Healthy Families New York Site-Specific Policy and Procedures Manual

April 2021

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INTRODUCTION AND MISSION

Healthy Families New York Approach

Healthy Families New York (HFNY) is committed to relationship-based practice and recognizes the significance of the Parallel Process. Through our relationships – with families, within our program system, and in our communities – we work to decrease risk to children and families and build Protective Factors. These most basic philosophical and practical concepts underlie all HFNY training, assessment, home visiting, ongoing support and supervision, internal and external quality assurance, and program administration.

The relationship-based approach informs all the policies and procedures described in this manual. Adherence to these policies and procedures promotes fidelity to the Healthy Families America (HFA) model, which has its foundation in 12 Critical Elements.

Healthy Families America Mission Statement

The mission of the Healthy Families America is to promote child well-being and prevent the abuse and neglect of our nation's children through intensive home visiting.

Healthy Families New York Mission Statement

The mission of Healthy Families New York is to improve child and family outcomes for the state's at-risk families by providing supportive home visiting to new and expectant families.

HEALTHY FAMILIES AMERICA GOALS

- Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth
- Cultivate and strengthen nurturing parent-child relationships
- Promote healthy childhood growth and development
- Enhance family functioning by reducing risk and building protective factors

HFNY PROGRAM GOALS

- Support parent child bonding and relationships
- Promote optimal child and family health, development, and safety
- Enhance parental self-sufficiency
- Prevent child abuse and neglect

GUIDE TO THE HFNY POLICIES AND PROCEDURES MANUAL

The HFNY Site-Specific Policies and Procedures Manual (PPM) is organized around the HFA Critical Elements and the HFA Accreditation Program's Best Practice Standards. It serves as a guide to orient HFNY sites toward HFA model fidelity and the practical application of the model, and compliance with HFNY expectations for practice and program management. Further, the HFNY PPM – like the model itself – supports self-awareness and self-assessment so that sites are empowered to examine their own strengths and, in collaboration with the HFNY Central Administration, strengthen areas that contribute to program improvement statewide. In addition, the PPM is a critical tool for sites' preparation for HFA Accreditation.

The PPM has been designed in close parallel to HFA Best Practice Standards, and includes all policies prescribed by HFA. In some cases, HFNY's policies are state-specific and sites are held to a higher standard than indicated by the HFA BPS; these policies are noted in the manual. Intents for each policy are shared so that sites – as well as the state system – are consciously grounded in the rationale for required policies and practices. More detail on policy and practice expectations for each policy is included where helpful.

The title of each policy includes a date indicating when it became effective. In addition, each policy that has Management Information System (MIS) evidence components or supporting forms or documentation has these elements listed at the end of the policy.

The structure of the PPM includes specific guidance to support individual sites in incorporating prescribed site-specific policy content into the manual itself, in essence adding to the state system PPM, so that sites' policy manuals can be in compliance with national and state system standards, and all policies and procedures are located together as part of a coherent, whole document. Note that for some 2nd and 3rd order standards, while specific policies are not required, providing evidence of adherence to these standards is expected.

The Appendix offers links to many items referenced in the policies. An asterisk next to the item denotes that a hard copy of the resource is provided within the Appendix. Lastly, the PPM includes a glossary of important terms to ensure universal interpretation of the meaning of key terms and concepts used in the HFA model and HFNY state system.*(Glossary currently being updated 2021)*

THE POLICIES FOR

BPS 1 – INITIATE SERVICES EARLY

WERE UPDATED IN 2022

AND CAN BE FOUND UNDER

UPDATED POLICIES

ON THE HFNY WEBSITE

THE POLICIES FOR

BPS 2 – STANDARDIZED ASSESSMENT TOOL (FROG)

WERE UPDATED IN 2022

AND CAN BE FOUND UNDER

UPDATED POLICIES

ON THE HFNY WEBSITE

THE POLICIES FOR

BPS 3 – OFFER SERVICES VOLUNTARILY

WERE UPDATED IN 2022

AND CAN BE FOUND UNDER

UPDATED POLICIES

ON THE HFNY WEBSITE

THE POLICIES FOR

BPS 4 – SERVICE INTENSITY

WERE UPDATED IN 2022

AND CAN BE FOUND UNDER

UPDATED POLICIES

ON THE HFNY WEBSITE

THE POLICIES FOR

BPS 5 – DIVERSITY, EQUITY, INCLUSION

WERE UPDATED IN 2023

AND CAN BE FOUND UNDER

UPDATED POLICIES

ON THE HFNY WEBSITE

THE POLICIES FOR

BPS 6 – PROMOTE PCI, CHILDHOOD GROWTH & DEVELOPMENT

WERE UPDATED IN 2023

AND CAN BE FOUND UNDER

UPDATED POLICIES

ON THE HFNY WEBSITE

Medical/ Health Care Provider (EFFECTIVE 3/1/19)
HFA Best Practice Standard 7-1.A

POLICY: All target children will have a health care provider to assure optimal health and development, and support is provided to assist parents in using health care appropriately for their children.

Intent: It is important for each target child to have a medical home (partnership between the family and the child's primary health care professional) and to utilize preventive health care practices for children. The site is to have a process for informing and connecting target children to medical/health care providers available within the community. Through this partnership, the primary health care professional can help the parent access and coordinate routine well-child care, sick child care and specialty care when needed.

1. Information regarding the medical/health care provider is collected and documented during the visit **in** which the Parent Survey is completed.
2. FSSs assist the parent in securing preventive health care services, understanding the importance of a medical home, and reminding parents of upcoming immunizations, well-child and/or prenatal care visits.
3. When necessary, FSSs assist in coordinating health services through direct communication with the medical provider or physician office staff (with signed consent).
4. FSSs assist families in addressing barriers to obtaining health care services.
5. FSSs track and document the receipt of immunizations and well-baby care visits according to time frames indicated by the CDC, and any other medical care, on the TC Medical Form in the MIS.

MIS References:
TC Medical Form

Appendix:
None

Insert site-specific procedures that include:

1. How sites will ensure that all target children have a medical/health care provider.
2. How FSSs will support parents in using health care appropriately for their children.
3. Specific data to be collected, time frames for collection, and where these are documented.

IMMUNIZATIONS (EFFECTIVE 3/1/19)
HFA Best Practice Standard 7-2.A

POLICY: Families receive education on the importance of immunizations, and children are up to date on their immunizations.

Intent: Immunizations are very important in keeping children healthy. The regular schedule recommends shots starting at birth through 24 months of age, with boosters and catch-up vaccines continuing through the teenage years and adulthood. By immunizing, children are safeguarded against the potentially devastating effects of 11 vaccine-preventable diseases plus Hepatitis A and the flu. The catastrophic effects of childhood diseases can lead to life-long illness or death.

Vaccines help prevent infectious disease and save lives. Childhood immunizations are responsible for the control of many infectious diseases which were once common in this country, including polio, measles, diphtheria, pertussis (whooping cough), rubella, mumps, tetanus, and Haemophilus influenza type b. While the US currently has near record low cases of vaccine-preventable diseases, the viruses and bacteria which cause them still to exist. Vaccines prevent disease in the people who receive them and protect those who come into contact with an unvaccinated individual.

1. FSSs provide information to parents regarding the importance of immunizations and encourage timely receipt of immunizations according to the immunization schedule recommended by the American Academy of Pediatrics.
2. FSSs share an immunization schedule with parents. One example is the schedule of immunizations from the CDC individualized scheduler at http://www2a.cdc.gov/nip/kidstuff/newscheduler_le/.
3. FSSs document all scheduled immunizations and well-baby care visits on the TC Medical Form in the MIS.
4. When immunizations are missed, FSSs record the explanation on the Home Visit Narrative and work with parents to reschedule and address any barriers to getting the immunizations (i.e., transportation, language barriers, etc.)
5. FSSs document the target child's health care provider on the Target Child Identification and Birth Outcomes form in the MIS, and after that, on the Follow-Up form. Programs also document the current medical provider for the Primary Caretaker 1 on the Intake form and after that, on the Follow-Up form. There is no need to wait for a Follow-up form to be due when a family has a new doctor. This change can be documented on the Change Form and on the Medical Provider tab of the Case Home Page in the MIS.
6. Programs are required to report on Primary Caretaker 1 and Target Child having a medical provider, a HFNY Performance Target, on a quarterly basis.
7. Should a child have a medical reason for not getting immunizations or the family is declining immunizations owing to personal beliefs, this is documented in the family file and on the tracking form.

MIS References:

Quarter Performance Targets
Four Quarter Performance Targets
PC1/TC Medical Provider Listing
7-2. B/C Target Child Immunization

Appendix:

None

Insert site-specific procedures that include:

1. How parents are educated regarding the importance of immunizations
2. How receipt of immunizations is tracked per child
3. How FSSs work with parents when immunization appointments are missed

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POLICY: Families receive information, referrals, and linkages to available health care resources and other community resources based on family need and interest, and follow-up to ensure that families receive the services to which they were referred.

Intent: Sites are encouraged to provide information, referrals and linkages for all participating family members including the target child. Information could include a variety of topics which may benefit all participating members (e.g., smoking cessation support groups, free health clinics for adults, immunization clinic, flu shots, nutritional classes, birth spacing, etc.) Health care information includes the importance of dental care as well as referrals linking families to preventive services for dental care, as appropriate. Site staff are knowledgeable of health care resources within the community and are able to appropriately provide referrals and linkages to families. It is recommended sites only provide information, referrals, and linkages when necessary (e.g., when a pregnant mother needs assistance connecting to prenatal care, or when parents or siblings have health concerns and are without medical care provider). Therefore, if a family is receiving necessary services/care, there may be no need for further provision of the above-mentioned services.

1. During initial assessments and ongoing contact with families, FSSs assess needs and provide information and referrals to health care and other community resources as needs are identified.
2. FSSs are knowledgeable and well connected to community services that might be beneficial for families.
3. Depending on each family's capacity and comfort level, FSSs are involved in varying ways and intensity levels when making referrals. Involvement can range from solely providing referral information to the parent, to making the initial contact with referral source (with signed consent), to accompanying the family to the initial appointment.
4. When referrals are made, FSSs follow-up with the family and/or the referral source (with signed consent), as necessary, to support the connections and promote follow-through.
5. All referrals, follow-up actions, and outcomes are recorded on the Home Visit Narrative and Service Referral Form.

MIS References:

Case Filter/Site Options

- **Count of Service Referrals by Code**
- **Quarterly Service Referrals**
- **Parent Survey PC1 Issues**
- **Service Referrals Needing Follow-Up**

Appendix:

None

Insert site-specific procedures that include:

1. The process for assessing need and interest, and providing information, referrals and linkages to available health care and community resources for all participating family members.
2. The follow-up mechanisms used to determine whether parents received the services they were referred to, and how well they have met the families' needs.

DEPRESSION SCREENING (EFFECTIVE 3/1/19)
HFA Best Practice Standard 7-4.A

POLICY: FSSs conduct depression screening with the primary caregiver in each family using the PHQ-2 and the PHQ-9, standardized instruments.

Intent: With the extreme stress that many families experience, the risk of depression is high. When parents are depressed, their ability to be responsive and emotionally available to their child may be reduced, and they may negatively misinterpret their child's response to them. Screening for depression both during the prenatal and postnatal period allows home visitors to assist parents in becoming aware of the depression and determining if there are depressive issues that need to be addressed by a clinician.

Staff must receive training to administer a depression screen and be prepared to respond to the results of the screen, including developing relationships with service providers in the community.

Sites can refer to www.hfnymis.org/docs/PHQ9-procedures.pdf for guidance on timeframes and documentation for depression screening.

Staff members are not therapists, and it is critical for home visitors to support parents in alleviating their depression while a parent is awaiting treatment or while considering treatment options. They need to be prepared to: Provide referrals; use supervision for assistance in discussing depression with parents; promote stress reduction; employ Motivational Interviewing tools and strategies; encourage parents' efforts to meet their child's physical and emotional needs; and follow protocols for addressing critical situations.

PHQ-9 scores are interpreted as follows:

Total Score	Depression Severity	Action Steps
1-4	Minimal depression	Watchful waiting
5-9	Mild depression	Watchful waiting
10-14	Moderate depression	Referrals
15-19	Moderately severe depression	Referrals
20-27	Severe depression	Active Treatment- Contact with Supervisor

NOTE: Severe depression is life threatening and must be addressed by a licensed clinician.

1. Home visitors conduct depression screening using the PHQ-2 and PHQ-9 Depression Screens with all primary caregivers to assess for risk of perinatal depression, in accordance with the tool developer guidelines.
2. The PHQ-2 is administered during the assessment process and is incorporated into the Parent Survey form. Screenings are documented on the Home Visit Narrative and in supervision notes. If the participant (s) score is a 3 or more, the PHQ-9 should also be given.
3. The PHQ-9 is administered:
   - Within 30 days of the first prenatal home visit (if serving the family prenatally), and documented on the Intake Form
   - Within the first three months of the baby's birth for families enrolled postnatally, and at least once within three months of all subsequent births. This is documented on the Target Child Identification and Birth Outcomes form.
4. Depression screening will also be administered any time during home visiting services if a parent is displaying or reporting depressive behaviors or symptoms. This includes fathers as determined necessary by the FSS and supervisor.

5. Families receive education on risks for, and signs and symptoms of perinatal depression during the course of home visits, and specifically when the PHQ-9 is administered. If the participant scores positive on question 9 of the PHQ-9, move to the site-specific safety protocols.
6. If a participant's score on the PHQ-9 indicates depression, they are referred to mental health resources in the community (or provider of family's choice) for a follow up mental health assessment. If a participant scores 20 or above, the home visitor must consult immediately with the supervisor for emergency treatment referrals.
7. In the instances where the depression screening is done as a part of a collaborative process with other service providers involved with the family, the site must be in receipt of a copy to show that the screen was completed on time and to make and track any necessary follow-up referrals or interventions for the family.
8. The FSS and supervisor discuss the results of depression screens and develop plans to assist the family (i.e., addressing problem solving, building positive self-esteem, building family supports, referrals, etc.) as needed.
9. FSSs promote stress reduction, and support parents to be responsive to their child's physical and emotional needs
10. FSSs share community resource information with all families when they enroll in the program. For families at risk of depression, home visitors highlight community resources that specialize in depression, and encourage and assist families to access these resources. All families are given the suicide prevention hotline number, as well as contact information for mental health clinics.
11. If a referral is needed, the FSS documents the referral, as well as the outcome of the referral on the Service Referral Form.
12. When depression screen scores are elevated or are considered at-risk of depression, FSSs use activities to support the primary caregivers, such as:
    a. Providing linkages and referrals to appropriate resources
    b. Providing referrals for mental health consultation (when available)
    c. Using motivational interviewing (when trained) to assist parents in accepting resources, treatment
    d. Utilizing supervision to assist staff in discussing depression with parents
    e. Getting parents out in the sunshine (sun increases serotonin)
    f. Encouraging parents to walk, exercise, or engage in other forms of physical movement
    g. Encouraging parents to smile (even a "practice" smile increases serotonin)
    h. Encouraging parents to keep hydrated (hydration increases brain functioning)
    i. Encouraging self-care
    j. Practicing gratitude
    k. Using healthy strategies that have worked for the parent in the past
    l. Utilizing Procedures for Working with Families in Acute Crisis
    m. Encouraging parents to meet their baby's physical and emotional needs
    n. Using other strategies/activities identified locally
13. All staff who administer the PHQ-2 and PHQ-9 will complete training on the use of the tool prior to using it.

MIS References:

Intake Form
TC ID

Appendix:

Procedures for Working with Families in Acute Crisis*
https://app.box.com/s/kd2bfdeecpqjtqjyzf9c

Insert site-specific procedures that include:

1. That the PHQ-9 is used to screen for depression.

2. How the depression screening tool is to be used
3. When the depression screening tool is to be used.
4. Community resources and information for agencies and programs that provide services to address depression.
5. Activities appropriate for home visitors to do with families to address stress and depression.
6. That staff are trained prior to administering the tool, and who administers the training.
7. Safety protocol for staff if the suicide screening question is positive.

NOTE: 7-5. B is a SENTINEL STANDARD

THE POLICIES FOR

BPS 8 – CASELOAD SIZES

WERE UPDATED IN 2022

AND CAN BE FOUND UNDER

UPDATED POLICIES

ON THE HFNY WEBSITE

THE POLICIES FOR

BPS 9 – SERVICE PROVIDERS SELECTION

WERE UPDATED IN 2023

AND CAN BE FOUND UNDER

UPDATED POLICIES

ON THE HFNY WEBSITE

THE POLICIES FOR

BPS 10 & 11 – TRAINING

WERE UPDATED IN 2023

AND CAN BE FOUND UNDER

UPDATED POLICIES

ON THE HFNY WEBSITE

ON-GOING SUPERVISION FOR DIRECT SERVICE STAFF (EFFECTIVE 12/17/20)
HFA Best Practice Standard 12-1. A

POLICY: All direct service staff, FSSs and FRSs, receive regular, ongoing supervision, are provided with skill development and professional support, and are held accountable for the quality of their work.

Intent: All full-time direct service staff (Family Resource Specialist and Family Support Specialist) receive weekly individual supervision for 1.5 to 2 hours and part time staff receive at least 1 to 1.5 hours. Supervision sessions must be received individually each week, unless excused owing to the FSS or FRS not working the entire week.

1. Full-time staff and part-time staff that are at least .75 FTE participate in regular, individual supervision for a minimum of 1.5 to 2 hours a week (over a seven-day period). For part-time staff that are .25 FTE to .74 FTE, the requirements are 1-hour weekly (over a seven-day period of time). HFNY Performance Indicators set the expectation that this frequency and duration of supervision is achieved at least 75% of the time.
2. For staff that works less than .25 FTE, supervision may be provided according to role and occurrence of services.
3. Full time supervisors (35 hours a week or more), will supervise no more than five full time direct service staff. The maximum number of direct service staff a part-time supervisor can supervise is pro-rated based on the percentage of time in the supervisory role.
4. Volunteers and interns may serve as a support to direct staff, but may not assume the role of FSS or FRS.
5. Supervision is usually conducted in one session per week. Supervision must be completed in no more than two sessions per week.
6. Supervisors document the dates, duration, and content of all supervisory sessions, in MIS. This is tracked to ensure staff are receiving supervision according to the threshold established in the standard.
7. The only acceptable reason for missing a supervision session is the supervised staff person's absence for an entire "week", calculated as the 7-day period after their assigned supervision date.
8. Group reflective supervision is not officially recognized at this time as contributing to expectations for reflective supervision and will remain unrecognized until the HFNY system encompasses the Infant Mental Health Endorsement.
9. It is required that when staff are in the field, they always have access to a supervisor.

MIS Reports:

Accreditation/12-1.B Regularly Scheduled and Protected Supervision – Details and Summary
Lists/Supervisor Case list

Appendix:

Guidance for Using the Healthy Families New York Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf

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Insert site-specific procedures that include:

A description of the procedures and practices that ensure that policy expectations are met.

Administrative, Clinical & Reflective Supervision and Professional Support (EFFECTIVE 12/17/19)
HFA Best Practice Standard 12-2.A

Policy: All direct service staff receive regular, ongoing supervision, are provided with skill development and professional support, and are held accountable for the quality of their work.

Intent: All direct service staff (Family Resource Specialists and Family Support Specialists) are provided with supervision including administrative, clinical and reflective components, are held accountable for the quality of their interactions with families on a regular and routine basis and are provided with professional support. Sites are encouraged to develop mechanisms to measure the quality of work as well as develop strategies to provide feedback on performance measures. Sites are to have clear policy and procedures regarding supervision including professional support, skill development and ways to demonstrate accountability for the quality of their work.

1. Supervisors utilize the HFNY Supervisor Form for each supervision session. Supervisor organizes notes within the supervisor form for any and all conversations for each family. Supervisors ensure each family on the staff's caseload is discussed. All Parent Surveys are reviewed at a frequency that provides timely administrative, clinical and reflective conversations needed to meet the family's and staff's needs.
2. Families who are on Level 1, 1P, Level SS Level 2, Level 3 must be discussed in-depth at least once a month in reflective supervision and documented. More frequent discussions are encouraged if needed and must be documented. For families on Level 4 the discussion and documentation must occur before or after each visit.
3. During supervision, staff are provided with supervision that includes administrative, clinical and reflective components, are held accountable for the quality of their interactions with families on a regular and routine basis and are provided with professional support (as noted in 12.1B). Supervisors focus on various areas including:

Within supervision sessions

Any activity engaged in by a supervisor with staff can and probably will have aspects of administrative, clinical, and reflective supervision. These supervision tasks have been grouped by the type of supervision most often, but not exclusively associated with each task:

Administrative Tasks
- integrating quality assurance results that include review of all assessments and assessment records (including inter-rater reliability practices)
- monitoring due dates for screenings and measurement tools
- discussing family acceptance, retention and attrition
- providing feedback on documentation
- assisting staff in implementing new training or new policy into practice
- sharing of information related to community resources

Clinical
- discussing activities to address assessment issues/risk factors
- developing the Service Plan
- supporting Parent-Child Interaction work and CHEERS observations
- guiding culturally sensitive practice
- providing guidance on use of curriculum
- integrating results of tools used (developmental screens, evaluation tools, etc.)
- identifying areas for growth
- strengthening engagement techniques

- discussing strategies aimed at building protective factors
- reviewing Family Goal progress and process
- reviewing family progress and level changes
- integrating policy changes into practice

Reflective
- exploring/reflecting on impact of the work on the worker
- coaching and providing feedback on strength-based approaches, reflective strategies, and interventions used (e.g. motivational interviewing)
- encouraging self-care
- guiding culturally sensitive practice
- identifying areas for growth
- identifying and reflecting on role boundaries
- discussing ongoing worker safety

Outside of/Prior to Supervision sessions (12-2.C practice):

Administrative
- reading home visit narratives & Parent Surveys
- reviewing of CHEERS and CHEERS Check In
- reviewing home visit completion rate
- discussing home visit/assessment rates
- offering regular staff meetings
- monitoring Family Support Specialist records, and all documentation used by the site
- monitoring productivity
- providing tools for performing job
- scheduling flexibility
- offering employee assistance program when available
- providing a career ladder for direct service staff
- acknowledging performance

Clinical
- observing Family Support Specialists and Family Resource Specialists according to HFNY QA Policy
- Providing multi-disciplinary teams (holding team meetings for specific professional development purposes or building areas of expertise)
- assuring on-call availability is provided to support workers in the field

Reflective
- Creating a nurturing work environment that provides opportunities for respite
- Assuring an open-door policy with supervisors to support growth and professional development the following:
  - **a.** All FSSs and FRSs are provided with feedback on the results of quality assurance reports
  - **b.** Family files are reviewed, and feedback is provided in accordance with the HFNY QA Policy
  - **c.** Home visit observations are conducted in accordance with the HFNY QA Policy
  - **d.** Parent Survey observations are conducted in accordance with the HFNY QA Policy

MIS References:

Accreditation/12-2. B Home Visit Observation by Supervisor
Accreditation/12-2. B Parent Survey Observation by Supervisor
Accreditation/12-2. B Summary of Supervision Activities

Appendix:

Guidance for Using the Healthy Families New York Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf
Supporting Home Visitor Supervision (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/supporting-fsss-in-supervision/
Supporting Parent Survey Supervision (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/supporting-frss-in-supervision/

Insert site-specific procedures that include:

1. The site's supervision policy and procedures which ensure supervisors are responsible for providing all direct service staff with professional support and supervision which includes administrative components, clinical components, reflective components in order to continuously improve the quality of their performance. The site's procedures include the mechanisms for quality improvement and tasks in each of the three components listed above.
2. Frequency of supervision for workers
3. How workers are held accountable for the quality of their work (i.e., using information gathered through MIS reports and forms).
4. How workers are provided skill development and professional support and include procedures mentioned in addressing topics above (clinical, administrative and reflective)

SUPERVISION OF SUPERVISORS (EFFECTIVE 12/1/19)
HFA Best Practice Standard 12-3.A

POLICY: Supervisors receive regular ongoing supervision, are provided with skill development, professional support and are held accountable for the quality of their work.

Intent: Sites are to have clear policy and procedures regarding the frequency of supervision of supervisors including professional support, skill development and ways to demonstrate accountability for the quality of their work.

1. Supervisors receive individual, regularly scheduled, comprehensive reflective supervision (discussions will include administrative, clinical and reflective elements) from the program manager or designee for at least ninety minutes per month (sixty minutes if supervisor is less than .49 FTE). Supervisions can be broken up into shorter sessions with one expected to be at least 45 minutes. Additional supervision is strongly recommended, as needed for skill development especially with new supervisors. Additional supervision time can be either individual or group sessions.
2. The program manager or designee conducting the supervision documents the topics discussed and strategies developed on the HFNY Supervision Form.
   Topics may include but are not limited to:
   - **a.** Addressing personnel topics
   - **b.** Feedback/reflection to supervisors regarding team development/dynamics and agency topics.
   - **c.** Review of documentation including supervisor notes, family documentation, site goals, quarterly reports, other statistics and reports.
   - **d.** QA feedback from QA activities i.e., participant satisfaction surveys, staff observations (external and internal).
   - **e.** Feedback from Supervisor Observation
   - **f.** Strategies to promote professional development and growth.
   - **g.** Use of and support of reflective strategies, discussion of protective factors, integration of Service Plan, etc.
   - **h.** Clinical support related to families in the program.
3. If the supervisor serves four or more families on a permanent basis (for more than 3 months), the supervisor will receive supervision according to the policies related to Standard 12-1 and 12-2 for their direct service.
4. For supervisors carrying caseloads between 1-3 families on a permanent basis (for more than 3 months) or carry a larger caseload but on a temporary basis or conduct occasional assessments as a back-up the supervision session can occur based on the frequency of contact and does not have to occur weekly.

MIS Reports:

12-3 Supervision of Supervisors Report (new on MIS)

Appendix:

Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Supervision%20Paper%20Form%202.0.pdf
Guidance for Using the Healthy Families New York Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf

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Insert site-specific procedures that include:

1. Frequency of supervision for supervisors not carrying a caseload: at least 90 minutes per month, that can be divided into 2 sessions of 45 minutes. (60 minutes for part time, less than .49 FTE) Additional supervision is strongly recommended and can be individual or in group.

2. Frequency of supervision for supervisors carrying a caseload.
3. How supervisors are held accountable for the quality of their work (i.e., use MIS Supervision Form; Pre-Planning Session to document all discussions had outside of scheduled supervision)
4. How supervisors are provided skill development and professional support and include procedures for:
   a. Addressing personnel topics
   b. Feedback/reflection to supervisors regarding team development/dynamics and agency topics.
   c. Review of documentation including supervisor notes, family documentation, site goals, quarterly reports, other statistics and reports.
   d. QA feedback from QA activities i.e. participant satisfaction surveys, staff observations (external and internal).
   e. Feedback from Supervisor Observation
   f. Strategies to promote professional development and growth.
   g. Use of and support of reflective strategies, discussion of protective factors, integration of Service Plan, etc.
   h. Clinical support related to families in the program.
5. How Supervisors are in receipt of reflective supervision and how they provide feedback about the supervision received.

SUPERVISION OF PROGRAM MANAGERS (EFFECTIVE 11/26/19)
HFA Best Practice Standard 12-4. A

POLICY: Program managers receive regular, ongoing supervision, are provided with skill development and professional support, and are held accountable for the quality of their work.

Intent: Program managers are provided with skill development, professional support and are held accountable for their work. Accountability can be addressed through quarterly reports, Annual Service Reports, Annual Performance reviews, regularly scheduled meetings with the program manager's supervisor or chair of the advisory/governing board, peer supervision with a HF program manager from a neighboring site and attendance at conferences or other trainings.

1. The program manager receives regular ongoing support from their direct supervisor at least monthly.
2. The program manager maintains documentation indicating dates of these meetings and topics discussed. Topics may include:
   - **a.** Personnel issues
   - **b.** Review of progress on QA plan
   - **c.** Review of site goals and mechanisms to address goal issues
   - **d.** Input and recommendations from the advisory board.
   - **e.** Advocacy, marketing, system building and outreach.
   - **f.** Implementation challenges (i.e., accessing target population, accessing training, data issues, etc.)
   - **g.** Supervision of supervisors
   - **h.** Skill development in program development and management.
   - **i.** Strategies developed during supervision to address any concerns
3. Accountability of the program manager can be addressed through quarterly reports, Annual Service Reports, annual performance reviews, regularly scheduled meetings with the program manager's supervisor.

Note: The program manager role is distinct from that of the program supervisor, and while both roles can be assumed by the same person, status of both roles must be protected to ensure sustainable program leadership and adequate support to staff being supervised. If these roles are assumed by the same person, supervision must include support in each role that meets the Best Practice Standards.

MIS Reports:
None

Appendix:
None

Insert site-specific procedures that include:

1. That the program manager receives supervision at least once a month, who provides their supervision, and how their supervision is documented.
2. How the program manager is held accountable for the quality of his or her work.
3. How the program manager is provided skill development and professional support.
4. For program managers that also assume the supervisor role, describe how support is provided in the supervisor role and how this is documented.

FAMILY SATISFACTION FEEDBACK (EFFECTIVE 7/24/20)
HFA Best Practice Standard GA-2.A

POLICY: Families are given the opportunity to provide formalized input through satisfaction surveys

Intent: When families provide sites with their observations and experiences, it can highlight particular areas of strength or staff skill and illuminate areas in which staff would benefit from additional training or support.

1. Each family is given the opportunity to provide input on the program annually by completing a satisfaction survey. This survey is in addition to the feedback solicited from families by supervisors as part of regular, ongoing QA activities.
2. The results of all returned surveys are compiled in a summary report.
3. Additional opportunities for parent input are encouraged, including service on the Advisory group, being interviewed as participating families at site visits, participation in focus groups and/or other survey opportunities.
4. Recommendations for action based on family feedback are discussed at least annually as a team and with the Advisory Group to develop strategies to improve quality of services.

MIS Reports:
None

Appendix:
None

Insert site-specific procedures that include:

1. A description of the mechanisms used to obtain feedback from families (i.e., surveys, supervisor phone calls to parents, at FSS shadowing opportunities, from parent participation on advisory groups, being interviewed as participating families at site visits, and participation in focus groups and/or other survey opportunities).
2. How feedback from families is compiled and used.
3. How recommendations for actions based on family feedback are discussed at least annually as a team and with the advisory group. This also includes how feedback from families related to site materials, communications with staff and staff/family interactions are included in the Cultural Analysis and Plan (CAP). (Note: *the CAP requires the summarized input from families and staff as well as to identify patterns and trends related to site strengths as well as areas to improve upon).*

QUALITY ASSURANCE (EFFECTIVE 4/30/21)
HFA Best Practice Standard GA-3

POLICY: The site annually establishes goals/benchmarks, monitors the progress toward its goals/benchmarks, and develops follow-up mechanisms to address identified areas of improvement. The site develops and implements a comprehensive quality assurance plan for reviewing and documenting the quality of all aspects of site implementation (initial engagement, home visiting, supervision, and management) and implements follow-up mechanisms to address identified areas of improvement and to ensure fidelity to the model.

Intent: Each year the site identifies one or more benchmarks or goals it wants to focus on (such as increasing home visitation rates or increasing the number of children receiving at least two developmental screens each year). The site usually identifies its goals based on areas it is striving to improve, though continuous quality improvement expectations may also be established by Healthy Families New York Central Administration, funders, and contractual obligations. However decided, once the site has articulated its goals, it should indicate what the baseline is (e.g. home visit completion is 42% at the start of the year), what the goal is (home visit completion rate will increase to 75% by year end) and a process for monitoring and evaluating goals and addressing any identified issues. Sites use this information for continuous quality improvement. Site may use PDSA (Plan Do Study Act) cycles to illustrate their efforts to achieve identified goals/benchmarks.

Sites will develop a Quality Assurance plan that will include activities such as shadowing of direct service staff (assessment, home visiting), satisfaction surveys, file reviews, reports related to site activities, etc. These activities help ensure accountability and support skills development of site staff as outlined in the 12-2 standards. Additionally, sites will document the completion of these activities and will implement strategies to address identified areas of improvement.

1. Sites use a variety of methods to monitor the quality of all of the services offered to families, as detailed in the Quality Assurance Table.
2. The state system's goals and objectives are monitored through ~~in~~ the HFNY Performance Indicators (every 6 months) and HFNY Performance Targets (quarterly).
3. The QA plan has specific internal quality assurance strategies, and includes monitoring initial engagement, home visiting, supervision practice, and management according to the HFNY Performance Indicators and HFNY Performance Targets.
4. The QA plan includes working with the Center for Human Services Research to monitor quality and completeness of the data.
5. The Quality Assurance Plan includes:
   a. Cultural Analysis and Plan (5-4 standards)
   b. Analysis of family engagement/acceptance (1-2 standards), family retention (3-4 standards), and prenatal enrollment
   c. Analysis of sites' Performance Targets and Performance Indicators are included in evaluation of quality.
6. Sites use information gathered through all QA activities to continue effective practices and develop follow-up mechanisms to identify and address areas for improvement. Annually, sites will identify one or two goals/benchmarks they are striving to improve, analyze data and conditions, develop and implement a plan, and review results. The efforts throughout the year will be reported in Quarterly Reports, the Annual Service Review, and Program Improvement Plans, when applicable.

HFNY QUALITY ASSURANCE TABLE

<table>
<tr><th colspan="4">Sites' Internal QA Activities</th></tr>
<tr><td colspan="4">MIS data completion</td></tr>
<tr><td colspan="4">Quarterly narrative and data reports (also regularly reviewed and addressed by OCFS Contract Managers)</td></tr>
<tr><td colspan="4">Annual program-wide participant satisfaction survey</td></tr>
<tr><td colspan="4">Annual staff satisfaction and retention survey</td></tr>
<tr><td colspan="4">Quarterly Performance Targets</td></tr>
<tr><td colspan="4">Performance Indicators – twice per year</td></tr>
<tr><td>Practice QA: All practice QA activities are reviewed in supervision to acknowledge practice strengths and support practice improvement. All QA follow-up is documented by the supervisor.</td><td>FSS
One home visit observation per quarter in the first year and each year thereafter
One participant file review per quarter
Two participant surveys per quarter via phone or in person (Program manager should review all participant satisfaction surveys that are conducted by the supervisor)
Annual performance review and professional development plan</td><td>FRS
One assessment observation per quarter in the first year of FRS practice, then twice per year, including "inter-rater reliability" of the observed assessments
One Assessment refusal call or observation of assessment calls per quarter
Annual performance review and professional development plan</td><td>Supervisor
One supervision observation of each supervisor per quarter by PM or approved designee
One review of supervisor binder/notes by supervisor of supervisors per quarter
Annual performance review and professional development plan</td></tr>
<tr><td colspan="4">Dual Role Staff Staff regularly performing both the role of FSS and FRS will have two home visit observations and one assessment observation annually. QA activities such as participant surveys and assessment refusal calls/call observations will be conducted in proportion to the staff's time allotment in each role.</td></tr>
<tr><td colspan="4">Annual Service Review (ASR) The ASR represents the culmination of all of the site's QA activities, and is shared with the site's advisory board and funder. The ASR is studied by the site and used as a tool to develop a specific plan for program enhancement and improvement.</td></tr>
<tr><th colspan="4">External QA Activities</th></tr>
<tr><td>PCANY Quality Assurance visits</td><td colspan="2">FSS: Observation of program practice, including at least one supervisor observation *see PCANY QA Protocol. Additional role specific support, training, and/or technical assistance may be offered as follow-up to QA activities.

Occur every 24 months, and follow PCANY protocols for planning,</td><td>FRS: Observation of program practice, including at least one supervisor observation *see PCANY QA Protocol. Additional role specific support, training, and/or technical assistance may be offered as follow-up to QA activities.

Occur every 24 months, and follow PCANY protocols for planning, expectations, and</td></tr>
</table>

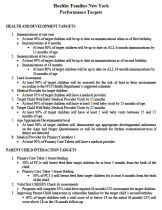
	expectations, and follow-up for the visit	follow-up for the visit
Technical Assistance Visits	Scheduled as needed and offered by one or more Central Administration partner in accordance with HFNY TA protocol.	
OCFS site visits	OCFS Program Contract Managers visit sites approximately every 12 months (at least twice a year for new programs). PCMs provide follow-up documentation and support sites in developing specific plans and time lines for quality improvement.	
HFA Accreditation	While HFA accreditation occurs every 5 years, sites will begin to update their Self-Assessment Tool 24 months prior to accreditation.	

MIS Reports:

Quarterlies /Quarterly 4 Quarter Performance Targets
Accreditation/3-4 A and B Retention Rate Analysis
Accreditation/1-2 C Assessment Information
Accreditation/1-3 B Timing of First Home Visit
Analysis/Quality Assurance Report
Training/10-2 Orientation, 10-4 Intensive Role Specific Training for Staff, Shadowing,11-2 E Prenatal, and 11-2F FGP/ IFSP
Training/11-1 Wraparound 3 months, 11-2 Wraparound 6 months and 11-3 Wraparound 12-month reports
Accreditation/4-2 B. HFA Home Visiting Completion Rate Analysis – Summary
Accreditation/12-2 B. Observations by Supervisor
Accreditation/12-3 B. Supervision of Supervisors
Quarterlies/Quarterly Program Information for 8 quarters
Accreditation/ 12-1 B. Regularly Scheduled and Protected Supervision – Summary

Appendix:

Annual Service Review Guidelines- *(Currently being updated 2021)*
PCANY QA Protocols
https://www.healthyfamiliesnewyork.org/Staff/support.htm
OCFS Quarterly Report
https://healthyfamiliesnewyork.org/Staff/Documents/Quarterly_Report_Guideline_for_Data_Reports_final_draft022020.docx
OCFS Site Visit Tool
https://www.healthyfamiliesnewyork.org/Staff/support.htm
Performance Indicators
https://healthyfamiliesnewyork.org/Staff/Documents/PIdetails4-1-17to9-30-17.pdf
Quarterly Performance Targets



Healthy Families New York
Performance Targets

HEALTH AND DEVELOPMENT TARGETS

1. Immunizations at one year
   - At least 90% of target children will be up to date on immunizations when as of first birthday
2. Immunizations at two years
   - At least 90% of target children will be up to date on ALL 4 month immunizations by 15 months of age
3. Immunizations at three years
   - At least 90% of target children will be up to date on immunizations as of second birthday
4. Lead Screening
   - At least 90% of target children will be screened for the risk of lead in their environment according to the NYS Health Department's suggested schedule.
5. Medical Provider by Three Months
   - At least 85% of target children will have a medical provider.
6. Target Child Well Child Medical Provider Visits by 12 months
   - At least 90% of target children will have had 4 well child visits by 15 months of age.
7. Target Child Well Child Medical Provider Visits by 2 years old
   - At least 90% of target children will have had 7 well child visits between 12 and 15 months of age.
8. Developmental Screening
   - At least 90% of target children will demonstrate age appropriate developmental milestones on the Ages and Stages Questionnaire or will be referred for further evaluation/services if indicated by the ASQ.
9. Medical Provider for Primary Caretaker 1
   - At least 90% of Primary Care Takers will have a medical provider.

PARENT CHILD INTERACTION/CHILD ABUSE TARGETS

1. Primary Care Taker 1 Home Healing
   - 90% of PCTs will foster-heal their target children for at least 3 months from the birth of the child.
   - Primary Care Taker 1 Home Healing
     - 90% of PCTs will foster-heal their target children for at least 6 months from the birth of the child.
2. Valid Self CHEERS Check-In assessments
   - 90% of target children with a valid score of or better 18 on the initial (0 month) CCI will score above 15 on the 12 month follow-up.

Revised 2/2020

Sample Participant Survey
https://www.healthyfamiliesamerica.org/network-resources/5-4-family-satisfaction-survey-english/
https://www.healthyfamiliesamerica.org/network-resources/5-4-family-satisfaction-survey-spanish/
QA Quarterly Activities Calendar

https://www.healthyfamiliesnewyork.org/Staff/Documents/QA_quarterlyactivitiescalendar_PMs_and_Sups032021_not%20MIECHV.pdf
https://www.healthyfamiliesnewyork.org/Staff/Documents/QA_quarterlyactivitiescalendar_PMs_and_Sups032021_MIECHV%20(1).pdf (MIECHV)

Guidelines for Supervision Notes
https://healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf

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Insert site-specific policies and procedures that include:

1. Details on how the site will implement the HFNY quality assurance plan.
2. Details on how the site will follow-up on quality assurance activities to address identified areas of improvement and to ensure fidelity to the model.
3. Details on how participant file reviews are done, documented, and how feedback is given.
4. Details on how supervision note reviews are done, documented, and how feedback is given.
5. Details on how sites will monitor the practice of supervisors who regularly conduct home visits and/or parent surveys and how feedback is given.
6. Details on how the site will determine approved designees for performing supervision observations. At a minimum, designees will have demonstrated a comprehensive knowledge of reflective supervision and must be approved by the site's Program Contract Manager.

RESEARCH PROPOSALS (EFFECTIVE 7/24/20)
HFA Best Practice Standard GA-4

POLICY: The site has a process for reviewing and recommending approval or denial of research proposals, whether internal or external, which involve past or present families. The policy and procedures include:

- A description of the group or body of people who could conduct this review
- Procedures (or steps) for the review
- A timeline for completion of the process, and if approved/accepted
- Steps to ensure participant privacy and voluntary choice
- Communication with the National Office (via the Healthy Families America (HFA)
- Implementation Specialist) regarding summary of research design and contact information for principal investigator.

Intent: The site's policy and procedures ensure a committee or defined group of people is available to make recommendations regarding ethics of proposed or existing research, decide whether to approve research proposals, and monitor ongoing research activities including procedures to protect family privacy and voluntary choice. In HFNY, the responsibility for the review of research proposals resides with HFNY Central Administration (CA), followed by review and approval by the NYS Office of Children and Family Services. However, sites must also have policy and procedures for handling these types of requests prior to their submission to HFNY CA for review. In cases when a funder requires research as a condition of the funding, the need for policy and procedures still exists.

Only bona fide researchers may conduct research involving past or present families served by HFNY programs. To be eligible to conduct research, the researcher must be a faculty member or graduate student at an accredited institution of higher education or hold a research position at a reputable research organization or government agency.

1. When approached to participate in a research study, the program manager should contact their OCFS program contract manager to discuss the study and data collection requirements. If there are questions about whether a funder is conducting research versus collecting data on program services to monitor performance or improve services as a condition of funding, this should be discussed. The OCFS program contract manager may request assistance from OCFS researchers as necessary to determine whether the project is a research study[3].
2. Programs should follow their own agency policy and procedures regarding whether they will allow bona fide researchers (other than HFNY system researchers) to engage in research activities with past or present families receiving services from HFNY programs.
3. If the agency agrees to allow the researcher to use their program for research purposes, the agency must provide the researcher with a letter of support to indicate their willingness to participate in the research study.
4. Prospective researchers must submit a proposal that meets all the requirements of the OCFS Research Proposal Application, which includes obtaining letters of support from participating programs and Institutional Review Board approval, to the HFNY Program Supervisor who will put the research proposal on the agenda for review at the next HFNY CA meeting. These meetings occur at least six times per year and include partners from OCFS, PCANY, and CHSR. Review by the full group allows multiple aspects of impact to be considered.
5. The HFNY CA will have up to 90 days to review the proposal based on the following standards: 1)

[3] If the primary purpose of the data being collected or requested is to contribute to monitoring, oversight, or improvement of the program and the requestor is affiliated with the program as a stakeholder, employee, funder, etc., then the study may not need to follow these procedures. When in doubt, reach out to the OCFS program contract manager for assistance.

relevance to the HFNY mission or contribution to the body of literature in the field; 2) methodological adequacy; 3) procedures for ensuring participant privacy, confidentiality, and voluntary choice; 4) potential risks and benefits to participants; 5) impact on HFNY or program operations; and 6) support from involved parties. HFNY CA will also assess the extent to which the program is providing services with fidelity to the HFNY model. In order to ensure that any research results are relevant to the state system, the program in which the research will be conducted must be meeting state performance standards. Exceptions may be allowed if the research is being conducted to specifically address areas in which the program is not yet meeting standards. Researchers should be sure to address the following questions within their proposals:

- What is the added value to families involved in the research study over and above the services provided by HFNY?
- Can the results of the study be generalized to other HFNY programs?

6. Once HFNY CA has reviewed the research proposal, the OCFS researcher and the program's OCFS contract manager will contact the researcher to address any concerns that were expressed by HFNY CA or told that their study is conditionally approved pending review by the OCFS Bureau of Research, Evaluation, and Performance Analytics (BREPA). If the researcher is unable to address all the concerns raised by HFNY CA, the study will be rejected. After all concerns are addressed to the satisfaction of HFNY CA, the HFNY Program Supervisor will provide a letter of support indicating conditional approval of the research study by HFNY.
7. Upon receipt of the letter of support from the HFNY Program Supervisor, the researcher may proceed with the OCFS Research Approval process and should submit a complete research proposal to:

    OCFS Research Proposal Review Team
    Bureau of Research, Evaluation, and Performance Analytics
    NYS Office of Children and Family Services
    e-mail: ocfs.sm.ResearchProposal@ocfs.ny.gov

Please note in your email that this is an HFNY research proposal.

8. HFNY CA will abide by OCFS timeframes for review of all research proposals. Currently, the BREPA review of the research proposal is conducted by researchers who are also members of HFNY CA which expedites the initial stages of the OCFS review.
9. Once OCFS approval of the research proposal has been received, the OCFS researcher will notify HFNY CA and send a summary of the approved research design and contact information for the Principal Investigator to the HFA National Office (via the HFA Implementation Specialist).
10. HFNY programs that participate in a research study will need to add a filter in the HFNY MIS for the study. This filter should be selected for each family participating in the study. The Active Enrolled Cases report in the HFNY MIS can be run with the filter selected to track participation. A copy of the research study's informed consent form should be kept in each participant's file. Participant files will be reviewed to make sure the consent form is included during the annual site visit.
11. If a participant involved in a research study at one program site transfers to a new program site, the program manager should notify their OCFS program manager. The participant's continued participation in the research study will be addressed on a case by case basis via consultation between the research study principal investigator/project director, the OCFS program contract manager, and the OCFS HFNY researchers.
12. Any concerns about the research study (e.g., participant feedback, changes to the approved plan, etc.) should be communicated to the program's OCFS program contract manager within 5 business days.
13. Any final reports or findings should be shared with OCFS and HFNY prior to dissemination so that OCFS and HFNY may confirm that the safety and privacy of families or program staff has been protected and so that OCFS and HFNY may benefit from the research results. Up to 20 business days shall be required to review and approve draft posters, presentations, journal abstracts, and

manuscripts. Researchers should also notify OCFS and HFNY in advance of any media, publicity, or other public presentation related to the research study.

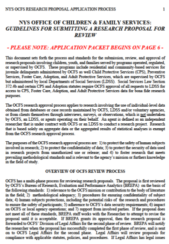
MIS Reports:

Active Enrolled Cases Report

Appendix:

NYS OCFS Research Proposal Application Process

Double click to open embedded document.



NYS OCFS RESEARCH PROPOSAL APPLICATION PROCESS 1

NYS OFFICE OF CHILDREN & FAMILY SERVICES:
GUIDELINES FOR SUBMITTING A RESEARCH PROPOSAL FOR REVIEW

- PLEASE NOTE: APPLICATION PACKET BEGINS ON PAGE 6 -

This document sets forth the process and standards for the submission, review, and approval of research proposals involving children, youth, and families served by programs operated, regulated, or supervised by OCFS. These programs include residential and community-based services for juvenile delinquents administered by OCFS as well Child Protective Services (CPS), Preventive Services, Foster Care, Adoption, and Adult Protective Services, which are supervised by OCFS but administered by local Departments of Social Services (LDSS). Social Services Law Section 372.4b and certain CPS and Adoption statutes require OCFS approval of all requests to LDSS for access to CPS, Foster Care, Adoption, and Adult Protective Services data for bona fide research purposes.

The OCFS research approval process applies to research involving the use of individual-level data obtained from databases or case records maintained by OCFS, LDSS and/or voluntary agencies, or from clients themselves through interviews, surveys, or observations, which is not undertaken by OCFS, an LDSS, or agents operating on their behalf. An agent is defined as an independent researcher that is under contract with OCFS or an LDSS to conduct a research project. Research that is based solely on aggregate data or the aggregated results of statistical analyses is exempt from the OCFS research approval process.

The purposes of the OCFS research approval process are: 1) to protect the safety of human subjects involved in research; 2) to protect the confidentiality of data; 3) to protect the security of data used in research projects from unauthorized use or release; and 4) to foster research that meets prevailing methodological standards and is relevant to the agency's mission or furthers knowledge in the field of study.

OVERVIEW OF OCFS REVIEW PROCESS

OCFS has a multi-phase process for reviewing research proposals. The proposal is first reviewed by OCFS's Bureau of Research, Evaluation and Performance Analytics (BREPA) on the basis of the following standards: 1) relevance to the OCFS mission or contribution to the body of literature in the field; 2) methodological adequacy; 3) procedures for ensuring confidentiality of subject data; 4) human subjects protections, including the potential risks of the research and procedures to ensure the safety of participants; 5) adherence to OCFS's data security requirements; 6) impact on OCFS or local agency operations; and 7) support from involved parties. If the proposal does not meet all of these standards, BREPA staff works with the Researcher to attempt to revise the proposal until it is acceptable. If BREPA grants its approval, then the research proposal is forwarded to OCFS' Division of Legal Affairs for the second phase of review. BREPA will notify the researcher when the proposal has successfully completed the first phase of review, and is sent on to OCFS Legal Affairs for the second phase. Legal Affairs will review proposals for compliance with applicable statutes, policies, and procedures. If Legal Affairs has legal issues

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Insert site specific procedures that include:

1. The program's own agency and/or program policies and procedures regarding whether they will allow bona fide researchers (other than HFNY system researchers) to engage in research activities with past or present families. The procedures should specify:
   - **a.** Whether the program will allow researchers who otherwise meet the requirements to conduct research within their program;
   - **b.** The name of the contact person for the agency/program who should be approached regarding participation in a research study;
   - **c.** Other individuals at the agency/program who will need to be contacted to review the request to participate;
   - **d.** Who will make the decision to participate; and
   - **e.** Who will provide a letter of support to the prospective researcher for inclusion in their application to HFNY CA and OCFS.
2. The location where informed consent forms for participants included in research studies are stored (e.g., secured paper files, electronically in MIS, etc.).

FAMILY RIGHTS AND CONFIDENTIALITY AND PARTICIPANT GRIEVANCE (EFFECTIVE 7/27/20)
HFA Best Practice Standards GA-5. A, GA-5. B, GA-5C

POLICY: Families are informed of their rights and ensured confidentiality of information both during the intake process as well as during the course of services.

Intent: A family-centered approach to service delivery requires that practices reflect a profound respect for personal dignity, confidentiality and privacy. When a request for confidential information about a family is received, or when a release of confidential information is necessary for the provision of services, sites must obtain the family's informed, written consent prior to releasing the information. Informed consents are time specific.

1. All families enrolled in HFNY have the right to be treated with dignity and respect and to know the scope and limitations of the services offered. Any information shared between the family and staff must be protected and treated in a confidential manner. Home visitors inform families of their rights and confidentiality and provide them with the **Family's Rights and Confidentiality Form** before or on the first home visit. The form includes:
   - **a.** The right to refuse services (voluntary nature of the program).
   - **b.** The right to referral, as appropriate, to other service providers.
   - **c.** The right to participate in the planning of the services they will receive.
   - **d.** The right to file a grievance/complaint and how to do so should the need arise.
     - Specific steps for reviewing and acting on any grievances received.
     - The timeframe for addressing any grievances.
     - The follow-up mechanisms used to address identified areas of improvement.
2. Confidentiality is an essential part of the agency's services. Every family has the right to private and confidential interaction with staff. The only exception to this right occurs when the law mandates report of illegal or potentially life-threatening behavior. The home visitors inform families of their confidentiality using the **Family's Rights and Confidentiality Form** before or on the first home visit. The form includes:
   - **a.** The manner in which information is used to make reports to funders, evaluators, Central Administration and/or researchers (in aggregate format).
   - **b.** The manner in which consent forms are signed to exchange information with other providers.
   - **c.** The circumstances when information would be shared without consent such as the need to report child abuse and neglect.
3. All HFNY sites adhere to the following confidentiality standards:
   - **a.** All HFNY staff sign a confidentiality agreement to keep participant information confidential including the acceptable use of HFNY MIS. Staff keep their MIS password confidential.
   - **b.** All family files are stored in locked file cabinets or electronically on the MIS or other computer-based filing system (encrypted and password protected).
   - **c.** Files are not left open on staff's desk.
   - **d.** Staff log off MIS when leaving the desk or office.
   - **e.** In case of staff leaving the job, the site must inform CHSR within 24 hours using the ticket system.
   - **f.** FSSs and FRSs discuss information related to families only with site staff, administration, funders, OCFS, HFNY Central Administration and HFA. (If site were to participate in any outside evaluation project –see GA-4)
   - **g.** A family's information cannot be discussed with an outside provider unless Consent for the Release of Information form has been signed. Consent to release information forms will only list one agency per form in order to maintain confidentiality related to the various services that a family might receive. Consent forms must include:
     - 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 specific date the release takes effect.
- The timeframe or date the release expires. * No release agreement can exceed 12 months.
- The name of the person/agency to whom the information is to be released.
- The name of the HFNY site providing the confidential information.
- A statement that the person/family may withdraw their authorization at any time.

h. Staff do not talk about the families being served with friends or family members.

i. Staff do not use the name of the family member (or any identifying information) in any public area.

j. Staff who breach confidentiality commitments face disciplinary action up to and including dismissal.

4. All families are asked to participate in the HFNY evaluation at enrollment and sign the Informed Consent. They are informed of the scope and intent of the evaluation, the voluntary nature of their participation, that they have the right to refuse participation without it having effect on the services they receive and that all evaluation results will be presented in aggregate form. (For participation in any outside evaluation project –see GA-4).

5. Families are informed of the grievance process on the first home visit as part of the process of reviewing the **Family's Rights and Confidentiality Form** and provided with a business card with the Program Manager or Supervisor's information for them to contact if they have any concerns with the services.

6. The grievance process within the **Family's Rights and Confidentiality Form** includes:

a. Any grievances received are immediately discussed with program management, agency leadership, and/or OCFS and appropriate action is taken including contact with the family, to ensure there is clear understanding of the family's concern. Follow-up needed will be determined within five business days of receiving the grievance. The local Advisory Group may be called upon to help resolve grievances.

b. The family will be made aware of the resolution strategy and steps as soon as they have been determined.

c. The family has the right to appeal any decision they believe does not adequately resolve their grievance by applying to the Agency Director and the Advisory Group.

d. Families may request a change in FSS at any time. The site honors these requests whenever possible.

e. Staff members are removed from work with families immediately, pending resolution of a grievance involving allegations that, if true, would endanger families' safety and well-being.

f. The site works with staff named in grievances through coaching in supervision and takes any additional personnel actions needed.

MIS Reports:

None

Appendix:

Family's Rights and Confidentiality Form including Grievance Policy
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-spanish/
MIS User Agreement
https://www.healthyfamiliesnewyork.org/Staff/Documents/HFMISUserAgreement.pdf
HFNY Data Request Needing OCFS Approval Form (MIS Paper forms)
MIECHV Informed Consent (HFNY MIS)

Sample Consent to Share Information with External Source (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/ga-5-c-release-of-information-english/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-c-release-of-information-spanish/

Insert site-specific procedures that include:

1. How families will be informed of their rights at enrollment, both verbally and in writing (how it will be documented on the Home Visit Log) regarding:
   - The right to refuse services.
   - The right to referral.
   - The right to participate in the planning of services.
   - The right to file a grievance/complaint and the specific steps for reviewing and acting on any grievance received and how grievances will be documented and kept regarding:
     - Discussion with supervisor and/or program management.
     - Contact with the family to ensure there is clear understanding of the family's concern.
     - The timeframe for addressing any grievances.
     - The follow-up mechanisms used to address identified areas of improvement.
2. How your site adheres to confidentiality and how you share this with families including:
   - The manner in which information is used to make reports to funders, evaluators or researchers.
   - The manner in which staff are oriented to the MIS and sign the User Agreement.
   - The manner in which files are protected (in family binders or electronic files: locked cabinets, password protection, encryption)
   - The manner in which consent forms are signed, and the family is informed every time information is shared with a new external agency.
   - The manner in which information is protected and kept confidential when there are multiple participants in the same household or dwelling.
   - The circumstances when information would be shared without consent (i.e., need to report child abuse and neglect).
3. How will families be informed of any additional data requests and the approval process that follows (i.e., Informed Consent).

REPORTING CHILD ABUSE AND NEGLECT (EFFECTIVE 12/20/19)
HFA Best Practice Standard GA-6

POLICY: All suspected cases of child abuse and neglect are reported to the appropriate authorities and the program manager and/or supervisor are notified immediately.

Intent: A clear understanding of child abuse and neglect indicators and the state's definitions of child abuse and neglect will assist staff with knowing how and when to report it. It is important for staff to know whom to contact for support when abuse or neglect is suspected. It is the intent that site leadership is notified in advance of a CPS report being made, however imminent child safety concerns are a higher priority. Therefore, Sstaff clearly understand that contacting the police or State Central Register prior to the immediate notification of the site manager or supervisor is appropriate ONLY IF waiting to contact the authorities (police or SCR) may cause greater risk to the child (ren).

All direct service staff (including supervisors) should be viewed as mandated reporters and adapt a mandated reporter philosophy, even if the state does not identify them as mandated reporters. Therefore, it is also important to familiarize staff with mandated reporting laws, which places ultimate responsibility on direct service staff to report a suspicion of child abuse or neglect to the New York State Central Register (SCR) without risk or jeopardy, even in situations where site leadership may not agree with the need to report.

1. Home visitors are not considered mandated reporters under section 413 of New York State Social Service Law. In order to meet the HFA Best Practice Standards, home visitors, supervisors, and program managers are required to make a report to the NYS Central Register when they suspect child abuse or maltreatment.
2. Families are informed of the limits of confidentiality at intake, including the requirement to report to the SCR if needed.
3. If staff suspects abuse or neglect, they should immediately speak with their supervisor and make a report to the SCR. If imminent danger is threatened, the home visitor is to call 911 prior to calling the supervisor or SCR.
4. Supervisors should provide support and guidance regarding the staff member's observations and concerns. The supervisor should not attempt to dissuade the FSS or FRS from making a report. It should be noted that proof of abuse or maltreatment is not necessary to call the SCR. If program staff are unsure whether a report should be made, the SCR will be called. The SCR staff will make the determination as to whether a report will be registered.
5. All program managers, FRS and FSS supervisors, FSS and FRS, interns and volunteers receive orientation prior to direct services with families or supervision of staff. This orientation, BPS 10-2. D, must ensure that staff clearly understands how to identify child abuse and neglect indicators, fully understands the State's definition of child abuse and neglect, and is aware of the legal limits of confidentiality. Additionally, as per BPS 11-4. B, all staff receive annual training related to child abuse and neglect in order to stay updated on current child welfare policies, practices, and trends in their community.
6. A report to the State Central Register must be made if a staff member suspects
   that a child has experienced one of the following types of Abuse or Maltreatment (includes neglect) including but not limited to failure to exercise a minimum degree of care or sexual/physical abuse against the child or allowing sexual/physical abuse to be committed.

Definition of Maltreatment: A child's physical, mental or emotional condition has been impaired, or placed in imminent danger of impairment by the failure of the child's parent or other person legally responsible to exercise a minimum degree of care.

Definition of Abuse: Abuse encompasses the most serious injuries and/or risk of serious injuries to children by their caregivers. When a child whose parent or other person legally responsible for his or her care inflicts

serious physical injury or commits a sex offense against the child. Abuse also includes situations where a parent or other person legally responsible knowingly allows someone else to inflict such harm on a child.

Indicators of Maltreatment and Abuse:

1. Indicators of maltreatment can include but are not limited to:
   a. Failing to provide the child with food, clothing, shelter, education, medical or surgical care, though financially able to do so or offered financial or other reasonable means to do so.
   b. Failing to Provide a child with proper supervision or guardianship.
   c. Unreasonably inflicting, or allowing to be inflicted, harm or substantial risk thereof, including but limited to the infliction of excessive corporal punishment.
   d. The misuse of drugs or alcohol to the extent of loss of control.
   e. By abandoning the child.
2. Indicators of sexual abuse can include but are not limited to:
   a. Injury to genital area.
   b. Symptoms of sexually transmitted diseases.
   c. Sexually suggestive, inappropriate, or promiscuous behavior or verbalization.
   d. Expressing age in-appropriate knowledge of sexual relations.
   e. Sexual victimization of other children.
3. Indicators of physical abuse can include but are not limited to:
   a. Injuries to the eyes or both sides of the head or body.
   b. Frequent injuries of any kind. These may appear in distinctive patterns such as grab marks, human bite marks, cigarette burns, or impressions with other instruments.
   c. Destructive, aggressive, or disruptive behaviors.
   d. Passive, withdrawn, or emotionless behavior.
   e. Fear of going home
4. Whenever possible, home visitors should inform the family that a report is going to be made. When circumstances make informing the family, either prior to or after calling the SCR, unsafe for family members or staff, it is up to the supervisor and home visitor to determine how to handle the incident and move forward to preserve the family.

MIS Reports:

None

Appendix:

Child Abuse Maltreatment Policy Presentation GA-6
https://www.healthyfamiliesnewyork.org/Staff/programmanager.htm

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Insert site specific procedures that include:

1. The program will use the above criteria to make a report of suspected child abuse and neglect.
2. Requirement that the program manager and/or supervisor must be notified immediately when abuse or neglect is suspected.
3. How all observations of suspected abuse and neglect, and any next steps are documented.
4. How the family will be informed of any report made to the State Central Register. Include when the family may not be informed.
5. Any other program requirements.

GA-6. A and GA-6. B are Safety Standards

Critical Incident Policy (EFFECTIVE 7/24/20)
HFA Best Practice Standard GA-7

POLICY: Home visitors must immediately notify the program manager and/or supervisor in the event of a participant or participant's household member's death, critical injury, serious abuse incidents which prompt local investigation or media involvement, as well as litigation pertaining to Healthy Families work or services, **or other critical incident. The OCFS program contract manager (PCM) must be notified within 24 hours. Affected participants and staff are offered counseling when a participant death or critical incident occurs.** Programs are also required to report any misuse of funds as a critical incident.

Intent: Critical incidents that affect the program staff and participant families, including the death or critical injury of a program participant, serious abuse incidents which prompt local investigation or media involvement, as well as litigation pertaining to HFNY work or services, staff witnessing a violent incident, an assault of program staff, threats against the program or program staff, and natural disasters, may create a deep sense of loss for the families and staff. This policy assures that both staff and family members are supported through the grief/loss process, or to address their sense of safety. This could include additional reflective supervision, short term transitional home visits with the family, the offer of grief counseling when these resources are available etc.

1. In the event of critical incident, including the death or critical injury of a participant household member, serious abuse incidents which prompt local investigation or media involvement, as well as litigation pertaining to HFNY work or services, threats against the program or program staff, serious injury of staff on duty, the staff that becomes the first one aware of the incident immediately informs the program manager and/or supervisor. The OCFS PCM should be notified as soon as possible by phone or email, but within a maximum of 24 hours of the program becoming aware of the incident. This notification is to include preliminary information such as name and age of the participant and a brief description of the incident.
2. Support is offered to the family, including services for grief counseling or other therapeutic services, if desired by the family, and short-term transitional home visits in the case of the death of the target child.
3. Appropriate support should also be provided to the home visitor(s) and supervisor, including additional reflective supervision, and counseling or access to an Employee Assistance Program (EAP).
4. If the program staff suspect that death or critical injury of the target child or other child in the home may be the result of child abuse or neglect, staff follow the agency's procedures consistent with the child abuse reporting policy and cooperates fully with any investigation.
5. Critical Incidents are documented on the OCFS Critical Incident Report forms. (see Appendix).
6. If a report is made to the State Central Register concerning the death or critical injury, documentation on the OCFS Critical Incident Report includes: who made the initial report to the Statewide Central Register, if known; the contact information for the CPS worker or supervisor, if known; the notifications that followed the initial report; whether follow-up HFNY services will be provided to the remaining household members, and length of time they will be provided. Programs should refer to the GA-6A Policy for reporting of Child Abuse and Maltreatment.
7. Healthy Families New York programs funded through contracts with the New York State Office of Children and Family Services and are required to report any misuse of such funding to the Office of Children and Family Services.
8. A preliminary written report of the critical incident, with available information, will be made to OCFS using the OCFS Critical Incident Report within 72 hours of the

program becoming aware of the incident at most. A final OCFS Critical Incident Report, with all required information included, is submitted to the OCFS PCM with updates weekly as necessary.

MIS Reports:

None

Appendix:

Critical Incident Report*

Insert site-specific procedures that include:

1. Immediate notification of the program manager and or supervisor when a critical incident occurs. For subcontractors, this would also include notifying the contract manager of the contract holder.
2. Staff is offered grief counseling when a death or critical injury occurs.
3. The support that will be offered to the family who has experienced loss.
4. Protocol for notifying OCFS program contract manager when a critical incident occurs.
5. Requirements for completing the necessary documentation when a critical incident occurs and that a report will be made to the State Central Register when required.
6. Protocols for when multiple participating families are impacted by a critical incident.
7. Protocols for when there is an incident of media involvement concerning a critical incident the program is involved in.
8. Protocols surrounding the misuse of funds and the notification to OCFS PCM.

Appendix

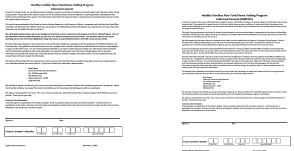
1-2.A Screening and Assessment Process
HFNY Screen Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/HFNY%20Screen%20form.pdf
Quarterly Report Guidelines
https://healthyfamiliesnewyork.org/Staff/Documents/Quarterly_Report_Guideline_for_Data_Reports_final_draft022020.docx
Annual Service Review Guidelines- Currently being updated (2021)
HFNY Performance Indicators
https://www.healthyfamiliesnewyork.org/Staff/Documents/Performance%20Indicators2021.pdf

1-3.A First Home Visit
HFNY Performance Indicators
https://www.healthyfamiliesnewyork.org/Staff/Documents/Performance%20Indicators2021.pdf
Sample Service Agreement Form*
Sample Family Rights and Confidentiality Form (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-spanish/

2-1.A Eligibility Requirements
HFNY Screening Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/HFNY%20Screen%20form.pdf
Pre-Assessment Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Pre-Assessment%20Activity%20Form.pdf
HFNY Parent Survey Narrative Standardized Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/PSSTANDARDIZEDFORM%20Rev.1-21.pdf

2-2.A Assessment Narratives
HFNY Parent Survey Worksheet
https://www.healthyfamiliesnewyork.org/Staff/Documents/PSWORKSHEETpaperworksheetRev.0121.pdf
HFNY Parent Survey Narrative Standardized Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/PSSTANDARDIZEDFORM%20Rev.1-21.pdf

3-1.A Voluntary Nature of Services
Sample Family Rights and Confidentiality Form (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-spanish/
Informed Consent



(MIECHV)

3-2.A Building Trust and Engaging Families
None

3-3.A Creative Outreach
Creative Outreach Activities/Checklist*
HFA Level Change Forms (need HFA Login)
https://www.healthyfamiliesamerica.org/hfa-restricted.php?file=Level-Change-Packet-6.18.pdf
https://www.healthyfamiliesamerica.org/network-resources/?topic=level-change

Sample Family Rights and Confidentiality Form (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-spanish/
Informed Consent


(MIECHV)

Annual Service Review Guidelines- Currently being updated (2021)

4-1.A Minimum Length of Time to Offer Weekly Home Visits
None

4-2.A Levels of Service
HFNY Sample Level Change Criteria Forms (need HFA Login)
https://www.healthyfamiliesamerica.org/hfa-restricted.php?file=Level-Change-Packet-6.18.pdf

4-2.B Home Visit Completion
None

4-3.A Duration of Service
HFA's Level Tool Guidance (need HFA login)
https://www.healthyfamiliesamerica.org/hfa-restricted.php?file=Level-Change-Packet-6.18.pdf

4-4.A Services Closure/Transition Planning
HFNY Transition Plan Form (in English and Spanish) (HFNY MIS)

5 Providing Culturally Respectful Services
Guidelines for Annual Service Review- Currently being updated (2021)
HFA Cultural Analysis and Plan workbook (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/cultural-analysis-and-plan-guide/

6-1.A Reviewing and Addressing Risk Factors and Challenging Issues
HFNY Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Supervision%20Paper%20Form%202.0.pdf
HFNY Service Plan (HFNY MIS

6-2.A Family Goal Plan
None

6-3.A CHEERS: Assessing Parent-Child Interaction
Infant Mental Health
https://www.zerotothree.org/early-development/infant-and-early-childhood-mental-health
HFA CHEERS Guide for Home Visitors
https://www.healthyfamiliesnewyork.org/Staff/Documents/CHEERSGuideforHomeVisitors0819.docx
HFA CHEERS Discussion Guide for Supervisors
https://www.healthyfamiliesnewyork.org/Staff/Documents/CHEERSDiscussionGuideforSupervisors%20022020.doc
Home Visit Narrative Content Instructions
https://www.healthyfamiliesnewyork.org/Staff/Forms/ContentInstructionsNewYorksHomeVisitingProgram.pdf

6-4.A Promoting Child Development, Parenting Skills, Health and Safety
HFNY website
https://healthyfamiliesnewyork.org/default.htm
HFNY Approved Evidence Informed Curriculum
https://www.healthyfamiliesnewyork.org/Staff/curriculum.htm

6-5.A Policy: Developmental Screening
None

6-6.A Tracking Developmental Delays
HFNY Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Supervision%20Paper%20Form%202.0.pdf

7-1.A Medical/Health Care Provider
None

7-2.A Immunizations
None

7-3.A Referrals/ Linkages to Health Care and Community Resources
None

7-4.A Depression Screening
Procedures for Working with Families in Acute Crisis*
https://app.box.com/s/kd2bfdeecpqjtqjvzf9c

8-1.A and 8-2.A Caseload Size and Caseload Management
Home Visiting Levels Table
https://www.healthyfamiliesnewyork.org/Staff/Documents/Home%20Visiting%20Levels%20Table.pdf

9-1.A and 9-4.A Selection of Staff
Sample interview Questions (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/sample-interview-questions-spanish/
https://www.healthyfamiliesamerica.org/network-resources/sample-interview-questions/
Interview Rating Scale
https://www.healthyfamiliesnewyork.org/Staff/Documents/Interpersonal_Rating_Scale.pdf

10 and 11 Training Plan/ Policy
HFA FRS Stop-Gap Training for Supervisors (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/stop-gap-supervisors-of-family-resource-specialists/
HFA FSS Stop-Gap Training for Supervisors (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/stop-gap-supervisors-of-family-support-specialists/
Recommended Order of Trainings
https://www.healthyfamiliesnewyork.org/Staff/Documents/RecommendedOrderofTrainings12152020.docx
Site Training Record (HFNY MIS)

12-1.A Ongoing Supervision for Direct Service Staff
Guidance for Using the Healthy Families New York Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf

12-2.A Administrative, Clinical and Reflective Supervision and Professional Support
Guidance for Using the Healthy Families New York Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf
Supporting Home Visitor Supervision (need HFA login)

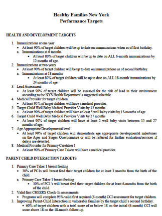
https://www.healthyfamiliesamerica.org/network-resources/supporting-fsss-in-supervision/
Supporting Parent Survey Supervision (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/supporting-frss-in-supervision/

12-3.A Supervision of the Supervisor
Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Supervision%20Paper%20Form%202.0.pdf
Guidance for Using the Healthy Families New York Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf

12-4.A Supervision of the Program Manager
None

GA-2.A Family Satisfaction Feedback
None

GA-3 Quality Assurance
Annual Service Review Guidelines- *(Currently being updated 2021)*
PCANY QA Protocols
https://www.healthyfamiliesnewyork.org/Staff/support.htm
OCFS Quarterly Report
https://healthyfamiliesnewyork.org/Staff/Documents/Quarterly_Report_Guideline_for_Data_Reports_final_draft022020.docx
OCFS Site Visit Tool
https://www.healthyfamiliesnewyork.org/Staff/support.htm
Performance Indicators
https://healthyfamiliesnewyork.org/Staff/Documents/PIdetails4-1-17to9-30-17.pdf
Quarterly Performance Targets


Healthy Families New York
Performance Targets

HEALTH AND DEVELOPMENT TARGETS

1. Immunizations at one year
   - At least 90% of target children will be up to date on immunizations when as of first birthday.
   - a. Immunizations at 6 months.
     - At least 80% of target children will be up to date on ALL 6-month immunizations by 12 months of age.
2. Immunizations at two years
   - At least 90% of target children will be up to date on immunizations as of second birthday.
   - a. Immunizations at 18 months
     - At least 80% of target children will be up to date on ALL 18-month immunizations by 24 months of age.
3. Lead Assessment
   - At least 90% of target children will be assessed for the risk of lead in their environment according to the NYS Health Department's suggested schedule.
4. Medical Provider for target children
   - At least 95% of target children will have a medical provider.
5. Target Child Well Baby Medical Provider Visits by 15 months
   - At least 90% of target children will have at least 5 well baby visits by 15-months of age.
6. Target Child Well Baby Medical Provider Visits by 27 months
   - At least 90% of target children will have at least 2 well baby visits between 15 and 27 months of age.
7. Age Appropriate Developmental level
   - At least 98% of target children will demonstrate age appropriate developmental milestones on the Ages and Stages Questionnaire or will be referred for further evaluation/services if delays are detected.
8. Medical Provider for Primary Caretaker 1
   - At least 90% of Primary Care Takers will have a medical provider.

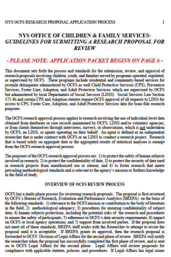
PARENT CHILD INTERACTION TARGETS

1. Primary Care Taker 1 breast feeding
   - 30% of PC1s will breast feed their target children for at least 3 months from the birth of the child.
   - a. Primary Care Taker 1 breast feeding
     - 30% of PC1's will breast feed their target children for at least 6-months from the birth of the child.
2. Valid first CHEERS Check-In assessments
   - Programs will complete 95% valid first required (6-month) CCI assessment for target children.
3. Improving Parent-Child Interaction in vulnerable families by the target child's second birthday.
   - 60% of target children with a total score of or below 18 on the initial (6-month) CCI will score above 18 on the 18-month follow-up.

Revised 1/2020

Sample Participant Survey
https://www.healthyfamiliesamerica.org/network-resources/5-4-family-satisfaction-survey-english/
https://www.healthyfamiliesamerica.org/network-resources/5-4-family-satisfaction-survey-spanish/
QA Quarterly Activities Calendar
https://www.healthyfamiliesnewyork.org/Staff/Documents/QA_quarterlyactivitiescalendar_PMs_and_Sups032021_not%20MIECHV.pdf
https://www.healthyfamiliesnewyork.org/Staff/Documents/QA_quarterlyactivitiescalendar_PMs_and_Sups032021_MIECHV%20(1).pdf (MIECHV)
Guidelines for Supervision Notes
https://healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf

GA-4 Policy: Research Proposals
NYS OCFS Research Proposal Application Process*
Available upon request: ocfs.sm.ResearchProposal@ocfs.ny.gov
Double click to open embedded document.


NYS OCFS RESEARCH PROPOSAL APPLICATION PROCESS 1

NYS OFFICE OF CHILDREN & FAMILY SERVICES:
GUIDELINES FOR SUBMITTING A RESEARCH PROPOSAL FOR REVIEW

- PLEASE NOTE: APPLICATION PACKET BEGINS ON PAGE 6 -

This document sets forth the process and standards for the submission, review, and approval of research proposals involving children, youth, and families served by programs operated, regulated, or supervised by OCFS. These programs include residential and community-based services for juvenile delinquents administered by OCFS as well Child Protective Services (CPS), Preventive Services, Foster Care, Adoption, and Adult Protective Services, which are supervised by OCFS but administered by local Departments of Social Services (LDSS). Social Services Law Section 372.4b and certain CPS and Adoption statutes require OCFS approval of all requests to LDSS for access to CPS, Foster Care, Adoption, and Adult Protective Services data for bona fide research purposes.

The OCFS research approval process applies to research involving the use of individual-level data obtained from databases or case records maintained by OCFS, LDSS and/or voluntary agencies, or from clients themselves through interviews, surveys, or observations, which is not undertaken by OCFS, an LDSS, or agents operating on their behalf. An agent is defined as an independent researcher that is under contract with OCFS or an LDSS to conduct a research project. Research that is based solely on aggregate data or the aggregated results of statistical analyses is exempt from the OCFS research approval process.

The purposes of the OCFS research approval process are: 1) to protect the safety of human subjects involved in research; 2) to protect the confidentiality of data; 3) to protect the security of data used in research projects from unauthorized use or release; and 4) to foster research that meets prevailing methodological standards and is relevant to the agency's mission or furthers knowledge in the field of study.

OVERVIEW OF OCFS REVIEW PROCESS

OCFS has a multi-phase process for reviewing research proposals. The proposal is first reviewed by OCFS's Bureau of Research, Evaluation and Performance Analytics (BREPA) on the basis of the following standards: 1) relevance to the OCFS mission or contribution to the body of literature in the field; 2) methodological adequacy; 3) procedures for ensuring confidentiality of subject data; 4) human subjects protections, including the potential risks of the research and procedures to ensure the safety of participants; 5) adherence to OCFS's data security requirements; 6) impact on OCFS or local agency operations; and 7) support from involved parties. If the proposal does not meet all of these standards, BREPA staff works with the Researcher to attempt to revise the proposal until it is acceptable. If BREPA grants its approval, then the research proposal is forwarded to OCFS' Division of Legal Affairs for the second phase of review. BREPA will notify the researcher when the proposal has successfully completed the first phase of review, and is sent on to OCFS Legal Affairs for the second phase. Legal Affairs will review proposals for compliance with applicable statutes, policies, and procedures. If Legal Affairs has legal issues

GA-5.A, GA-5.B, GA-5.C Family Rights and Confidentiality, Informed Consent, Participant Grievance
Family's Rights and Confidentiality Form including Grievance Policy*
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
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HFNY Data Request Needing OCFS Approval Form (MIS Paper forms)
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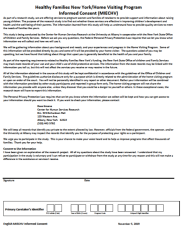

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https://www.healthyfamiliesamerica.org/network-resources/ga-5-c-release-of-information-spanish/

GA-6 Reporting Child Abuse and Neglect
Child Abuse Maltreatment Policy Presentation GA-6
https://www.healthyfamiliesnewyork.org/Staff/programmanager.htm

GA-7 Critical Incident
Critical Incident Report*

FAMILY RIGHTS AND RESPONSIBILITIES

I, _____ hereby agree to participate in the Healthy Families (insert Program Name), Home Visiting Program. I understand that; I have the right to give or refuse written signed consent if information is to be released. I understand that any information about me is otherwise private and confidential. The only exception to this right occurs when the law mandates reports of illegal or potentially life-threatening behavior. Additional rights include the following:

- The right to refuse services
- The right to services without regard to race, color, gender, religion, age, handicap, marital status, national or ethnic origin, including sexual orientation.
- The right to ongoing participation in the planning of services to be provided and in the development and periodic revision of my service plan.
- The right to file a grievance/complaint.

The grievance policy was reviewed with me (us) on: Date: _____

Healthy Families services are available to me for up to five years; or for 3 years if my child starts a Head Start program and no longer require services.

I further understand that a Family Support Specialist will be required to make regular visits to my home in order to ensure that the health and educational needs of myself and/or my child(ren) are being met. To achieve this goal, I must take the responsibility of doing the following if applicable.

- ♥ *Being cooperative in maintaining home visit appointments (I will contact my Family Support Specialist to cancel/reschedule whenever a change of plans is necessary).*
- ♥ *Following up with **referrals** provided by my Family Support Specialist.*
- ♥ *Keeping medical appointments (i.e. Prenatal Visits, Well Baby Visits, Immunizations)*

If I choose to do so, I know that I can discontinue services with Healthy Families Brookdale at any time. I may also contact the Supervisor_____(ext_____), or Program Director, (insert name), with any questions or concerns about my Support Specialist or the program services.

Parent's Signature_____ Date_____

FSS Signature_____ Date_____

Grievance Policy and Procedure:

Families are informed of the grievance process, provided with a "Report of Complaint" form**,** and with contact information for the Program Director and Supervisor on the first home visit as part of the process of reviewing the **Family's Rights and Responsibility Form.**

The grievance process includes the following:

1. Any grievances received are immediately (or within 24 business hours) discussed with program management (i.e. Supervisor, Coordinator and Program Director) and appropriate action is taken including contact with the family to ensure there is a clear understanding of the family's concerns.

2. The family will be made aware of the resolution strategy and steps as soon as they have been determined.

3. Families may request a change in Family Support Specialist at any time. The site honors these requests whenever possible.

4. Staff members are removed from work with families immediately, pending resolution of a grievance involving allegations that, if true, would endanger families' safety and well-being.

5. The site works with staff named in grievances through coaching in supervision and takes any additional personnel actions needed.

6. Documented grievances and provided to the Program Director to be stored electronically or in a locked file cabinet.

Family: _____ Home Visitor: _____

OUTREACH AND ENGAGEMENT FORM

(Check Outreach Stage Below & Insert Date Outreach Level Began)

☐PRE-ASSESSMENT: _____ ☐PRE-INTAKE:_____ ☐LEVEL CO: _____

Phone Calls/TEXTS:

- Pre-Assessment – Time frame to be determined based on engagement
- pre-intake – Weekly (for 30-45 days/ or 6 weeks)
- level CO – every other week (for 92 days/ or 13 weeks)

	List Dates		List Dates		List Dates
WEEK 1		WEEK 6		WEEK 11	
WEEK 2		WEEK 7		WEEK 12	
WEEK 3		WEEK 8		WEEK 13	
WEEK 4		WEEK 9		WEEK 14	
WEEK 5		WEEK 10		WEEK 15	

LETTERS:

- **pre-assessment - MAIL LETTER MONThly**
- **Pre-intake - Mail letter bi-weekly**
- **Level Co - MAIL LETTER MONTHLY**

	List Date(s)
OUTREACH LETTER(S)	
PRE-CLOSING LETTER	
CLOSING LETTER WITH REFERRALS: (SEND ON CLOSING DATE)	

Attempted visits: (ATTEMPTED VISIT monthly on Level CO only)

	List Date(s)
MONTH 1	
MONTH 2	
MONTH 3	

OTHER CREATIVE OUTREACH ACTIVITIES (AS NEEDED):

	List Date(s)		List Date(s)
REACH OUT TO REFERRAL SOURCE		SEND FAMILY A SPECIAL NOTE/ MAGNET OR CARD	
CALL/EMAIL EMERGENCY CONTACT		MAIL CURRICULUM OR ASQ/ASQ-SE2	
INVITE FAMILY TO PROGRAM/COMMUNITY EVENT		PROVIDE A REFERRAL	
PROVIDE A GIFT		OTHER (SPECIFY):	

Invite family to multiple program events to build trust

Share some of your knowledge around child health and development

Emphasize the program's voluntary nature and committment to partnering with families to raise happy healthy children

Demonstrate your interest in the family by exploring their interests and needs and providing relevant referrals

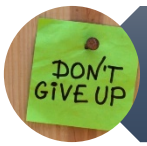
Focus on the relationship by reaching out in between visits & remembering info. previously shared by family

Engage the father BEFORE the assessment is scheduled

Call 24-48 hours after receiving the referral

Show genuine care and concern

Get help from your team



BE PERSISTENT!

Healthy Families America

PROTOCOLS: Working with Families Experiencing Acute Crisis

On occasion, you may encounter a family who is experiencing an acute crisis related to one or more social issues, such as mental illness, substance abuse, or domestic violence. Regardless of educational background or experience, it is not the home visitor's responsibility to provide clinical intervention/treatment to home visiting participants. Your first priority will be your safety, the safety of the individual in crisis, and the safety of their child(ren). This means gathering information while *avoiding* provocative questions or making statements that minimize or exacerbate the situation, such as "It is not so bad" or "Why would you say that?" "You don't mean that" or "Everything will be fine." Always consult with your supervisor as soon as possible when such situations arise. **ALL SITES MUST HAVE SPECIFIC WRITTEN PLANS FOR COVERAGE WHEN A SUPERVISOR IS NOT READILY AVAILABLE.**

Assessment staff should report any of the following situations or suspected situations to their supervisor as "red flags" to be passed on to the home visitor. Personal safety procedures should be followed at all times.

GENERAL PRACTICES FOR IMMEDIATE SAFETY:

IF YOU BELIEVE YOU OR SOMEONE ELSE IS IN DANGER DURING A HOME VISIT:

1. **LEAVE IMMEDIATELY.** If you need a way to more safely remove yourself from the setting, claim an emergency has come up that you need to go and address, say you left something in your car and need to go out to get it, claim that you are ill and need to reschedule.
2. Call 9-1-1 (or local emergency number)
3. Call your supervisor to advise him or her of the situation.
4. Call child protective services (CPS) if children are in danger.
5. Contact the family as safety permits (in consultation with your supervisor) to ensure that everyone is safe. Assure the parents that you will continue to work with them, if possible, within program guidelines.
6. Document all activities, consultations (including with your supervisor), and the outcomes of each.

IF YOU BELIEVE SOMEONE IS IN DANGER DURING A TELEPHONE CONTACT:

1. Get as much information about her/his location as possible.
2. Tell the person you are calling 9-1-1, unless you fear that doing so might exacerbate the situation or cause the caller to hang up. Try to keep the person on the line.
3. Enlist the assistance of a third party (i.e. your supervisor, a coworker) to make the 9-1-1 call.
4. Consult with your supervisor immediately.
5. Stay in touch with the family as safety permits.
6. Document all activities, consultations (including with your supervisor), and the outcomes of each.

IF YOU ARE IN DOUBT ABOUT OR UNCOMFORTABLE WITH ANY UNUSUAL SITUATION, CONSULT YOUR SUPERVISOR IMMEDIATELY. FOR THE SAFETY OF ALL INVOLVED, *DO NOT* TRANSPORT ANY INDIVIDUAL WHO IS INVOLVED IN THE CRISIS (VICTIM, CHILD, OR PERPETRATOR).

The following are specific situations that *may* arise with families including the definition, assessment, and specific procedures for each. Your site may have additional requirements.

A. MENTAL ILLNESS/PYSCHIATRIC EMERGENCIES

Definition: Being in a home with one or more family members who exhibit behaviors related to a mental illness or has scored positive using a *depression screening tool*; and when the mood represents a change from previous functioning. Mental illness may include, but not be limited to:

- depression
- post-partum depression
- schizophrenia
- bipolar disorder
- borderline personality disorder

Assessment:

1. Observe for physical symptoms such as:
   a. Sleep disturbances (too much or too little sleep)
   b. Appetite disturbances (over or under eating)
   c. Unexplained aches and/or pains
2. Non-physical symptoms of depression:
   a. Feeling sad and/or crying
   b. Avoiding pleasurable experiences
   c. Withdrawing from family and/or friends
   d. Loss of interest in daily activities
   e. Feeling guilty, hopeless, helpless, irritable, angry
   f. Having trouble concentrating, memory problems
   g. Having thoughts of suicide (*see suicidal ideation)*
3. Determine if there is an immediate danger to you, the child(ren), or any adult in the home, including the person with the mental illness considering the following *signs/symptoms* of acute mental instability and possible risk:
   a. Suicidal ideation, threats, attempts
   b. Homicidal ideation, threats, attempts
   c. Hallucinations: auditory, visual, or tactile (voices, visions, or sensations that are internal only, but perceived as coming from an external source)
   d. Delusions (unshakeable, persistent belief that something is true even in the face of evidence that it is not true, or even impossible)
   e. Severely disorganized or bizarre behavior
   f. Extreme lethargy, catatonic state (unresponsive)
   g. Severe deterioration in day-to-day hygiene and functioning
   h. Severely disorganized or bizarre speech, incoherence, pressured speech
   i. Very rapid mood changes and extremes of mood (e.g. excessive crying or excessively giddy)
   j. Dangerous or severely risky behavior
   k. Aggressive behavior, angry outbursts
   l. Self-injurious behavior, such as cutting, pulling hair out, burning oneself
   m. Self-medication with drugs, alcohol, prescription medications not prescribed to him/her, or over use of prescribed medications
   n. Stopping medications without prescribing physician knowledge or approval

- Some of the above symptoms may be present as regular symptoms of the illness; but if they are ***new, worse*, or in any way *frightening*,** follow the stated procedures to assure safety listed on pages 1 and 2.

Procedure:

- **IF YOU BELIEVE THERE IS RISK OF IMMEDIATE DANGER TO YOU OR ANY OTHER PERSON, FOLLOW THE STEPS OUTLINED ON PAGE 1 and 2.**

- If you do not feel comfortable making a judgment regarding the person's safety, request a police officer and/or mental health specialist be sent out to do a welfare check.

- If there is no immediate danger, but mental illness is suspected:
  1. When depression is suspected, administer the *depression screening tool* selected by your program.
  2. If not known from the Parent Survey, explore whether the parent has ever been diagnosed with a mental illness; and, if so, whether s/he is currently receiving any kind of treatment for the disorder.
  3. Offer intervention and treatment referrals, including psychiatrists, therapists, and/or support groups or services.
  4. Assist the parent in completing any forms/paperwork/calls required to access services, as needed. Always comply with confidentiality restrictions and secure written consent when making calls for the parent. Use a *Do for, do with, cheer on* approach.
  5. Follow-up with the parent in a timely manner on referrals, and assist in overcoming any barriers to accessing services.
  6. *Only with written consent*, inform the treating physician and/or therapist of current symptomology.
  7. See safety plan section on page 13.
  8. Immediately inform your supervisor of your concerns.
  9. Document all activities, consultations (including with your supervisor), and the outcomes of each.

- Routine activities that can be helpful:
  - When first becoming aware of a parent's mental illness, attempt to secure consent to talk with the treating physician and/or therapist regarding the individual's illness, risks, symptoms, medicines, etc.
  - Provide educational materials related to the identified disorder.
  - Support the parent in complying with treatment and regular communication with the physician/therapist when questions arise.
  - Continue to support the parent in identifying self-care activities, postive social supports, and stress reduction strategies.
  - If the mother is using psychotropic medications, encourage her to speak with the treating physician about the safety of continued use during pregnancy and/or breastfeeding.

- Self-care activities can be done to manage mild depression (while awaiting treatment or encouraging a parent to get to treatment). These may include the following:
  - Encourage the parent to spend time outside in the sunshine (without sunglasses). The sun increases seratonin levels, which help reduce depressed mood.
  - Encourage outdoor activities as weather allows (walking, going to the park, trips to the library, etc.).
  - Encourage positive social support (support groups, parenting classes, positive acitivities with supportive friends/family).

- Reference materials staff can use:
  - Community mental health clinics/hospitals
  - Some curricula have information on depression

- Resources:
  - Online resources:
    - www.nami.org
    - www.nimh.nih.gov
    - www.samsha.gov

        - www.guideline.gov
        - www.mayoclinic.com
        - www.apa.org.
    - Online support groups for individuals living with mental health disorders

- Add your site's local community resources for mental illness here:

B. SUICIDAL IDEATION OR ATTEMPT

Definition: Thoughts or comments about committing suicide, an attempt to do so, or statements about wishing to be dead.

Assessment: In most cases, a person will not come right out and state that they are considering suicide. It is important to be aware of and follow up on subtle hints or signs:

1. The person may make a vague statement such as: "sometimes I don't want to be here anymore," or "The world would be better off without me."
2. They may also exhibit a sudden change in their feelings or behavior. This could include a sudden lack of concern about things that had previously been upsetting to them.
3. The person may give away prized belongings.
4. Do not ignore vague statements, as these may be the person's way of testing the waters. Use solution-focused questions (*Problem Talk*) directly towards any statements made.
5. **Do not assume the responsibility of assessing the genuineness or level of intent of suicidal statements - treat all statements with equal concern.**
6. Observe for and ask about:
    a. Family history of suicide, current trauma, various mental disorders, familial support (both at the time of Parent Survey and throughout the course of services)
    b. Talking in a negative manner ("I am worthless, there is no hope," "I hate everyone, I hate myself," "Everyone would be better off if I just never existed," etc.)
    c. Destructive/high-risk behaviors (cutting; hypersexual activity; racing, theft, or other illegal behaviors not typical of the person; sudden excessive spending).

Asking someone if they are thinking about suicide does NOT put the idea in their head, increase their risk, or lead them to an attempt.

Procedure:

- **IF YOU BELIEVE THERE IS IMMEDIATE DANGER, REMOVE YOURSELF FROM THE SITUATION AND USE THE SAFETY PROCEDURES DESCRIBED ON PAGE 1 and 2.**

- For suicide *attempt*:
    1. Call 9-1-1 (or other local emergency number)
    2. Apply first aid, as appropriate and safe (for you and the victim)
    3. Ensure safety of children
    4. Consult with supervisor immediately
    5. Document all activities, consultations (including with your supervisor), and the outcomes of each.
- For suicidal *ideation:*
    1. Ask the person if they are considering killing themselves, their children, or someone else. Remember asking about suicide does not make someone more likely to do it.
    2. If the person indicates that they feel like killing themselves, ask if they have a plan.
    3. Once they tell you their plan, explore whether or not the means is available to carry it out (i.e. Does someone planning to shoot themselves own or have access to a gun and ammunition?).

a. **If they report a plan and means to carry it out, call 9-1-1 immediately. Remove yourself from the site if you feel at risk of potential harm.**
b. Request a police officer and/or mental health specialist be sent out to do a welfare check.
c. When possible, stay with the person until help arrives.
d. If the interraction is by phone, enlist someone else to assist in calling 9-1-1 while you keep talking to the suicidal person. Try to keep her or him on the telephone until help arrives at the location of the person.
e. Call your supervisor immediately for futher direction.

4. If the person does not have a specific plan or the means available to carry out a plan, talk to the person about making a safety plan, including a verbal or written "contract" not to harm themselves while you support them in getting assistance *(see safety plan oon page 13).*
5. If person has a mental health provider, have the person contact the provider immediately and tell him or her about the currernt suicidal ideation.
6. If the person has no therapist or psychiatrist, discuss the importance of this and offer referrals.
7. The home visitor may offer to be present while the parent shares his or her ideation with others residing in the home who may provide an additional source of support and monitoring.
8. The home visitor may offer to make contact with other support figures, such as family members, friends, etc. outside of the home who may provide added monitoring or other assistance - again, *always in keeping with confidentiality regulations*.
9. Consult supervisor immediately to discuss the situation.
10. Document all activities, consultations (including with your supervisor), and the outcomes of each.

- Add your site's local community resources for suicidal ideation or attempt here:

C. HOMICIDAL IDEATION OR ATTEMPT

Definition: Thoughts or comments about committing homicide (killing another person), an attempt to do so, or statements about wishing another person was dead.

Procedure:

- **IF YOU BELIEVE THERE IS IMMEDIATE DANGER, REMOVE YOURSELF FROM THE SITUATION AND USE THE SAFETY PROCEDURES DESCRIBED ON PAGES 1 and 2.**

- For *homicidal ideation:*
  1. If a person indicates that they feel like killing another person, ask them if they have a plan to do so.
     a. If s/he indicates a plan, explore whether or not they have the means to carry out the plan (i.e. If they are planning to shoot someone, do they own or have access to a gun and ammunition?).
     b. **If they report a plan and have realistic means, call 9-1-1 immediately after you have removed yourself from the situation.**
     c. Request that a police officer and/or mental health specialist be sent out to do a welfare check.
     d. If the interraction is by phone, enlist someone else to assist in calling 9-1-1 while you keep talking to the homicidal person. Try to keep her or him on the telephone until help arrives at the location of the person.
     e. Call your supervisor immediately for futher direction.
     f. Contact CPS if a child is in danger.

g. Document all activities, consultations (including with your supervisor), and the outcomes of each.

2. If no plan, *and if person has a mental health provider*, have person contact the provider immediately and inform the provider about the homicidal ideation.

a. If person has no therapist, discuss the importance of this and offer referrals.

b. Consult supervisor immediately to discuss the situation.

c. Document all activities, consultations (including with your supervisor), and the outcomes of each.

- Routine activities that can be helpful
  - Follow-up with parent to determine if she has contacted her physician/therapist.
  - Obtain written consent to speak with the physician/therapist(s).
  - Provide referrals to support groups in the community or access an approved on-line support group.
  - Provide educational materials related to the identified disorder.
  - Support the parent in complying with recommended treatment and regular communication with the physician/therapist when questions arise.
  - Continue to support parent in identifying self-care activities, postive social supports, and stress reduction strategies.
  - Ask your supervisor and/or coworkers for agency-approved articles related to topic and relay information to the parent.

- Resources:
  - Online resources include:
    - www.suicidepreventionlifeline.org
    - www.samsha.gov
    - www.guideline.gov
    - www.aca.org
    - www.nimh.nih.gov
  - 1-800-273-TALK (8255)
-
- Add your site's local community resources for homicidal ideation or attempt here:

D. DOMESTIC VIOLENCE

Definition: Working with a family in which there is a violent or abusive relationship; and/or one characterized by power and control tactics, with one person being victimized by the other. (This may consist of a man controlling a woman, a woman controlling a man, or one person controlling another of the same gender; occasionally, there is mutual battering or violence.)

Assessment:

1. Determine if there is *immediate danger* to you or any member of the household.

2. Observe for behaviors and indicators that violence may be present:

a. Raised voices

b. Walls with holes/damage or other broken items in the home

c. Anxious behavior (hypervigilance, nervousness, distraction, etc.)

d. Unexplained or poorly explained bruises or injuries

3. Be familiar with the *power and control tactics* characteristic of domestic violence:

a. Emotional abuse: verbal assaults, name calling, criticisms, blaming.

b. Intimidation: scaring a person with frightening looks, gestures, or body language; smashing and throwing things; punching walls; harming pets; displaying weapons in a threatening manner.

c. Use of Coercion and Threats: verbal threats to harm or leave the partner, harm or take the children, commit suicide or homicide, or make the partner participate in illegal activiity.
d. Isolation: controlling what a partner does, where a partner goes, who the partner sees and talks to; limiting outside involvement; using jealousy as an excuse to justify isolation.
e. Using Children: making the partner feel guilty about the children; using children to relay messages; using visits to harass the partner; threats to take children away.
f. Economic Abuse: controlling expenditures; giving an allowance; making a partner ask for money; preventing the partner from getting or keeping a job; not letting the partner know about or have access to family income.
g. Using Male/Female Privilege: treating a partner like servant; acting like "master of the castle"; defining male and female roles; making all the "big" decisions.
h. Minimizing, Denying, and Blaming: making light of the abuse and not taking the partner's concerns seriously; denying the abuse happened; shifting responsibility for the abuse; blaming the partner for causing the abuse.
i. Physical and Sexual Abuse: hitting, slapping, punching, pinching, beating, choking; forcing a partner to perform involuntary sexual acts; having sex after a beating; marital rape; affairs with others.

Procedure:

- **IF YOU BELIEVE THERE IS RISK OF IMMEDIATE DANGER TO YOU OR ANY OTHER PERSON, FOLLOW THE STEPS OUTLINED ON PAGE 1 and 2.**

- **If there is no immediate danger**, but domestic violence is detected:
  1. Explore the situation fully, and listen first for safety issues for child, parent, and staff. Use open-ended questions to identify discrepencies and ambivalence.
  2. Use solution-focused questions (The reflective strategy*, Problem Talk,* is especially effective for exploring with parent.).
  3. Discuss with the participant the power and control tactics that you observe or learn of from descriptions given by the victim. Advocate counseling for the parent. Address this as an advocacy issue affecting the victim and the child(ren).
  4. Develop a basic safety plan as outlined on page 13.
  5. Use reflective strategies to help the victim consider the impact of the domestic disruption upon the child(ren).
  6. Encourage the parent to contact local community resources: (be aware of local resources and requirements for those resources) to get counseling, legal assistance, shelter, court order for protection, etc. Do *not* transport families to shelters.
  7. If the abuser admits to the problem and wants help, assist with referrals to treatment programs for abusers (be aware of local treatment options).
  8. Consult with your supervisor.
  9. Continue to provide support, regardless of whether the abused parent stays, leaves, or returns to the home after leaving.
  10. Be aware that first time violence and exacerbation of frequency in already violent relationships are at higher risk during the prenatal period, as perpetrators try to gain control over any out-of-control situation.
  11. Remember that a parent experiencing intimate partner violence is at greatest risk of death when trying to leave – 75% of intimate partner homicides occur after the victim leaves the relationship, so do not pressure her/him to leave before that person feels ready. A PERSON EXPERIENCING INTIMATE PARTNER VIOLENCE LEAVES AN AVERAGE OF 7 TIMES BEFORE FINALLY ENDING A RELATIONSHIP.

- Routine activities that can be helpful:
  - Maintain a supportive, healthy relationship with the family

- Find a common interest to build and maintain the relationship (think of ways to make home visits fun)
- Use motivational interviewing and values clarification, when appropriate

- Resources:
  - Some curricula include content and ways to interact with families related to violence in the home
  - Online resources include:
    - www.mayoclinic.org
    - www.apa.org (search 'anger management' in each)
    - www.thehotline.org
    - http://www.ovw.usdoj.gov/domviolence.htm
      www.nlm.nih.gov/medlineplus/domesticviolence.html

- Add your site's local community resources for domestic violence here:

HELPING PARENTS CREATE A SAFETY PLAN

- Each agency should have a basic safety plan, which can be individually tailored.
- Always carry extra safety plans when going on home visits.
- The safety plan should include:
  - Numbers for:
    - Primary Care Physician
    - Counselor/Therapist/Psychologist/Psychiatrist
    - 3 friends or family members the person may contact in acute emergency
    - Number to the national and/or local suicide prevention hotline
  - A reminder of 9-1-1 and 2-1-1 (if available in state)
  - Strategies for care and protection of the children in an emergency
  - List of positive ways to cope
  - Self-care activities
  - Referrals (names, addresses, phone numbers) to a counselor and/or psychiatrist, if needed, along with other community resources that have been noted in earlier sections
  - Helplines with 24 hour support via telephone or internet.
  - Scheduled date for the next home visit.
  - A schedule of dates and times for phone check-ins by the home visitor

PARTICIPANT CRITICAL INCIDENT REPORT
Policy- GA-7A
TO BE COMPLETED BY PROGRAM MANAGER

Program/Site Name:Click or tap here to enter text.

Child Name: *Click or tap here to enter text .*D.O.B.*Click or tap here to enter text*. Sex: ☐ M ☐ F

Incident Occurrence Date:Click or tap to enter a date. Time: ☐ AM ☐ PM

Notified Contract Manager Date:Click or tap to enter a date.

PARTICPANT

Identification Number: Click or tap here to enter text.

Relationship to Child: Click or tap here to enter text.

Service Level: ☐ Level 1P ☐ Level 2P ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4
☐ Level CO ☐ Level TO ☐ Level TR

STAFF

Family Support Specialist Name: Click or tap here to enter text.

Supervisor Name: Click or tap here to enter text.

Type of Incident *(please check all that apply):*
☐ household members death ☐ critical injury ☐ serious abuse
☐ litigation pertaining to a particular participant ☐ participant threat against a staff member
☐ other *(which would include any information regarding a non-participant that would warrant a report)*

Description of the incident: Give a brief summary here and attach a detailed narrative if necessary. Specific information to include: Description of Incident- Include the following information, if applicable: Names of individuals involved in incident(1) Details leading up to the incident; (2) brief family history; (3) service history (number of visits, referrals made); (4) Criminal charges/report to Statewide Central Register, if any.
Click or tap here to enter text.

HFNY Critical Incident Report, Cont.

Describe Action Taken- Include the following information, if applicable: (1) Authorities notified, such as Child Abuse Hotline, police, Child Protective Services (2) name and location of hospital, as well as cause of death, diagnosis of illness or injury: (3) Notification of lead agency Director, OCFS Contract Manager, or any other pertinent parties; (4) Referrals/services provided to family and staff since the incident.

Click or tap here to enter text.

Initial Report by name: Click or tap here to enter text. Title:Click or tap here to enter text.

Report Date: Click or tap to enter a date. Time: ☐ AM ☐ PM ☐ Oral ☐ Written

Report to Name: Click or tap here to enter text. Title: Click or tap here to enter text.

Was this incident reported to the NY Statewide Central Register *(if applicable)*? ☐ No ☐ Yes

If yes, register call ID number: Click or tap here to enter text.

If no, please explain:Click or tap here to enter text.

FOR OCFS USE ONLY

Date initial notification received:Click or tap to enter a date.

VIA ☐ Email ☐ Voicemail ☐ Phone Call ☐ In-Person

By: Click or tap here to enter text. To: Click or tap here to enter text.

Date form received: Click or tap to enter a date. Initials: Click or tap to enter a date.

Litigation ☐ No ☐ Yes Media Coverage: ☐ State ☐ Local ☐ National ☐ N/A

HFA Notification Date: Click or tap to enter a date.

Updates since initial report:

Program Critical Incident Report
Incidents involving a Healthy Families NY Program
Policy- GA-7A
TO BE COMPLETED BY PROGRAM STAFF

Program/Site Name: Click or tap here to enter text.

Name of staff making the report: Click or tap here to enter text.

Role of the staff making the report: Click or tap here to enter text.

Incident Date: Click or tap to enter a date. Time: ☐ AM ☐PM

Notified Contract Manager Date: Click or tap to enter a date.

Type of Incident *(please check all that apply):*

☐ Natural disaster ☐ Serious injury to staff ☐ Threats against the program
☐ Media Involvement ☐ State ☐ Local ☐ National
☐ Litigation against program ☐ Misuse of funds ☐ Other

Description of the incident: Description of the incident should include- Name(s) of program staff involved ,what led up to the incident, what are the details regarding the incident including whether there is media attention, details regarding any litigation against the program, specifics regarding misuse of funds, what impact the incident has had on services to families, the nature of the natural disaster, if staff has been threatened action taken to protect the staff, (such as order of protection), if there was a serious injury to staff, the nature, cause, and extent.

HFNY Critical Incident Report, Cont.

Describe Action Taken-
Include the following information, if applicable:(1) Authorities notified, such Law Enforcement, Child Abuse Maltreatment Hotline (2) if injury to staff, extent of injury and treatment received (3) Notification of lead agency Director, OCFS Contract Manager, or any other pertinent parties; (4) Support provided to staff since the incident.

Initial Report by name: Click or tap here to enter text. Title: Click or tap here to enter text.

Report Date: Click or tap to enter a date. Time: ☐ AM ☐ PM ☐ Oral ☐ Written

Report to Name: Click or tap here to enter text. Title: Click or tap here to enter text.

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Date initial notification received:Click or tap to enter a date.

VIA ☐ Email ☐ Voicemail ☐ Phone Call ☐ In-Person

By: Click or tap here to enter text.To: Click or tap here to enter text.

Date form received:Click or tap to enter a date. Initials: Click or tap here to enter text.

Litigation: ☐ No ☐ Yes Media Coverage: ☐ State ☐ Local ☐ National ☐ N/A

Was HFA notified? ☐ No ☐Yes Date: Click or tap to enter a date.

Updates since initial report: