, development and well-being of at-risk children and families through evidence-based home visiting programs. The Healthy Families America program model has been identified by the U.S. Department of Health and Human Services as meeting the standard for “evidence-based” in the program’s authorizing legislation. In collaboration with the OCFS, the New York State Department of Health (DOH) was awarded a federal grant to implement a NYS MIECHV program responsive to the requirements of the establishing legislation and guidance materials. As part of this grant, the funding directed at OCFS was used to enhance and expand four existing HFNY programs in the Bronx and Erie counties. One condition of receiving these funds is the maintenance of state investment in home visiting.

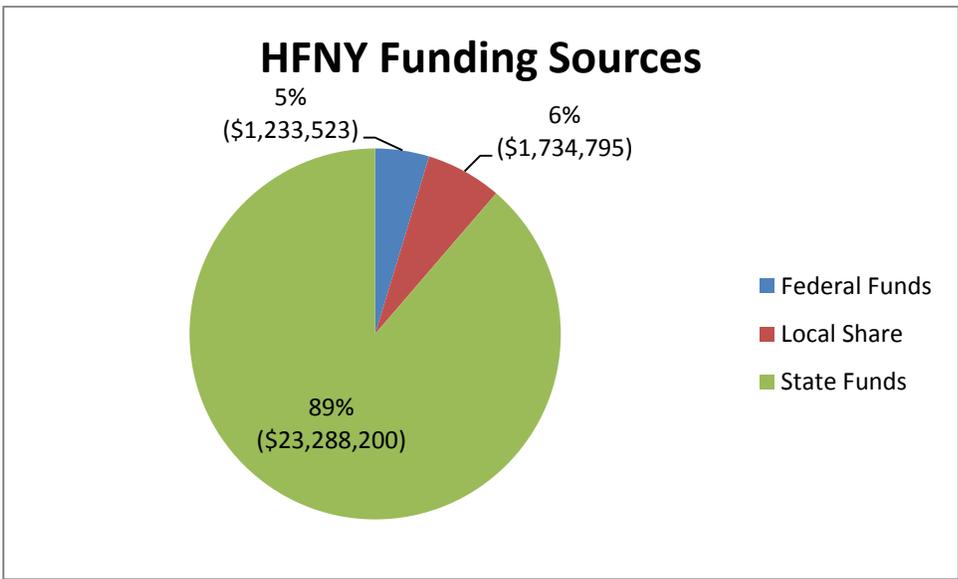
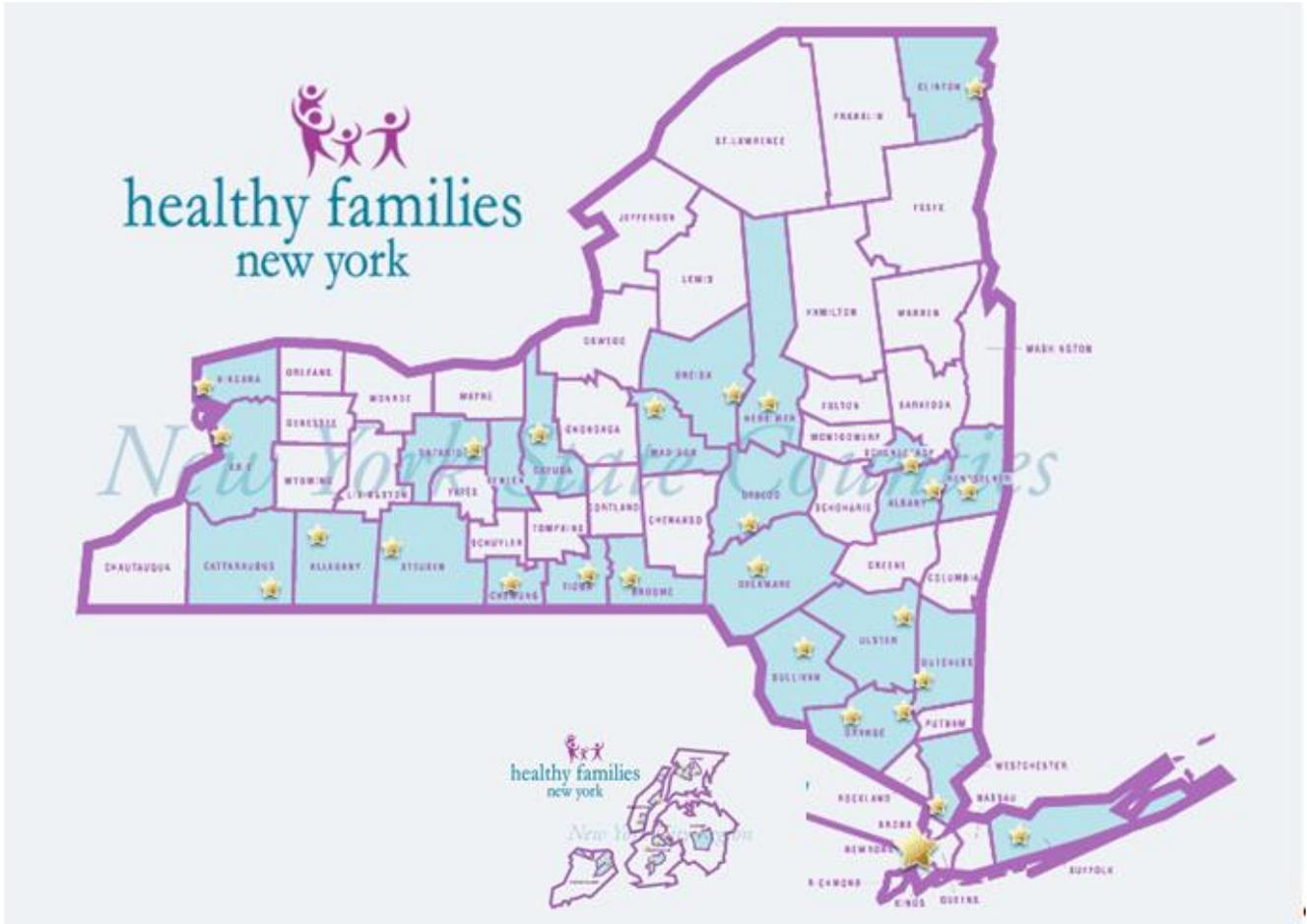


Figure 10: HFNY Funding Sources

**Home Visiting Programs (HFNY)**  
**Funded under Section 429 of the Social Services Law**



**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 government 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 African American families and recent immigrants. Although Albany County has an array of services available; many families struggle with homelessness, mental health issues, domestic violence and substance abuse issues, resulting in many families having one or more significant barriers to achieving their parenting goals. Albany County Healthy Families provides support and services to this needy population.

## **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 14% teen mothers and 82% unmarried mothers, with 51% of families having the biological father in the household. As a result of the lack of transportation, education and training, there is a high unemployment/underemployment rate, resulting in 55% of families receiving Food Stamps. Families face particular challenges with mental health issues and substance abuse issues.

## **Bronx County**

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

South Bronx Healthy Families provides services to an average of 154 families a year in the South Bronx community target areas. The community served, known by the residents as Morrisania, has over 30% 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.

Catholic Guardian Services (\$496,310 State, \$164,960 MIECHV) \$661,271

Healthy Families Parkchester provides services to an average of 116 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, \$206,203 MIECHV) \$821,987

Healthy Families Morris Heights provides services to an average of 160 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 neighborhood. The population is racially diverse, young, and headed by a mostly by single head of household.

## **Broome County**

Broome County Health Department \$541,449

Healthy Families Broome provides services to approximately 145 families a year in Broome County. This program serves expectant and new parents who reside in Broome County, outside of the Binghamton City School District. The Healthy Families Broome Home Visiting Program provides an innovative fatherhood program to families, offering tandem home visits by a Fatherhood Specialist and Family Support Worker. The challenges of the population include a high risk for child abuse and

neglect and poverty. The program is committed to providing information to both mothers and fathers about their child’s health, development and well-being during this critical time of brain development.

**Cayuga and Seneca County**

Cayuga/Seneca Community Action Agency \$460,661

This program serves approximately 113 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.

**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% of the counties’ newborn population is Medicaid eligible. There is a 14% poverty rate and eight percent unemployment rate. 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 99 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.

## **Dutchess County**

Institute for Family Health

\$715,729

Dutchess County Healthy Families provides services to an average of 183 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. 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 neglect 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 600 families a year in the Erie County target areas. The targeted area is primarily urban and culturally diverse. The majority of participants are African American and Hispanic. The targeted areas suffer from the effects of poverty. 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 30.3% of its residents living in poverty.

## **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.

## **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% of the population is below 200% 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.

Brookdale Hospital Medical Center

\$496,310

The program serves approximately 220 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.

CAMBA

\$666,804

CAMBA's Healthy Families Program provides services to an average of 224 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, and 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.

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% of children aged 0-13 live in linguistically isolated households. The residents of Bushwick face many economic difficulties. The median household income in 2010 was \$34,142, which is significantly lower than the NYC-wide average. A larger percentage of adults in Bushwick face unemployment (14.7%) than adults in NYC (11.2%). 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.

### **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% rate of child abuse and neglect. The 2011 data shows 1,018 families were under investigation for 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. This is a new Healthy Families program, starting in 2013, and is just beginning to serve families.

Northern Manhattan Perinatal Partnership, Inc. \$592,468

Healthy Families Central Harlem provides services to approximately 98 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 serves approximately 87 families in East Harlem and sections of the Lower East Side of Manhattan. The program serves immigrants who are predominately low-income families. Most families are living on the economic margins and grappling with poverty, unemployment, language barriers, housing issues and the struggle to provide for their children. Specifically, the two most apparent issues that families struggle with are the affordable housing crisis and the challenges associated with 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% of the city’s children live in poverty.

## **Oneida County**

Kids Oneida, Inc.

\$585,710

Healthy Families Oneida County services approximately 140 families annually in the county. Oneida County is home to the Mohawk Valley Resource Center for Refugees. Oneida County serves predominantly low income families who encounter struggles in various areas, i.e. criminal involvement, substance abuse, mental health and child protective services involvement.

## **Ontario County**

Ontario County Department of Social Services

\$200,008

Healthy Families Ontario 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. The community faces several challenges due to the lack of transportation, limited services, low income and the lack of affordable housing.

## **Orange County**

Occupations, Inc.

\$943,109

Healthy Families Orange serves 204 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. 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.

## **Queens County**

Safe Space, Inc.

\$535,108

Currently the program serves approximately 96 families of a diverse ethnic background residing in the Jamaica area of Queens. Approximately 73% originate from fifteen (15) other countries, predominantly the Caribbean, South America, Mexico and Spain. The people in this area speak Spanish, English and Haitian Creole languages. The majority of enrolled families are households led by single mothers, while 29% 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.

## **Rensselaer County**

Samaritan Hospital of Troy

\$789,866

This program has the capacity to serve 213 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, 9.9% 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.

## **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. Furthermore, domestic violence continues to be on the rise in Staten Island, even as it decreases in other parts of New York City.

## **Schenectady County**

Schenectady County Public Health

\$564,220

Healthy Schenectady Families target area of Schenectady County is the second smallest county in area in New York State. 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. Healthy Schenectady Families focuses much of its outreach on enrolling these city residents.

## **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.

## **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.

## **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. Sullivan County is known for its history as a summer vacation destination for city dwellers, when the population increases by 300% for two months of the year. Less well known are the consequences of seasonal tourism for the local population and the many multigenerational displaced workers. Risks 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, Sullivan County was deemed the second-worst ranking county in New York for health risks, including premature deaths, smoking, adult obesity and lack of insurance.

## **Tioga County**

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

Tioga Families Healthy Families provides services to approximately 118 families annually. Tioga 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 home visiting program available in the county. Tioga County is a rural community with limited services for families. Most of these

families do not have reliable transportation to access needed services.

**Ulster County**

Institute for Family Health

\$1,012,057

Ulster County Healthy Families provides services to an average of 234 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 115 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.

## **A Story from the Field**

“Mom began our program at 10 weeks gestation and was determined to not only keep her baby but be a good parent. Mom has had a very hard life and is wheel chair bound with cerebral palsy. Mom was a victim of child abuse even before she was born. In her Kempe assessment, she stated that she could not recall a happy moment in her childhood. Her parents were drug addicts and her father was very violent. Mom and her three siblings (one brother and two sisters) lived in constant fear of him. When Mom’s mother was carrying her, her father began beating her mother which put her in preterm labor. On their way to the hospital, Mom’s father deliberately crashed his car into a tree. Consequently, Mom was born with severe cerebral palsy. Because of her disability, she has always been wheelchair bound. Despite her disability, she had the responsibility of caring for her younger siblings. All of her siblings have some type of special need resulting from the abuse and neglect of her parents. When Mom was 11, she and her siblings were removed from their parents’ home when it was discovered that she was responsible for raising her siblings. Her siblings were taken in by a relative and Mom spent the next seven years living on a nursing home floor at a local hospital.

When Mom turned 18, she was released from the hospital and found an assisted living facility. She began a relationship with a resident in the facility (also wheel chair bound) and eventually became pregnant. Mom was filled with joy over the pregnancy, but her struggles were just beginning. Because of her disability, her doctors, case manager and hospital social worker all recommended that she terminate her pregnancy. There wasn’t a lot of experience dealing with a pregnancy of someone with such a severe case of cerebral palsy. Although she was given this advice, she was determined to have a healthy pregnancy and baby. Mom heard about the services of the Healthy Families Home Visiting Program from someone at her prenatal clinic and gave the program a call. After her assessment, she was immediately assigned a worker and they began the journey together. After a case conference with all of her providers, Mom’s home visitor, learned that not only was Mom at risk with this pregnancy but everyone was in agreement that Mom might not even be able to keep her baby. Most of the providers on her team did not believe that Mom would be able to care for and parent her child. Mom had aides that came to her home but they would not be allowed to help her with her baby. Additionally, Mom could only afford 18 hours of help per day and the other six, she spent alone. If she had to use the bathroom, she would be stuck waiting for an aide to arrive.

During her pregnancy, Mom’s home visitor helped her to build a support system. Together, they had two major goals: to have a healthy baby and to bring that baby home from the hospital. Mom had a lot of hurdles to overcome, but was also determined to succeed. Mom gave birth to a healthy baby girl in December of 2012. She had a care plan in place at the time of birth so that she could safely bring the baby home. Mom receives plenty of help from her child’s father who is also active in the program and participates in all of the program’s activities. Mom has built a support system, which includes her home visitor and many friends who take shifts in helping Mom with the baby. Mom’s baby is a happy six months old and is beginning to talk and is even sitting up! Her baby is on target in her development and is up-to-date with her shots and well-baby check-ups. Mom continues to excel as a parent and is eager to keep her visits and learn all that she can about parenting.”