Standard 4: Offer Services Intensely

**MINIMUM LENGTH OF TIME TO OFFER HOME VISITS**

(EFFECTIVE 11/27/2024)

**HFA Best Practice Standard 4-1.A**

**POLICY: Families are offered weekly home visiting services at the start of services and continue to be offered weekly visits until the family meets progress criteria to move to every other week. Services are offered long term (3 to 5 years).**

HFNY Policy Guidelines

* If pregnant and prior to 28 weeks gestation, families enter services at 2P and weekly visits ​​are offered until a relationship is established and then the home visitor can begin conducting visits every other week. Program and family can determine how long weekly visits will be offered on 2P. If the family begins services when the mother is at or beyond her 28th week of pregnancy, they enter services on Level 1P with weekly visits.
* If the family has a new baby (target child), they begin services on Level 1.
* Families on Level 1 and 1P will be offered weekly home visits. If a family requests less frequent home visits prior to meeting progress criteria, sites will respect the family’s wishes and adjust visit frequency to family request (documenting the parent’s request in the home visit narrative or case notes when this occurs), while maintaining the family on Level 1 and continuing to offer and encourage the family’s receptivity to weekly visits. The expectation is weekly visits will be offered until the family meets progress criteria to move to Level 2.
* Families whose infant is hospitalized in NICU after birth will not be placed on Level 1 until the baby comes home from the hospital, unless the parents want weekly visits during that time. The FSS will place the family on Level TO until the baby comes home from the NICU. The home visitor will ask the family how often they would like to have contact with the program in the form of visits, phone calls and/or other outreach methods. Based on the conversation with the family, the supervisor and home visitor will add the outreach plan to the Service Plan. All outreach will be documented in the MIS case notes (unless a home visit takes place, which will be documented in the home visit narrative)
* Families moved to a creative outreach level from Level 1 will return to Level 1 once re-engaged until the family has met the criteria outlined on the Level Change Form for movement to Level 2.
* Families transferring from another HFA site or re-enrolling with the same target child will be placed on Level 1 and offered weekly visits until the relationship has been established with the home visitor. The FSS and supervisor discuss/review the criteria for level changes to make sure that the family continues to meet the progress criteria prior to moving them through the levels. The speed with which the family moves through the service levels (with a transfer or re-enrollment) will be dependent on the family’s need and done at the discretion of the supervisor and FSS. The key here is making the effort to build a relationship with the transferred or re-enrolled family. Conversations on family's progress in meeting criteria will be documented in supervision notes.
* The supervisor and the home visitor discuss and formalize all level changes during regular supervision. Level change discussions are documented in supervision notes
* Level change forms will be completed and signed after the family, home visitor and Supervisor agree to the level change (**see 4-2 for more details about level changes**)

**The site will adhere to all NYS policy guidelines specified above. In addition, please insert site-specific procedures that:**

1. Describe how the program will ensure families are moved from 2P to 1P once the 28th week of pregnancy has been reached
2. Describe how the program will make sure that a family with a target child in the NICU is receiving outreach based on the family’s preference and ensure this outreach plan is documented in the Service Plan
3. Describe how the program ensures that a transfer or re-enrolled family receives weekly visits until the relationship is established and criteria are met to move the family through the levels.
4. Describe how the program ensures that conversations about all level changes, re-enrollments and transfers are documented in the supervision notes

**LEVELS OF SERVICE**

(EFFECTIVE 11/27/20224)

**HFA Best Practice Standard 4-2.A**

**POLICY: The intensity of services is based on clearly defined levels of service and criteria for moving from one level of service to another. Progression from one service level to another is based on the progress of the family and involves the family, the home visitor and the supervisor.**

HFNY Policy Guidelines

* When families agree to participate in intensive home visiting services:
  1. If pregnant and prior to 28 weeks gestation, they enter services at 2P and weekly visits ​​are offered until a relationship is established and then the home visitor can begin conducting visits every other week.
  2. If the family begins services when the mother is at or beyond her 28th week of pregnancy, they enter services on Level 1P with weekly visits being offered.
  3. If the family has a new baby (target child), they begin services on Level 1 and are offered weekly visits.
* Families served prenatally move to Level 1 with the birth of the new baby, except if the baby is in the NICU **(Programs will refer to policy 4-1 for details).**
* Service intensity is based on criteria on the HFA Level Change Forms. Level Change Forms are required for changes from Level 1 to Level 2, Level 2 to Level 3, and Level 3 to Level 4.
* Families can **temporarily** be placed on Level 1SS, 2SS or 3SS (Special Services) when in crisis, or during a high-need time period while on Level 1, 2 or 3, after discussion with the supervisor. The SS level should generally not exceed 3 consecutive months but there may be situations in which SS extends beyond 3 months, if the crisis is still ongoing.Staff and supervisors may consider the need for continued special services within 3 months of placement to determine whether the family should move back a level (e.g., a family on Level 3SS not able to return to Level 3 after three months on Level 3SS would be moved back to Level 2; for families on Level 1SS consideration to extend SS for longer time), or whether HFA home visiting should be supplemented with other services.
* There might be circumstances under which a family requires more time for the home visitor to plan and/or conduct visits on a more **permanent** basis, not due to a temporary crisis but due to an ongoing need (*including but not limited to: child welfare involved families, families that require translation, families with special needs on the part of the parent or child, multiple births, lack of other resources available in the community to meet family need, extensive travel and other non-direct service time required to fulfill the home visitor’s responsibilities*). In these circumstances, the supervisor may use their discretion to add an additional .5 to the family's case weight permanently to ensure that the home visitor has the time and space to adequately serve the family.
* Sites measure whether families at various levels of service receive the expected number of home visits based upon the level to which they are assigned using the *Home Visit Completion Rate Analysis* report in the MIS **(4-2B)**.
* Movement from one level to another is based on the progress of the family determined by the criteria defined in the HFA BPS (8th Edition) Level Change Forms. Level changes are discussed and agreed upon between the FSS and Supervisor during supervision first **(4-2C)** and then between the FSS and the family during home visits after the FSS and supervisor agree that a family’s progress indicates readiness for movement to a less intensive service level **(4-2D).** TheHFA Level Change Forms (*signed by FSS and supervisor*) and HFA Celebration Certificates (aka Accomplishment Forms) (*signed by FSS and family*) meet all documentation needs for 4-2C and 4-2D. **These forms are required and copies of these forms must be uploaded to the Case Documents section of the MIS.**
* During home visits, the FSS discusses with the family their achievements, visit schedule, family circumstances and readiness for change in frequency of home visits. The family’s receptiveness or resistance to the proposed level change is documented in the home visit narrative.
* Level Change Forms are not required for moving families to Levels CO, TO, and TR or for moving from Level 2P to 1P or Level 1P to 1. These levels are not based on family progress. Documentation of activities the home visitor carries out on behalf of the family (*such as phone calls, mailing materials, service referrals etc*) while on these levels is entered in the MIS into case notes.

**HFNY Level System**

|  |  |  |  |
| --- | --- | --- | --- |
| **Level** | **Duration** | **Case weight** | **Visits expected** |
| 2P(Prenatal) | Prenatal up to 28 weeks gestation | 2 | Weekly visits until relationship established, then every other week until 28 weeks gestation |
| 1P (Prenatal) | Prenatal: 28 weeks gestation to to birth | 2 | 1 visit every 7 days (Weekly) |
| 1 | Postnatal until HFA progress criteria is met for change to Level 2 | 2 | 1 visit every 7 days (Weekly) |
| 2 | Until HFA progress criteria is met for change to Level 3 | 1 | 1 visit every 14 days (Biweekly) |
| 3 | Until HFA progress criteria is met for change to Level 4 | .5 | 1 visit every 28 days (Monthly) |
| 4 | Until HFA progress criteria is met for Program Completion | .25 | 1 visit every 84 days (Quarterly) |
| Level SS | Temporary periods of crisis (typically no more than 3 months) | Add 1 point to current case weight | Additional 1 point added to Level 1, 2 or 3 during temporary periods of intense crisis |
| Level CO (creative outreach) | Family not able to be engaged for regular visits for either 3 months (or a cumulative 3 month period) over the course of 6 consecutive months (**see policy 3-3A**) | .5-2 (Case weight determined by level family was on prior to CO) | Creative Outreach engagement activities. |
| Level TO (temporarily out of area) | Temporarily Out of Area, for up to 3 months | .5–2 (Sites maintain a family’s case weight while on Level TO equal to the family’s level prior to being placed on creative outreach to ensure space is retained to move family back to that level if re-engaged) | N/A |
| \*Level TR (temporary reassignment) | Temporary reassignment to another staff person during extended staff leave or turnover up to 3 months when family is not receptive or able to receive visits at previous frequency  ***\*If the family is receptive and able to continue receiving services at the frequency associated with their previous level, then the level and case weight would not be changed to TR.*** | .5 | As agreed upon between the FSS and the family. |

**Circumstances that Warrant Additional Case Weight Points**

|  |  |  |  |
| --- | --- | --- | --- |
| **Level** | **Criteria for Use** | **Case weight** | **Visits expected** |
| “Enhanced” designation added to family’s current level | Families that require more time for the home visitor to plan and or conduct visits due to ongoing, more permanent needs. | Add .5 points to current case weight. (*All levels except TR*) | Visits take place based on current service level |

**The site will adhere to all NYS policy guidelines specified above. In addition, please insert site-specific procedures that:**

1. Describe how the home visitor engages in a discussion with the family about the frequency of visits based on the family’s service level upon enrollment.
2. Describe how the program ensures that NICU families are placed on Level TO until the baby comes home from the NICU.
3. Describe how the program ensures that families are receiving the correct service intensity based on criteria in the HFA Level Change Forms.
4. Describe how the program determines a family’s need to add SS to their current level (Levels 1, 2 and 3 only) and how the supervisor and home visitor monitor the family’s progress to determine when SS can be removed from the current level.
5. Describe how the Supervisor and home visitor will assess whether a family needs an extra .5 case weight.
6. Describe how the program uses the *Home Visit Completion Rate Analysis* report in the MIS to assist staff in ensuring that families are receiving the number of home visits specified based on the family’s level.
7. Describe how the program ensures that families meet the progress criteria in the HFA Level Change Forms prior to changing family’s levels and ensures 3 way agreement among the family, FSS and Supervisor. **Please note that 4-2C is an Essential Standard**. Also include that HFA Level Change Forms and HFA Celebration Certificates will be uploaded to Case Documents in the MIS and describe how the site will provide monitoring to ensure the certificates are signed by the appropriate parties and uploaded to Case Documents (*keep in mind that Level Change Forms are not required for moving families to Levels CO, TO, and TR or for moving from Level 2P to 1P or Level 1P to 1 as these levels are not based on family progress).*
8. Please note that the home visitor will document family’s responses to the level change (receptiveness or resistance) in the home visit narrative and describe how the program will provide monitoring to ensure these conversations are documented.

**HOME VISIT COMPLETION**

(EFFECTIVE 11/27/2024)

**HFA Best Practice Standard 4-2.B**

**POLICY: Families at the various levels of service (e.g., weekly visits, bi-weekly visits, monthly visits, etc.) offered by the site receive the appropriate number of home visits, based upon the level of service to which they are assigned.**

HFNY Policy Guidelines

* All home visits, which include in-home, out-of-home and virtual visits must follow these goals:
  1. The assessment and documentation of parent-child interaction using CHEERS.
  2. A focus on the promotion of healthy growth and development of the child.
  3. The enhancement of family functioning.
* Out-of-home visits and virtual visits need supervisory approval in order to count toward the home visit rate.
* Supervisors and home visitors will discuss the reasons for conducting out- of-home and virtual visits and strategies will be developed to gain the family’s trust and ultimately conduct visits in the home, whenever possible.
  1. The reasons to conduct out-of-home visits might include things such as safety, home infestation, a gatekeeper in the home, refusal from PC1, the opportunity to promote positive PCI out of the home, promote healthy childhood growth and development or to enhance family functioning.
  2. The reasons to conduct virtual visits include extreme circumstances[[1]](#footnote-1) such as a pandemic, special weather conditions, natural disaster and community safety advisory ,when the family is not initially comfortable with a new person coming into the home or when continuity of service can only be maintained virtually. In such circumstances, programs will follow HFNY Central Administration’s protocols and procedures.
  3. When out-of-home visits will occur for more than two consecutive visits, or if in-home visits are refused by PC1 or unsafe, the Service Plan will be used to identify the factors that contribute to the family not permitting in- home visits and strategies will be developed to move to in-home visits if possible.
  4. When out of home visits will occur for more than two consecutive visits, the family’s reasoning for out-of-home visits will be reviewed during the in-depth discussion and strategies will be developed to ultimately conduct visits in the home.
  5. Programs should reach out to their program contract manager if out-of-home visits should continue for more than 3 months (for L4 families after 2 consecutive visits).
* The FSS will discuss strategies with the family and use the Family Goal Plan in cases where the family chooses to work on a goal that would lead to in-home visitation.
* In the case of supervised out-of-home visits, the site will follow their agency’s policy.
* Sites are permitted to count one group meeting per month as a home visit while families are on Level 1 or 1P; however, to do so requires that a Family Support Specialist be present during the group meeting and that the group meeting be documented on a home visit note, including some (2 or more) aspects of CHEERS for that particular family (when the group includes parent-child interaction time).
* The site may also count one visit per month conducted by a multidisciplinary team member (if with documentation to demonstrate the staff person received HFA Foundations for Family Support training and receives supervision consistent with 12-1 and 12-2 standards). Examples may include doulas, lactation consultants/counselors, child development specialists, therapists, etc.

**HFNY’s expectations:**

Out-of-home visits can count as a home visit if the content of the visit matches the goal of a home visit, can be documented as such, including documentation of CHEERS and have supervisory approval. Under extreme circumstances, when in-person home visits are not possible due to severe weather conditions, natural disaster, pandemic or community safety advisory virtual visits may be conducted.

**The site will adhere to all NYS policy guidelines specified above. In addition, please insert site-specific procedures that:**

1. A description of the goals of the home visits and how you document them using the Home Visit Log.
2. How the supervisor will approve the use of out-of-home and virtual visits.
3. A description of how the site tracks out-of-home and virtual visits:
   1. the frequency permitted
   2. the location they occur
   3. the reason for out-of-home and virtual visits (i.e., using the Home Visit Log).
4. How the site will discuss families who receive out-of-home visits or virtual-visits and the strategies used to move to in-home visits and how this will be documented.
5. A description of the strategies the FSS will use to promote in-home visits with families.
6. Insert your agency’s policy and procedures regarding supervised visits in foster care or when PC1 is incarcerated.

**DURATION OF SERVICES**

(EFFECTIVE 11/27/2024)

**HFA Best Practice Standard 4-3.A**

**POLICY: Intensive home visiting services are offered to families for a minimum of three years after the birth of the baby or after enrollment (whichever is later), with the exception of families who transfer from another program.**

HFNY Policy Guidelines

* HFNY services are offered to families up to age five.
* Families are made aware at the time of enrollment that services are offered through age five.
* If a family should choose to leave services prior to three years of service, staff will determine if the family has met the criteria for HFA’s Successful Completion of the program using the HFA Level form and acknowledge the family as having completed. The family would have needed to complete Level 3 or Level 4 and meet HFA program completion criteria to be considered a completion.

**The site will adhere to all NYS policy guidelines specified above. In addition, please insert site-specific procedures that:**

1. Describe how the program will ensure that all families are made aware at the time of enrollment that services are offered through age five (*eg. Family Rights & Confidentiality forms etc.*)

**SERVICE CLOSURE AND TRANSITION PLANNING**

(EFFECTIVE 11/27/2024)

**HFA Best Practice Standard 4-4.A**

**Policy: Transition plans are developed when a family is ending services with a planned service closure (i.e., when a family is graduating from the program or is moving from the service area, or other circumstances indicate departure from the program).**

HFNY Policy Guidelines

* Transition plans will be developed for families who are completing services or who have notified the FSS they are leaving services at least three months prior to closure. The FSS will initiate formal transition planning by discussing with the parents their current and continuing goals for their child and for their family as a whole and discussions will be documented in the Transition Plan form and Home Visit Narrative in the MIS. The transition plan will include the reason for closure, the date of the initial discussion regarding closure and date of planned closure, or date the family declined a transition plan.
* Circumstances leading to an unplanned or unexpected closure, or a planned closure with less than three months’ notice would not be held to the standard, though the site is encouraged to provide as much support as possible in these situations.
* The home visitor assists the family in identifying resources and/or services needed or desired by the family and any other services available to them in the community (eg. Head Start, childcare, or other community-based early childhood education programs, or another HFA site if the family is moving). The home visitor makes referrals as needed and obtains family’s signed consent where necessary.
* Steps are outlined to obtain any identified resources or services.
* The home visitor and supervisor review and discuss family goals, transition plan and discharge form and keep documentation of these discussions in supervision notes.
* Prior to closure the site or family (based on family preference) follows up with identified resources to determine availability and assist with successful case closing transition.
* The Follow-Up Form is completed at discharge.

**The site will adhere to all NYS policy guidelines specified above. In addition, please insert site-specific procedures that:**

1. Describe how the program will determine when formal transition planning needs to begin for planned closures and how the program will ensure that the Transition Plan form is completed in the MIS for all planned closures.
2. Describe how the program will handle and document support offered to families when FSS is notified that the family will have to end services unexpectedly (ie. death of the parents, loss of pregnancy, loss of TC etc.).
3. Describe the process by which the FSS assists the family in identifying other service providers near to where they are or will be living. Describe how sites will ensure consents are completed for referrals when needed and specify where the family’s written consent to referrals will be kept.
4. Describe how the program will ensure that steps are outlined to obtain any identified resources or services.
5. Describe how the program will ensure that discussions the FSS and supervisor have about the transition plan and/or planning for unexpected closures is documented in the supervision notes.
6. Describe how the program will ensure that prior to closure, the home visitor or family has followed up with identified resources to determine availability and assist the family with the transition.

**Reference Table**

**Best Practice Standard 4**

*This reference table contains a list of reports in the MIS that can be used to help programs monitor fidelity as well as helpful links and documents related to each policy.*

|  |  |  |
| --- | --- | --- |
| **Policy** | **MIS Reports & Forms** | **Appendix & Links** |
| **4-1.A**  **Minimum Length of Time to Offer Weekly Home Visits** | * 4-1.B Intensive HV Services after Target Child is Born report * Level Change History Report * Case Home Page: Basic Information tab |  |
| **4-2.A**  **Levels of Service** | * Supervisor Case List * FSS Case List * Program Caseload Summary * Level Change History Report * Home Visiting Completion Rate Analysis - Detail and Summary * Level Change History report * Level Form (in Basic Information Tab) for each case * Home Visit Log * Supervision Form | * [Level Change Tool Guidance & Instructions](https://www.healthyfamiliesamerica.org/network-resources/level-change-tool-guidance-english/) (need HFA login) * [HFA Level Change Forms and Celebration Certificates (aka Accomplishment forms)](https://www.healthyfamiliesnewyork.org/Staff/FSS.htm) (need HFNY login) |
| **4-2.B**  **Virtual and Out of Home Visits** | * Home Visiting Completion Rate Analysis – Detail and Summary * Summary of Home Visit Log Activities * Quarterly Home Visit Log Summary report * Home Visit Log * Supervisor Form | * **Virtual and Out of Home Visit Guidance Documents**:   + [Critical Incident Report](https://www.healthyfamiliesnewyork.org/Staff/Documents/CRITICAL_INCIDENT_REPORT.doc)   + [FSS Guidelines for Conducting Virtual Home Visits](https://www.healthyfamiliesnewyork.org/Staff/Documents/FSSGuidelinesfo%20ConductingVirtua%20HomeVisit0320.pdf)   + [FRS Guidelines for Conducting Virtual FROG Scale Visits](https://www.healthyfamiliesnewyork.org/Staff/Documents/FRS-Guidelines-for-Virtual-FROG-Scale-Visits-(7.5.22).pdf)   + [CHEERS: A Guide for Use During Visits by Phone and Video](https://www.healthyfamiliesnewyork.org/Staff/Documents/CHEERSvirtualvisitsguidelines032020.pdf)   + [Considerations for Resuming in Home Visits](https://www.healthyfamiliesnewyork.org/Staff/Documents/ConsiderationsforResumingIn-HomeVisitsFINALDRAFT.docx) |
| **4-3.A**  **Duration of Services** | * Participant in Program for at Least 3 Years as of Today * ‘New Levels (January 2019)’ PowerPoint on MIS | * [HFA Level Change Guidance & Forms](https://www.healthyfamiliesamerica.org/hfa-restricted.php?file=Level-Change-Packet-6.18.pdf) (need HFA login) |
| **4-4.A**  **Service Closure and Transition Planning** | * Transition Plan on HV log * MIS Goal/Transition Plan Form * Follow-Up Form |  |

1. Extreme circumstances such as pandemic, could lead to long-term virtual visits. In that case, programs will follow HFNY Central Administration’s protocols and procedures developed for that special situation. Guidance is published and updated regularly on the HFNY Website. [↑](#footnote-ref-1)