

REPORT TO THE TWENTY-THIRD LEGISLATURE

STATE OF HAWAII

2006

PURSUANT TO SCR 227 SD1 HD1,  
2005 SESSION LAWS HAWAII  
CREATING A PLANNING TASK FORCE  
FOR THE HEALTHY START PROGRAM

PREPARED BY:  
STATE OF HAWAII  
DEPARTMENT OF HEALTH  
DECEMBER 2005

## **S.C.R. 227**

# **Healthy Start Advisory Task Force Report**

October, 2005

### **Introduction**

The 2005 Legislature adopted Senate Concurrent Resolution (S.C.R.) 227 requesting the Department of Health (DOH) to convene a Task Force to work with the Hawaii Healthy Start (HHS) network of providers to restructure the program for greater effectiveness. In addition to working with current contracted purchase of service providers of the HHS program, the Resolution asks that the following representatives be included as members of the Task Force:

- One representative each from Family Health Services administration, Maternal and Child Health Branch, and the Early Intervention Services,
- One representative from the Child Welfare Services Branch, Department of Human Services,
- Healthy Start provider agency representatives from the family assessment, home visiting and training components of the Healthy Start program,
- the University of Hawaii John A. Burns School of Psychiatric Medicine,
- the Department of Education,
- the Hawaii Chapter, American Academy of Pediatrics, and
- the Hawaii Family Support Institute

Seven (7) areas of focus are outlined in the resolution for the work of the planning Task Force which include, but are not limited to:

1. Strengthening the program focus on and effectiveness of interventions in prevention of child abuse and neglect based on strategies of nurturing, promoting capacity through parallel process, addressing family risk factors, and strengthening protective factors;
2. Reducing program complexity, streamlining requirements related to IDEA and OSEP to enable staff to achieve goal (1) above;
3. Considering restructuring intensity of services, such as a two-tier system based upon severity of risk;
4. Considering restructuring contract goals in terms of outcomes required by funders and establishing output monitoring within quality assurance at program and state-wide levels;
5. Considering piloting curriculum to structure home visits and ensure inclusion of basic activities to promote positive child development;

6. Reviewing and considering evidence-based best practices to enhance overall program effectiveness, particularly related to engagement and retention and outcome indicators, with a view to incremental piloting and state-wide adoption; and
7. Considering reallocating more resources to training and technical assistance mentoring to enhance staff effectiveness and to program outcome data evaluation for regular reports to funders.

## **Background**

HHS began as a demonstration child abuse prevention project in July 1985. Starting at one location on Oahu, a para-professional model was developed to support at-risk families with newborns through home visits. As the model developed, the program expanded to focus on key geographic areas with higher proportions of families with identifying characteristics of risk. HHS also served as the model for the international Healthy Families America (HFA) home visiting program. During this same time (1986), Congress enacted legislation, the Individual with Disabilities Act (IDEA), Part C, to minimize cost and unsatisfactory outcomes for individuals with disabilities by enhancing services and capacity. The Office of Special Education Programs (OSEP) manages national compliance with regulations of IDEA, Part C, (revised in 1997) which is to oversee implementation of an early intervention (EI) service system for children ages birth to three years, and their families. The State opted for a broad definition for eligibility in EI to include environmentally at-risk families as well as families with children who are developmentally disabled, biologically at risk, or medically fragile.

In the fall of 2001, HHS was approved as a Felix mandated early intervention service and additional State general funds were allocated to enable the program to expand to statewide service delivery. This rapid expansion occurred at around the same time that a new client data management and tracking system was being developed. Concurrently, OSEP requirements had an impact on Healthy Start Program design as it is part of the Early Intervention System of care for the “environmentally at risk” classification.. Additional requirements to come into compliance with IDEA law have been placed on HHS as a Part C covered entity for the State.

The SCR 13/45 Resolution, “REQUESTING THE ESTABLISHMENT OF A STATEWIDE INTERAGENCY TASK FORCE TO DEVELOP A PLAN FOR COORDINATION AND EXPANSION OF SERVICES PROVIDED THROUGH HEALTHY START TO YOUNG CHILDREN AND THEIR FAMILIES” in place for three consecutive years has analyzed service delivery vis-à-vis service coordination between the DOH and the Department of Human Services (DHS) and has resulted in a pilot program in two sites serving Child Welfare Services cases. This model is being replicated statewide beginning in November, 2005 through funding from the Department of Human Services (DHS).

The establishment of an Advisory Task Force at this time provides additional resources and support to assist the HHS program in its efforts to examine programmatic and fiscal details of the program and adopt strategies for quality improvement.

## **Process for Achieving Task Force Outcomes**

The HHS Advisory Task Force has met monthly since July, 2005 for a total of four (4) sessions. The planning process objectives for the first six months include the following:

- Develop a common understanding of the history and historical mandate for the program.
- Review the current evaluation of Healthy Start, particularly to identify areas of strength and areas in the program needing attention.
- Review best practices in home visiting programs as determined in studies conducted on this approach over the past twenty years. This activity would address the resolution's areas of focus related to reviewing and considering evidence based best practices to enhance overall program effectiveness.
- Analyze, from the perspective of the Advisory Task Force participants, seven areas of the program including:
  - Strengthening the program focus on and effectiveness of interventions
  - Reducing program complexity, streamlining requirements
  - Considering restructuring intensity of services
  - Considering restructuring contract goals in terms of outcomes
  - Considering piloting curriculum to structure home visits and ensure inclusion of basic activities
  - Reviewing and considering evidence based best practices to enhance overall program effectiveness
  - Considering reallocating more resources to training and technical assistance mentoring
- Areas in need of improvement will be identified as short-term and/or long term issues. Working in committees which would include DOH, service providers and Advisory Task Force members, The Task Force will develop recommendations to address short-term, immediate changes needed in the program. These recommendations would meet some of the areas of focus identified in the resolution, particularly:
  - Reducing program complexity;
  - Streamlining requirements related to IDEA and OSEP; and
  - Considering restructuring contract goals.
- Some discussion on the long-term direction of the Healthy Start program may take place in the remainder of 2005, but this will be a primary activity for the Advisory Task Force in 2006. Based on the discussions already held in Task Force meetings, program mission and

focus will be fundamental issues needing resolution prior to any discussion on the long term prospects of the program.

Reports from the meetings to date are as follows:

July 18, 2005

- The first meeting was used to organize the HHS Advisory Task Force. Primary members of the Advisory Task Force were identified and confirmed as members. Meetings of the Advisory Task Force are open to all service providers interested in attending the meetings. This has resulted in about thirty participants at each meeting. (A full list of meeting participants is attached (Attachment A))
- Participants reviewed legislation and the requirements of SCR 227. The resolution provided focus that helped organize the Task Force's work. The group decided to start with goals one (1): Strengthening the program focus on and effectiveness of interventions in prevention of child abuse and neglect based on strategies of nurturing, promoting capacity through parallel process, addressing family risk factors, and strengthening protective factors; and six (6): Reviewing and considering evidence-based best practices to enhance overall program effectiveness, particularly related to engagement and retention and outcome indicators, with a view to incremental piloting and state-wide adoption; (see Attachment B)
- Presentations on the history of the HHS program were shared to develop a common understanding of the program's foundation and to identify the changes that have impacted the program.
- Questions to analyze the program were disseminated to stimulate reflection on program issues. This analysis would serve as the basis for discussion through the next several months of meetings. (See Attachment C, for the scored program analysis document)
- Concerns about the HHS program shared at the meeting included expansion of the purpose of the program as changes occurred in the administrative entity and in public policy and funding.

August 18, 2005

- A presentation and review of research on the HHS program was conducted by Johns Hopkins University. (see Attachment D).
- A presentation and review of best practices was conducted by the Hawai'i Family Support Institute. (see Attachment E)

These presentations provided documented information that was used in the program analysis exercise which would be the primary activity at the Task Force's October meeting.

### September 15, 2005

- Program data collected by the DOH was shared at this meeting. Additional information on this data would also be presented at the group's October meeting. (See Attachment F)
- Discussion on organizing the Task Force also took place with recommendations on the structure and work of the Task Force to be presented at its October meeting. Critical to this was to discuss the non-negotiable items inherent in the contract scopes of work between the DOH and the service providers. It was agreed this would be shared at the next meeting. (See Attachment G)
- The group also discussed the format and content of the report to the legislature understanding that the report will document the Task Force's deliberations on process to accomplish the work with the goal of being able to provide both short and long-term recommendations for program retooling in the future.
- Several areas of consensus emerged from the meeting including a willingness to expand the scope of the HHS program beyond child abuse and neglect prevention.

### October 13, 2005

- Following the program presentations and a review of best practices, as a basis for future program restructuring, the "Healthy Start Program Analysis" results were distributed to the Advisory Task Force members and other interested parties to solicit their perspectives on the value of the Healthy Start Program. At the October meeting, members voted for their top three priorities of the responses submitted for each survey question using colored dots. DOH staff marked their dots with an "X" to distinguish their choices from the rest of the group. This group activity identified the prevailing consensus about the:
  - Most important outcomes produced by the HHS program.
  - Most important elements of HHS's program implementation.
  - Most important barriers (internal to provider programs) impeding HHS program success.
  - Most important barriers (specific to the DOH) impeding HHS's program success.
  - Most important barriers (external to both DOH and the providers) impeding program success.
  - Family issues and other characteristics that impede program success.
  - The results of this effort may be found in Appendix H.
- The Advisory Task Force also organized two (2) working committees to address details of the responses and to identify short-term and long-term issues. These two committees include a Data Committee, responsible for continued collection and analysis of data from the DOH and other sources, and a Program Redesign Committee.

- Of immediate concern are those issues identified in the program analysis process that are affecting program quality and efficiency. Both committees will identify short-term and long-term issues. Remedies for immediate concerns and to address the short-term issues will be identified. When this is done, both committees will examine long-term program issues and provide recommendations for changes in 2006.

There are three additional areas the Advisory Task Force addressed in the program analysis survey, but did not have time to prioritize as of yet. These three areas include the following:

- What are the three most important measures of program implementation that should be monitored to assure high quality HHS services?
- What are the three most important needs (it might be curriculum or topics or methods) to improve current training for home visitors?
- What do you think is a reasonable amount of dollars to spend on HHS services per family per month?

## **Healthy Start Changes to Improve Outcomes**

As the Advisory Task Force completes discussions and makes recommendations on the program analysis topics outlined earlier in this report, areas such as outcome measures, training, and costs are being addressed incrementally.

The HHS program has been working closely with the purchase of service providers this past year on identification of areas to improve program effectiveness. Act 178/SLH 2005 has also required a report on six aspects of home visitation which have been addressed as well in discussions with the Advisory Task Force. The HHS program has prepared and submitted a detailed report in response to H.B. No. 100 evaluating its delivery of services. A new contract cycle for HHS services is beginning in January 2006 which will incorporate incremental changes in the program which we anticipate will lead to higher rates of retention of eligible families, streamlined service delivery, and increased fiscal accountability.

The list below indicates changes to the program design and implementation which have been implemented to date:

- Increased prenatal referrals in Healthy Start
- Extended window of eligibility from 3 months to 12 months
- Less intensive visitation schedule
- Less child development screening- retaining the critical months of assessment
- Reassessing the definition of program success linking it to family progress as opposed to length of stay until 3 years of age
- Revised training curriculum and adoption of the cognitive appraisal model for home visiting pilot project as part of CDC research grant.
- Adding reports to the Child Health Early Intervention Resources System (CHEIRS) database to streamline reporting of progress on Office of Special Education Services (OSEP) required program data
- Elimination of “other contacts” as a billable item in home visitation system

- Adding another data field to the CHEIRS database to capture data for families who successfully left the program prior to age 3 years.

In order to achieve the Task Force goal of restructuring the Healthy Start program, further data analysis and discussion is warranted:

- Cost effectiveness in delivery of services is a priority and is in the initial stage of system development,
- Retention is difficult for all home visiting programs that are voluntary and there is currently no *one* program model with evidence-based research, or even clear best practice indicators, to guide restructuring in one clear, successful direction. Review of other Healthy Start programs in other states will provide ideas for program improvement. The continued work with Johns Hopkins University (JHU) will provide an opportunity to evaluate improvement as a result of enhanced home visitor training. Three (3) of JHU published articles, one (1) meta-analysis evaluation summary, and three (3) reports from other HHS-like home visitation programs (in two states and from Canada) based on the Hawaii model and who have completed evaluations are attached. (See Attachments I: a – g).

A summary of research findings to date is provided below:

### **Critical Research Findings**

At the August 18th, 2005 Advisory Task Force meeting, Anne Duggan, ScD, from Johns Hopkins University, presented a summary of prevention science and the research and experience gained from the HHS program over the past ten years. Some of the highlights of her report include the following:

- Home visiting can be more effective than other strategies to prevent child abuse and neglect (CAN). Evidence from multiple studies suggests that both paraprofessional and professional home visiting models are effective in preventing child abuse and neglect. It is worth investing in home visiting and in efforts to improve the HHS program.
- Home visiting can be effective in addressing a range of outcomes (e.g. promoting child development, addressing parent risks, preventing child abuse and neglect). However effects tend to be small.
- In home visiting there is considerable variation among providers in the implementation and delivery of services to families. These differences are also seen in the health care, education and other social service programs.
- Basic program attributes such as the type of staff hired, length of service model and primary program goal do not clearly explain variability in program impact.
- Research is needed to test interventions to reduce variability, increase quality, and ascertain resulting changes in impact. Discrete interventions can improve the effectiveness of the basic HHS model.

- Discrete interventions which are added-on, even if theory and evidence-based, must be tested to establish efficacy and effectiveness.
- HHS should invest in research to test the impact of such interventions if it wants to be confident and have evidence that it is achieving intended outcomes.
- The malleable risks (e.g. domestic violence, substance abuse and maternal depression) for which families are targeted are, in fact, strongly associated with CAN and the quality of parenting.
- Risk reduction should be an explicit outcome measure.
- Without adequate training, protocols and supervision, HHS staff failed to address the risks for which parents had been targeted.
- Recent and future changes to HHS training, protocols and supervision should be tested for their impact on service quality and family outcomes.
- HHS retention rates have not changed much overall since the original study. HHS retention rates are not too different from those of other Healthy Families America programs.
- Retention goals need to be realistic.
- Consider “second chances” for enrollment.
- Children’s primary care doctors saw HHS families frequently in the child’s first year of life. Test ways to improve service integration and to improve HHS impact through reinforcement of messages.

Some implications for policy and practice include:

- evaluating long as well as short term impacts, and a range of outcomes,
- serving families until assessment shows risks have been substantially reduced, and
- identifying families via prenatal screening.

Experts agree that in order to provide effective services there needs to be a complete conceptualization of program design and implementation. There must be detailed measurement of service delivery: programs need to be designed with evaluation in mind. (See Attachment D) for detailed presentation on research findings.) Efforts are now underway to examine aspects of HHS program design and service delivery which, through restructuring, could lead to more effective outcomes for children and families.

## **Summary**

The HHS Advisory Task Force has defined its working structure and is organized to proceed with the task of planning and restructuring the HHS. Analysis of best practices in home visitation and current research and evaluation models and results will assist members in the job of program redesign. As mentioned earlier, work on restructuring contract goals in terms of outcomes, streamlining requirements, piloting a curriculum to structure home visits with the goal of improving quality of home visitors’ performance, as well as piloting a two-tier system of service delivery (in the form of the Enhanced Healthy Start services pilot serving Child Welfare Services families) had already begun prior to the first meeting of the Task Force. These efforts

will be closely monitored over time to analyze their effect on overall effectiveness of the program in meeting its goals.

DOH would like to thank all the members of the Task Force for their commitment to this process and the hard work involved, and in particular Gail Breakey of the Hawaii Family Support Institute, and Anne Duggan of Johns Hopkins University for their timely and informative presentations.