

Healthy Start ~ Healthy Families Oregon

Reference Guide
for
Program Managers and Supervisors



Oregon Commission on Children and Families
October 2011

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Evaluation Support (NPC): healthystart@npcresearch.com

Useful Resources:

"Red Book" Evaluation Manual

"QuickStart" Orientation Manual

Healthy Families America – Site Self Assessment Tool

Status Report Data Tables

Healthy Start~Healthy Families Oregon Program Policy & Procedure Manual

- Quality Assurance Plan
- Training Plan

Useful Links:

www.oregon.gov/occf

www.npcresearch.com

www.healthyfamiliesamerica.org

www.preventchildabuse.org

www.zerotothree.org

www.aap.org

www.circleofsecurity.org

Building Healthy Start ~ Healthy Families Oregon

History

The 1993 Oregon Legislature established Healthy Start/Family Support pilot projects to assist families in giving their newborn children a “healthy start” in life through ORS 417.795. The Oregon Commission on Children and Families (OCCF) established pilot projects in selected counties throughout Oregon. There were several key ingredients:

- Healthy Start was designed to be for *all* families with newborns, reaching those with first-born children at a minimum.
- Services were built around the critical elements that provide the foundation for Healthy Families America (HFA) programs.
- A statewide performance measurement system identified outcomes for children and families.

In 1999, under Senate Bill (SB) 555, Healthy Start’s home visiting/family support services were reconfirmed as a primary prevention program dedicated to creating wellness for Oregon children and their families. In 2001, with HB 3659, Healthy Start services reached all of Oregon’s 36 counties although funding for the system remained level.

Voluntary

During the 2003 legislative session, ORS 417.795 was amended to ensure the voluntary nature of Healthy Start by requiring that express written consent be obtained from the family *before* any screening or other services could take place. The legislative intent at this session was to ramp up Healthy Start to reach 80% of first birth within the biennium. Due to diminished resources, this did not occur.

Restructuring

Faced with diminished resources, the 2005 legislature further reduced funds to Healthy Start by an additional 20%, requiring a re-examination of the Healthy Start delivery system. A Restructure Committee, formed with wide representation, recommended: continued adherence to the HFA model; performance-based decision-making; streamlining the system by which families were offered intensive service; modifying the funding formula; and encouraging regionalization to reduce overhead and pool resources.

Accreditation

At the same time, Healthy Start ~ Healthy Families Oregon embarked on the groundbreaking process of accreditation through the national HFA initiative, considered to be an evidence-based promising practice by the Rand Corporation (www.promisingpractices.net).

During the accreditation process, each program conducted an extensive self-study, documenting how each of the HFA best practices standards was being met. Simultaneously, Central Administration at OCCF conducted a self-study of the state multi-site system. Throughout 2005-06, HFA reviewers examined the self-studies and interviewed families, staff and collaborators.

By June 2007, all requirements had been met and Healthy Start ~ Healthy Families Oregon became fully accredited as a statewide system of exemplary home visiting programs through HFA.

Healthy Start ~ Healthy Families Oregon at a Glance

Purpose of Home Visiting

Healthy Start ~ Healthy Families (HS/HF) is a statewide home visiting program designed to prevent child maltreatment using the evidence-based Healthy Families America (HFA) program model.

HS/HF is a key component of Oregon's system of supports and services for families with young children.

HS/HF promotes wellness for Oregon families with first-born babies by offering universal, accessible, and non stigmatizing screening and outreach services tailored to the family's unique situation.

By enhancing family functioning and supporting positive parenting practices, HS/HF contributes to Oregon Early Childhood Benchmarks, including:

- prevention of child maltreatment,
- improvement of health outcomes for children and families and
- support of school readiness.

Goals

For families receiving intensive home visiting services, HS/HF seeks to:

- promote positive parent-child relationships,
- support healthy childhood growth and development,
- enhance family functioning by teaching parents to identify strengths and utilize problem-solving skills, and
- improve the family's support system through linkages and referrals to available community services.

Target Population

HS/HF attempts to reach all consenting first-birth parents to offer screening, referral, and information. Families may also receive a Welcome Baby gift packet filled with information about parenting and child development.

Families that are identified through HS/HF's screening process as being at higher risk for adverse childhood outcomes are offered ongoing home visiting service. Services are offered to new families either during the prenatal period or at the time of birth (or soon after).

Screening and Referral Services

Screening systems vary across programs, and are designed to be cost-effective, locally-organized systems that reach families during the prenatal period or within two weeks after birth.

Using a research-based screening tool, the *New Baby Questionnaire (NBQ)*, HS/HF workers or volunteers screen new parents for characteristics associated with poor child and family outcomes, such as social isolation, lack of prenatal care, financial stress, depression and substance abuse.

Families with few, or no characteristics that place them at risk for poor outcomes, receive information and referral services. For example, lower risk families may receive a packet of child development and parenting information, or a telephone call with information about community resources such as parenting support groups or breast-feeding assistance.

Intensive Services

Families who screen positive (NBQ identified characteristics associated with poor childhood outcomes) are offered Intensive Home Visiting Services (as caseloads allow). Using the evidence-based HFA model, HS/HF offers up to three years of home visiting services for Oregon's high risk families. In some cases families can remain in the program for up to five years of age.

Newly enrolled families receive weekly home visits from a qualified and trained Home Visitor. Visits decrease in frequency as the family's needs decrease. Programs use the HFA system of well-defined levels of service to determine the frequency of home visits based on a family's current needs and resources.

Home Visitors have limited caseloads in order to support their intensive work with families. Caseloads for a full-time worker may range from 15 – 25 families, depending on how frequently each family is being visited.

The Intake Process

Home visitors spend the first several visits getting to know the family. The intake process begins with a family values activity, to learn about what is important to the family, their strengths, resources and culture. Then the Family Assessment Interview (FAI) areas are discussed to identify areas of stress. During that time or at the end of the FAI, Home Visitors walk families through the Family Concerns and Resources activity to learn about the family's concerns, needs and any resources the family may desire to help meet those needs. After the FAI information is gathered, Home Visitors lead a Wishes for my Child Activity that

allows for a conversation about what the parent(s) want for their child and what they can do to encourage those qualities in their child.

Family Assessment Interview Over the first two to three home visits; Home Visitors use the standardized Family Stress Checklist (FSC) to better understand any issues and challenges that may put the family at risk for negative outcomes. Many of the topics will naturally be addressed in the course of conversation, going over the New Baby Questionnaire and during the Family Values activity. Learning about the family's risk factors is essential to ensure safety for the family and the Home Visitor. Additionally, addressing those risk factors and building protective factors guides the home visiting services.



Family Goal Plan (FGP)

The Home Visitor works with the family to assist them in setting one, or at the most two, meaningful goals at a time. Through the development of a Family Goal Plan the Home Visitor and family discuss the family strengths and resources to support them in achieving their goal, along with potential barriers to accomplishing the goal. Contingency plans, along with specific strategies for achieving the goal are discussed. Goals are broken down into small, mini goals that allow families to

experience successes and build critical problem solving skills. FGPs are discussed and updated regularly during home visits.

In addition, Home Visitors encourage families to be active participants in solving their problems. As part of that process, Home Visitors may share information and empower families to access needed community resources, including basic tangible supports such as food, clothing, baby supplies and housing, as well as more specialized assistance such as mental health counseling, substance abuse treatment, or health services.

Positive parent-child relationships

Promoting positive parent-child relationships is the cornerstone of this program. Home Visitors regularly promote and encourage positive, research-based attachment behaviors between parent and child. The CHEEERS parent-child interaction assessment is conducted on every home visit, allowing Home Visitors and Supervisors to identify which areas of the parent-child interactions could use extra support. Home visits focus on supporting parents in their role as the child's first teacher,

providing evidence-based parenting and child development information, coaching, and support. Parent-child activities are typically a part of each home visit. The Home Visitor encourages the parent to do the activities with their child and looks for ways to utilize items from the home environment for the activities.

Healthy growth and development

Home visitors work with parents to make sure children are developing appropriately. Home Visitors provide regular developmental screening utilizing the Ages and Stages Developmental screens and families are referred for early intervention services when appropriate to ensure the best possible developmental outcomes. Home Visitors monitor children's immunization status and access to preventive health care, encouraging regular well-baby checks and appropriate use of medical services. Additionally, Home Visitors provide families with information about nutrition, stress-reduction, age appropriate toys and developmentally appropriate activities to encourage optimal growth and development.

Roles of Program Manager and Supervisor

Managing a Healthy Start ~ Healthy Families program and supervising home visitors are complex processes that are both challenging and rewarding. This handbook is designed to make the tasks easier by providing information, resources, and guidelines for program managers and supervisors as they fulfill their roles.¹

Program Manager

Program managers (PM) are responsible for the day-to-day, hands-on management of the program, and are involved in program planning, budgeting, staffing, training/service, program evaluation and office management. PMs are also responsible for ongoing collaboration with community/state partners, public relations and for maintaining positive working relationships with health care providers.

Depending on the size and resources of the site, program managers may also provide direct supervision to Home Visitors. If a site has a supervisor, the PM typically provides supervision to that individual. The PM receives regular supervision according to the personnel policies of the employing agency.

Program Manager Key Responsibilities

| Tasks | Frequency |
|---|----------------------------------|
| Strive to meet Oregon Performance Indicators and maintain HFA standards | Ongoing |
| Write local Healthy Start Program Policies and Procedures Manual and update the manual annually | At outset and then annual review |
| Analyze and develop plans required by HFA regarding Acceptance, Retention, Home Visit Completion, Cultural Sensitivity, and Staff Turnover | Minimum of every two years |
| Monitor screening, program acceptance, and home visit completion data | At least quarterly |
| Develop, implement and monitor comprehensive Program Training Plan; update as appropriate | Annual Review |
| Establish Memorandum(s) of Agreement with hospitals and/or other appropriate entities to provide access to first time parents. | Ongoing |
| Maintain and enhance relationships with volunteers providing donations for program | Ongoing |
| Liaison with local CCF, early childhood team, appropriate community agencies and community partners | Ongoing |
| Liaison with Central Administration HS staff and attend semi-annual PM/Supervisor Training | Semi-Annual |
| Work with Local Advisory Committee to promote and support program | As scheduled |
| Develop and monitor program budget, including monitor expenditures, Medicaid Administrative Claiming, leveraging community contributions and other additional revenue | Ongoing |
| Research opportunities for leveraged resources, alternative funding sources, cash contributions, in-kind services, and grant prospects | Ongoing |
| Prepare for and follow up on annual site visit by OCCF and LCCF | Annually |

¹ Role and responsibilities for local Commissions on Children and Families are described separately in OCCF's *Healthy Start Reference Guide for Local Commissions on Children and Families*.

Supervisor

Supervisors provide ongoing, intensive, professional supervision to the home visitors. Supervision is directed to assuring quality of service provision and protecting the integrity and respect of the families served. Supervisors assist Home Visitors to:

- support families in developing realistic and effective support plans that will empower them to meet their objectives/goals,
- understand why a family may not be making the expected progress around personal and program goals, determining effective methods of intervention, and
- reflect on their practice and make sense of their experiences in working with over-burdened families, avoiding burnout.

Supervisors assist in staff selection, participate in orientation and training, conduct family file reviews, assist in or maintain the data collection system, and monitor the performance of the home visitors. The supervisor may also act as a liaison with other agencies and works with the program manager to assure overall quality in program services.

Supervisor Key Responsibilities

| Tasks | Frequency |
|--|-----------------------|
| Assign families to home visitors (HVs) and manage caseloads | Weekly |
| Be available for immediate de-briefing w/HVs and provide individual reflective supervision with each HV | Min. 1.5 hrs. week |
| Provide home visits as needed to cover HVs absences | As needed |
| Work with HVs to develop a Home Visitor Plan to Support Family | Initial and Ongoing |
| Monitor all aspects of home visiting including: Referrals; Consent; Interactions w/ families; Family Assessment Interview; Levels of Service; Culturally specific strategies; Caseload Management; Goals (family and program); and Curriculum guidance | Ongoing |
| Review/discuss home visit records in supervision | Weekly |
| Review home visit completion data with HVs | Monthly |
| Monitor and ensure that HVs submit evaluation forms on a timely basis | Monthly |
| Research/coordinate training for staff to meet professional development requirements. Follow up with implementation strategies | As needed |
| Telephone two families per HV to ask about satisfaction | Every 180 days |
| Observe HVs conduct home visit | Annually ² |
| Observe each HV conduct a Family Assessment Interview | Annually ³ |
| Comprehensive review of family files | Annually |
| Review/discuss family retention rates with HVs | Annually |
| Develop an individual training plan per HV | Annually |
| Participate in hiring, training, and performance evaluation of new staff | As needed |

Note: The ratio of supervisors to staff is no more than 1:6 for a full-time supervisor. Supervisors who are also program managers or who have other responsibilities, or part-time supervisors pro-rate the ratio accordingly, based on the amount of time they actually have dedicated to their supervisory role.

² More frequent shadowing for newly employed home visitors

³ More frequent observations are done for home visitors who are new to conducting the FAI.

INTENSIVE SERVICE AND SUPERVISOR SPECIFIC HFA STANDARDS

Healthy Start ~ Healthy Families supervisors are responsible for making sure the program follows certain HFA Standards including Sentinel and Safety Standards. These standards are listed below. **S** indicates Sentinel or Safety Standard.

- 3-2.B. Staff uses the policy and procedures in order to build family trust, engage them in services, and maintain family involvement.** *To the best ability of the home visitor and supervisor, these services should be uniquely tailored to individual family. The activities should be focused on strategies that will show the family that the worker is genuinely interested in them and willing to continue to offer family support services.*
- 3-3.B. The program places families in creative outreach appropriately and continues creative outreach for three months, only concluding creative outreach services prior to three months when the families have engaged in services, refused services or moved from the area.**
- 4-1.B.** The program ensures that families remain on a weekly home visitation level for a minimum of six months after the birth of the baby.
- 4-2.B. Families at the various levels of service offered by the program receive the appropriate number of home visits, based upon the level of service to which they are assigned.**
- 4-2.D. Each family's progression (as identified on level change criteria) to a new level of service is reviewed by the family, home visitor and supervisor and serves as the basis for the decision to move the family from one level of service to another.** *Supervisors and home visitors should have documented conversation about potential level change during routine supervisory sessions where family progress is discussed.*
- 5-2.B. Ethnic, racial, linguistic, demographic, and other cultural characteristics identified by the program are taken into account in overseeing staff-family interactions.**
- 6-1.A. The supervisor and home visitor discuss and review the issues identified by the family in the initial assessment during the course of home visiting services.** *Supervisors and home visitors review the initial assessment, identifying and documenting an initial approach. This is the beginning of the Home Visitor Goal Plan. Supervisors and home visitors refer back to the initial assessment / home visitor goal plan during the course of services offered to families to clarify how the issues that place families at-risk for poor childhood outcomes are addressed over time. The frequency of this review depends on the level of service the family is on and the complexity of the issues identified in the initial assessment. Additionally, the supervisor and home visitor plan how to discuss the information from the initial assessment with families. Clear documentation of crisis issues assures continuation of intervention plans should there be any staff changes.*
- 6-2.C. The home visitor and supervisor review Family Goal Plan (FGP) progress regularly.** *The supervisor and home visitor collaborate to insure the goals for families remain relevant, challenges to achieving goals are addressed, successes for each of the steps/objectives are celebrated, and the services the home visitor provides are connected to the goals (e.g., serves as the guide for services). Additionally, the supervisor and home visitor brainstorm any barriers the home visitor is facing.*
- 6-2.D. The FGP serves as the guide for delivering services.**
- 6-3.B. The home visitor routinely builds skills and shares information with families on appropriate activities designed to promote positive parent-child interaction and child development skills.**

6-3.C. The home visitor *routinely* shares information with families designed to promote positive health and safety practices.

S 6-6.B. The program tracks target children suspected of having a developmental delay and follows through with appropriate referrals and follow-up, as needed.

7-2. Based on the program's identified *immunization schedule*, the program ensures that immunizations are up-to-date for target children.

7-3. Home visitors provide information, referrals, and linkages to available health care resources for all participating family members.

7-4.A. The program connects families to appropriate referral sources and services in the community as needed.

7-4.B. The program tracks and follows up with the family, and/or service provider (if appropriate) to determine if the family received needed services.

8-1.C. Home visitors are within the caseload ranges, as stated in standard 8-1.A and 8-1.B.

S 11-2.A. The program has supervisory policy and procedures to assure that all direct service staff and volunteers and interns (performing the same function) are provided with the necessary skill development to continuously improve the quality of their performance and are held accountable for the quality of their work. Procedures can include a variety of mechanisms such as:

- discussing family retention and attrition,
- shadowing, coaching and providing feedback on strength-based approaches and interventions used (e.g., problem-solving, crisis intervention, etc.),
- reviewing family progress and level changes,
- providing feedback on documentation;
- integrating results of tools used (e.g., developmental screens, evaluation tools, etc),
- integrating quality assurance results that include regular, and routine review of assessments and assessment records, home visitor records, and all documentation used by the program,
- discussing home visit/assessment rates,
- assisting staff in implementing new training into practice,
- assessing cultural sensitivity/practices,
- providing guidance on use of curriculum,
- providing reflection on techniques and approaches,
- identifying areas for growth;
- identifying and reflecting on potential boundary issues, and
- sharing of information related to community resources.

S 11-2.B. The program has supervisory policy and procedures to assure that direct service staff (e.g., assessment and home visitation staff) and volunteers and interns (performing the same function) are provided with the necessary professional support to continuously improve the quality of their performance.

Procedures can include a variety of mechanisms, such as:

- regular staff meetings,
- open door policy with supervisors
- multi-disciplinary teams,
- on-call availability to service providers,
- exploration/reflection of impact of the work on the worker,
- employee assistance program,
- clinical supervision,
- acknowledgement of performance,
- provision of tools for performing job,

-
- creating a nurturing work environment that provides opportunities for respite,
 - scheduling flexibility,
 - providing a career ladder for direct service staff.

S GA-5.A. The program ensures that all parents are notified of family rights and confidentiality at the on-set of services, both verbally and in writing. At a minimum these forms should include the following:

Family Rights

- the right to refuse service (voluntary nature);
- the right to referral, as appropriate, to other service providers; and
- the right to participate in the planning of services to be provided or the write to an individualized service plan (IFSP).

Confidentiality

- the manner in which information is used to make reports to funders, evaluators or researchers (typically in aggregate format);
- the manner in which consent forms are signed to exchange information; and
- the circumstances when information would be shared without consent (i.e., need to report child abuse and neglect).

S GA-5.B. Parents are informed and sign a Release of Information (ROI) every time information is to be shared with a new external source. The consent includes the following, but is not limited to:

- a signature of the person whose information will be released or parent or legal guardian of a person who is unable to provide authorization;
- the specific information to be released;
- the purpose for which the information is to be used;
- the date the release takes effect;
- the date the release expires;
- the name of person/agency to whom the information is to be released;
- the name of the HFA program providing the confidential information; and
- a statement that the person/family may withdraw their authorization at any time.

S GA-6.B. The staff uses the policy and procedures in order to report suspected cases of child abuse and neglect.

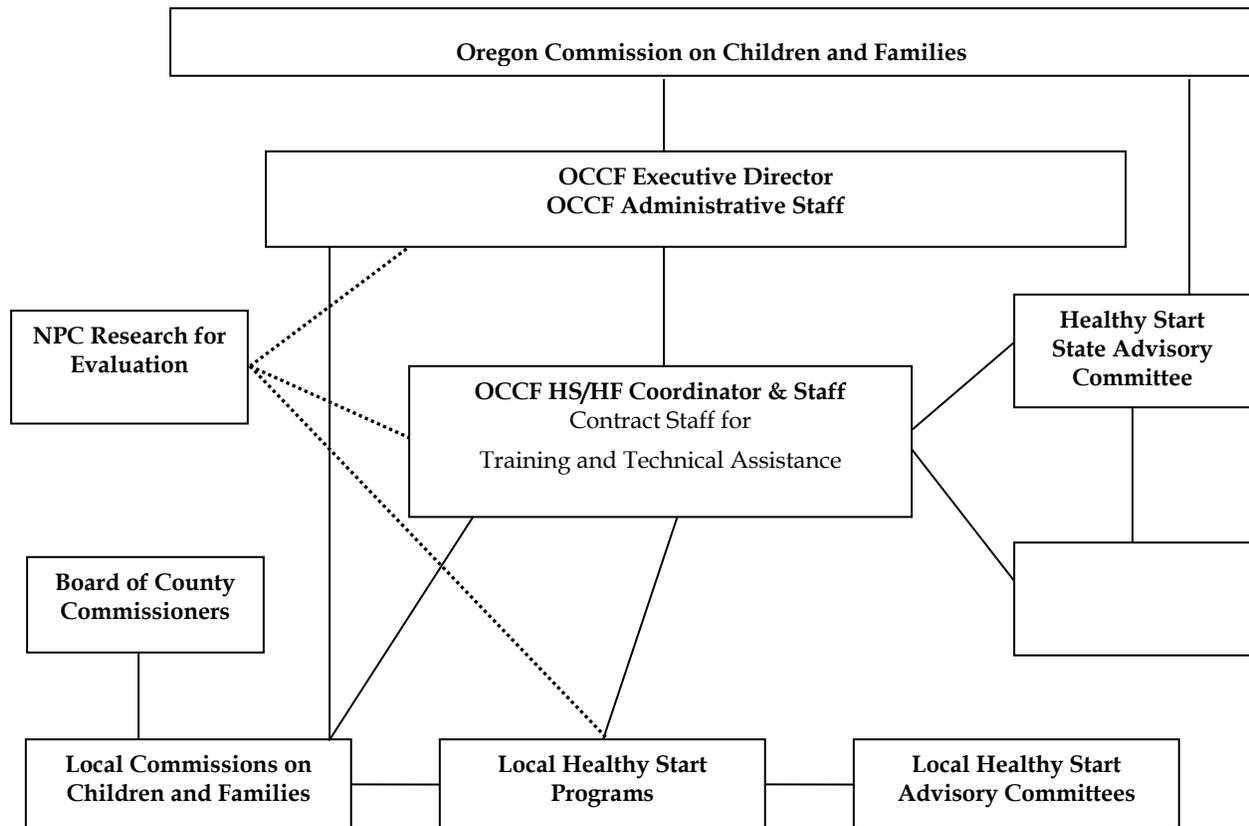
Healthy Start ~ Healthy Families Oregon State System

Healthy Start ~ Healthy Families Oregon programs operate under the Oregon Commission on Children and Families (OCCF) and the Local Commission on Children and Families' (LCCFs). Central Administration provides programs with specialized training and technical assistance and work with LCCFs to ensure quality cost-effective services.

Oregon' Healthy Start state system enhances the capacity of individual programs to meet the needs of children and families. Healthy Start operates under governing legislation (see OCCF website www.oregon.gov/OCCF/Mandate/malaws.shtml):

- Oregon Revised Statutes (ORS 417.795)
- Oregon Administrative Rules (OARs), Division 45, 423-045-005-ff

State System Organization



To qualify for Healthy Families America (HFA) accreditation as a multi-site system, Healthy Start's Central Administration meets standards established for the following five functional areas:

1. Program Policies
2. Training and Technical Assistance
3. Quality Assurance
4. Evaluation
5. Administration

State Policies and Procedures

The HS/HF Program Policies and Procedures Manual (PPPM) creates a statewide set of operational definitions for HFA's evidence-based critical elements. Local programs adopt the state PPPM, adding procedures where noted to ensure that the program runs smoothly in the local community.

The PPPM is reviewed on an annual basis. The multi-site system has a period of time for revision suggestions and input. The manual is then finalized by the HS State Steering Committee and distributed electronically on the State Commission's website. In turn, programs update local PPPMs to reflect changes within 90 days.

Training and Technical Assistance

Central Administration provides a variety of training resources, including the Core Integrated Strategies for Home Visiting (formerly FSW Core), Family Assessment Interview, Supervisor and Program Manager trainings for new staff and Quick Start, a self-study orientation manual. Other trainings are offered periodically.

Local programs are responsible for providing regular ongoing training on specialized topics to meet HFA requirements during the first year of employment. All required training is available online through HFA. In addition, programs must provide regular ongoing training for the entire staff.

Training Tracker, a web-based database, allows Central Administration to monitor scope and timeliness of training statewide.

Technical assistance is provided on an as needed basis and through the annual site visit process.

Central Administration conducts Program Manager/Supervisor semi-annual meetings with updates and training on implementation issues and quality management practices.

Quality Assurance A state Quality Assurance (QA) plan outlines quality management processes both for the state system and for local programs. Each site adopts the state QA plan and adds any specific details to clarify local strategies.

In partnership with the LCCF, Central Administration staff or contractors visit each site annually to assess quality assurance indicators and processes.

After receiving a written report, sites develop a Program Goal Plan (PGP) to address any identified challenges and set goals for the coming year.

Evaluation As required by legislation, OCCF contracts with an independent evaluator to measure performance indicators and participant outcomes. Programs are responsible for ensuring that data reaches the evaluators in a timely manner. Semi-annual reports allow Central Administration, LCCFs and program staffs to monitor progress on key indicators and outcomes.

A biennial Status Report presents a comprehensive review of implementation and program outcomes including the effects of HS/HF on child maltreatment rates. Data are reported in aggregated form and may be omitted when sample size is so small that family privacy would be threatened.

Central Administration

Central Administration staff is responsible for guiding the program statewide and assuring its continued quality. Central Administration staff serves as liaison between the program and the state Early Childhood System, linking the program to state and local commissions and to the national Healthy Families America and Prevent Child Abuse America organizations. Central Administration staff ensures local HS/HF programs are kept up to date on program goals, policies and procedures. Central Administration staff and contractors provide training and technical assistance, and support programs and local commissions in their management of HS/HF programs. Central Administration staff administers all OCCF databases. They maintain communication with the evaluation team, and represent the program through public relations and media relations.

State Advisory Committee

As a Standing Committee of the Oregon Commission on Children and Families (OCCF), the State Advisory Committee is responsible to and advocates for the HS/HF program and its goals. In 2011 this committee merged with the Steering Committee, expanding its role and function. The Advisory Committee serves as a venue for communication among persons representing various aspects of the state system of supports and services for early childhood. This group is composed of community members (advocates and

stakeholders) in addition to representation from local program managers/supervisors, LCCF staff, OCCF staff, the evaluation team and HS/HF contractors.

This Committee is responsible for guiding, overseeing, and monitoring overall program implementation of HS/HF statewide to follow the HFA critical elements. The committee implements, reviews, and monitors the HS/HF Program Policies and Procedures Manual (PPPM), and the Quality Assurance, Training and Technical Assistance Plans. Other roles and functions include communicating with HS/HF programs regarding program implementation, overseeing system-wide training and technical assistance, reviewing annual status reports and developing the program implementation section of the of the Strategic Plan.

Budget

Each HS/HF program is responsible for developing and monitoring their site-specific budget. The site-specific budget is submitted to the Local Commission on Children and Families (LCCF) at the beginning of each biennium. OCCF State staff report the amount of Medicaid earned each quarter, both to the LCCF Director and local program manager. The LCCF Director and the program manager are responsible for implementing changes in the budget based on fluctuations in Medicaid earnings, unexpected costs or funding changes occurring during a legislative session.

Building Community Connections

Programs work with their local Advisory Group members and LCCFs to ensure that the community understands HS/HF's mission and the successes that the local program has achieved. By creating a positive image of HS/HF and letting people know how they can help; programs can build community support.

Communication

Effective public relations depend on having a plan for what messages will be conveyed, how they can best be conveyed and by whom and/or what. In planning, program managers should recognize that people are drawn to positive visions and actions, not problems and guilt. Consider including the following strategies:

- Produce and distribute a local "Status Report" by using NPC Research's *Implementation and Outcome Data Report* (www.npcresearch.com). Use the information to trumpet local successes.
- Recruit parents to tell stories about how HS/HF has affected their lives. Statistics will have more punch when coupled with success stories from real people in the community.
- Use local media to get your messages out. Provide press releases to draw attention to successes. Develop information on positive parenting practices and make it available to the media. Write letters to the editor about HS/HF.
- Make presentations about HS/HF to local organizations and agencies. Sponsor or co-sponsor special events for families and young children.
- For HS/HF programs, the key to success lies in partnering with other groups who share a commitment to children and families. Let people know how the
-

community is working together to achieve HS/HF's results. Highlight how others *can* and *do* get involved.

Seek opportunities to present about HS/HF to community agencies, hospitals, and partners. Have these partners come present their services to your staff as well.

Hospitals, Clinics, Agencies

Establish working relationships and agreements with hospitals, clinics and other sources where first birth families will be identified. Written agreements will clearly define expectations and responsibilities for both the cooperating organization and the HFA site, and will usually provide stability when there are staff changes at these organizations.

Matching Funds

HS/HF programs are required to demonstrate at least a 25% local match as part of their base operating budget. At least 5% must be cash or cash equivalent. The match includes such items as cash contributions, in-kind contributions, volunteer hours and the value of donated items.

Some of the ways in which HS/HF programs have successfully involved community members and/or organizations to create these matching resources include:

- sharing resources like space, staff, or training opportunities,
- receiving cash contributions or conducting fund-raisers,
- providing material goods, such as groceries or baby supplies, and
- volunteering to assist with grant-writing or providing services such as screening/outreach and clerical support.

Promotional Materials

Central Administration has a variety of materials and other resources that programs can use to promote Healthy Start ~ Healthy Families Oregon. Central Administration can provide information on these items and technical assistance for their effective use.

Healthy Start ~ Healthy Families Oregon Materials

| Materials | Availability |
|--|---|
| <i>Healthy Start ~ Healthy Families Brochures:</i> Family friendly program description – with information on local contacts. | Available in English and Spanish |
| <i>Healthy Start ~ Healthy Families Video:</i> Video presentation describing the program, showing the home visiting process and highlighting family success stories. | Available in English on DVD |
| <i>Reading for a Healthy Start:</i> Brochure describing the importance of and effective practices for reading to young children. | Available in English, Russian and Spanish |
| <i>Oregon's Child, Everyone's Business:</i> Photo cards with developmental information and positive parenting activities and different age periods. | Available in English and Spanish |
| <i>Healthy Start ~ Healthy Families Display Board Layout</i> (words and pictures) for a standard table-top tri-fold display. Local contact information can be added. | Available in English and Spanish |
| <i>Healthy Start ~ Healthy Families Elevator Cards:</i> What you might say if somebody asked "What is Healthy Start~ Healthy Families?" | Available in English |



Performance Indicators

Healthy Start ~ Healthy Families (HS/HF) uses performance measurement strategies to systematically assess progress toward its goals. On a biennial basis, the State Commission reviews and approves a set of Service Delivery and Outcome Indicators after input from the state's Steering and Advisory Committees.

Expectations. Central Administration sets statewide expectations for the service and outcome indicators. When possible, expectations are based on HFA standards described in the PPPM.

Service Delivery Indicators (#1–#8)

Expectations for the first six indicators are related to specific HFA standards as outlined in the PPPM. These focus on

- identification and screening of first birth families in a timely manner (#1 and #2)
- timely first home visit (#3)
- ensuring higher risk families receive appropriate numbers of home visits (#4) and
- engagement and retention for higher risk families (#5 and #6).

The remaining two service delivery indicators follow legislative intent to serve as many higher risk families as possible in a cost-effective manner.

Caseload capacity (#7) is calculated from home visit completion data. Match expectations (#8) ensures local contribution.

Family Outcomes Indicators (#1–#6)

These indicators have been selected to assess interim progress toward HS/HF's high-level outcomes of reducing child

maltreatment and helping children become ready for school.

Outcome expectations for #1 and #2 follow HFA standards as described in the PPPM.

Expectations for the remaining outcome indicators are based both on past achievements and goals for these important supports.

Reviewing indicators. *No single indicator* is sufficient to judge program quality. Different programs will have different strengths and different areas in need of further support. However as a group, the performance indicators provide a useful snapshot of successes and challenges in reaching and serving higher risk families.

**Performance Indicators and Service Expectations
2001-2013 Biennium**

| <i>Service Delivery Indicators</i> | Exceeds HFA or Oregon Standard (Target) | Adequate | Below Oregon Standard |
|---|--|---------------------------------------|---|
| 1. Percentage of first births screened based on birth records from the previous year | 60% or more screened | 50%-59% screened | Fewer than 50% screened |
| 2. Percentage of screenings occurring prenatally or within the first 2 weeks of the child's birth | 80% or more screened prenatally or within 2 weeks of birth | 70-79% screened within 2 weeks | Fewer than 70% screened within 2 weeks |
| 3. New Indicator: Percentage of new IS families receiving the first home visit prenatally or within 3 months of baby's birth. | 90% | 80-89% | Fewer than 80% |
| 4. Percentage of families receiving 75% of expected visits based on assigned level | 75% or more receive 75% of expected visits | 65-74% receive 75% of expected visits | Fewer than 65% receive 75% of expected visits |
| 5. Percentage of IS families engaged in Intensive Services for 90 days or longer (early engagement) | 90% or more | 75-89% engaged | Fewer than 75% engaged |
| 6. Percentage of families remaining in Intensive Services for 12 months or longer | 65% or more | 50-64% remained | Fewer than 50% remained |
| 7. Percentage of Expected Adequate Caseload Capacity. | 25-30 ave. caseload points per 1.0 FTE | 18-24 ave. caseload points per 1 FTE | Less than 18 ave. caseload points per 1 FTE |
| 8. Match Expectations Met. Programs currently expected to have a 25% match, of which 5% is cash. | NA | 25% match, with at least 5% cash | <25% match or < 5% cash match |
| <i>Outcome Indicators</i> | | | |
| 1. Number of IS children with Primary Health Care Provider | 80% or higher | 70-79% | Less than 70% |
| 2. Immunizations. Percentage of IS children whose immunizations are up-to-date | 80% or higher | 70-79% | Less than 70% |
| 3. Reading to children. Percentage of IS children whose parents report reading to them 3 times/week or more | 85% or higher | 70-84% | Less than 70% |
| 4. Positive Parent-Child Interaction: Percentage of Parents reporting positive parent-child interactions | 85% or higher | 70-84% | Less than 70% |
| 5. Reduced Parent Stress. Percentage of parents reporting reduced parenting stress | 65% or higher | 50-64% | Less than 50% |
| 6. Help with social support. Percentage of parents reporting that HS/HF helped with Social Support. | 85% or higher | 70-84% | Less than 70% |

Healthy Families America

What is Healthy Families America?

Healthy Families America (HFA) is a national initiative to help parents of newborns get their children off to a healthy start. Participation in HFA services is *strictly voluntary*. HFA offers home visiting and other services to families in over 450 communities, with a ninety percent acceptance rate.

In 1992, Prevent Child Abuse America, formerly known as the National Committee to Prevent Child Abuse, launched Healthy Families America in partnership with Ronald McDonald House Charities. The initiative promotes positive parenting and child health and development, thereby preventing child abuse, neglect and other poor childhood outcomes.

What is the Relationship between HFA and Prevent Child Abuse America?

Prevent Child Abuse America is the nation's leading child abuse prevention organization. Founded in 1972, Prevent Child Abuse America is committed to preventing child abuse in all its forms by working at national, state and local levels. Prevent Child Abuse America, in collaboration with its Chapter Network in most states, is improving quality of life for at-risk children and families.

Prevent Child Abuse America/Healthy Families America has nationally recognized strengths in public awareness, research, training, quality assurance, and a system to provide technical assistance to state HFA leadership teams. This combination of strengths enables HFA to put research into practice, and assures the consistent provision of quality services as programs grow and expand.

What are Healthy Families America's Critical Elements?

All HFA programs adhere to a series of Critical Elements, which represent the field's most current knowledge about implementing successful home visitation programs. Critical Elements serve as the framework for program development and implementation. Only those programs that apply for affiliation and promise to adhere to all the elements, as determined through the HFA accreditation system, may be referred to as HFA sites. In addition to helping assure quality, these basic elements allow for flexibility in service implementation to permit integration into a wide range of communities and provide opportunities for innovation.

What is Healthy Families America's Accreditation Process?

The development of the HFA accreditation process was initiated as a result of requests from HFA sites and state leaders for a process that would help preserve the quality of the HFA movement as it grows and expands. This process supports each program in monitoring and maintaining its quality over the long term, as well as put into place a mechanism to ensure the overall quality of the HFA program.

Changes to the Accreditation Process

In 2007 HFA made significant changes to the accreditation process including streamlining the standards and adding *Intent* and *Tips* for many standards. This provides a concrete way for programs to demonstrate quality services.

The Critical Elements are the core of HFA program design, implementation and quality. They are split into three major categories: Initiation of Services, Service Content and Service Providers.

The following are brief descriptions of each element.

Service Initiation

- #1 · Initiate services prenatally or at birth.
- #2 · Use a standardized assessment tool to systematically identify families who are most in need of services.
- #3 · Offer services voluntarily and use positive outreach efforts to build family trust.



Service Delivery

- #4 · Offer services to participating families over the long term (i.e., three to five years), using well-defined criteria for increasing or decreasing frequency of services.
- #5 · Services should be culturally competent; materials used should reflect the diversity of the population served.
- #6 · Services are comprehensive, focusing on supporting the parent as well as supporting parent-child interaction and child development.

#7 · All families should be linked to a medical provider; they may also be linked to additional services.

#8 · Staff members should have limited caseloads.

Staff Characteristics

#9 · Service providers are selected based on their ability to establish a trusting relationship.

10 · All service providers should receive training in areas such as cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community, as well as ongoing training.

#11 · Service providers should receive ongoing, effective supervision so they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively and to express their concerns and frustrations to see they are making a difference and to avoid stress-related burnout.

Programs are also held to Best Practice Standards in the **Governance and Administration (GA)** standard. This is not a critical element; however it ensures that the program is governed and administered in accordance with principles of effective management and ethical practice.

In addition, three safety standards must be met for HFA accreditation since they affect the safety of families being served.

Seven sentinel standards are also identified as critical for ensuring program quality. These also must be met to receive accreditation.

| Safety Standards | Sentinel Standards | |
|--|--|---|
| Personal background checks (9-3. B) Orientation training on child abuse/neglect reporting (10-2. C.) Reporting suspected cases of child abuse and neglect (G-12. C.) | Notifying families of their rights, of confidentiality practices, and obtaining consent before information is shared with others (6-7. A.; 6-7. B.) Developmental screening of program children and follow-up of suspected delays (6-4. B.; 6-7 B.) | Supervision time, skill development and accountability, and professional support for direct service staff (11-1.B.; 11-2.A.; 11-2.B.) |

Implementing Program Standards

Programs will find that there are many demands and pressures to take shortcuts. Examples of these demands include:

- Pressure to hire or redeploy existing staff who may not be suitable for the program’s needs in order to “get started” with families
- Pressure to accept families whose babies are older than the eligibility age, who live outside the designated services area or who do not otherwise meet the established program eligibility criteria
- Pressure to accept higher caseloads “just for now” in order to meet organizational needs or funder requirements
- Pressure to shorten the training process for new staff in order to save money or start services sooner
- Pressure to reduce supervision time so that program managers or supervisors can meet organizational demands such as budgeting, public relations, or identifying potential funders
- Pressure to take families as part of a mandated plan compromising the voluntary nature of services
- Pressure to focus solely on case management or crisis intervention rather than parent-child relationship or child development needs

In order to maintain adherence to the critical elements, the program management team must clearly understand the years of research and practice experience which are the basis for the HFA approach. The most successful program manager will become an advocate for quality service delivery, knowing that following the critical elements will promote real success with families-even if this promotes short term challenges in program implementation.

Healthy Families America Critical Elements at a Glance

Healthy Start ~ Healthy Families Oregon follows HFA’s Critical Elements that represent best practices for effective home visitation programs. Based on over 30 years of research, these critical elements form the backbone of the quality assurance system.

The HS/HF Program Policies and Procedures Manual (PPPM) creates statewide operational definitions for the research-based critical elements. The following tables, while not comprehensive, give an overview of key policies and procedures each program must follow.

Service Initiation

Sections 1-3 of the PPPM cover identification and screening of first time parents and processes to engage those at higher risk in Intensive Home Visiting Services (IS).

| <i>Critical Elements</i> | <i>Overview of Key Policies and Procedures</i> |
|--|--|
| <p>1. Initiate services prenatally or at birth.</p> <p>2. Use a standardized assessment tool to systematically identify families who are most in need of services.</p> <p>3. Offer services voluntarily and use positive outreach efforts to build family trust and engage parents in program services.</p> | <ul style="list-style-type: none"> • Through agreements with hospitals, clinics and other health providers, programs identify first birth families either while mother is pregnant (prenatally) or at the birth of the baby. • Families receive information about the program and if they interested, are give their written consent for participation. • After consenting, families complete the <i>New Baby Questionnaire (NBQ)</i>, a standardized tool for identification of risk factors associated with poor child/family outcomes. • <i>Performance goal: 60% or more first births are screened.</i> • <i>Performance goal: 80% of screenings occur prenatally or within 14 days after the baby’s birth</i> • Screening process includes giving all parents information about community resources for families, parenting and child development information and individualized referrals to appropriate services. • Where program capacity allows, Intensive Home Visitation is offered to families showing current/history of depression, substance abuse, or any two risk factors identified on the NBQ. • Healthy Start Intensive Services are offered to families on a voluntary basis and cannot be mandated. • Program staff uses a variety of positive methods to engage newly enrolled Intensive Service families, build trust and maintain involvement in the program. • <i>Performance goal: 90% or more new families receive the first home visit prenatally or within three months of birth.</i> |

Service Delivery

Sections 4 – 6 of the PPPM describe the content and the processes for how Intensive Services (IS) are delivered to higher risk families.

| <i>Critical Elements</i> | <i>Overview of Key Policies and Procedures</i> |
|--|--|
| <p>4. Offer services to participating families over the long term (i.e., three to five years), using well-defined criteria for increasing or decreasing frequency of services.</p> <p>5. Services should be culturally competent; materials used should reflect the diversity of the population served.</p> <p>6. Services are comprehensive, focusing on supporting the parent as well as the parent-child relationship and child development.</p> | <ul style="list-style-type: none"> • <u>Performance goal:</u> 90% of IS families are engaged in Intensive Services for 90 days or longer. • <u>Performance goal:</u> 75% or more of IS families remain in Intensive Services for 12 months or longer. • Families are offered weekly home visits for at least the first six months of service (Level 1) after the birth of the baby or after a post-natal first home visit (whichever is longer). After that time, visits may become less frequent depending on family progress and/or interest (Levels 2 – 4). • <u>Performance goal:</u> 75% or more IS families receiving at least 75% of the appropriate number of home visits based on the level of service to which they are assigned. • Programs demonstrate culturally sensitive practices in all aspects of service delivery. Every two years, programs develop a Cultural Sensitivity Review to ensure that practices are appropriate. • Home Visitors lead a Family Values activity, including family strengths and culture in order to learn what is important to and unique about each family. • Home Visitors conduct a Family Assessment Interview on the initial home visits to identify needs and better understand the family’s history and situation. • Service delivery is guided by a Family Goal Plan (FGP), created together by the parent(s) and the HV. Steps to achieve goals are outlined and reviewed continually. HVs provide resources and referrals to assist with progress toward goal achievement. • Home visits last for approximately an hour. HVs bring information on child development, health and safety and activities to promote positive parent-child interactions and positive parenting skills. • Children’s development is regularly monitored using a standardized developmental screening tool. |

Service Delivery (continued)

| <i>Critical Elements</i> | <i>Overview of Key Policies and Procedures</i> |
|---|---|
| <p>7. All families should be linked to a medical provider; they may also be linked to additional services.</p> <p>8. Staff members should have limited caseloads.</p> | <ul style="list-style-type: none"> • Home Visitors (HVs) inform families about available health care resources and assist them in connecting with a medical/health care provider for their child and themselves. • HVs support IS children in receiving timely immunizations according to current recommendations from Centers for Disease Control and Prevention (CDC). • HVs provide families with preventative child health and safety information based on American Academy of Pediatrics (AAP) recommendations. • Families are connected to additional services available in the community on an as needed basis. • Programs ensure services are coordinated with other service providers who may be working with the family. • HVs have limited caseloads to ensure that they have an adequate amount of time to spend with each family. • A full-time home visitor carries no more than 15 family's at the most intensive levels. Programs pro-rate caseloads for part-time home visitors based on their Full Time Equivalency (FTE). • Full time HVs carry no more than 25 families at various service levels, or no more than a weighted caseload of 30 points at any one time. Programs prorate caseload size for part time HVs. Caseloads are weighted as follows: <ul style="list-style-type: none"> Level P-1, 2, 3, 4 0.5—2 points Weekly – quarterly visit Level 1 2 points Weekly visits Level 1 SS 3 points Weekly + visits Level 2 1 point Every other week visits Level 3 0.5 points Monthly visits Level 4 0.25 points Quarterly visits Level X 0.5 points Weekly to monthly contact to engage family (Creative Outreach) |

Service Providers

Sections 9 – 11 of the PPPM focus on personnel, training and supervision.

| <i>Critical Elements</i> | <i>Overview of Key Policies and Procedures</i> |
|--|--|
| <p>9. Service providers are selected based on personal characteristics and their ability to establish a trusting relationship.</p> <p>10. Service providers should have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families.</p> <p>10. Service providers should receive thorough training specific to their roles to understand the essential components of family assessment and home visitation.</p> <p>11. Service providers should receive ongoing, effective supervision.</p> | <ul style="list-style-type: none"> • Staff members are selected because of a combination of personal characteristics, educational qualifications and experience. • All staff and volunteers who have responsibilities relating to families or family files must have a criminal background check before contact with families. • Before contact with families, all staff receive orientation to familiarize them with HS/HF’s philosophy, policies and procedures, and the functions of the local program and the state system. Central Administration provides a self-study training manual (QuickStart) for this purpose. • During the first year in a HS/HF program, staff members attend Integrated Strategies for Home Visiting Core Training and Family Assessment Interview trainings. These core trainings are 3-4 days in length and offered through Central Administration 2-3 times per year. • Within the first year of service, home visitors and supervisors either receive or demonstrate knowledge on a variety of topics necessary for effectively working with families and children. This training is provided through local programs. • All staff receive ongoing training that takes into account the worker’s knowledge and skill base. • Supervision provides staff necessary skill development to continuously improve the quality of their performance while at the same time, holding them accountable for its quality. • Full-time home visitors receive at least 1 ½ hours (2 is preferred) of individual supervision per week. Visitors who work less than 20 hours/week receive at least 1 hour of individual supervision. • Programs maintain a ratio of 1 full-time supervisor to 6 home visitors. If the supervisor is part-time, the number of home visitors is adjusted to maintain an overall ratio of 1:6. |

In-Depth Look

REACHING THE TARGET POPULATION (CE 1-1)

Healthy Start ~ Healthy Families Oregon programs target all first birth families that live within the local county. Programs need to have key information about the demographic characteristics of this population that is updated periodically:

- number of resident first births per year
- race/ethnicity/linguistic/cultural characteristics
- community organizations where target families can be reached, such as hospitals, clinics, and health centers

Collaborate with Partners

HS/HS programs collaborate with organizations where first-birth families can be reached. Screening and referrals comes from a variety of partnerships including local hospitals, clinics, public health nurses, prenatal and postnatal health care providers, Department of Human Services - Self-Sufficiency and Child Welfare, Oregon's Mothers Care, OHP and WIC.

These relationships may require formal Memorandums of Agreement and in other cases, may be verbal agreements or informal in nature. In either case, the system of organizational agreements should enable the program to identify at least 75% of the first birth families to offer screening services.

Memorandum of Agreement

A Memorandum of Agreement (MOA) is a document that clearly outlines the scope, nature and extent of services provided by each organization. Sample agreements are available from Central Administration.

The MOA should address:

- How your program will identify families of newborns (deliveries within past 24 hours) or expectant parents.
- The role of clinic/hospital staff and HS/HF staff.
- Logistical arrangements to be made so screening can be completed in a timely manner (prenatally or within 14 days after the baby's birth).

MOAs should be reviewed and updated annually, as attrition of programs, staff and other programmatic changes can impact the nature of relationships.

Neighboring Counties

Some families may give birth in a neighboring county. Cooperative arrangements between programs can address this issue. An MOA can be established between neighboring sites to provide a structure for sending family screens to the county where the family resides. When families consent to screening, they are consenting to HS/HF statewide, so additional consent is not needed for this transmission of information. However, it may help to clarify expectations about this process among neighboring programs through the development of MOAs.

SCREENING (CE 2-1)

The New Baby Questionnaire screens for a number of risk characteristics research has shown are associated with poor child and family outcomes. While risk factors do not create a "destiny," the more risks a family possesses raise the chance for poor outcomes. The risk factors identified by the

NBQ are strongly correlated with those in the Family Stress Checklist (FSC)⁴.

Scoring is positive if any two risk characteristics are present, *or* if depression or alcohol/drug issues is present since either creates a high risk situation for a family. A 2007 study showed that barely 2% of Healthy Start ~ Healthy Families NBQs were scored "higher risk" on the FSC with only one risk factor.

NBQ risk characteristics

- Teen parent, 17 years or younger
- Unmarried parent
- Late prenatal care (after 12 weeks)
- Lack of comprehensive prenatal care
- *Both* mother & partner (if present) unemployed and/or seasonally employed in unstable job
- Less than a high school education
- Trouble paying for basic living expenses
- Problems in marital/family relationships
- ***Depression***
- ***Drinking/drug use issues***

Training Screening Staff

Screening staff, volunteers and any others who conduct screening must have an adequate understanding of how to use the screening tool appropriately before they engage in the screening process, including:

- knowledge of the HS/HF program,
- theoretical background of the screening tool and

- process for obtaining written informed consent

Training includes hands-on practice describing the program effectively, obtaining informed consent and completing the NBQ. Intensive home visiting services are described to all families with a positive screen, who are then asked whether they would be interested in receiving home visiting services if available. Screeners are trained to give families clear information on what follow-up to expect from the program after this initial "offer" of services.

The Evaluation Manual (Red Book) provides suggested protocols for in-person and phone screening. Training exercises for screeners are also included in *QuickStart: Orientation Manual for Healthy Start Staff*.

Informed Consent (CE 3-1 & GA 5)

By law, Healthy Start ~ Healthy Families Oregon programs must obtain the express written consent of families before services can take place. Programs are responsible for obtaining informed, written consent from families BEFORE beginning the screening process. *Note: phone consent may be given. See PPPM for details.* Programs use a two-step approach to reach as many first birth families as possible in each county:⁵

- **Consent to contact.** *Give Your Baby A Healthy Start* and *¡Dé su bebé un comienzo saludable!* are optional forms including a description of Healthy Start. It can be distributed to potential clients by partners for the parents to indicate interest. Completed forms are

⁴ Korfmacher, J. (1999). The Kempe Family Stress Inventory: A review. *Child Abuse & Neglect*, 24(1), 129-140.

⁵ Consent forms and training on their use is available electronically on the NPC Research website: www.npcresearch.com/materials.php

forwarded to the local program where staff contact the parent(s) to obtain informed consent for screening.

- **Consent to participate.** *Welcome to Healthy Start* and *¡Bienvenidos a Comienzo Saludable!* are standardized and required forms used to obtain express written consent from the parent. The back of each page explains what is involved in the evaluation and how information will be handled to ensure privacy. If parents give their “express written consent” as specified in Healthy Start’s legislation, they complete a *New Baby Questionnaire (NBQ)*. They may also be contacted later by the program to complete the screening process.

What is informed consent?

Prospective participants need to understand the purpose, the procedures, the potential risks and benefits of involvement with HS/HF as described on the reverse side of *Welcome to Healthy Start ~ Healthy Families*. They need to know they can receive Healthy Start services without participating in the evaluation.

In addition, prospective participants also must be provided with information regarding local privacy practices to meet requirements of the Health Information Portability and Accountability Act (HIPAA). These are specific to the agency providing HS/HF.

Details about the consent need to be presented in simple language by someone knowledgeable about the program. Training on obtaining parents’ consent can be found both in *QuickStart: Orientation for Healthy Start Home Visitors* and in the Evaluation Manual (“Red Book”) on NPC Research’s website.

Family Manager Data Base

Programs enter family information from the *Consent to Participate* form into the web-based Family Manager database ensuring that consenting families have been provided with information regarding privacy practices to meet HIPAA requirements. Once entered, a family identification number is generated that will be used on all subsequent evaluation forms transmitted to NPC Research.

Strategies for Screening and Enrollment (CE 3-2)

Screening is a natural point to involve the community in HS/HF – as volunteers, in-kind contributors, or providers of a setting for screening to occur. Managers ensure that local outreach policies and procedures are described in the program’s Policies and Procedures Manual (PPPM).

Effective strategies for reaching new parents include the following:

- Individual screening by partners, staff or volunteers – in hospitals, clinics, social service waiting rooms, and over the phone. Healthy Start ~ Healthy Families screens can become a part of routine paperwork during prenatal care, the hospital stay, or TANF, WIC, OHP and Oregon Mothers Care (OMC) appointments.
- Screening by partner agencies. Potential screeners include hospital admissions or birth certificate clerks; home visiting nurses employed by hospitals, clinics or public health, and TANF, WIC, OHP or OMC workers.
- Screening in group settings, such as childbirth education or WIC classes, teen parent programs or “baby showers” sponsored by community groups.

- Self-screening where parents complete NBQs by themselves. These may be provided in a physician’s office, a clinic or other location, and are available on-line on the OCCF webpage.

Enrolling families

Intensive home visiting services are described to all families with a positive screen and, at that time, they are asked to indicate whether they would be interested in receiving services if services are available.

If services are available, programs use a variety of strategies to contact all families who indicate interest. When services are not available, programs ensure that interested families learn about any other community resources that may be available. Specific procedures are detailed in the local version of the PPPM.

Enrollment strategies that programs have used successfully include:

- Before the first home visit, offer a “sample” to hesitant families to see if they like it and want to continue.
- Provide incentives. Let the family know that the visitor will be bringing “gifts” from the community.
- Ask the parent(s) if the program can help with any immediate needs, and following through with promised help or linkages to services.
- Hold an open house to introduce the program. Assure transportation is not a barrier.

Monitor Screening (CE 1-1)

The process of service initiation begins with screening. Programs monitor the screening process to ensure they are connecting

appropriately with the target population. Two service indicators focus on the screening process:

| Performance Indicators |
|--|
| <ul style="list-style-type: none"> • Percentage of first births screened based on birth records from the previous year (<i>Screening Rate</i>): <i>Target: 60% or more screened</i> • Percentage of screenings occurring prenatally or within the first 2 weeks of the child’s birth: <i>Target: 80% or more screened during this period</i> |

Information on both indicators can be found in the Status Report. Semi-annual reports from NPC Research provides preliminary date on the screening rate only. This information is posted on the NPC website by February 15 and August 15.

On-site monitoring

Screening information also is kept on-site for monitoring purposes. Typically, larger programs establish database systems to track information. Smaller programs may prefer to keep the information in a spreadsheet format.⁶ Tracking data usually includes:

- Contact date and, if available, child’s birth date (or expected birth date)
- Screening date and result (positive, negative, or refused screen)
- For positive screens, whether family is interested in Intensive Services

⁶ An optional Screening and Acceptance Monitoring Spreadsheet is shown in the Healthy Start Forms Manual and available electronically from OCCF.

- For families interested in IS, date of first home visit

Questions to consider while monitoring the screening processes:

- ? Are processes for offering screening services to target families effective? What are the program's strengths in identifying and offering services?
- ? What proportion of targeted families decline to be screened? What needs to happen to reduce this proportion?
- ? Are partners within the community referring families for screening in a timely manner? If not, why and what can be done to improve the process?

ACCEPTANCE ANALYSIS & PLAN (CE 1-2)

Program managers are responsible for monitoring acceptance rates on an annual basis, using information from the Status Report as well as local data. Acceptance rates for Intensive Service are calculated at two points in time:

1) Initial Acceptance Rate

- Counting the total number of participants with a positive NBQ who indicated that they were interested in Intensive Services (if available) during the fiscal year (July 1 – June 30) and
- Dividing by the total number of participants with a positive NBQ who were asked if they were interested in Intensive Service (if available) during that same time period.

2) Final Acceptance Rate

- Counting the total number of participants who receive a first home visit in the fiscal year (July 1 – June 30) and
- Dividing by the total number of potential participants who screened

eligible, indicated they were interested in Intensive Services (if available) *and were offered* available Intensive Service during that same time period.⁷

Analysis

Every two years at a minimum, managers conduct an in-depth analysis of patterns and trends in the acceptance rate to identify potential improvement strategies. The analysis includes data from the Status Report as well as informal, anecdotal information gathered through discussions with staff and others involved in program services. A standard required Acceptance template is provided and available on the OCCF website.

The following criteria are included in the analysis:

programmatic factors such as procedures for conducting outreach, staffing issues, training of staff, number of days between screening and offer of Intensive Service and program funding,

demographic factors like age, race/ethnicity, language, marital status, education, and employment status, and

social factors such as employment/school status, available support networks, relationships, and way of life.

Using the Status Report information, note the percentage of families who were offered Intensive Services⁸ and the percentage of those who accepted the offered services. The latter is the final Acceptance Rate.

⁷ See HS Forms Manual for an optional *Screening and Acceptance Tracking Sheet* that will automatically calculate these rates once appropriate information is entered.

⁸ For 2007-08 Status Report, acceptance rates will be reported as Number of Eligible Families Offered IS and Number of Families Offered IS who Accepted since the box for "interested if available" was added July, 2008. The 2008-09 Status Report will reflect the new designations.

- What percentage of eligible families are offered Intensive Service? What are the reasons for not offering services?
- What percentage of eligible families accept offered Intensive Services? What are the reasons families give for declining offered services?

Use anecdotal and other informally-gathered information from staff/partners to analyze program strengths and challenges in facilitating acceptance of services. If the Acceptance Rate is less than 90%, consider what might be done to increase the rate.

Compare subgroups. Demographic and social data from the Status Report compares acceptance among various subgroups. It may be helpful to display numbers and percentages for your program in chart form. Ask yourself the following questions:

- Are any groups of families more or less likely to accept services than another contrasting group? Do they vary by demographic or social factors?
- What reasons can you think of for any variations? What strategies might increase rates for these groups specifically?

Plan for Improvement

Review the analysis with the staff and the local Advisory Committee. Include parents in the review wherever possible. Identify the program strengths in facilitating parent acceptance of services. Discuss the primary reasons for families not accepting services and strategize ways to address these reasons. Based on the review, develop, implement, and monitor a written plan to help increase acceptance rates. A standardized Acceptance Template is provided and available on the OCCF website.

Maintaining Family Involvement

(CE 3-2) Programs identify a variety of positive methods to engage families, build their trust and maintain their involvement in the program. Guidelines for these strategies are then inserted in the local Policies and Procedures Manual and used in supervision with home visitors.

Engagement strategies that programs have used successfully include:

- Telephone family to see how parent(s) and child are doing. Send a packet of parenting information.
- Send hand-written note (thinking of you, how is the baby?) and follow-up with phone call.
- Mail curriculum handouts that might of helpful, along with a personalized note.
- Offer help with practical concerns, such as getting a WIC appointment, filling out an application, or finding free/low-cost baby supplies.
- Ask if you can bring something for the baby next time, such as a book, quilt or baby clothes.

Creative outreach

When enrolled families have missed a home visit and then have not been available for home visits for at least 10 working days, they are placed on creative outreach for a period of at least 90 days. Many higher risk families have had past experiences with individuals who let them down and did not deliver on promises. Overcoming this kind of past history requires "creative" ways to reconnect, hence the name "creative outreach."

Documentation

Families on creative outreach are discussed in weekly supervision and documented on

the Service Level Assignment form.⁹ Attempts to re-engage the family can be entered on Contact Logs or elsewhere in the family file.

Central Administration offers an *optional* Level X (Creative Outreach) Tracking Form designed specifically to monitor re-engagement efforts. This form, printed on pink paper for easy identification, provides information on home visitor responsibilities while the family is on creative outreach, and gives space for describing the date, type of contact, and notes about what happened.

RETENTION ANALYSIS & PLAN (CE 3-4)

Program managers monitor retention rates utilizing information provided in the Status Report. Every two years, managers conduct an in-depth analysis of retention rates and then develop and implement a plan to increase retention.

Retention is a critical quality improvement issue and is measured by two performance indicators:

Performance Indicators

- Percentage of Intensive Service families engaged in IS for 90 days or longer: *Target: 90% or more engaged*
- Percentage of families remaining in Intensive Services for 12 months or longer: *Target: 65% or more remaining*

Measuring Retention

Families are considered to be enrolled when they have their first home visit – thus, retention rates are reported based on the time period between the first and last home visit. Rates are calculated as:

- total number of Intensive Service families who had a first and last home visit during a given period
- divided by the total number of Intensive Services families who had a first home visit (may or may not have had a last home visit) during the same period.

The Status Report provides information on retention rates for 3, 6, 12, 18 and 24 month periods. Rates are calculated for the fiscal year ending two years previously to ensure that all families with children born during that year have had an opportunity to be enrolled for 24 months.

Analysis

The analysis includes data from the Status Report as well as informal and anecdotal information gathered through discussions with staff and others involved in program services. The analysis considers the impact of a variety of factors on family decision-making:

programmatic factors such as staffing issues, program policies, approaches to service delivery, relationships with other agencies, training and program funding

demographic factors like age, race/ethnicity, language, marital status, education, and employment status

social factors such as existing risk characteristics, available support networks, employment/school status, family relationships, and connections to religious groups, and way of life.

Retention Rates. Use Status Report information to chart the percentage of families that remain after 3, 6, 12, 18 and 24 month periods. Is there any pattern to when families drop out?

⁹ See *Healthy Start Program Forms Manual*.

- What is the median age of the child for exiting families in your program? How does that compare with the statewide median?
- What are the reasons for families dropping out? What informal/anecdotal information do you have relating to the reasons that parents decline further service?

Compare subgroups. Demographic and social data from the Status Report compares retention among various subgroups. Numbers and percentages for your program can be displayed in chart form. For each comparison, look for differences that are larger than 10-20%.¹⁰ Which groups have lower retention rates? What reasons can you think of for this? Can you think of anything your program could do to increase retention rates for these groups specifically?

Plan for Improvement

Review the analyses with the staff and the Advisory Committee. Include parents in the review wherever possible. Discuss the primary reasons for families dropping out of services and strategize ways to address these reasons. Based on the review, develop, implement, and monitor a written plan to help increase retention rates.

SERVICE INTENSITY (CE 4-1)

HS/HF programs use the Healthy Families America (HFA) Level System to ensure that home visiting services are offered intensively and over the long term. Services are most intensive in the beginning and gradually decrease in

intensity as families achieve goals and gain confidence and skills.



¹⁰ Remember that percentages can be misleading when numbers are small. Comparing differences (without appropriate statistical tests) only gives some possible ideas or hypotheses to explore with other available evidence.

| Level | Caseload Points | Schedule |
|--------------------|-----------------|-------------------------------|
| Level P-1, 2, 3, 4 | 0.5 - 2 points | Prenatal: weekly to quarterly |
| Level 1 | 2 points | Weekly |
| Level 1SS | 3 points | Weekly or more, high needs |
| Level 2 | 1 point | Every other week |
| Level 3 | 0.5 points | Monthly |
| Level 4 | 0.25 points | Quarterly |
| Level X | 0.5 points | Weekly to monthly contact |

Using the Level System

The supervisor and home visitor routinely review each family's progress during supervision in order to determine the appropriate level of service. As long as 80% of the criteria for a level change have been met, the supervisor and home visitor can use their discretion (with parent agreement) to make a change.

While the goal is for families to progress through the levels, families may be moved from less intensive to more intensive levels of service at times, depending on individual needs.

After the birth of the baby, all families begin on Level 1 even if they began on a less intensive level during the prenatal period. Families stay on level 1 for at least six months after the birth of the baby or six months after enrollment (whichever is longer). At that time, if meeting the criteria, families participate in the decision-making process regarding moving to a less intense level of service.

- Level 1-SS is reserved for families in crisis or parents who have cognitive limitations or need translation services due to a language barrier or illiteracy. This level is also for families who live beyond the programs usual travel

area/time, need an interpreter or require intensive case management.

- Level X is used for families who have missed at least one home visit followed by at least 10 working days of unsuccessful attempts to reschedule. Level X also can be used for families who are temporarily out of the service area for over one month.
- Families receiving services during the prenatal period may be assigned to Levels P1, P2, P3 or P4 depending on the intensity of services required as determined by the home visitor, supervisor and family. However, it is recommended that families stay on P1 for at least the first 4 to 6 weeks to ensure required activities and documentation timelines are met and to encourage the development of a trusting relationship prior to the baby's birth.

Service Level Assignment Form

The Service level assignment form is printed on green paper.

(CE 4-2) The service level assignment form objectively measures the gradual progress that families make toward program goals, with new accomplishments recognized at each level. Families moving

to levels 2, 3, or 4 must meet at least 8 out of 10 criteria. Families returning from Level X-Creative Outreach are assigned to their previous service level, unless file documentation demonstrates that they meet or exceed the criteria for

another service level. Supervisors and Home Visitors review the criteria during supervision and document the level change, date and any comments directly on the Level Assignment form. This form may be kept in the supervision notebook or the family file. Families must be consulted with and approve level changes.

Using the Comparison Chart

Look at the Comparison Chart on the following page. The following examples show how 3 different families completing their 6-month Level 1 requirement are re-assigned to levels based on individual needs and capacities:

Comparison of Level Achievements: Families remain on Level 1 for a minimum of 6 months. At that time they must meet at least 80% of the criteria to move to level 2. Families may move back to level 1 or level 1-SS when in crisis or not meeting the criteria of their current level.

| Goal Areas | Level 2 | Level 3 | Level 4 |
|-------------------------------------|---------------------------------|---|---|
| 1. Primary Care Providers | Identified | Established | Maintained |
| 2. Immunizations | Initial received | Up-to-date | Up-to-date |
| 3. Personal Goals | Established | Planning and problem solving | Demonstrated ability to set and attain |
| 4. Parenting Goals | Established | Planning and problem solving | Demonstrated ability to set and attain |
| 5. Developmental Delays | Addressed, resolved or N/A | Same as 2 | Same as 2 |
| 6. Positive Parenting | Skills observed | Comfortably demonstrating skills and attachment | Effectively demonstrating skills and attachment |
| 7. Learning Environment | Safe and nurturing, established | Safe and nurturing, maintained | Safe and nurturing, sustainable – established/ arranged |
| 8. Personal/ Parent Supports | At least 1 identified | At least 1 utilized with assistance | At least 2 utilized without assistance |
| 9. Community Resources | Identified | Utilized with assistance | Utilized without assistance |
| Family Agrees to Change | Yes | Yes | Yes |

SUPPORTING HOME VISIT COMPLETION

(CE 4-2) Home visiting is the foundation of the Healthy Start ~ Healthy Families program and the means by which family outcomes are achieved. Home visits are often described as “doses of prevention” underscoring the importance of completing each visit.

Home visit completion information allows program managers to monitor the following service indicator on at least a quarterly basis:

Performance Indicator

Percentage of families receiving 75% of expected visits based on assigned level: *Target: 75% or more receive 75% of expected visits*

Monitoring

Home visit completion rates are reported in the Status Report. Programs enter Home Visit Completion and Caseload information into Family Manager. Family Manager tracks the number of home visits completed for each family and auto-calculates home visit completion rates and caseloads for each home visitor. In order to meet this standard, Home Visitors are expected to have at least a 75% home visit completion rate.

Reviewing Home Visit Completion

Supervisors review and discuss the form with the home visitor, problem-solving ways to improve the home visit completion rate. Questions to consider:

- Are some families routinely getting lower completion rates than others? What are the barriers for the families not receiving their expected visits?

What can be done to reduce the barriers?

- What approaches does the home visitor use to schedule home visits? What reminders are used? How might “creative outreach” type strategies be used to improve rates?
- Are there any patterns or trends among the families relating to cultural characteristics? If so, what strategies can be used to ensure families receive the appropriate level of visits?
- Are there any programmatic barriers to home visit completion, such as scheduling issues where part-time staff are working the “wrong hours” for the family? What strategies can be used to address these barriers?

Planning for Improvement

Programs use a variety of organizational strategies and develop a written plan to increase home visit completion rates. Some strategies programs have used successfully include:

- Team approach, where team members may cover for each other during vacations, training or sick days,
- Planning periodic group meetings such as two or three families getting together for a play date, or meeting at the library (home visit components are covered for each family and home visit records completed),
- Flexible scheduling for home visitors, including after hours visits, and/or
- Time management techniques such as scheduling a month at a time and dedicating time for make-up visits.

CULTURAL SENSITIVITY (CE 5)

For HS/HF programs, cultural sensitivity has been defined as the degree to which the program continually modifies or tailors its system of service delivery to the cultural characteristics in its service population including:

- Personnel/staff selection,
- training and development,
- assessment,
- service planning, implementation, and
- program evaluation/participant care monitoring.

Broadly speaking, culture is a way of life of a group of people -- the behaviors, beliefs, values and symbols that they accept, generally without thinking about them, and pass along from one generation to the next.

Many people think of culture as only ethnic heritage. Although ethnicity is important, other aspects such as language, gender, sexual orientation, age, religion, social class and geographic origin also play a role.

These elements combine to create a unique cultural identity, based on both experience and history. Understanding a family's culture helps home visitors avoid stereotypes and biases that can undermine their work.

HS/HF programs are responsible for ensuring that services provided meet cultural sensitivity standards. Program managers should:

- Know the cultural, racial/ethnic and linguistic characteristics of their service and target populations. Address the needs of the service population through appropriate staff,

volunteers and community partners, while conducting culturally appropriate outreach to the target population so no groups are unintentionally excluded.

- Ensure that all staff receive training in cultural sensitivity which is *unique to the program's community* within the first 6 months of hire, and annually thereafter.
- Ensure program materials reflect the diversity of the current service population and target population. Materials in families' native languages and at various literacy levels need to be provided. Materials need to be father-friendly and address various age groups.
- Take cultural and linguistic factors into account when assigning workers to participants and in overseeing home visitor/family/participant interactions. Monolingual families are assigned to a home visitor who speaks their language. If that is not possible, skilled translators must be provided.
- One of the most common strategies for creating culturally competent programs is to hire services providers from the same racial/ethnic background as the families in the program. Then the cultural characteristics of the staff reflect the community it services there is a greater sense of connection.

Cultural Sensitivity Review (CE 5-4)

Each HS/HF program conducts an analysis every two years to assess the extent to which its service delivery systems are culturally competent (PPPM 5-4.). The

OCCF website provides guidelines and a sample.

At a minimum, the review addresses materials, training and the service delivery system, includes both participant and staff feedback, and identifies future actions to be taken. This analysis is reviewed by staff, the program's advisory committee and Central Administration staff to ensure the program meets cultural competence criteria.

A workbook for HFA sites, *Cultural Sensitivity: A Process of Self Awareness and Integration*, provides detailed information on conducting the review and is available electronically. The following are a sampling of questions to consider:

Training

What training has the staff had during the year that focuses on the unique characteristics of the families described in the target and service populations?

Are additional trainings necessary to broaden the scope of families with whom staff can work? What training needs are identified for the future and how do they connect with the unique characteristics of the target and service population?

Materials

- Does the program have materials written in the language(s) participants speak? If not, are there resources to obtain them?
- Are the cultural characteristics of the families served represented visually in curricula, videos, brochures, etc?
- To what extent does the reading level of materials match the literacy level

of participants? Is the writing style friendly? Easy to understand?

Service Delivery System

- Is the program able to meet the needs of the target and service populations through the unique characteristics of its staff and its relationships with community agencies? Are there any groups among the target population that the program does not seem to be reaching?
- Any patterns or trends related to cultural characteristics for who is not accepting services? Dropping out of services? Are home visitors having higher completion rates for some groups of families than others?
- Is the program able to refer families to both medical providers and community agencies in a manner that respects the family's individual cultural characteristics? Does the program need to create any new relationships to better serve families in the target and service populations?

FAMILY ASSESSMENT INTERVIEW

(CE 6-1) HS/HF uses the standardized Family Stress Checklist (FSC) to assess ten separate domains that may impact family well-being and parenting outcomes. The home visitor interviews the parent(s) using the FSC *within the first three visits*.

Training

All Healthy Start staff must complete the Core Family Assessment Interview (FAI) training within 180 days of hire. Local programs have procedures for training staff on the use of the tool if they must use it before core training. This training includes shadowing a certified staff

member, working with the supervisor to learn the theory and practice involved in the KFSI, and performing their first assessment with a skilled observer present.

Certification

After training, home visitors are required to submit their first five assessments to the state Trainer for feedback prior to becoming certified in the Family Stress Checklist / FAI. Two role plays may be used if fewer than five new families are available for assessment during the six month period. Supervisors complete and submit a minimum of two assessments and submit three assessments they have reviewed using the standardized and required *Inter-Rater Reliability Checklist*.¹¹

The certification process is completed within six months of the Core Training for home visitors and three months for supervisors.

Monitoring

Supervisors review, sign and discuss each completed assessment. Documentation is reviewed for thoroughness, accuracy of scoring and presence of referrals. Narrative descriptions for each domain include the family's own words in quotes whenever possible.

Supervisors ensure that FAI scores are entered into Family Manager. Assessments must be complete with no more than one unknown for the primary caregiver. Further, data can't be used by NPC Research if there are more than two unknowns for the secondary caregiver. *Supervisors must ensure that families are asked all of the questions and unknowns are not due to questions being omitted.*

¹¹ See *Healthy Start Program Forms Manual*.

This is to ensure safety for the Home Visitor and family.

Inter-rater Reliability Checks.

Supervisors complete an inter-rater reliability checklist for each home visitor at least once every 180 days. If a home visitor has not conducted a Family Assessment Interview for 180 days, s/he role plays conducting the FAI and writes up the assessment for the review and inter-rater reliability check.

Quality Assurance Observations.

Supervisors or team leaders shadow each home visitor for a minimum of one assessment per year, and more frequently for home visitors new to conducting the FAI. The *QA Observation of Family Assessment Interview* form is used to summarize the observation and is shared with the home visitor during a supervisory session.

THE HOME VISIT (CE 6)

The home visit is defined as a *face-to-face* interaction that occurs between the participant(s) and visitor.

- Home visits last for a minimum of an hour; the child typically must be present.
- Visits may occur outside the home, but the content must match the definition of a home visit. These visits are documented using the Home Visit Record form.
- A parent group meeting may substitute for one home visit per month for under conditions specified in the PPPM (4-2.H.). These are documented using the Home Visit Record form for every participant in the group for whom a "home visit" is being claimed. Each

family for whom a home visit is claimed must have had the kind of interaction with staff that qualifies as a home visit by the criteria given above.

A combination of parent- and child-related goals differentiates HS/HF from traditional

case management or early childhood education programs. The well-being of children is intimately linked to the well-being of their parents. Therefore, each visit typically includes activities designed around the goals for both, including but not limited to the following:

| | |
|---|--|
| <p>Goal: Promoting positive parent-child interactions</p> <p>Support of attachment</p> <p>Social-emotional relationships</p> <p>Support for parent role as child’s first teacher (language and emergent literacy)</p> <p>Parent-child play activities</p> <p>Goal: Promoting healthy child growth and development</p> <p>Child development milestones</p> <p>Child development screening</p> <p>Child health and safety</p> <p>Nutrition</p> <p>Access to health care</p> <p>Linkage to appropriate early intervention services</p> | <p>Goal: Enhancing family functioning</p> <p>Assessment tools</p> <p>Coping and problem-solving skills</p> <p>Home management and life skills</p> <p>Linkage to appropriate community resources</p> <p>Access to health care</p> <p>Support for the reduction of self-defeating behaviors such as substance abuse and/or domestic violence</p> <p>Crisis management</p> <p>Advocacy</p> |
|---|--|

Monitoring Home Visits (CE 6,11,GA)

Home visits are documented using the standardized *Healthy Start ~ Healthy Families Home Visit Record (HVR)* and are written within 48 hours of contact with families. The HVR is available as (1) a “form-fill” document for entering information on the computer and (2) a lined format for completing the record by hand.

Reviewing the Home Visit Records

Home visit records provide the structure for the supervision and should be reviewed *prior to* the supervisory session. The review ensures appropriateness of support activities for the family, including referrals, parent-child activities, service level assignments and the timeliness and thoroughness of documentation. In reviewing the cases, the supervisor must keep in mind:

- How is the relationship (home visitor and family) impacting the family’s

ability to develop competencies and become empowered to pursue their goals?

- How is the home visitor promoting positive, nurturing parent-child relationships in the family?

Home visitors often find it difficult to see the progress families are making, or they are unable to assess for themselves the progress that they are making with a family. Supervisors can help to recognize the areas in which the family and/or the home visitor are achieving success.

Shadowing Home Visits

Supervisors accompany each home visitor they supervise on a home visit at least once annually and more frequently for new home visitors. Central Administration provides a sample form for documentation of these observations that includes types of interventions and visit management approaches. The supervisor reviews the home visitor's HVR documentation of the visit to assure it is consistent with the supervisor's observation. Overall performance is described in terms of strengths identified, ideas for next time, and any necessary follow-up.¹²

Phone Calls to Families

Every six months, supervisors contact two families per home visitor to determine parent satisfaction. Central Administration provides a sample form for the survey¹³ that provides introductory language and then asks questions such as:

¹² See *Healthy Start Program Forms Manual, QA Observation of Home Visit*

¹³ *Ibid.*, *QA Phone Surveys for Active Families*

- What do you like best about HS/HF?
- What happens on the visits?
- How would you like to see HS/HF changed?

The bottom of the form is for follow-up such as feedback to the worker, and whether any corrective actions were taken.

Family Goal Plan (FGP)

During the first few visits, the home visitor works with the family to identify needs, and the strengths or competencies the family might have to address their needs. This along with the Family Values and Wishes for my Child activities help build a foundation for goal setting. The Family Goal Plan (FGP) is developed within 60 days of the first home visit.

With the Home Visitor's support, families are encouraged to set at least one goal every six months. The family works on one or at the most two goals at a time. The goal is broken down into mini goals that will help ensure success. Having regular conversations about goal helps parents develop problem-solving skills and increases their sense of power over their situations.

Continued review by the parent, the home visitor and the supervisor helps families accomplish their goal.¹⁴ Additionally the FGP helps to guide service delivery. If a FGP is not developed, there is no road map for where the family is hoping to go. Still, most HS/HF families have had little experience in setting goals and creating

¹⁴ See *Healthy Start Program Forms Manual*.

change in their lives. Home Visitors often find it challenging to engage parents in the process.¹⁵ Supervisors play a key role in supporting this process. Here are a few tips.

- Encourage the home visitor to spend more than one visit developing the FGP. Many programs use the optional Reachables Goal cards or the optional *What I Want for Myself* or *What I Want for My Family* to explore family interests and dreams (forms available in both English and Spanish).
- The goal of the FGP process is for families to feel empowered, not to further the program's agenda. Home visitors must avoid taking control and suggesting goals to the family. Encourage home visitors to keep asking questions so that the families explore what they really want.
- Assist the home visit to honor the family's ideas even when goals appear unrealistic. If families are unable to meet the goals, see if they are prepared to make them more realistic. Don't shortcut their learning process by spoon-feeding them goals, or judging their goals. "Unreachable" goals may be just the catalyst needed to get a family moving in a positive direction—but specific, small goals leading to those are the focus of the FGP and the ongoing work. Building on and celebrating small successes develop confidence and help the "big goals" to become more realistic.
- Coach home visitors on how to ask families about their activities towards the goals in a way that is positive and supportive, not judgmental. Open-ended questions such as "How are things going?" are helpful.
- Remind home visitors to read the FGP before they go on a home visit. This gives them an opportunity to discuss activities related to the family's goals.
- Read FGPs regularly and during supervision, ask home visitors "where is the family on this particular goal?" Doing this models a parallel process for home visitors to go back to their families and check in with them about their FGP goals.
- Conduct a formal review of the FGP every 6 months, at a minimum. Remember, it's all right to keep the same goals if they've not been met at the end of 6 months. Perhaps there are ways they can be updated or made more realistic.
- Provide "refreshers" for your staff on the FGP process. Have them pair up and help each other develop their own FGPs as a refresher exercise. Ask them to bring in some challenging situations to discuss.

Home Visitor Plan to Support the Family

The Supervisor and Home Visitor collaborate develop a Home Visitor Plan to Support the Family (HVP), intended to thoughtfully focus on specific ways to support the family in meeting HFA goals. An initial approach is developed after the FAI is completed and one or two

¹⁵ Further information about the IFSP process is included in *QuickStart* (see Exercise 24).

areas of focus are strategized at a time. The HVP addresses risk factors from the FAI by strategizing on ways to build protective factors for families.

Home Visitor Plans build on information from the Family Assessment Interview (FSAI) and home visitor observations to get a picture of overall strengths and challenges. Areas of focus are targeted to high priority needs and/or issues that may or may not have been identified by the family but relate to the HFA goal areas of family functioning, parent-child relationships and child development.

Recognizing parent strengths, the Supervisor and Home Visitor discuss potential barriers/challenges for each focus area and develop strategies and activities to address the concerns. The HVP is kept in the supervision notebook and is meant to guide supervision discussions. A copy is given to Home Visitors or Home Visitors may document the strategies in another way. HVPs are working documents and need to be updated frequently with at least one area of focus current at any given time.

Curriculum Resources

HS/HF policy specifies that curricula are selected and used to meet the individual needs of the family with special attention to the interests of the family and any cultural, linguistic and cognitive factors that may be present.

All child development, health and safety information given to parents are in accordance with the recommendations of the American Academy of Pediatrics (www.aap.org).

Supervisory Guidance

Supervisors provide guidance on curriculum resources to help home visitors weave information and materials together in a way that keeps parents interested, excited, and involved in their child's development. Typically, resource materials focus on:

- Information on child development milestones
- parent-child activities that are appropriate to child's developmental level and foster bonding and attachment
- health and safety such as prevention strategies or needed interventions

Some curricula that may be used are:

Healthy Families San Angelo The focus of this curriculum is building healthy parent/child relationships and developing positive self-esteem in the child. Developmental stages, developmental needs, and parenting skills are among the topics covered. Lessons are written at a level most parents can understand. Available in English and Spanish.

Parents as Teachers Born to Learn provides child development and parenting information for ages prenatal through 3 years, offering practical ideas on ways to encourage learning and parental interaction with children. To use the curriculum, home visitors must attend a 5-day training to become certified parent educators. Available in English and Spanish.

Growing Great Kids prenatal to 36 month, evidence-based curriculum that focuses on growing nurturing, empathic, parent-child relationships and strong

attachment. This curriculum comes with parent-child activities, is culturally sensitive and father friendly. The curriculum was developed to meet the needs of families under stress.

Partners for a Healthy Baby begins during the prenatal period and covers parenting issues during the first 3 years of life. Organized month by month, the curriculum includes instructions and prompts for home visitors and color handouts for families. Available in English and Spanish.

HFA Great Beginnings Start Before Birth supplies service providers with strategies for supporting families during the prenatal period. Based on best practice standards, with a special focus on the psycho-social issues facing expectant parents, home visitors learn how to help parents enhance prenatal bonding, stimulate brain development and reduce stress, thereby increasing healthy mother/baby birth outcomes. Available in English and Spanish.

Monitoring Child Development (CE 6-6) HS/HF programs use the Ages and Stages Questionnaires® (ASQ) and the Ages and Stages Questionnaires® – Social-Emotional (ASQ-SE) to monitor children’s development. Both instruments have been shown to be reliable as a first-level screening program to identify those children who are in need of further evaluation to determine whether they are eligible for early intervention services.

- ASQ: Screens five developmental areas: communication, gross motor, fine motor, problem solving, and personal-social development.

- ASQ-SE: Screens seven behavioral areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect and interaction with people.

Questionnaires are completed by the parent with the home visitor’s assistance. Program staff converts each response to a point value, totals these values, and compares the total score to established screening cutoff points.

Program Responsibilities

Home Visitors use the ASQ and ASQ-SE at designated timeframes (ASQ: 4, 8, 12, 18, 24, 30, 36, 48, and 60 months and ASQ-SE – due every six months) to monitor children’s development. The ASQ and the ASQ-SE must be administered within 30 days of the due date to ensure validity. Due dates are adjusted for babies born prematurely (36 weeks + 6 days or less).

Information on results is transmitted to NPC Research on a timely basis using the Family Update form.

Training. All staff are trained prior to using the ASQ or ASQ-SE. Training dates are entered into the online *Training Tracker*. Training includes reading the ASQ manual, watching the training video, observing a qualified staff member administer the tool, being observed administering the tool, and receiving orientation to local Early Intervention (EI) services. The date if the first independent ASQ and ASQ-SE screening is entered in Training Tracker.

Home visiting is based on a personal relationship between parents and visitor, encouraging parents to disclose personal information to their visitor. Ensuring family rights and confidentiality of

information is an ethical obligation of all family support programs.

Family Rights and Confidentiality

On or before the first home visit, families are informed of their right to confidentiality using the standardized *Healthy Start Confidentiality and Family Rights Policy*¹⁶ form:

- All HS/HF sites use the same standardized form (available in both English and Spanish) to outline family rights and program expectations.
- Instances where information may be shared without the family's consent are explained (mandated reporting).
- The backside of the form describes confidentiality procedures including who can see material in the family file and how the information will be used for evaluation.

Security

Precautions are taken to ensure participant and staff information is secured so only authorized personnel have access to this information. This includes using locked file cabinets to store paper files or, for database users, using a password protection system. Procedures need to be in place to ensure former database users no longer have access.

Linkage with the medical community. It is important to health care providers to know when children have had developmental screens. Encourage parents to sign a Release of Information (ROI) for their child's health

care provider so you can send them screening results. Parents may also be given copies of their ASQ results to take to their well-child visits. This assures effective identification of possible delays and promotes communication between the program and the medical community.

Developmental Delays

Programs develop and implement guidelines for tracking and following through with appropriate actions for children suspected of having a developmental delay.

Home Visitors ensure integration of services between HS/HF and Early Intervention (EI). If children do not meet eligibility criteria for EI, home visitors ensure the family is encouraged to stimulate the child's development and continue to conduct screening to monitor progress.

HEALTH AND COMMUNITY RESOURCES (CE 7-3)

Today's families typically have a wide variety of needs. While programs can address some of the needs, other organizations in the community will provide needed services. HS/HF programs assist *all* participating family members to establish a consistent medical provider for health care. Medical/health care providers are defined as any health care provider licensed by the state. Information is recorded in the family file.

Immunizations

Families are supported in getting timely immunizations for their children. Some children may be ill or have other reasons preventing them from receiving immunizations according to the identified schedule. While children may

¹⁶ See *Healthy Start Program Forms Manual*.

not necessarily receive immunizations “on time”, it is essential to keep them up-to-date.

HS/HF programs identify immunization schedules as recommended by the most current guidelines from the Centers for Disease Control and Prevention (www.cdc.gov). Individualized schedules with appropriate dates for coming immunizations can be printed from the CDC website by entering the child’s birthdate. Schedules are shared with families; copies are kept in the family file with dates for completion of each immunization.

Child health and safety information

Home visitors regularly provide families with child health and safety information that is based on recommendations from the American Academy of Pediatrics (AAP). Programs should have a reference copy of the latest edition of the AAP handbook, *Caring for Your Baby and Young Child, Birth to 5 years*. Other helpful information can be found on the AAP website, www.aap.org.

Referrals to community services

Based on information gathered in the assessment process and needs expressed by the family during the development of the FGP and home visits, families receive appropriate referrals for medical and other available community services. Follow-up ensures that families are connected to needed resources in a timely manner.

All referrals and follow-up activities are discussed in regular supervisory sessions and documented either on the

Home Visit Record or on a *Referral Tracking Form*.¹⁷ This form, printed on blue paper for easy access in the family file, sets the stage for referrals by summarizing a review of current family linkages and needs at intake and then tracks subsequent referrals.

Community partners. Be sure that staff are updated on community resources regularly so contacts can be facilitated. Nurturing relationships with community partners means better services for families. Invite program partners to speak at staff meetings on a regular basis.

CASELOAD MANAGEMENT (CE 8)

Reasonable caseload expectations for staff help to ensure that HS/HF programs provide necessary services to achieve success without risking worker burnout. Limited caseloads ensure that home visitors have enough time to spend with each family to meet the family’s needs and to plan for future activities.

- Full-time home visitors carry no more than 15 families at the most intensive levels (Levels 1 and 1-SS).
- Full-time home visitors carry no more than 25 families at various service levels, or no more than a maximum total weighted caseload of 30 points at any one time.
- Programs pro-rate caseloads for part-time home visitors based on their full-time equivalency (FTE). For example, a .5 FTE Home Visitor should have no more than 7-8 families at the most

¹⁷ See *Healthy Start Program Forms Manual*.

intensive levels or no more than 13-14 families at various service levels.

- Circumstances may arise when caseload size is exceeded, such as when a home visitor leaves and the caseload is dispersed among existing staff members. This practice must be limited to 3 months or less and programs are encouraged to clearly document the reasons and time period for the deviation.

Weighting for Caseload Management

| Level | Caseload Points | Schedule |
|--------------------|-----------------|-------------------------------|
| Level P-1, 2, 3, 4 | 0.5 - 2 points | Prenatal: weekly to quarterly |
| Level 1 | 2 points | Weekly |
| Level 1SS | 3 points | Weekly or more, high needs |
| Level 2 | 1 point | Every other week |
| Level 3 | 0.5 points | Monthly |
| Level 4 | 0.25 points | Quarterly |
| Level X | 0.5 points | Weekly to monthly contact |

PERSONNEL PRACTICES (CE 9)

Healthy Start ~ Healthy Families Oregon programs administer personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, handicap or the religion of the individual. Each program must have a written Equal Opportunity Policy that clearly states its practices in recruitment, employment; transfer and promotion of employees (see PPPM 9-2.).

Hiring Practices

Careful hiring practices are critical to successful delivery of services and include:

- Job descriptions that detail essential functions and responsibilities, requirements for education and

A weighting system assigns points to each service level and helps supervisors equalize the amount of work required among families receiving different levels of service.

Caseload Review

Family Manager uses the point system to automatically calculate each Home Visitor's caseload at the end of each month. The number of home visits for families on their caseload is entered each month.

experience, and any preferred personal characteristics¹⁸

- Notification of its personnel of available positions before or concurrent with recruitment elsewhere,
- Utilization of standard interview questions that comply with employment and labor laws, and
- Verification of 2-3 references and credentials.

HS/HF programs may hire people who were previously enrolled in the program provided that at least one year has past

¹⁸ Sample job descriptions for Healthy Start positions are available from OCCF.

since the applicant participated in the program. Standard hiring procedures must be followed. The applicant's HS/HF family file is kept locked and inaccessible to all staff during the hiring process and, if the individual is hired, during the duration of employment.

Research supports that fact that educational preparation alone should **not** be the basis for identifying individuals who will provide services to families. Without staff that are able to forge a relationship with parents that will facilitate and maintain positive parenting, the goals of HFA cannot be met.

The selection process should attempt to identify individuals who are:

- Nonjudgmental
- Compassionate
- Able to establish trusting relationships
- Work closely with their supervisors
- Advocate for themselves and families
- Work as team members

Background Checks

Programs ensure the safety of the families and children served by conducting criminal background checks on all prospective employees and/or volunteers who have responsibilities relating to families or their files (*Safety Standard – see PPPM 9-3.B.*).

Criminal background checks are conducted before contact with families and should include all states of residence in the past and records verified against all known names and social security numbers.

Programs are also encouraged to conduct background checks on supervisors and program managers. Programs are not required to conduct background checks for

licensed staff if the program has verified that background checks are part of the licensing process.

Staff Turn-over Analysis & Plan (CE 9-4)

As a part of personnel management, programs measure and evaluate the rate of personnel turnover every two years. Turnover is examined for a given period, such as one or two years. A sample is available on the OCCF website. Turnover rate is calculated as:

- the total number of staff who leave during the period divided by
- the total number of staff during the same period.

Turnover rates are examined both for the program as a whole and for the various job categories in the program to identify any patterns or unusual levels of turnover specific to certain categories.

Staff are given an opportunity to complete an exit survey provided by the statewide evaluation contractors on their website. In addition, supervisors are required to offer optional exit interviews to all staff leaving the program.

Turnover rates are examined in the context of job satisfaction as evidenced in interviews and/or surveys. Reasons for leaving are analyzed and actions are taken to correct any identified problems.

Staff Retention

Program managers must continually think about ways to retain staff members. Turnover in this field can be high. While salaries and benefits play an important role, people are more likely to leave for reasons related to career progression, seeking new challenges and achieving greater recognition.

Job satisfaction. A variety of approaches support staff engagement and enthusiasm, key components of retention. Staff members need to know they are valued. Nurturing staff should be ongoing – a day-to-day activity built through clear and open communication.

In addition, program managers can seek out opportunities for staff development that will open new doors and expand skill sets. Career development doesn't only mean promotion to a more senior level. Rather, it means moving through different stages of contribution, each one adding more value to the individual and the program.

Other contributors to job satisfaction are time off, office space, special tasks that recognize skills and public recognition for achievements.

TRAINING (CE 10)

Research supports formal training to prepare staff to assume the responsibilities of their job because of the following:

- Formal training prepares home visitors to assess families; strengths and needs, assist with the parent-child relationship, provide accurate information to the family, engage in appropriate case management activities, and meet certain standards of service delivery.
- Training establishes a link between theory and practice
- Training provides the opportunity for home visitors to develop and implement practical approaches to real situations in a safe environment
- Training allows staff to share information and experiences and to learn from each other

- Training helps home visitors feel supported in their work and promotes their professional development
- Training home visitors ensures consistent service delivery and allows for improved programs outcomes
- In order for programs to provide quality services, the staff must be trained in the specific tasks of the job

Training for HS/HF program staff is an ongoing process, designed to ensure that children and families receive high quality services. Training should be geared to the unique aspects of home visiting services and be culturally sensitive, taking into account each staff member's skills and needs.

HS/HF standards require staff to have training in a variety of topics that are relevant to the field of home visiting. Supervisors work with staff to determine what experience or education received prior to working with the program meets these requirements and where additional training is needed. Formal education, previous training and previous experience must have occurred within the last three years and apply directly to the identified topics. Otherwise, these experiences can qualify as training when coupled with competency-based testing and/or supervisory follow-up to assure knowledge and understanding of the topic.

Self-study Training

Researching and reading, watching videos, or going through self-paced training materials can qualify as training. Supervisory follow-up is essential to determine successful knowledge acquisition and understanding of concepts or materials.

Training Records

Training sessions are documented by training certificates, brochures or agendas that describe the content of the training and information about the qualifications of the trainer.

Documentation for self-study should include (1) what was studied, (2) author or producer of the materials, (3) what was learned and (4) how learning was assessed. Central Administration provides a required form, *Documentation of Learning through Training or Self Study*, for this purpose.

All training is recorded in the online Training Tracker and approved by the supervisor. Although not required, programs may find it advantageous for staff members also to complete paper *Training Logs* to have the information readily at hand in a training notebook.

A *Training Topics Checklist* provides a quick glance at a newly hired person's progress in meeting training requirements during the first year of service. Both optional forms are available from Central Administration.¹⁹

Program Training Plan

Programs develop a comprehensive training plan that assures timely access for all staff to all required training. The training plan addresses all required topics and sub-topics and assures that training provided is of high quality. Each of the topics required during the first year of service (PPPM 10-4 and 10-5) is addressed separately with identification of:

- training method
- qualifications or expertise of presenter

- assessment/evaluation of what has been learned and
- any program processes for supervisory follow-up.

The plan also includes ongoing training topics, selected to meet the needs and interests of current staff. Remember that, after the first year of service, staff are required to have at least 20 hours of ongoing training. Ongoing training often focuses on new information and/or specialized aspects of the first year training topics.

Individual Training Plans

Together with the supervisor, each staff member creates an individual training plan that recognizes existing knowledge and competencies.

The plan shows how any training requirements will be met and identifies additional training topics that would be beneficial in enhancing job performance and supporting professional development. Elements of the plan include:

- Training goal – overall results or capabilities attained
- Training objectives – what you will be able to do as a result of the learning activities
- Learning methods/activities – what you will do to achieve the objectives
- Evaluation – assessment of what you learned

Training Tracker

The Training Tracker is a web-based application that allows Central Administration and HS/HF programs to monitor required training. The tool can be found at

<http://egov.oregon.gov/OCCF/webapps.shtml>.

¹⁹ See *Healthy Start Program Forms Manual*.

Technical Assistance for Training Tracker is available by email at linda.p.jones@state.or.us.

The Training Tracker has two separate areas: (1) Training Management for entering and editing trainings and (2) Training Reports for running queries on information that has been entered in order to monitor training.

Training Management

Through Training Management, programs enter and edit trainings that have been taken. Training Management has three sections:

1. **Add/Edit Training Profile.** Before any training can be entered for an individual staff member, a training profile must be established that includes information about dates when various types of work started. These dates will be used in reports to calculate the extent to which training was accomplished on a timely basis.

2. **Add/Edit Training Received** lists existing training records. Program managers/ supervisors will see all the trainings for individuals in their section – home visitors will only see a list of their own trainings. Adding records requires the individual to select a training name and a method by which training was achieved.

Standardized training names have been established for required training topics. Newly hired staff working on required first year training choose among these names. Supervisors use what they know about the training content to help the new employee select the appropriate training topic.²⁰

3. **Add/Edit Training Topics** This section allows program managers and supervisors to enter ongoing training topics which do not fit in topic areas. Please check with Central Administration prior to creating an “ongoing” training.

Two dates are entered for each topic:

Activation Date – Date the training topic becomes available, typically the day preceding the actual training date. After this date, the topic will show up on the training topics list for your section, ready for individual users to select.

Deactivation Date – Future date when this training topic will no longer be available for data entry. Most training will be available as a choice so please check with Central Administration about choosing a date that keeps it in the system for as long as possible. Central Administration has the ability to inactivate a training if necessary.

Training Reports

The Comprehensive Training Tracker report displays all trainings taken. Programs can search for their records for specific staff members and run an automated (pre-formatted, ready to use) 2 sheet Excel Workbook. This report can be run at any time using the most updated data in the database.

²⁰ Some trainings that workers attend cover more than one training topic.

TRAINING TOPICS CHECKLIST

Name: _____ Role: _____ Role Start Date: _____

The following 3 trainings must be completed prior to performing the activity:

| | | |
|----------------------------|-------------|-------------------------|
| ASQ Training | Date: _____ | First ASQ: _____ |
| ASQ SE Training | Date: _____ | First ASQ SE: _____ |
| Medicaid Training | Date: _____ | First MOTT Entry: _____ |
| Annual Medicaid Trainings: | _____ | _____ |

The Following Core Trainings must be completed within 6 months of role start.

| | | |
|-----------------|---|-------------|
| 10-3 A. | Family Intake Assessment Training | Date: _____ |
| 10-3 B. | Integrated Strategies for Home Visiting Core Training | Date: _____ |
| 10-3. C. | Supervisor Core Training | Date: _____ |

Staff are required to have a majority of the topics (51% +) under each heading during the first 6 months and the first 12 months after starting their role. Two or more topics may be completed in a single training. Completed training is entered into the on-line Training Tracker (TT) state database.

Six-Month Training

| REQUIRED AREAS OF KNOWLEDGE AND SKILLS PRIOR TO WORK WITH FAMILIES | | | |
|---|------------------|---|---|
| ORIENTATION (A-E MUST BE COMPLETED PRIOR TO 1 ST HV USING ORIENTATION MANUAL.) | Training Date | First Independent Work with Families | First Independent Supervision of Staff |
| 10-2 A. Program goals, services, policies and procedures and philosophy of home visiting | | | |
| 10-2 B. Community Relationships/Resources | | | |
| 10-2 C. (CAN) Child Abuse and Neglect indicators and reporting requirements | | | |
| 10-2 D. Issues of Confidentiality | | | |
| 10-2 E. Boundaries | | | |
| Evaluation Forms | | | |

| Date Complete | Training Tracker Title | Topic |
|----------------------|--------------------------------|---|
| | Child Health and Safety 1 | Assessing and promoting home safety |
| | Child Health and Safety 2 | Shaken baby syndrome |
| | Child Health and Safety 3 | Sudden Infant Death Syndrome (SIDS) |
| | Child Health and Safety 4 | Seeking medical care |
| | Child Health and Safety 5 | Promoting well child visits and immunizations |
| | Child Health and Safety 6 | Seeking appropriate child care |
| | Child Health and Safety 7 | Car seat safety |
| | Child Health and Safety 8 | Failure to thrive |
| | | |
| | Infant and Child Development 1 | Language and literacy development |
| | Infant and Child Development 2 | Physical and emotional development |
| | Infant and Child Development 3 | Identifying emotional delays |
| | Infant and Child Development 4 | Brain development |
| | | |
| | Infant Care 1 | Infant sleeping patterns |
| | Infant Care 2 | Feeding/breastfeeding promotion |
| | Infant Care 3 | Physical care of the baby |
| | Infant Care 4 | Crying and comforting/consoling a baby |
| | | |
| | Maternal and Family Health 1 | Family planning |
| | Maternal and Family Health 2 | Nutrition |
| | Maternal and Family Health 3 | Pre-natal/post-natal healthcare |
| | Maternal and Family Health 4 | Pre-natal/post-natal depression |
| | | |

| Date Complete | Training Tracker Title | Topic |
|---------------|--|---|
| | Role of Culture in Parenting 1 | Working with diverse cultures/populations (e.g., age, religion, ethnicity, gender, sexuality, disabled populations, etc.) |
| | Role of Culture in Parenting 2 | Culture of poverty |
| | Role of Culture in Parenting 3 | Values clarification |
| | | |
| | Supporting the Parent-Child Relationship 1 | Methods for supporting attachment |
| | Supporting the Parent-Child Relationship 2 | Positive parenting strategies |
| | Supporting the Parent-Child Relationship 3 | Discipline techniques |
| | Supporting the Parent-Child Relationship 4 | Supporting parent-child interactions |
| | Supporting the Parent-Child Relationship 5 | Observing and assessing parent-child interactions |
| | Supporting the Parent-Child Relationship 6 | Strategies for working with difficult parent-child relationships |

Date Six Month Training Completed: _____ **Supervisor:** _____

Twelve Month Training

| Date Complete | Date in TT | Training Tracker Title | Topic |
|---------------|------------|---------------------------|-------------------------------------|
| | | Child Abuse and Neglect 1 | Etiology of child abuse and neglect |
| | | Child Abuse and Neglect 2 | Working with survivors of abuse |
| | | | |
| | | Family Issues 1 | Life skills management |
| | | Family Issues 2 | Engaging families |
| | | Family Issues 3 | Multi-generational families |
| | | Family Issues 4 | Teen parents |
| | | Family Issues 5 | Family relationships |

| Date Complete | Date in TT | Training Tracker Title | Topic |
|----------------------|-------------------|-------------------------------|--|
| | | Family Issues 6 | HIV and AIDS |
| | | Family Violence 1 | Indicators of family violence |
| | | Family Violence 2 | Dynamics of domestic violence |
| | | Family Violence 3 | Intervention protocols |
| | | Family Violence 4 | Strategies for working with families with family violence issues |
| | | Family Violence 5 | Referral resources for domestic violence |
| | | Family Violence 6 | Effects on children |
| | | Family Violence 7 | Gangs |
| | | Mental Health 1 | Promotion of positive mental health |
| | | Mental Health 2 | Behavioral signs of mental health issues |
| | | Mental Health 3 | Depression |
| | | Mental Health 4 | Strategies for working with families with mental health issues |
| | | Mental Health 5 | Referral resources for mental health |
| | | Substance Abuse 1 | Etiology of substance abuse |
| | | Substance Abuse 2 | Culture of drug use |
| | | Substance Abuse 3 | Strategies for working with families with substance abuse issues |
| | | Substance Abuse 4 | Smoking cessation |
| | | Substance Abuse 5 | Alcohol use/abuse |
| | | Substance Abuse 6 | Fetal alcohol syndrome |
| | | Substance Abuse 7 | Street drugs |
| | | Substance Abuse 8 | Referral resources for substance abuse |
| | | Staff-related Issues 1 | Stress and time management |
| | | Staff-related Issues 2 | Burnout prevention |

| Date Complete | Date in TT | Training Tracker Title | Topic |
|---------------|------------|------------------------|--------------------------|
| | | Staff-related Issues 3 | Personal safety of staff |
| | | Staff-related Issues 4 | Ethics |
| | | Staff-related Issues 5 | Crisis intervention |
| | | Staff-related Issues 6 | Emergency protocols |

Date 12-Month Training Completed: _____ **Supervisor:** _____

Additional Training for Program Managers and Supervisors Only

| Date Complete | Date in TT | Training Tracker Title | Topic |
|---------------|------------|----------------------------|---|
| | | Managers and Supervisors 1 | Understanding program policies and procedures |
| | | Managers and Supervisors 2 | Effective supervision |
| | | Managers and Supervisors 3 | Quality management techniques |
| | | Managers and Supervisors 4 | Crisis management |
| | | Managers and Supervisors 5 | Case management |
| | | Managers and Supervisors 6 | Role of family assessment and home visitation |

Date Program Manager/Supervisor Training Completed: _____

Supervisor: _____

REFLECTIVE SUPERVISION (CE 11)

Supervision of staff plays a critical role in the success of any program. Program staff, who often work autonomously, need ongoing input from supervisors to ensure that the work they are doing is consistent with program goals. Each home visitor that works 20 hours or more/week receives 1 ½ -2 hours of individual supervision/week. Any home visitor who works less than 20 hours receives at least one hour.

Supervision serves multiple purposes:

- Promotes both staff and program accountability
- Encourages personal and professional development
- Can reduce staff burnout and turnover
- Enhances the quality of service families receive
- Provides opportunity to teach, develop skills, and offer support
- Provides opportunity for supervisor to learn from staff

Three Essential Features of Supervision

Reflection – Sensitivity, authentic listening skills, explaining things well. Reflection helps the home visitor come to terms with what it means to go beyond doing what comes naturally in helping families to becoming a professional who work with families. The supervisor should offer an enlarged perspective, another set of eyes, a mirror.

Collaboration – Mutual respect, giving staff autonomy, constructive handling of conflict, willing to work alongside the home visitor. Collaborative relationships involve shared posed, clear mutual expectations and shared communication.

Regularity – Time must be allocated and protected. Supervision is also a relationship. The same steps utilized in developing trusting, supportive relationships with families should also be evident in the supervisory relationship.

Parallel Process

Reflective supervision is parallel to the service delivery process. Supervisors facilitate the conversation in the same way the Home Visitor works with the family by:

- engaging in a two-way conversation about issues,
- genuinely listening to the staff member's perspective and ideas and
- fostering creative problem solving.

Using the parallel process, the supervisor will rarely give advice or suggest solutions. In effect, the supervisor takes on the role of coach as she supports the staff member's professional growth and the resolution of a specific problem.

Both the supervisor and home visitor should be able to observe the parallel between the relationship the home visitor establishes with the families to the relationship that supervisors and home visitor develop with each other.

The relationship between the parent, home visitor and supervisor forms a triangle in which the home visitor has a relationship with the parents just as the supervisor has a relationship with the home visitor. The same qualities a home visitor demonstrates to establish the relationships with the parents are equally important for establishing a trusting, mutually supportive relationship between the home visitor and supervisor.

Home visitors have a very challenging and often stressful job. They are working with families that have multiple needs and are, sometimes, confronted with crisis situations. Staff working in these settings sometimes find it difficult to see the progress families are making, or they are unable to assess for themselves the progress that they are making with the family. During individual supervision, the Supervisor helps the home visitor recognize the areas in which the family and/or home visitor are achieving success.

It is hoped that the supervision session parallels best practice for home visiting by:

- Building trust;
- Practicing rapport-building skills;
- Demonstrating respect;
- Building on strengths;
- Accentuating the positives; and
- Practicing intervention strategies that support home visitors in critical thinking and problem solving.

Keys to Motivating Staff

Encourage team building

- In addition to regular supervisory sessions, foster time for staff to learn and share with one another
- Incorporate educational and fun activities into the agency's work plan.
- Share outcomes of program evaluations

Let staff know that they are valued

- Create opportunities for staff input in planning the direction of the agency
- Hold a staff retreat at least once a year

- Encourage staff to play a role in the hiring process
- Allow staff to attend and speak at conferences
- Create a staff development fund for conferences
- Develop a career ladder to encourage internal promotions
- Create an environment that encourages creative thinking
- Design the office space to promote interaction
- Set aside periods of time for brainstorming
- Put staff suggestions into practice
- Encourage staff to be in touch with other service providers of similar programs
- Encourage staff review of key journals that your agency receives

Accountability and Skill Development

All direct service staff are held accountable for the quality of their interactions with families on a regular and routine basis. Supervisors evaluate the performance of staff and shadow assessments and home visits. They ensure accountability and provide feedback encouraging professional development.

Supervision for home visitors includes the following activities:

- coaching and providing feedback on strength-based approaches and interventions
- reviewing FGP progress and process
- reviewing family progress and level changes

- assessing cultural sensitivity/practices
- providing guidance on curriculum and materials used with families
- discussing home visit completion rates, family retention and attrition
- providing feedback on documentation
- sharing information related to community resources
- assisting staff to put new training into practice
- identifying and reflecting on potential boundary issues
- identifying areas for growth
- assisting staff to reflect on their practice in order to build skills and prevent burnout

Documenting Supervision

Supervisors are responsible for keeping records of each supervisory session with home visitors.

HFA recommendations suggest that supervisors keep information in notebooks, either with a separate section for each supervisee or in a separate notebook for each supervisee. They further recommend that there be a section for each active family as well as a staff section.

Reflective Supervision is documented on the standard required General Weekly Supervision form. Strategies, outcomes and next steps are documented on the standard required Family Progress Review form.

- *Supervision notes* provide detailed information about the session to show that supervisees are provided with (1) skill development, (2) professional support, (3) held accountable for

quality of their interactions with families on their caseload and (4) frequency and duration per standards.

Weekly Supervision (CE 11)

The purpose of weekly supervision is to offer an opportunity for home visitors to:

- Updates
- Supervisors on what is going well and what concerns there are regarding all families in the caseload.
- Receive support, guidance and suggestions on each family as appropriate.
- Review in detail families in crisis. (These families may be reviewed at a separate time because of the special attention they take).
- Receive feedback on what they are doing right.
- Vent! Home visitors can discuss their frustrations, boundary issues, and when they are having trouble with families.
- Learn what paperwork is due in the near future (next 30 days).

It is not enough for supervisors to do case management. In reflective supervision, the supervisor inquires about and reflects on the following:

- The home visitor's observations and interventions. How family members behaved and what they said as well as how the home visitor responded, etc.
- What the family values, strengths, and commitments are?
- What is the home visitor commitment to the family?
- Where does the home visitors get stuck with the family and why?

- How the family's methods of interacting might be in conflict with the home visitors values.

It is the supervisor's responsibility to help the home visitor align oneself with the families and to creatively explore methods of intervention that support family growth.

The home visit record will be the structure for the supervision. The supervisor should review the home visit records prior to supervision. Notes should be taken while reading the record to provide the structure for the supervisory session. The focus on supervision is parallel to the home visitors work with families.

Here are some sample questions or areas you may want to explore with the home visitor in supervision:

1. Who participated actively in the home visit?
2. What is the home like and is it safe for those who live there (pets, rodents, family violence, dangerous and unpredictable people, indicators of substance use/abuse, mental health problems, adequate heat, safe water, sanitation. Etc.)?
3. Have there been any significant changes since the last home visit?
4. What were the parents focused on (the child, relationships with others, domestic violence, expanding support systems, personal problem solving, etc.)?
5. Are there any indicators of substance abuse and/or mental health concerns? (Appropriate referrals made)
6. How are the parents demonstrating problem-solving skills? How is the home visitor assisting in this area?
7. What community resources is the family using?
8. Did the baby/children appear happy and safe?
9. What and how much is the baby eating? (First six months, especially)
10. Is the baby up-to-date on well-care checks and immunization?
11. Are there any developmental concerns per Denver or other home visitor observations requiring interventions? If there are concerns, have referrals been made? How are parents and home visitor following up with these referrals?
12. What did the home visitor observe the parent saying or doing with the other children?
13. Are these children safe and healthy? Do they need referral to community resources?
14. Discuss any interventions the home visitor did regarding the other children and their relationships with the parents.
15. How did the home visitor use "Accentuate the Positive" in other areas outside the Parent-Child Interaction?
16. How did the home visitor use the program curricula or assessment instruments and how did parents respond?
17. Discuss how the parents are incorporating this information into their relationships and daily living.
18. Supervisor should discuss and explore any boundary issues that might be

impacting the relationship with this family.

19. What great thing did the parent and child do?
20. When did the work feel good, effective?
21. When did the child (parent/visitor) feel secure (valued/successful)?
22. When was your work most successful?
23. When did the parent seem most engaged?
24. What did you do that seemed most helpful?
25. What intervention worked?
26. What is not recorded in this home visit?
27. Do you like to go to this home? (Why, why not?)
28. What was a successful pivot (approach) that acknowledged the concerns and moved to action or a plan?
29. How did you help the parent feel in resolving concerns (guidance used vs. fixing)?
30. Who took the lead in this visit? (Home Visitor, parent, other)

Constructive Feedback

It teaches. It motivates. It facilitates change. It improves performance.

Feedback can enhance communication, generate new and better ideas, and support goals. It helps home visitors know where they stand and keeps them on track. It takes discipline, practice, and commitment.

Feedback is only productive when it serves two functions. The first and most

obvious is **to discover** — identifying pluses and minuses of behavior. Improved performance comes more easily to people who are made aware of both the positives and negatives — their strengths and weaknesses.

Too often though, the process stops there. The second function of effective feedback is **to instruct**. Feedback is fundamental to learning and improving. Not only should we critique specific behavior(s), but as supervisors, we must indicate how or why such actions will produce a good outcome or a poor one.

Feedback should be constructive. Whether positive or negative, the purpose of feedback is to enhance performance and produce better outcomes. Flawed technique can quickly turn a feedback meeting into a fruitless scolding. Instead of blurting out every thought that comes to mind, successful supervisors are cognizant of how their words will be perceived by others. Keep the outcome in mind. Do you want the person to get angry or beat themselves up after the discussion, or do you want them to start fixing the problem? Maintaining a helpful attitude will keep feedback recipients comfortable and motivated to listen.

Feedback should always be specific. Global statements are to be avoided. No one can respond adequately to vague generalizations about performance.

"That was a nice presentation," gives a person little to go on.

A more explicit assessment, such as: *"The information you presented was easy to follow. You looked confident, and your overheads highlighted your major points effectively,"* provides ample direction and

establishes some firm performance expectations.

Feedback should be immediate. "Just-in-time" delivery keeps production on track. Likewise, "just-in-time" feedback keeps performance on track. Don't wait for annual appraisals or other traditional feedback encounters. The shorter the interval between the work and the feedback, the more effective it will be. Such immediacy also implies the work being performed has importance. Seize every opportunity to provide constructive feedback.

Feedback should be depersonalized. The consequences that make all of us uneasy about giving feedback are usually produced when feedback becomes personal. Potential conflict and discord can be minimized by keeping the discussion on the issues. Focus on behavior, not on the person.

A simple tactic can be employed to keep feedback both impartial and constructive. When offering corrective feedback, use first-person statements. When offering positive feedback, use second-person statements. This may sound too simple, but it's not an oversimplification; it really works!

Performance feedback can be given two ways: through constructive feedback or through praise and criticism.²¹ Praise and criticism are personal judgments about performance- so these are best avoided. Instead, supervisors provide specific feedback to staff. Constructive feedback is information-specific, issue-focused, and

based on observations. It comes in two varieties:

- Positive feedback is news or input to an employee about an effort well done.
- Corrective feedback is news or input to an employee about an effort that needs improvement. Corrective feedback provides information that helps to change behaviors so better outcomes will result. It's normal that corrective feedback will need to be given at times to any employee.

Tips for giving feedback

Constructive feedback is collaborative, informative and non-judgmental. Here are a few tips for giving constructive feedback:

1. Start off by checking in with the person.
2. Begin each key point with an "I" message, such as "I have noticed, I have observed, I have seen" or when the need exists to pass on feedback from others, "I have had reported to me . . ." "I" messages help you to be issue focused and get into specifics.
3. Identify the behavior that you want to see changed. Direct your feedback at the action, not the person.
4. Make your comments specific and base them on observations, not interpretations. Instead of "You always miss deadlines" say "You missed the March 30th deadline for completing the Family Update."
5. In positive feedback situations, express appreciation. That alone is praise. When you add specifics, your

²¹ Adapted from *Coaching and Mentoring for Dummies* by Marty Brounstein

message carries an extra oomph of sincerity.

6. In corrective feedback situations, express concern. A tone of concern communicates a sense of importance and care and provides the appropriate level of sincerity to the message.
7. Be sincere and avoid giving mixed messages. Mixed messages such as "Susan, you've worked really hard but . . ." create contradictions. In essence, putting "but" in the middle tells the other person, 'Don't believe a thing I say.'
8. Make sure the other person understands the reason for your feedback.
9. Don't belabor the point. Keep it short and sweet -- no lectures. Follow up with something positive.
10. Offer incentives for changed behavior. Offer to help the person correct the problem.
11. Effective feedback needs to be specific and timely. Praise should also be public, and a reprimand should be private.
12. Honest feedback, delivered at the appropriate time and place, can be a highly effective tool for employee morale.
13. Consider your motives for giving the feedback - Are you really trying to "help" the other person or show your superiority? There is seldom a more inaccurate statement than the often repeated, "I am doing this for your own good."

Data Monitoring

Supervisors are responsible for ensuring that evaluation forms are collected and mailed to NPC Research on a monthly basis. Data must be postmarked by the 10th of the month to ensure timely entry. Healthy Start's Evaluation Manual (the "Red Book"), available online at www.npcresearch.com, contains comprehensive information about data collection processes.

Screening

Consent forms (*Welcome to Healthy Start*) are completed for each family who is approached by HS/HF, even if the family declines to participate. Programs tabulate the results of the consent forms for end of the year reporting. Consent forms for families who participate in Intensive Service are added to the family file.

ID Numbers. Each New Baby Questionnaire is entered into OCCF's online Family Manager (www.oregon.gov/OCCF/webapps.shtml). This creates an identification (ID) number that will be used for the evaluation project. Programs must keep a master list of the ID numbers assigned to each child along with the child's name and family name for monitoring purposes.

Intensive Service

Central Administration provides a *Data Tracking Form* to monitor due dates and completion dates for all required forms that track Intensive Services. This Excel[®] spreadsheet automatically calculates due dates once the child's birth date and the first home visit date have been entered. The form is organized by child's age to ensure that appropriate information is collected in a timely way. *Evaluation forms should always be completed within*

one month of the scheduled due date otherwise validity is threatened.

Team Meetings

Because isolation from colleagues can create a serious occupational hazard and lead to burnout, team meetings take on even greater importance. Staff can share information and enjoy the support of other team members during these meetings, although they do not provide a substitute for individualized supervision.

Consider the following recommendations for team meetings:

- Team meetings form the foundation for reflective practice.
- The atmosphere of the team meeting encourages a feeling of inclusiveness. Staff input is valued and, if at all possible, included in the program's decision-making process.
- Programs have team meetings on a regular basis (weekly, bi-weekly or monthly) and insist that *all* members of the team attend. Remember to begin and end on time.
- If a team is comprised of part-time workers, extra time is allowed for these members to come to the meeting, or a time should be determined that will allow them to attend.
- An agenda is created for each meeting and an opportunity given for each staff member to add to the agenda.
- The meeting is no longer than 1 to 1 ½ hours and is divided into three main components:

- Business/administrative (i.e., changes in policy or procedures, general agency information, etc.);
- Supportive (time for staff to discuss challenges that could be addressed through team input); and
- Educational (an opportunity for learning and sharing of new information).

Team meetings provide an excellent opportunity for building and restoring staff morale. Every team meeting does not have to be only business. One meeting every other month could be dedicated to fun and team-building activities such as potluck dinners or lunches, stress relief activities or make-it/take-it workshops. Some sites hold periodic meetings away from the office. The meeting's agenda still contains business and educational items but the changed atmosphere allows the staff to develop and maintain supportive relationships with each other.

Supervision of Supervisors

Supervisors receive regular (at least monthly) and on-going supervision that assures supervisors are held accountable for the quality of their work, receive skill development and professional support.

Supervision of Program Managers

Program managers are held accountable for the quality of their work, receive ongoing skill development and professional support at least quarterly.

Supervision of supervisors and program managers needs to be documented. A form is provided on the OCCF website.

Forms and Documentation

A variety of forms are used to document and evaluate Healthy Start services throughout the state system. Forms have been designed to meet Healthy Families America (HFA) quality assurance standards while at the same time, streamlining paperwork as much as possible. Reference the *Healthy Start Program Forms* as needed. The forms are available electronically on a CD and/or are sent on request.

Evaluation

NPC Research provides “scannable” forms for the evaluation – these are described in this manual and more detailed instructions can be found in the Evaluation Manual (“Red Book”) available on web at www.npcresearch.com/materials.php.

Scannable evaluation forms are provided by NPC Research on an as needed basis at state meetings or by mail. Programs request forms from NPC as needed. Scannable forms are expensive to produce so programs are requested to use them judiciously.

Coding system

Forms are coded according to a system that establishes requirements for their use:

State Standardized & Required (SR).

Programs must use these forms. Cosmetic

changes (such as adding the name of local program) are allowed, but the content of the existing form may not be modified.

Required (R). Programs are required to have forms that meet this purpose.

Sample forms are provided by Central Administration but programs may prefer local versions as long as key information is captured.

Optional (O). Programs have found these forms to be helpful in meeting Healthy Families America standards but they are not required. Sample forms are provided and may be modified depending on local needs.

Color Coding. Service level assignment, creative outreach tracking Family Referrals and Concerns and referral tracking forms are printed on colored paper for easy monitoring.

Future Changes

Changes to state standardized and required (SR) forms will be kept to a minimum and if needed, will occur at the beginning of a fiscal year. Programs that have versions of required or optional forms that are working particularly well are asked to transmit them to central administration so they can be offered as samples to others in the statewide system.

Healthy Start ~ Healthy Families Forms List - 2011-2012

| | Form Type | Eng/ Span | Comments |
|---|-----------|-----------|-----------------------------|
| Service Initiation | | | |
| Give Your Baby a Healthy Start (Consent to Contact) | O | √ | NPC Research |
| Welcome to Healthy Start (Consent to Participate) | SR | √ | NPC Research |
| New Baby Questionnaire | SR | √ | Family Manager (Jan 2011) |
| Service Delivery | | | |
| Ages & Stages Questionnaire (ASQ) & ASQ-SE | SR | √ | See Training Manuals |
| Authorization to Release Information | SR | √ | |
| Data Tracking Form (and Prenatal Data Tracking Form) | SR | | Auto fills due dates |
| Family Concerns and Referrals (Intake) | SR | √ | Blue paper |
| Family Values (two options) | SR | √ | |
| Wishes for my child (three options) | SR | √ | |
| Exit/Re-Entry | SR | | Family Manager (Jan 2011) |
| Family Assessment Interview Narrative | SR | | |
| Family Intake | SR | | NPC Research |
| Family Rights & Confidentiality | SR | √ | |
| Family Update | SR | | NPC Research |
| Home Observation for Measurement of Environment (HOME) Forms: 12-24 months, 36-48 months | SR | | NPC Research |
| Home Visit Record (two options available) | SR | | |
| Parent Surveys I and II-A, II-B | SR | √ | NPC Research |
| Service Level Assignment (P, 1-SS, 1, 2, 3, 4, X) One Form | SR | | Green paper |
| Contact Log and/or Monthly Service Log | R | | |
| Family Goal Plan (FGP) | R | √ | |
| Immunization Tracking | R | | CDC Website or Alert System |

| | | | |
|--|---|--|------------|
| Referral Tracking Form | O | | Blue paper |
| Family Transfer Summary Form | O | | |
| Service Level X: Creative Outreach Tracking Form | O | | Pink paper |
| Referral Tracking Update Form | O | | |

| Staff Support | Type | Eng/ Span | Comments |
|--|------|--------------|-------------------------------------|
| Home Visitor Plan to Support Family – Initial Approach | SR | | One time after FAI |
| Home Visitor Plan to Support Family – formerly HV Goal Plan | SR | | Fluid, on-going |
| Family Assessment Interview Inter-rater Reliability | SR | | Every 180 days |
| Family Progress Review | SR | | |
| General Weekly Supervision | SR | | |
| Home Visit Completion / Caseload Management | SR | | Family Manager |
| Supervision Log (two options available) | SR | | New Requirement |
| QA Observation of Family Assessment Interview | R | | Min. 1 x year |
| QA Observation of Home Visit | R | | Min. 1 x year |
| QA Phone Surveys for Active Families | R | | 2 every 180 days |
| Supervision of Supervisors and Program Managers | R | | Monthly Sups and quarterly Managers |
| Documentation of Learning (form or on General Sup Record) | R | | |
| Training Logs (Prior to Work, Core Training, 6 mo., 12 mo., Ongoing) | O | | Enter in TT (R) |
| Training Topics Checklist | O | | |
| Home Visitor Development Plan | TS | | |
| Supervision Binder Organization & Review Calendar | TS | | |
| Governance and Administration | | | |
| Healthy Start Program Budget & Expenditure Worksheet | SR | | |
| Program Goal Plan | SR | | |
| Staff Exit Survey | SR | | NPC Research |
| Family Retention Analysis Template | SR | | |

| | | | |
|--|----|--|--|
| Family Acceptance Analysis Template | SR | | |
| Cultural Sensitivity Template and Guidelines | R | | |
| Staff Cultural Competency Survey | R | | |
| Staff Satisfaction Survey | R | | |
| Medicaid Time Tracker Log | R | | |
| Advisory Group Review Calendar | TS | | |
| Samples for Staff Retention, Screening, HVC Rates | TS | | |

Governance & Administration

QUALITY ASSURANCE PLAN (GA 3)

A state Quality Assurance (QA) Plan has been adopted to ensure that all local programs provide comprehensive, high quality and effective home visiting services. Programs base a local QA Plan on the state model, adding additional practices as necessary.

Policies and procedures. To ensure relevance, the state QA Plan specifies that the PPPM be reviewed annually by the Healthy Start State Steering Committee.

- Suggestions for changes are actively solicited 90 days before the annual review although proposals for changes may be submitted at any time.
- No later than 30 days after approval, program managers and LCCFs are notified of changes and date on which changes become effective.
- Programs receive an electronic copy of the updated PPPM and add local procedures where indicated. The updated manual is reviewed and adopted by the local Advisory Committee – a copy is then sent to Central Administration within 90 days.

Internal QA procedures. Under the state QA Plan, program managers and supervisors use a variety of strategies to monitor service quality. These include:

- monitoring the screening rate and screening processes,
- planning how to prioritize eligible families when program does not have the capacity to provide intensive services to all,
- observing home visitors periodically as they conduct visits and intake assessment interviews,

- discussing home visit records with home visitors to ensure appropriateness of support activities for family,
- reviewing caseloads and home visit completion routinely,
- examining family files periodically to ensure proper documentation,
- looking at family retention rates for each home visitors,
- ensuring evaluation paperwork is submitted in a timely manner,
- developing training plans and organizing in-service training opportunities,
- periodically, contacting families on an individual basis to determine parent satisfaction and
- every two years, conducting a cultural sensitivity review that examines materials, training and the service delivery system.

Technical assistance and monitoring

Central Administration offers programs technical assistance based on needs/requests and information gathered during the annual site review and program evaluation.

Twice a year, program managers and supervisors attend a state meeting for training and updates on program implementation.

ANNUAL SITE VISIT

(GA 17 – PPPM Multi Site Standard Q3.6) Programs receive at least one site visit per year from Central Administration staff and/or contractors to review quality assurance procedures and provide technical assistance for any identified

issues. The intent of the visit is to (1) highlight and celebrate successes and strengths, and (2) identify areas of work for the coming year.

QA Review Team

The program manager, LCCFs and Central Administration staff work together to set the date and agenda for the visit. The team of reviewers includes:

- LCCF staff member(s)
- Central Administration staff and/or contracted employee(s)
- Any other interested people (i.e., local CCF members, Early Childhood Team or HS Advisory Group members)

Review Content

The review begins with an introductory *Welcome Meeting* to set the stage for the day. The team uses a *Site Visit Checklist* to assess the extent to which the standards identified in the PPPM are being addressed. Copies of the checklist are provided prior to the visit.

Following the annual site visit, LCCFs and local programs receive a written report from Central Administration staff addressing program strengths, quality assurance issues, HFA compliance and performance measures.

Program Goal Plan

Based on the report, each program then develops Program Goal Plan (PGP) to address all areas that need improvement. The plan sets goals for the coming year and identifies actions needed to reach the goals.

LCCFs and the program's advisory group are involved in the development and subsequent monitoring of the plan. Central Administration staff provide

technical assistance and support during this process.

Quality Improvement Plan

There are times when programs may have difficulty meeting goals set forth in the IPSP. When this occurs, programs receive specific written feedback from Central Administration and/or their LCCF about issues such as:

- significant non-adherence to the PPPM,
- falling below the threshold for maintaining HFA credentialing standards,
- issues with meeting performance indicators, and
- data collection processes and data quality.

In collaboration with the LCCF, a written Quality Improvement Plan (QIP) is prepared by the local program within 60 days of being notified of concerns. The plan addresses each area of concern with specific action steps and timelines for accomplishment.

Within 90 days of implementation of the QIP, programs receive a follow-up visit from LCCF and Central Administration to assess progress. Central Administration provides a written report, addressing any progress that may have been noted.

Corrective Action Plan

If steps to effectively address the issues in the QIP are not in place 60 days after receiving the follow-up site visit report, the LCCF, in collaboration with Central Administration, write a *Corrective Action Plan* with a maximum completion time of 90 days after the plan is signed. As outlined in the PPPM (see G-17.D. – G-17.L.), inability to meet the implementation goals may lead to change

of provider or disaffiliation from the state system.

BUDGET PROCESS (GA 9)

Programs prepare budgets in consultation with LCCFs, using the *Healthy Start ~ Healthy Families Program Budget and Expenditure Worksheet* (shown below).

The worksheet documents expenditures by resource type in order to show appropriate use of Healthy Start General Funds (GF) and Medicaid Administrative Claiming (MAC) reimbursements.

The LCCF presents the program budget to the BOCC for approval at the beginning of each fiscal period (biennially) or whenever significant changes occur, such as change of provider. The completed budget is then submitted to OCCF.

Budget Guidelines

HS/HF General Funds (GF) are allocated solely for providing quality services to higher risk families who are first-time parents. These Core Services include:

- screening to identify higher risk families (including parenting and resource/referral information),
- intensive home visiting services for higher risk families as described in the PPPM, and
- materials and supplies, staff training, and administrative costs needed to directly support these services.

If a local community wishes to provide additional services to lower risk families who are not eligible for home visits, resources other than GF and MAC must be used. Any activities for lower risk families must be clearly distinguishable from core services.

Screening. OCCF recommends that no more than 10 – 15% of GF be used for this function. Costs of screening can be kept low through the use of linkages with community partners.

Screening activities eligible for GF include:

- conducting screens,
- community outreach to screening partners and coordination of any screening volunteers, and
- materials for information and referral packets distributed during the screening process.

Staffing. The following positions are central to Core Services and may be paid with Healthy Start GF:

- home visitors
- supervisors for home visitors
- program managers
- clerical support staff
- any community outreach workers necessary for screening

In planning the budget, the total FTE allocated for home visitors must be adequate to meet performance indicators such as service expectations for total higher risk families served each year. Home Visitors carry limited caseloads to ensure quality services. In addition, families can continue to receive service for up to five years.

Supervision. Because supervision plays such a critical role in quality assurance, standards require that programs maintain one fulltime supervisor for every six home visitors. When a supervisor is part-time, the number of home visitors is adjusted to keep an overall ratio of 1:6. This is particularly important to plan for in programs where the roles of program manager and supervisor are combined.

Non-Required Positions

Note that additional staff such as nurses, early childhood specialists, mental health consultants, the supervisor of the program manager, or playgroup coordinators whose roles are not required under the PPPM may not be paid for with GF as specific positions. Supervision for the program manager may be included as part of the indirect costs.

Training

A cost sharing strategy to cover the cost of core training has been adopted. Central Administration provides mandatory core trainings and meetings at no cost to programs. Local programs must cover travel and related expenses.

Programs must budget adequate funds to provide required in-service training during a staff member's first year. This training (approximately 80 hours) covers a variety of topics central to Healthy Start's goals. These trainings are offered free of charge online, by HFA. Typically, home visitors carry lighter caseloads until this training is completed.

Regular, ongoing training also must be provided for the entire staff as part of the quality assurance process.

Indirect Costs

Costs of indirect support to the program from a parent organization or a separate agency may be charged to GF but should be maintained within reasonable limits, generally not exceeding 5% of the total budget. Note that if indirect costs are too high, there may not be adequate funds to provide necessary core services.

Not eligible for Healthy Start General Funds. Services that are not appropriate for GF include the following:

- Services to low risk families beyond screening
- Welcome Baby home visits to lower risk families
- Welcome Baby gifts
- Program incentives such as diapers or transportation vouchers

These services can help a program to be successful and hence, are a productive way to spend local resources.

Healthy Start Program Budget and Expenditure Worksheet

| | | | State | | Ctny | Cash | Fed | Pvt | In- | |
|---------------------------------------|------------------------|-------|-------|-----|------|---------------|-------|-------|------|-------|
| | | Total | GF | MAC | GF | Dona- tion | Grant | Grant | Kind | Other |
| REVENUE (source) | | | | | | | | | | |
| Total Revenue | | | | | | | | | | |
| EXPENDITURES | FTE/ People | | | | | | | | | |
| Salary and Benefits | | | | | | | | | | |
| Home Visitor Salary | ²² | | | | | | | | | |
| Program Supervisor Salary | | | | | | | | | | |
| Program Manager Salary | | | | | | | | | | |
| Clerical Support Salary | | | | | | | | | | |
| Benefits | | | | | | | | | | |
| Total Salary and Benefits | | | | | | | | | | |
| Materials and Services | | | | | | | | | | |
| Office Supplies | | | | | | | | | | |
| Program Supplies | | | | | | | | | | |
| Mileage Costs | | | | | | | | | | |
| Dues and Subscriptions | | | | | | | | | | |
| Employee Training | | | | | | | | | | |
| Data Processing | | | | | | | | | | |
| Professional Contracted Services | | | | | | | | | | |
| Rent | | | | | | | | | | |
| Utilities | | | | | | | | | | |
| Telephone | | | | | | | | | | |
| Other: (Itemize) | | | | | | | | | | |
| Indirect Costs: (Itemize) | | | | | | | | | | |
| Total Materials & Services | | | | | | | | | | |
| Capital Outlay (Itemize) | | | | | | | | | | |
| Total Capital Outlay | | | | | | | | | | |
| TOTAL EXPENDITURES | | | | | | | | | | |
| PROJECTED ENDING BALANCE | | | | | | | | | | |

²² Salaries are calculated for total FTE by people for each position. Thus, 1.5/3 indicates 3 people working at a position with a total of 1.5 FTE.

HEALTHY START ADVISORY GROUPS (GA1)

All Healthy Start ~ Healthy Families programs are required to establish local advisory groups to support, review and advise the program as it plans implements and reviews its services. The group provides a venue for community collaboration and supports the creation of stronger links between formal and informal systems of support for young children and their families. In many communities, the Early Childhood Team also serves as the HS/HF Advisory Group.

Program managers are responsible for keeping members informed and actively involved. Typically, the advisory group meets on a quarterly basis. The group plays a variety of roles:

- makes recommendations for planning, implementation, and policies of the local program,
- promotes and advocates for the local program,
- takes an active role in resource development for the program, including the 25% local community match required for Healthy Start funds,
- leverages important non-monetary resources through their time and commitment, and
- serves as a forum for communication and resource sharing among community partners.

Organization

Advisory groups operate under by-laws or written procedures that include the purpose, membership, order of business and meeting schedule, parliamentary authority and other organizational

processes. Minutes are kept for each meeting and circulated to members unable to attend.

The local program manager is responsible for keeping members informed and actively involved. However, as non-voting members, HS/HF staff may not participate in decision-making nor are staff members involved in preparing reports to the LCCF.

Membership

Advisory group members are recruited both from partner agencies and from other venues such as service groups, advocacy groups for young children, businesses, the arts, and present/former program participants. LCCF staff are also involved. This heterogeneous mix of skills, strengths and community knowledge leads to increased understanding of diversity and more inclusive community decision-making.

Tips for Successful Advisory Groups

Here are some proven ideas for developing advisory groups to become interested and supportive friends:²³

Timing. Meet at a convenient time and place. Sometimes the difference between good and poor attendance is simply choosing the right time. Establishing a regular meeting schedule helps. Telephone conferences, mailed reports and individual contact, either by telephone or face-to-face, can be useful to keep interest alive between meetings.

Size. Advisory groups are most effective when every person has an opportunity to

²³ adapted from *Advisory Councils - Real Friends*, Julia Gamon, Iowa State University Extension Service, Ames IA

voice an opinion. Studies have shown that as members participate more in a meeting, they judge the meeting to be more successful and are more likely to continue.

Task-oriented. Make the advisory group a working group, not strictly an advising one. Identify tasks that are relevant and timely, require input from all the members and will have visible results. The strength of a group is proportional to the activity level. As members work together, they become a stronger, more cohesive group, better able to advise.

Organize. Set up a process for selecting and rotating chairpersons who will preside at the meetings and work with you to set agendas. Don't fall into the trap of serving simultaneously as chairperson, secretary, meeting notifier, refreshment server, and idea generator!

Rewarding. Make the advisory experience personally rewarding for the members. They're giving their time and expertise – they need to get something as

well. Members should have the satisfaction of seeing that their ideas have some real impact on the program. When appropriate, publicize their names and pictures, and activities.

Communication. Encourage members to keep other community groups with whom they may be involved informed about Healthy Start activities and successes. Public awareness and public support are central to the success of Healthy Start ~ Healthy Families programs. Advisory group members can play a powerful role in advocating for the program, both in the community and statewide.

Fun. Along with the advising and activities that are their work, advisory group members usually want some fun, sociability, and informal contacts with people. This helps build group cohesiveness and returns dividends in group morale and productivity. The kind of sociability will depend on the group, but food and time to talk are staples.

About Medicaid

Medicaid is a means-tested entitlement program providing health care coverage and medical services to millions of low-income children, pregnant women, families, persons with disabilities, and elderly citizens. Medicaid is financed jointly by the states and federal government. In Oregon, Medicaid is most commonly referred to as the Oregon Health Plan (OHP).

The majority of HS/HF families receiving Intensive Service are eligible for Medicaid/OHP health care coverage. Results from the state evaluation, presented in the annual Status Report, show that, on average, about 80% of the families have low incomes and are potentially eligible for Medicaid/OHP.

In order to assist low-income families to receive vital health care services, federal matching funds under Medicaid are available for administrative activities in support of the State Medicaid plan, including efforts to identify and enroll potential “eligibles” into Medicaid. Other allowable Medicaid Administrative Claiming activities are case planning, monitoring, coordination, referral of Medicaid covered services, and training of outreach staff on the benefits of the Medicaid/OHP program.

Through an interagency agreement, HS/HF programs receive reimbursement from the state Medicaid/OHP office for providing these outreach and coordination activities. This process, termed Medicaid Administrative Claiming, requires all HS/HF staff to track their activities for four random days each calendar quarter.

How does this work?

No greater than five days in advance, the state Healthy Start office advises local programs of the random day selected for time study via email. On that day, employees of the local Healthy Start program record all paid activities conducted during the time they are on the job. If they are working for other programs during that day, that time is not recorded on the Healthy Start claiming forms.

Activities are then allocated in 15 minute increments according to the codes on the following pages. Examples of reimbursable activities include:

- discussing access to health care with a client
- assisting in early identification of children who could benefit from health services provided by Medicaid
- discussing well baby care and immunizations
- providing referral assistance to families for Medicaid-covered services

Each HS/HF employee enters the coded time study into the web-based Medicaid Online Time Tracker (MOTT) System. The Medicaid Online Time Tracking (MOTT) System is a web-based application designed to monitor the administrative activities of HS/HF staff members that are eligible for reimbursement from the Office of Medical Assistance Programs (OMAP). Located on OCCF’s website, <http://www.oregon.gov/occf/webapps.shtm>, an online help document describes the system and provides navigational assistance. Additional assistance is available from OCCF staff or email (occfwebsupport@state.or.us).

Profiles

Before staff can log onto the system, program managers or supervisors must create a user profile. Each profile includes name, contact information, educational level, hire date and HS/HF job classification such as Home Visitor, Supervisor, or Program Manager. Once a profile is created, the individual staff member can login, update personal information such as phone, email, or alternative contact information, and enter time sheets. An individual staff member sees only her/his own profile. This profile is necessary for all staff, whether or not they participate in Medicaid Claiming.

Time Sheets

Central Administration notifies programs of each Random Time Study day using the electronic time sheet, each employee enters information on how time was spent during the Random Time Study day. Once information has been entered and successfully saved, employees print a paper copy of the online time study for documentation purposes.

All blocks within the electronic time sheet must be completed. Hours within the day that are not paid by HS/HF (either because the person is part-time and didn't work during those hours/day or is employed on a different program for those hours) are filled in as "non-HS."

Program Manager/Supervisor responsibilities

- Ensure that employees receive Medicaid training and participate in time studies on each Random Time Study day, regardless of what they are doing.
- Review time sheets to ensure correct coding. Enter time sheets

into MOTT for employees who are unable to do so themselves.

- Maintain and update profile information for each employee. Add a termination date when staff member is no longer employed by HS/HF. Hire and termination dates are especially important since they are used in calculating reimbursement. Omitting a termination date negatively impacts reimbursement due the program.
- Maintain and update salary information for each employee by quarter and current year. Salary information must reflect total Healthy Start dollars expended on the person in a specific quarter. If the salary is omitted for a quarter, then that staff person's time will not appear in the final reimbursement report and reimbursement will be adversely affected.