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HFA BEST PRACTICE STANDARDS

Effective January 1, 2018- December 31, 2021

QUALITY ASSURANCE AND ACCREDITATION

HFA Best Practice Standards
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1. Initiate services prenatally or at birth
1-1.A Target Population
1-1.B Referring Organizations
1-1.C Measuring Screens/Referrals
1-2.A Screening Process (policy)
1-2.B Screening Process (practice)
1-2.C Eligibility Timeframe
1-2.D Monitor and Address Not Offered
1-2.E Monitor and Address Declines
1-3.A First Home Visit within 3 months (policy)
1-3.B First Home Visit within 3 months (practice)
1-4.A Measure Acceptance Rate
1-4.B Acceptance Analysis
1-4.C Plan to Increase Acceptance

2. Standardized Assessment Tool
2-1.A Eligibility (policy)
2-1.B Eligibility (practice)
2-2.A Parent Survey Assessment (policy)
2-2.B Parent Survey Uniformity (practice)
2-2.C Parent Survey timeframes (practice)
2-2.D Parent Survey Supervision (practice)

3. Offer services voluntarily
3-1.A Voluntary Services (policy)
3-1.B Voluntary Services (practice)
3-2.A Trust Building/Initial Engagement (policy)
3-2.B Trust Building/Initial Engagement (practice)
3-3.A Creative Outreach (policy)
3-3.B Creative Outreach (practice)
3-4.A Measure Retention
3-4.B Retention Analysis
3-4.C Plan to Increase Retention

4. Offer services intensely
4-1.A Weekly Visits Six Months (policy)
4-1.B Weekly Visits (practice)
4-2.A Levels of Service (policy)
4-2.B Home visit completion (practice) Sentinel Standard
4-2.C Increase Home Visit Completion
4-2.D Level Changes in Supervision (practice)
4-2.E Level Changes with Families (practice)
4-3.A Services for a minimum of 3 years (policy)
4-3.B Services for a minimum of 3 years (practice) Sentinel Standard
4-4.A Transition planning (policy)
4-4.B Transition Planning (practice)

5. Services take into account family culture
5-1. Service population
5-2.A Appropriate staff, materials & partnerships
5-2.B Cultural Characteristics considered in staff/family interactions
5-3 Training on unique characteristics of service population
5-4.A Staff and Family Input Obtained
5-4.B Cultural Analysis and Plan
5-4.C Cultural Analysis and Plan Discussed with Advisory

6. Promote PCI, Childhood Growth & Dev
6-1.A. HFA Service Plan (policy)
6-1.B HFA Service Plan in Supervision (practice)
6-1.C HFA Service Plan with Families (practice)
6-2.A. Development of Family Goals (policy)
6-2.B. Family Goal Development (practice)
6-2.C. Family Goals in Supervision (practice)
6-3.A. PCI CHEERS (policy)
6-3.B CHEERS Used to Assess PCI (practice) Sentinel Standard
6-3.C PCI Addressed and Promoted (practice) Sentinel Standard
6-3.D Validated PCI Tool Annually (practice)
6-3.E SUP support staff in assessing, addressing, promoting PCI (practice) Sentinel Standard
6-4.A. Child Dev, Parenting, Health & Safety (policy)
6-4.B Child Dev, Parenting (practice)
6-4.C. Health & Safety (practice)
6-5.A ASQ-3 and ASQ:SE-2 (policy)
6-5.B ASQ-3 (practice) Sentinel Standard
6-5.C ASQ:SE (practice)
6-5.D Staff Trained on ASQ-3 prior to use
6-5.E Staff Trained on ASQ:SE-2 prior to use
6-6.A Tracks and refers for developmental delay (policy)
6-6.B Tracks and refers for developmental delay (practice) Sentinel Standard

7. Health Care and Community Resources
7-1.A Medical/Health Providers for Target Children (policy)
7-1.B Medical/Health Provider (practice)

7-2.A Timely Receipt of Immunizations (policy)
7-2.B Immunization Rates Measured for children 12-23 mo. (practice)
7-2.C Immunization Rates Measured for children 24+ mo. (practice)
7-3.A Health and Community Resource Info, Referrals & Follow-up (policy)
7-3.B Health Care Info, Referrals & Linkage (practice)
7-3.C Community Resource Info and Referral (practice)
7-3.D Follow-up on Receipt of Referrals (practice)
7-4.A Depression Screening (policy)
7-4.B Prenatal Depression Screening Sentinel Standard (practice)
7-4.C Postnatal Depression Screening Sentinel Standard (practice)
7-4.D Screening for Depression w/Subsequent Births
7-4.E Referral & F/U for Elevated Risk, based on tool criteria
7-4.F Staff & Sup Trained on Depression Tool Prior to Use

8. Limited caseload Sizes
8-1.A Policy for Caseload Size (most intense service level)
8-1.B Monitoring Caseloads (practice)
8-2.A Managing Caseloads (policy)
8-2.B Managing Caseloads (practice)

9. Service Providers Selection
9-1.A Screening & Selection of New Staff (policy)
9-1.B Screening & Selection of Program Managers
9-1.C Screening & Selection of Supervisors
9-1.D Screening & Selection of Direct Service Staff
9-2 Equal Opportunity Employment
9-3.A Recruitment and Selection practices
9.3.B Legally Permissible Background Checks Safety Standard
9-4 Report on staff retention and satisfaction

10. Intensive Role Specific Training
10-1. Training Plan/Policy
10-2.A-G Orientation Training
10-2.D - CAN Orientation Prior to Work w/ Family) Safety Standard
10-3.A Stop-Gap Training (policy)
10-3.B-D Stop-gap Provided (practice)
10-4.A HFA Core Assessment Training Sentinel Standard
10-4.B HFA Core Home Visitor Training Sentinel Standard
10-4.C HFA Core Supervisor Training Sentinel Standard
10-5. HFA Implementation Training

11. Training to fulfill job functions
11-1.A-C Three Month Wraparound Training
11-2.A-F Six Month Wraparound Training
11-3.A-F Twelve Month Wraparound Training
11-4:A-B: Ongoing Training

12. Ongoing, Effective Supervision
12-1.A Supervision Frequency & Duration (policy)
12-1.B Supervision Frequency and Duration (practice) Safety Standard
12-1.C Group Reflective Consultation
12-1.D Ratio of Supervisors to Staff
12-2.A Administrative, Clinical & Reflective Supervision and Professional Support (policy)
12-2.B Reflective, Clinical & Administrative supervision provided (practice) Sentinel Standard
12-2.C Professional Support Provided (practice)
12-3.A Supervisor Supervision (policy)
12-3.B Supervision of Supervisor (practice)
12-4.A Program Manager Support, Accountability (policy)
12-4.B Program Manager Support, Accountability (practice)

GA - Governance and Administration
GA-1.A Organization and Function of Advisory Group
GA-1.B Advisory with Wide Range of Skills & Knowledge
GA-1.C Program Manager & Advisory Group Work as Team
GA-2.A Formalized Input from Families (policy)

GA-2.B Formalized Input from Families (practice)
GA-3.A Review of Progress Site Goals & Benchmarks (practice)
GA-3.B Quality Assurance Plan
GA-4.A Research Proposals (policy)
GA-4.B Research Proposals (practice)
GA-4.C Site ensures privacy and voluntary choice for families' w/research (practice)
GA-5.A Family Rights & Confidentiality, & Grievance (policy)
GA-5.B Family Rights & Confidentiality & Grievance Sentinel Standard
GA-5.C Informed & Signed Consent Sentinel Standard
GA-6.A Policy for criteria to identify C.A. & N. Safety Standard (policy)
GA-6.B Implement Child Abuse Reporting Safety Standard (practice)
GA-7.A Participant Death & Grief Counseling (policy)
GA-7.B Implement support when participant death (practice)
GA-8 Policy & Procedure Manual
GA-9.A HFAST Data Up-to-Date National Office Requirement
GA-9.B Site Up-to-Date with Fees National Office Requirement
GA-9.C Site uses HFA name, logo and brand National Office Requirement

INTRODUCTION AND GLOSSARY

HFA BEST PRACTICE STANDARDS:

A **best practice** is a method or technique that sets the standard by consistently resulting in outcomes superior to those achieved by other means. Serving as an alternative to mandatory legislated standards, best practices are used to formulate self-assessments and benchmarks as a mechanism to maintain quality. [1] Best practices define a standard way of operating across multiple organizations. Not intended to be stagnant and immovable, best practices can and do evolve to become better as improvements are discovered.

The ***HFA Best Practice Standards (BPS)*** describe expectations for fidelity to the Healthy Families America model. Herein referred to as the *Standards*, they are structured around the twelve research-based critical elements upon which the Healthy Families America (HFA) model is based. The critical elements serve as the overarching 'big ideas' defining the Healthy Families America model. The *Standards* also have a section on Governance and Administration which articulates expectations for effective site management.

The policies, procedures and practices within each critical element are defined specifically so that HFA sites have clear direction on how to implement the HFA model. The expectation is not that sites would implement these policies, procedures, and practices to perfection, but that sites engage in a process of continuous quality improvement to strive for these benchmarks and goals. In order to ensure that all families being served through the HFA model receive high quality services, all HFA sites regularly submit themselves to HFA's Accreditation process, which evaluates the site's current degree of implementation.

On the next page in the section, *Quality Assurance and Accreditation,* details are provided about how HFA model implementation is monitored.

[1] *Bogan, C.E. and English, M.J. (1994). Benchmarking for Best Practices: Winning Through Innovative Adaptation. New York: McGraw-Hill.*

ADAPTATIONS TO THE HFA BEST PRACTICE STANDARDS:

The HFA National Office views an adaptation as an actual adjustment or modification to the specific best practices related to the critical elements. In rare situations, a site or system may be compelled to seek an adaptation to the model. In these situations, the site/system must complete and submit to the HFA National Office an Adaptation Request Form. Permission to implement any proposed adaptation is at the sole discretion of the HFA National Office. The HFA National Office will approve or deny the adaptation request and will provide its decision in writing. Whether the adaptation will be considered in adherence to HFA standards is also at the sole discretion of the HFA National Office. Sites should be aware that requests pertaining to any 1st order standard, safety standard or sentinel standard will not be approved.

Adaptations, which seek to change some aspect of the model, are not to be confused with Enhancements, which supplement the model. For example, sites that use Doulas in addition to Family Support Specialists during the prenatal and newborn period, or sites that augment services with clinical staff to provide therapy for mental health or substance use issues. Enhancements are encouraged and do not require permission from the model to implement.

QUALITY ASSURANCE AND ACCREDITATION:

Sites implementing HFA commit to provide high quality home visiting services and demonstrate model fidelity through ongoing quality assurance (QA) and periodic Accreditation site visits. The *Standards* serve as the site's guide to model implementation and are used to evaluate the site's status toward achieving model fidelity. Coupled with each standard are rating indicators used to determine the site's current degree of implementation. The rating indicators are used to determine if the site is exceeding, meeting, or not yet meeting the expectation of the standard. Each rating indicator is represented by a numerical system (3-exceeds, 2-meets, 1-does not yet meet).

Read more about the *Structure of the HFA Best Practice Standards* (next section) in order to understand how they are rated.

The Accreditation process is divided into three steps. Each of these steps allows the site to modify or tailor its current policies, procedures, or practices. While the Accreditation process is required every four years (five years for HFA multi-site systems), sites are encouraged to embrace a philosophy of continuous quality improvement by making the *Standards* a part of every day practices and ongoing quality assurance (e.g., referencing standards and intents in team meetings, supervision, training, etc.).

Step 1 - The Self-Study

The initial step in the Accreditation process is the development of the site's self-study. The self-study is the site's first opportunity to demonstrate implementation of the *Standards* and serves as both a process and ultimately a prepared document compiled by the site to reflect its policies, procedures and practices. **The first page of each site's self-study is a completed face sheet, which is required** to serve as the cover page of the self-study. Site staff engage in a process of internal review as they pull together the information necessary to illustrate implementation of the *Standards*. This self-study process is one of continuous quality improvement whereby growth and positive change is achieved through an intense examination of each site's policies, procedures and practices. The process also acknowledges and reinforces the standards that a site is already implementing to fidelity.

Step 2 - The Site Visit

The second step in the Accreditation process is the peer review site visit. The self-study document is used in conjunction with the peer review site visit to determine the site's current rating for all the *Standards*. Peer Review teams review the site's self-study to familiarize themselves with the site's processes during the weeks leading up to the site visit and identify areas requiring further clarification. Onsite, the peer team completes a review of family files and other documentation (e.g., personnel records, meeting minutes, supervision documentation, training logs, etc.) and conducts detailed interviews with site staff, families and advisory board members. Once compiled, the peer team utilizes its findings to determine the rating of each standard. As described above, a rating of 1, 2 or 3 is assigned to each standard and when a 1 rating is assigned to a standard, peer teams are required to provide detailed information to indicate the basis for the rating and to guide the site on what areas need to be strengthened. The peer team's rating for each of the standards is provided in the Accreditation Site Visit Report (SVR).

Step 3 - Response Period

The final step in the Accreditation process requires sites to address the standards rated out of adherence (1 rating) as outlined in the SVR when the site does not yet meet the threshold to be awarded accredited status. Sites submit detailed narratives along with documentation of implementation to the HFA National Office and to the HFA Accreditation Panel (the Panel). Upon review of the materials, it is determined whether the site has shown sufficient improvement and now meets the threshold for accreditation. The minimum threshold requires 100% of 1st order standards rated as a 2 or a 3, 100% of safety standards rated as a 2 or a 3, plus at least 85% of all remaining 3rd order and unsupported 2nd order standards (standards with Rating Indicators) rated as a 2 or a 3.

THE STRUCTURE OF THE HFA BEST PRACTICE STANDARDS:

The Standards:

The *HFA Best Practice Standards* contain a series of inter-related standards. A standard establishes the expectation for policy or practice that has been determined either through research or consensus from the field, as a demonstration of excellence. The *Standards* are broadly organized by the first order standards (the critical elements) and a section on governance and administration. The first order standard (e.g., Standard 1, Standard 2, Standard 3, etc.) states the overall purpose or aim of the practice within each section. Each first order standard is supported by a series of second order standards (e.g. within Standard 1 are second order standards 1-1, 1-2, 1-3 and 1-4). While the second order standards provide more detail and specificity than the first order standards, their main purpose is to provide further context to guide implementation. Some second order standards are unsupported or stand-alone, meaning they are not broken down any further into third order standards. These include 5-1, 5-3, 9-2, 9-4, 10-1, 10-5 and GA-8. However, most second order standards are further broken down into a series of third order standards (e.g., within second order 1-1, are third order standards 1-1.A, 1-1.B, and 1-1.C). The third order standards and the stand-alone second order standards allow for the formation of strong programmatic practice and are the most specific standards with which the site needs to show documentation of implementation.

Found with each third order standard and stand-alone second order standard are rating indicators used to determine the site's current degree of implementation. The rating indicators are used to determine if the site is exceeding, meeting, or not yet meeting the expectation of the standard. Each rating indicator is represented by a numerical system (3-exceeds, 2-meets, 1-does not yet meet). Read more about rating indicators below.

Rating Indicators:

Rating indicators are provided for every third order and stand-alone second order standard in the *Standards*. They were developed to help sites measure their own level of quality and model fidelity, and to ensure consistency of ratings from peer team to peer team. These rating indicators provide further interpretation of the standard. They also provide assurance to a site that standards are measured objectively, and help to identify areas in need of further improvement. The rating indicators are used, in combination with the standard and intent, as part of the criteria with which to evaluate site performance. The rating indicators have been designed using a three point system. Each rating indicator is represented by a numerical system (3-exceeds, 2-meets, 1-does not yet meet).

All rating indicators are found in grey boxes.

Standards that are specific to policy expectations are rated as a 2 or 1 rating only, owing to the fact that policy is either in adherence or not. However, there are a few exceptions to this rule. For standard 8-1.A regarding a site's policy on caseload size, sites will be acknowledged with a 3 rating if caseload sizes are required to be smaller than the maximum stated in the 2 rating indicator for this standard. This also applies to supervision policy standards 12-1.A and 12-3.A, where sites can receive a 3 rating if they have established policy that meet the added expectation about supervision duration for direct service staff (12-1.A) and availability of reflective supervision for supervisors (12-3.A).

It is also important to note that while most practice related standards will hold the site accountable to the standard, there are some standards that will hold the site to their policy, even if the site's policy expectation is more rigorous than the standard. It is useful for sites to keep this in mind when establishing policy for standards 2-1.B, 2-2.B, 2-2.C, GA-4.B and GA-5B.

1st Order Intent:

The 12 Critical Elements and Governance and Administration (GA) are represented in the first order standards 1-12 and GA and are found at the beginning of each section. Immediately following each of the 1st order standards is the overall intent of the critical element. The intent provides the context or foundation

for the critical element. The HFA Literature Review found in the Site Development Guide can also be utilized to provide greater understanding of the critical elements.

2nd Order and 3rd Order Standards Intent:
Intent has also been added to many of the 2nd and 3rd order standards to further clarify what is expected, or the purpose of the standards, as it relates to best practices. The intent focuses on providing more detail on the "why" behind the standards.

All intents are written in italicized purple font.

Tips:
The tips were designed to help sites with implementation of standards. The tips are not required, but typically focus on ideas related to how a site might choose to document or implement the standard.

☺ Tip: You can find tips in blue font, directly under the rating indicator.

Safety Standards:
These are standards that **must be met** in order to be accredited as they impact the safety of the families being served and the staff serving them. Safety standards include personnel background checks (9-3.B), orienting staff on child abuse and neglect indicators, role as a mandated reporter, and reporting requirements (10-2.D), supervision of direct service staff (12-1.B), and child abuse and neglect policy and procedures that include reporting criteria, definitions and practice (GA-6.A, GA-6.B). Each of these standards is identified as a safety standard in its respective rating indicator box.

Sentinel Standards:
Sentinel Standards are standards determined to be especially significant in the review of HFA site quality. These standards include key site functions in the areas of home visit completion and length of service (4-2.B, 4-3.B), parent-child interaction (6-3.B, 6-3.C, and 6-3.E), developmental screenings (6-5.B, 6-6.B), depression screening (7-4.B, 7-4.C), core training (10-4.A, 10-4.B, 10-4.C), supervision (12-2.B), notifying families of their rights, of confidentiality practices, and obtaining informed consent when family information is to be shared with others (GA-5.B, GA-5.C). While adherence to each of these standards is not required in order to receive HFA accreditation, a site with any of these standards rated out of adherence will be required to prepare and submit an improvement plan that clearly indicates the site's efforts to bring the standard into compliance, coupled with documentation of implementation.

Note: Safety and Sentinel Standards will be indicated in BOLD font at the bottom of the rating indicator box.

National Office Requirements:
In order to be accredited, sites must also demonstrate that they are in good standing and upholding responsibilities as an HFA affiliate pursuant to the HFA Affiliation and Licensing agreement. These are described in GA-9.A, B, and C and include providing HFA required data (e.g., maintaining up-to-date information in HFAST), having HFA fees paid and up-to-date, and using the HFA logo, name and graphics appropriately.

Tables of Documentation:
At the end of each Critical Element and the Governance and Administration section is a Table of Documentation. This table is intended for sites preparing for accreditation as it indicates the policy, procedures, and other documentation needed to demonstrate adherence to each standard. Details are provided about how a site should prepare this information, whether it needs to be included in the self-study (which is sent to the peer reviewers 6 weeks prior to the site visit) or if it is part of what peers will review in files and/or during interviews on site. Sites should utilize the Tables of Documentation as a checklist when

preparing their self-study, and when preparing materials that will be made available to the peer team when they arrive for the site visit.

USE OF HFA ANALYSIS TOOLS AND HFA SPREADSHEETS:

For certain standards (1-1.C, 1-2.C-E, 1-3.B, 1-4.A-C, 3-4.A-C, 4-1.B, 4-2.B, 6-3.D, 6-5.B, 6-5.C, 7-2.B, 7-4.B, 7-4.C,12-1.B, and all required training in standards 10 and 11) forms and spreadsheets have been created to support sites in measuring data consistent with HFA expectations and presenting documentation in a concise and manageable format. These forms should be used if the site does not have a current data system to present the information, or if the data system does not provide reports on any of these standards. If sites provide their own tracking reports they should ensure they include the same fields of information outlined in the HFA tools.

All tracking forms can be found here.

When using the HFA spreadsheets be sure to look carefully at all worksheets contained within (tabs at the bottom of each spreadsheet). This includes reading the tabbed worksheet that gives instructions on the correct use of the spreadsheet. Also, use all tabs on the analyses spreadsheets (1-4 and 3-4) so that in addition to entering data you analyze/interpret your data narratively in the space provided and formulate a plan for improvement. And be sure all data is compiled for the entire required time period. If the site works across multiple counties or with multiple partner agencies in the delivery of HFA services, the data from all counties or all partner agencies must be combined and reported collectively as one site.

GLOSSARY OF COMMON TERMS USED THROUGHOUT THE HFA BEST PRACTICE STANDARDS:

ADVISORY GROUP:
An organized voluntary group with responsibilities to advise on the planning, implementation and evaluation of the HFA site operations. The functions and responsibilities of this group may include making recommendations to the HFA site and the organization's governing group (if different from the advisory group) regarding site policy, operations, finances, community needs, etc. Advisory group members are a diverse group of individuals who represent the interests of the community as guided by the critical elements.
Note: This term is primarily used in 5-4.C and GA-1.

ASSESSMENT TOOL:
HFA requires the use of the Parent-Survey as the initial assessment tool used for eligibility or service planning. The Parent Survey is administered in a standardized manner by staff trained in the use of the tool. The initial assessment process is designed to more thoroughly explore family strengths and needs. The initial assessment is done conversationally, face-to-face and is completed in the home during the prenatal-newborn period or in the hospital (when conducted at birth). The Parent Survey is often used to determine service eligibility, except for when the site has determined a comprehensive screening tool will be the basis for determining eligibility instead. Regardless if used to determine eligibility or not, the Parent Survey is completed at the onset of services to support the development of individualized service plans.
A site seeking permission to use an alternate assessment tool instead of the Parent Survey must contact their HFA Implementation Specialist to obtain the necessary request form and process for submitting all assessment tool materials including instrument validity, training procedures for staff, etc. Approvals are at the sole discretion of the National Office and the Accreditation Panel, and if approved, must be renewed by the site or by the central administration (for multi-site systems) with each update to the HFA Best Practice Standards.

CASELOAD:
The total number of families assigned to a direct service staff person, and not to exceed the maximum case weight of 30 points (see Standard 8-1.A).

CENTRALIZED/COORDINATED INTAKE SYSTEMS: Sites can choose to use a centralized intake system for referrals into their program. This system needs to have a solid understanding of the site's target population so the site receives referrals from the intake system that meet the criteria for the program.
Note: This term is used in Standard 1.

CHALLENGING ISSUES:
Standard 6-1 uses terminology of challenging issues which in this case refers to parent behaviors or life circumstances which can place children at especially high risk. These include parental substance use, mental illness, cognitive disability, and intimate partner violence. Support from a supervisor, use of reflective consultation groups (where available) and additional training are critical, as are procedures for worker safety and addressing family safety concerns. The procedures outlined in this HFA Procedures for Working with Families in Acute Crisis can be a useful resource. The focus of this manual is to provide general guidelines to enhance understanding and awareness of supporting families who may be experiencing challenging issues and identifying safety practices for Family Support Specialists.

Safety considerations may vary from location to location as well as from situation to situation. For example, safety issues in rural areas may differ somewhat from safety issues in urban areas. Because each community is unique, the safety issues encountered in that community may also be unique. With regard to safety issues, there are other factors, in addition to context, that may need to be considered. Those factors include agency policies and procedures as well as current state laws.

Safety guidelines often need to be adapted or expanded to address the specific concerns of each location or situation. Supervision sessions provide an appropriate venue for discussion of specific safety concerns and fine-tuning of safety procedures. The supervisor should be available and immediately informed if the Family Support Specialist fears for his/her safety. The safety of the Family Support Specialist is of utmost importance.
Note: This term is used in 6-1.

CHEERS:
An acronym to support Family Support Specialists in understanding and observing the different dimensions of parent-child interaction that ultimately result in attachment over time. The elements of the acronym include Cues, Holding, Expression, Empathy, Rhythmicity/Reciprocity, and Smiles. These observations are expected to be made during each home visit as specified in the standard and intent. Training on CHEERS is also a significant part of HFA Core – *Integrated Strategies* - training.
CHEERS webinar and related resources may be helpful. Note: This term is used in 6-3.

CHEERS Check-In: The CHEERS Check-In is a validated measurement tool developed by HFA and used to assess parent-child interaction at least annually and up to quarterly. Web-based training (required) and support on the use of this tool is provided by HFA. Download CHEERS Check-In Training Package.
Note: This term is used in 6-3.

CONTEXTUAL DECISION-MAKING: On a site visit the peer reviewers may see mixed information pertaining to a standard (e.g. all families with an elevated depression screen were referred to services except for 1 or 2 families). In situations like this where there may be extenuating circumstances, peer reviewers are trained to use contextual decision making to rate a standard, which means they must ensure the site is operating from best practice. For example, if in the example above, the one or two elevated depression screens without referral were because the primary caregiver was already receiving mental health treatment services, the site could be rated in adherence even though not all families with an elevated screen received a referral. Or, in another example, if the site had a new staff signed up for Core training, however she missed it because she was out unexpectedly for 3 months on FMLA, but as soon as she returned from FMLA she went to Core, the site was operating from best practice so therefore this would be taken in to account to rate the standard in adherence vs out of adherence. This means sites should document the reasons for variances when they arise.

CRITERIA:
Rules upon which judgment or decisions are based.

CULTURAL ANALYSIS AND PLAN:
A process the site undertakes to examine critically and deliberately its current ability to provide culturally sensitive services. The Cultural Analysis and Plan (CAP), as a final product, is a written document that summarizes the strengths and needs for improvement in all areas of the service delivery system (initial engagement, home visiting, supervision and management), and integrates feedback received from parents and staff. The CAP includes recommendations/suggestions for how the site might advance its current level of cultural humility. Sites are encouraged to reference the Cultural Humility Workbook as a resource tool when compiling a CAP.
Note: This term is used primarily in Standard 5-4.

CULTURAL CHARACTERISTICS:
Distinguishing features and attributes such as the ethnic heritage, race, age, customs, values, language, gender, religion, sexual orientation, social class, and geographic origin among others, that combine to create a unique cultural identity for families, based on both experience and history.
Note: This term is used primarily in Standard 5.

CULTURAL HUMILITY:
A site's ability to be aware of and respectful to the diversity of each family it serves and its ability to integrate this awareness into practice. It is the degree to which the site continually modifies or tailors its system of service delivery to the cultural characteristics in its service population including personnel/staff selection, training and all components of the service delivery system (initial engagement, home visiting, supervision and management). In striving to find the richness of culture, both our own and that of the families we serve, we are able to learn more about ourselves, our families and the context of their life circumstances.
Note: This term is used primarily in Standard 5.

DEPRESSION SCREENING TOOL:
HFA requires that sites select a screening tool to screen the primary caregiver in each family for depression at least once prenatally and once within three months of birth or 3 months of enrollment (when enrolled after birth), and at least once within 3 months of all subsequent births. While HFA does not specify a particular tool, the tools most commonly used by sites are the Edinburgh (EPDS) and the PHQ-9. The PHQ-2 may be used as a pre-screening followed by the PHQ-9 when indicated. The CES-D and Beck are also used by some sites, though much less frequently. Tools like the EPDS have been used with both moms and dads.
Note: This term is used in 7-4.

ELIGIBILITY FOR SERVICES:
The process utilized to determine potential families who may be most in need of, or could benefit from intensive home visiting services. This occurs through an objective screening or assessment process with well-defined criteria.

1. One-step Eligibility: The site screens families based on established demographic or other risk factors to determine eligibility.
2. Two-step Eligibility: The site uses a screening tool and if the screen is positive this is followed by the Parent Survey assessment tool to determine eligibility.
3. Universal: Services: All pregnant families or families with newborns residing in the service area are eligible for services.

Note: This term is used in Standard 1.

ENGAGED FAMILIES:

Families, including caregivers (e.g., mother, father, significant other, grandparents, etc.) actively participate and are consistently available for the majority of home visiting services offered. Some engaged families may become disengaged from time to time during the course of services, at which time sites will extend creative outreach activities in an effort to re-engage the family.

ENROLLED FAMILIES:
Families who have accepted services and are considered to be participants in services. Enrolled families may or may not be engaged in services.

EVIDENCE-INFORMED PARENTING CURRICULA:
The site's primary parenting curricula must be evidence-informed, meaning that the information contained within it is based on scientific knowledge or research. Strategies employed, or goals of a curriculum, may also be grounded in scientific research (e.g. - strive to strengthen the parent-child relationship which research has shown to be a key factor in healthy development). The reason there is a focus on the use of evidence-informed materials is to ensure that families are receiving well-founded, factual, relevant and credible information versus materials that are opinion-based or outdated and no longer accurate.
Note: This term is used in 6-4.

FAMILY-CENTERED:
Services that are designed to be flexible, accessible, developmentally appropriate, strength-based, and responsive to family-identified needs.

FAMILY OUTCOME INDICATORS:
Family Outcome Indicators (FOIs) are required to be reported by all HFA sites to the HFA National Office. The FOIs correlate with existing HFA standards and MIECHV performance measures. By having sites report on these, the HFA National Office is able to speak with a stronger and more accurate voice about the impact the model is having on maternal and child health, child development, child safety, parent-child relationships, family self-sufficiency and other key variables.

FAMILY RESOURCE SPECIALIST (FRS):
HFA assessment workers are referred to in HFA training materials, the BPS and other HFA produced documents as Family Resource Specialists. This title conveys to families the purpose of the role in a way that families can relate to and that HFA staff most prefer. Sites are welcome use this title or to continue titling this role in a way that best fits within their organization.

FAMILY SUPPORT SPECIALIST (FSS):
HFA home visitors are referred to in HFA training materials, the BPS and other HFA produced documents as Family Support Specialists. This title conveys to families the purpose of the role in a way that families can relate to and that market-based research has demonstrated to resonate better with parents than home visitor. Sites are welcome use this title or to continue titling this role in a way that best fits within their organization.

FIRST HOME VISIT:
The first visit completed by the assigned Family Support Specialist after eligibility has been determined, where rights and confidentiality forms are signed (unless already signed), where CHEERS is observed, and at least one focus area (see glossary for home visit definition) occurs. The visit is documented on a home visit record.
Note: This term is used primarily in: Standard 1, 2-2, Standard 3, and GA-5.

FULL TIME EQUIVALENCY (FTE): The site determines what every staff's FTE is so they can establish what size caseload the Family Support Specialist is able to carry. Each full time Family Support Specialist can carry a caseload no larger than 30 case weight points (determined using HFA's Level system). This caseload expectation needs to be adjusted if the Family Support Specialist is less than 1 FTE. For example

sites will prorate a .5 FTE (1/2 time employee) so that their caseload does not exceed 7-8 families so that staff have an adequate amount of time to work with that family.
Note: This term is used primarily in Standard 8-1.

GRADUATE:
A Healthy Families participant who has completed the program in its entirety (3 or 5 years as defined by the site).

GRIEVANCE: HFA requires that all families be informed about how to file a grievance or a complaint. The site also needs to have a policy that describes how the family will be notified what to do when they have a complaint. The site needs to have steps to follow if they receive a grievance, and the follow up mechanisms to address the areas identified in the complaint. The family files need to have documentation that the grievance policy was reviewed with the family and a copy should be provided to the family.
Note: This term is used in GA-5.

HANDS-ON PRACTICE:
Actual utilization of a tool during training or orientation to a new role, which may include role play, videotaping assessments or portions of home visits, or scoring a videotaped or shadowed assessment.

HFA ACCELERATED:
An option for HFA service delivery available only to sites that enroll families at low risk (based on a comprehensive psychosocial assessment). This means the Parent Survey score must be 20 or less for each parent that has been scored (i.e. if only the mother is scored, she must be with a score of 20 or less, and if both parents are scored both must be at 20 or less). Families remaining at low-risk may move to level 2 in less than six months once level change criteria have been met, and the family may also complete services in less than three years, when criteria for successful completion of program (see HFA Level Change forms) have been met.

HFA CORE ASSESSMENT TRAINING (PSCO):
In-depth, formalized training which outlines the specific duties of the Family Resource Specialist role within Healthy Families and covers topics including, but not limited to: the role of family assessment, identifying overburdened families, interviewing skills, conducting risk assessments, completing necessary paperwork and documentation, family-centered support services, communication skills, etc. The trainer is certified by the HFA National Office and has been trained to train others.
Note: This term is used in 10-3

HFA FOUNDATIONS for FAMILY SUPPORT CORE TRAINING (formerly ISHV):
In-depth, formalized training which outlines the specific duties of the Family Support Specialist's role within Healthy Families and covers topics including, but not limited to: establishing and maintaining trust with families, completing necessary paperwork/documentation, the role of the Family Support Specialist, communication skills, and crisis intervention, etc. The trainer is certified by the HFA National Office and has been trained to train others.
Note: This term is used in 10-3

HFA CORE SUPERVISOR TRAINING:
In-depth, formalized training which outlines the specific duties of the supervisor's role within Healthy Families and covers topics including, but not limited to: the role of Family Resource Specialists and Family Support Specialists, administrative, clinical and reflective supervision, supervision session structure and content for all staff, reflective strategies for supervisors, and sample tools and forms to use for continuous quality improvement, etc. The trainer is certified by the HFA National Office and has been trained to train others.
Note: This term is used in 10-3

HFA IMPLEMENTATION TRAINING:
The HFA National Office provides this intensive three day in-person training to site and state leaders. Commonly referred to as HFA Boot Camp, Implementation training provides managers with details on the policy and practice expectations associated with model implementation, including each of the HFA Best Practice Standards.
Note: This term is used in 10-5

HFAST: This is the acronym for Healthy Families America Site Tracker (HFAST). HFAST is an online information and data system that allows for real time updates. Sites are required to communicate changes (demographics, personnel, etc.) on HFAST so that it remains updated. All sites will also complete their annual survey on HFAST.
Note: This term is used in GA-9.

HOME VISIT:
A face-to-face interaction that occurs between the family and the Family Support Specialist. The goal of the home visit is to promote positive parent-child interaction, healthy childhood growth and development, and enhance family functioning. Typically, home visits occur in the home, last a minimum of an hour and the child is present. Extenuating circumstances may occur where visits take place outside the home, be of slightly shorter duration than an hour, or occur with the child not present. These may be counted as a home visit only if the overall goals of a home visit and some of the focus areas (listed below) have been addressed. Also, in very limited, special situations such as when severe weather, natural disaster or community safety advisory impedes the ability to conduct a home visit with a family, a virtual home visit, via phone (skype, FaceTime or other video technology preferred), can be counted when documented on a home visit record and the goals of a home visit are met including some of the focus areas (below). Sites are permitted to count one group meeting per month as a home visit while families are on Level 1 or 1P, however to do so requires that a Family Support Specialist be present during the group meeting and that the group meeting be documented on a home visit note, including some aspects of CHEERS for that particular family (when the group includes parent-child interaction time). The site may also count one visit per month conducted by a multi-disciplinary team member (if with documentation to demonstrate the staff person received HFA Foundations for Family Support core (formerly ISHV) training and receives supervision consistent with 12-1 and 1-2 standards The focus areas during home visits may include, but are not limited to:

Promotion of positive parent-child interaction/attachment:

- Development of healthy relationships with parent(s)
- Support of parental attachment to child(ren)
- Support of parent-child attachment
- Social-emotional relationship
- Support for parent role in promoting and guiding child development
- Parent-child play activities
- Support for parent-child goals, etc.

Promotion of healthy childhood growth & development:

- Child development milestones
- Child health & safety,
- Nutrition
- Parenting skills (discipline, weaning, etc.)
- Access to health care (well-child check-ups, immunizations)
- School readiness
- Linkage to appropriate early intervention services

Enhancement of family functioning:

- Trust-building and relationship development
- Strength-based strategies to support family well-being and improved self-sufficiency
- Identifying parental capacity and building on it
- Family goals
- Building protective factors
- Assessment tools
- Coping & problem-solving skills
- Stress management & self-care
- Home management & life skills
- Linkage to appropriate community resources (e.g., food stamps, employment, education)
- Access to health care
- Reduction of challenging issues (e.g., substance abuse, domestic violence)
- Reduction of social isolation
- Crisis management
- Advocacy

IMMUNIZATION SCHEDULE:
Immunization schedules follow different guidelines, depending upon the schedule adopted by the site/multi-site system. The American Academy of Pediatrics, the Centers for Disease Control, and most Departments of Public Health at the state level issue immunization schedules which spell out what immunizations a child should have and at what age. The CDC has an interactive immunization scheduler where child's name and birthdate can be entered and an individualized schedule created for printing. HFA expects its sites site to follow one of these generally accepted immunization schedules, but does not recommend one schedule over another. However, if the state's schedule is used and it is without specific age requirements for immunizations between birth and 24 months, then the site will want to use the AAP or CDC schedule in order to calculate up-to-date status at 12 and 24 months in accordance with standards 7-2.B and C. Additionally, sites should be aware that in some states the ability for families to withdraw from immunizations due to personal beliefs may only be allowable until the child reaches school age, at which time all immunizations are required. Site staff will want to make parents aware if this is the case. Note: This term is used in 7-2.

INFANT MENTAL HEALTH:
Developing the capacity of the child from birth to age three to experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn - all in the context of family, community and cultural expectations (*Zero to Three IMH Task Force*). Additionally, children must master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system (*World Assn. IMH*).
Note: This term is used in 6-2, 9-1 and 12-1.

LEVEL CHANGE FORMS:
HFA has developed and requires that sites utilize HFA Level Change forms. These forms provide the criteria for making decisions about a family's readiness to move to less frequent visits. The process allows the Family Support Specialist the opportunity to acknowledge family achievements throughout the course of services and to have a way to determine when a family has successfully completed services. While sites cannot subtract from the criteria outlined on the HFA Level Change forms, they may be permitted to add criteria. A site wishing to do so will submit any proposed modification to the HFA National Office for approval. Please download HFA Level Change Forms and Documents.
Note: This term is used in 4-2.

MEDICAL/HEALTH CARE PROVIDER:

The primary individual, provider, medical group, public or private health agency, or culturally recognized medical professional where participants can go to receive a full array of health and medical services.
Note: This term is used in 7-1.

MONITORS & ADDRESSES:
Monitors: to keep track of through the ongoing collection of available information. The extent of the information collected for tracking/monitoring purposes will vary and is a less rigorous process than compiling data for an analysis. In some situations, available data will be minimal, such as when tracking missed screens, in which case the site may not be able to determine much more than the total number missed and the referral source. In other situations, such as when monitoring families that assessed positive yet verbally declined further involvement, the site will have more data available that it can use to address issues and inform its decision-making.
Addresses: to attempt to resolve or improve that which is learned from the monitoring process through identification of issues that may be affecting the outcome, along with development of strategies that seek to improve the outcome.

MOTIVATIONAL INTERVIEWING (M.I.):
A collaborative, goal-oriented method of communication with particular attention to the language of change. It is intended to strengthen personal motivation for and commitment to a change goal by eliciting and exploring an individual's own arguments for change. --William Miller, Steve Rollnick, 2012
Example M.I. questions:
What would you like to see different about your current situation?
What has you thinking you need to change?
What will happen if you don't change?
If you make changes, how would your life be different from what it is today?
How would you like things to turn out for you in 2 years?
When staff have been trained in motivational interviewing techniques, it is important for supervisors to also be knowledgeable in order to support staff in their practice.
Note: This term is used in 6-1, 7-4, and 12-1.

ONGOING TRAINING:
Supportive and regularly scheduled training provided to staff based upon the specific needs, job responsibilities and issues of families within the community served.
Note: This term is used in 10-1 and 11-4.

PARENT:
When referenced in the HFA Best Practice Standards, parent is inclusive of biological mother and father, as well as parent figures who have a significant relationship with the target child.

PARENT GROUP MEETING:
HFA sites are encouraged to hold regular parent group meetings as a way to build informal support systems and reduce social isolation for participant families. For those families assigned to a weekly level of service, one HFA site hosted parent group meeting per month may be counted as a home visit, as long as it is documented on a home visit record (by someone who has received HFA Foundations for Family Support Core (formerly SHV training) and at least one goal of a home visit (see home visit definition) is met.
Note: This term is used in 4-2.B

P.I.M.S.:
HFA has a database called the Program Information Management System (PIMS). Particularly well-suited for smaller sites with limited resources, PIMS provides necessary reports that are aligned with the Best Practice Standards, and a way for sites to maintain staff and family data electronically.

PLANNING, IMPLEMENTATION, AND EVALUATION (ADVISORY GROUP ROLE):
Planning refers to the planning of events, additional referral sources, integration of services between agencies serving families, etc. Implementation applies to supporting any implementation challenges the site faces, such as striving for early enrollment, engaging fathers, etc. Evaluation relates to feedback from the group related to the analyses, cultural reviews, and other performance measures developed by the site.
Note: This term is used in GA-1.

POLICY:
Written statements of principles, procedures and processes that guide site operation and services which are typically approved by the governing body, the host agency, or appropriate administrative body. Policy and Procedure Checklist and Sample Policy and Procedure Template/Guide

PRIMARY CAREGIVER: HFA embraces a family centered approach and allows the family to define who the child's family is. The primary caregiver is the individual with whom the baby lives and receives primary care from. This individual is generally, though not always, a parent, and is the primary point of contact for the Family Support Specialist when conducting home visits and observing PCI. In co-parenting or multi-generational parenting families, one person will be identified within the system as the primary caregiver. Depression screens are only required to be administered with this person.
Note: This term is used in 7-4.

PROCEDURE:
The step-by-step methods by which policies are expected to be implemented and site operations are to be carried out. Procedures are clearly outlined in writing within the site's Policy and Procedure manual.

PROGRAM MANAGER:
Each site has a designated Program Manager (PM) that is responsible for the day-to-day, hands-on management of the site, and is involved in planning, budgeting, staffing, training, quality assurance and evaluation. PMs are also responsible for ongoing collaboration with community/state partners, public relations and for maintaining positive working relationships with early childhood partners and providers.

If a site has a supervisor, the PM typically provides supervision to that individual. The PM receives regular supervision according to the personnel policies of the employing agency and in accordance with the *Standards*. Depending on the size and resources of the site, program managers may also provide supervision to Family Support Specialists or Family Resource Specialists in a dual role as Supervisor (see Supervisor definition).

PROTECTIVE FACTORS:

- Parental resilience
- Social connections
- Concrete supports in times of need
- Knowledge of parenting and child development
- Nurturing & attachment (children's social and emotional competence)

Additional description of these protective factors can be found at the Center for the Study of Social Policy website. Staff are encouraged to also access free online Protective Factors training made available by the National Alliance of Children's Trust and Prevention Funds.

Note: This term is used in 6-1, 6-2, 8-1, and 12-2

QUALITY ASSURANCE PLAN:
A plan to monitor and track quality of all aspects of implementation that includes performance measures, screening process, family acceptance, family retention, satisfaction surveys, case file reviews, shadowing, quality assurance phone calls, supervision rates, etc.
A sample Quality Assurance Plan is available.
Note: This term is used in GA-3.B

RECENT PRACTICE:
The period of time required to demonstrate consistent practice across all staff of any new policy or procedural changes. Most often this period of time is a minimum of the three most recent consecutive months, though there may be certain circumstances when additional time is necessary to illustrate implementation.

RE-ENROLLMENT:
A family that enrolls in HFA services may later choose to discontinue services prior to program completion. This may be owing to any number of situations such as the family needing time to "warm" to idea of home visiting, especially when existing stresses and past history complicate how the parent views the helping profession. Or it may be related to a move out of the service area but then family later returns to the area. A parent who is closed to services may decide weeks or months later that they would like to re-enroll with the existing target child. When sites have capacity to do so, they are encouraged to accept re-enrollments, and should do so at the site's discretion. If a site re-enrolls a family, that family will not be counted in several of the measurement standards. A family that discontinues services but requests to re-enter the program with a subsequent target child is considered a new enrollment. A family that is enrolled and making progress toward successful completion of the program should not be re-enrolled with a subsequent birth. This space should be reserved for new families that have not had any opportunity to participate in services. Note: This term is used in 1-3.B

REFERRAL: HFA sites are encouraged to provide linkages for families to community resources on as a needed basis. HFA staff need to be knowledgeable of resources within their communities and help families connect to these resources. HFA requires a signed consent to release information on all referrals to external agencies when the staff member is sharing information about the family. Referrals to services that are housed within the same agency as the HFA site, do not require a signed consent, though this is recommended, as is documentation of these connections to additional services as referrals.

REFLECTIVE CAPACITY:

The readiness a particular individual may have for practicing in a reflective way. It may be worthwhile for hiring organizations to think about an applicant's reflective capacity during the recruitment and screening process. Reflective Capacity questions may be useful at this stage. Note: This term is used in 9-1 & 10-2.

REFLECTIVE CONSULTATION GROUPS:
Sessions generally last 2 or more hours and are conducted by an individual with advanced training or credential in the area of reflective practice and professional group facilitation. Reflective consultation groups include but are not limited to:

- Case presentation
- Focus on holding the space that encourages self-reflection and self-regulation, both physically and emotionally
- Observation of the staff member's internal responses to the work including parallels between what might be going on for the worker as well as how that might impact the work
- Focus on the parallel process; expanding what might be going on for the staff to what might the family and the baby might be experiencing
- Considering what the supervisor might do differently for the next supervision, developing a plan with the Family Support Specialist for work going forward
- Opportunities for participants in the group to reflect on the group session they just observed.

Note: This term is used in 12-1 and 12-3

REFLECTIVE PRACTICE:
A safe place (where trust is established) for a regularly scheduled supervision session to collaboratively examine thoughts and feelings about an experience. The practice includes active listening and thoughtful questioning of both parties to gain a better understanding of the reasons for the thoughts and feelings and thus determining the best interventions for moving forward. Example: How does it make you feel when the participant doesn't accept your referral for substance abuse? What factors do you think contribute to the participant not accepting your referral? How do you think she feels about it?
Note: This term is used in 9-1.

REFLECTIVE STRATEGIES:
Reflective Strategies are intervention tools that create an environment of empowerment in which the parent can experience safety, predictability, comfort and pleasure; all of which lead to healthy relationships. These Strategies build on parental competencies rather than teaching. Reflective Strategies include: 1) Accentuate the Positive, 2) Strategic Accentuate the Positive, 3) Feel, Felt, Found (with emphasis on the Feel), 4) Explore and Wonder, 5) Normalizing and 5) Problem Talk, all of which are taught during HFA Core *Integrated Strategies for Family Support Specialists* training. These same strategies can also be used by supervisors to support staff during supervision sessions.
Note: This term is used in 6-3.

REFUSED SERVICES:
A family that is determined to be eligible for services, is offered services and declines participation in services (either verbally or in writing). Or a family who has been enrolled, and for whatever reason declines further participation.
Note: This term is used in 1-4 and 3-3

RESEARCH:
Scientific research refers to a systematic examination of information to answer a question and advance knowledge. Evaluation can be a type of research if the knowledge to be gained is applicable to and will be applied beyond the immediate participants and context of the study. Evaluation solely for purposes of quality assurance is not considered research and Standard GA-5D does not apply in these "evaluation for QA purposes" situations.
Note: This term is used in GA-5.

RISK FACTORS (FROM PARENT SURVEY ASSESSMENT):
- Childhood history of abuse or other early childhood trauma
- Substance abuse, criminal history, mental illness (depression)
- Past history with child welfare
- Compromised coping skills, social isolation
- Multiple stressors (housing, finances, relationship)
- Potential for violence and history or current intimate partner violence
- Unrealistic child development expectations
- Discipline methods that include physical punishment
- Perception of fetus/infant as difficult
- One or more biological parents not emotionally or physically available to child

Note: This term is used in 1-1, 2-1, 6-1, and 12-2.

SCREEN/SCREENING: A process for early identification of potential families that often occurs via medical record review, community or self-referral, questionnaire that gathers needs/risk data, or similar information collection system. Sites may establish screening criteria that when evident either results in the determination of service eligibility, or results in the completion of a more detailed assessment.
Note: This term is used in Standard 1.

SELF-STUDY:
The self-study is the site's opportunity to demonstrate implementation of the HFA Best Practice Standards and is the compilation of all of the policy requirements and the pre-site evidence requirements outlined in the Tables of Documentation (described below). The self-study serves as both a process and a product. Sites are encouraged to initiate improvement strategies (with HFA National Office Technical Assistance support as needed) whenever areas for improvement are identified during the compilation of the self-study.

SERVICE PLAN:
HFA requires sites to develop a Service Plan for each family. The Service Plan is documented by the supervisor in the supervision binder, with a working copy maintained by the Family Support Specialist. It is updated regularly and helps organize the risks, concerns and needs identified by families with the activities, interventions and supports provided by the Family Support Specialist to help ameliorate family risk. This is often a document that funders or third party billing entities might require. HFA provides a sample Service Plan for this purpose. Sites may adapt or develop their own Service Plan document, as long as it meets the expectation of the 6-1 standard. The HFA National Office is happy to review and advise on any modified forms.
Download the HFA Service Plan and HFA Service Plan Instructions.
Note: This term is used in 6-1.

SERVICE POPULATION:
The individuals currently enrolled and receiving services.
Note: This term is used in Standard 5.

SERVICES:
When referenced in the *Standards*, services include the Healthy Families assessment and home visiting services delivered by the site, and does not include Healthy Families service enhancements (i.e. groups, augmented support from clinicians, or other programs housed at the agency).

SITE:
The term used to describe an HFA affiliate.

STAFF DEVELOPMENT PLAN:
All staff bring professional experience and education to the job. Training and self-study are added to broaden the knowledge base and expertise. Each staff member has strengths to build on and will develop goals for professional development with their supervisor. To understand and document previous learning and experience, supervisors discuss topics with the staff member to ensure knowledge and how it is used in the work. When experiential gaps exist at the time of hire, the staff member and supervisor develop a plan to support staff development and the acquisition of new knowledge and experience.
Note: This term is used in 9-1.
Download Sample Staff Development Plan

SUPERVISOR:
Supervisors provide weekly individualized supervision to the Family Support Specialists and Family Resource Specialists within a Healthy Families site that incorporates administrative, clinical and reflective practices. The supervisor ensures quality of service provision. The supervisor protects the integrity of the program and demonstrates respect for the parallel process by supporting, guiding and building on the strengths of staff so that they may best support, guide and build on the strengths of the families served.

TARGET CHILD: HFA families are screened/assessed prenatally or before the target child is 2 weeks old. The target child is the child that is initially the focus of the parent child relationship and who the site intends to serve along with who is defined as his/her family.

TARGET POPULATION:
Members of a group the site has determined it will serve. The boundaries of the designated target population may be set by a variety of factors such as specific social problems, age, or community needs.
Note: This term is used extensively throughout Standard 1.

TRANSFER: There are about 600 HFA sites across the USA, Canada and the U.S. Territories. When families move from one location to another, HFA encourages sites to ask families if they would be interested in continuing with HFA home visiting services. Sites can look on the HFA website and locate a site close to where the family is relocating and see if they can provide services for this transitioning family. Sites who accept transferred families will not count them for several of the measurement standards. In addition, sites that affiliate with HFA, transitioning from a previous home visiting model to HFA, will transfer families from previous services to HFA when possible. These families are also not counted toward several of the threshold standards, though data will be collected.
Note: This term is used in 1-2.C, 1-3.B, 3-3, 3-4, and 4-1.

VERBAL ACCEPTANCE: Verbal acceptance is determined when the site offers services to the family. When a referral agency asks a family if they want home visiting this is their offer and not how HFA defines verbal acceptance. Verbal acceptance is when a family says yes to the offer of home visiting services from the HFA site subsequent to the referral being received. Note: This term is used in 1-2.E

VOLUME YEAR: HFA looks at a volume year when measuring retention of families. A volume year is a defined twelve month period of time. All families who had a first home visit between the beginning and end of the defined volume year are included in the measurement calculation for that year. Note: This term is used in 3-4.A

VOLUNTARY:
This term is used to differentiate between activities in which an individual chooses to participate (i.e., voluntary) and activities in which an individual is required, without choice, to participate (i.e., mandatory). Note: This term is used in 3-1, GA-4 and GA-5.

WAIT LIST:
When a local site is at capacity and unable to offer services to new families, the site may be inclined to put the family on a wait list. HFA discourages this practice given that wait listing a family gives the family false hope that they may soon access HFA services when this may not be possible. More concerning is that particularly vulnerable families should be connected to alternative resources in the community before existing risks become further amplified. This may also pose increased liability to the site if something were to happen to the family while on a wait list. Note: This term is used in 1-3.B

COMMON TERMS ASSOCIATED WITH ACCEPTANCE & RETENTION RATES AND STANDARDS REQUIRING AN ANALYSIS (1-4.A-C and 3-4.A-C):

HFA ACCEPTANCE RATE:
The methodology for tracking the percent of families who accept HFA home visiting services during a particular time period. Many factors may impact the acceptance rate. For example, numerous HFA sites have found that the narrower the window of time between initial referral to HFA and the offer of services, the higher the acceptance rate.

To ensure uniformity in measurement, HFA requires sites to track the acceptance rate of families based on the receipt of the first home visit (behavioral acceptance), regardless of how a site may define its enrollment date.

Measuring Acceptance Rates: HFA methodology for calculating a site's acceptance rate is:
1. Count the total number of potential families who, during a specified time period, were offered services after being determined eligible at the time of the initial screen/assessment (whichever is used to determine eligibility). (This number will be your denominator)
2. Of the families who were offered services within that specified period of time, count how many completed a first home visit (This is your numerator).
3. Divide the number of those who had a first home visit by those who were offered services.

The HFA National Office has a spreadsheet available that will calculate acceptance rates using HFA methodology. Standard 1 Spreadsheet (1-1.C, 1-2.C-E, 1-3.B and 1-4.A,B and C)

HFA RETENTION RATE:
HFA methodology requires that sites measure the percent of families who remain in the site over specified periods of time (6 months, 12 months, 24 months, 36 months, etc.) after receiving a first home visit.

Measuring Retention Rates: HFA methodology for calculating a site's retention rate is:
1. Select a specified time period, e.g., January 1, 2016 to December 31, 2016 – this is called a "**volume year**" (see definition in the glossary above) and can be a calendar year or fiscal year.
2. Count the number of families who received a first home visit during this time period,
3. Count the number of families in this group that remained in services over specified periods of time (six months, 12 months, two years or more, etc.);
4. Divide this number by the total number of families defined in step 2 (that received a first home visit during the time period.)
5. For accuracy, a time period must be selected that ended at least one year ago for one year retention rate**,** two years ago for two year retention rate, three years ago for three year retention rate, and so on. This is to ensure that all families beginning services during the specified time period have had the

opportunity to stay for the full retention period being measured. For example, a family enrolled in December 2016 could not be counted as retained for one year until December 2017.

The HFA National Office has a spreadsheet available that will calculate retention rates using HFA methodology. ***3-4.A Retention Measurement Worksheet (also includes 3-4.B and C)***

NOTE: To improve measurement of retention rate, HFA requires that retention calculations use **first and last home visit dates**, even if sites define enrollment and termination differently. As described above, the **first home visit is defined as the first visit from a Family Support Specialist that is completed and documented subsequent to the offer of HFA services. The last home visit applies only to families that have been closed to services. It is defined as the most recent date that a Family Support Specialist completed and documented a home visit with the family prior to closure (regardless of level at that time**). Families that are still considered "active" or "open" will not have a last home visit reflected until they have been closed. The retention rate is impacted by the way sites measure from the beginning to the end of services. For example, if retention is measured from initial screening/assessment date to termination date, retention will calculate lower than it does for sites that define acceptance later in the recruitment process (e.g., first home visit). Also, at the end of services, the termination date is often assigned after a period of creative outreach, which artificially extends the period of time a family was considered to be receiving home visiting services.

ANALYSIS:
A detailed study and reporting of site patterns and trends. For the purposes of analyzing HFA Acceptance Rates, sites will compare the families who accepted services (received first home visit) to those who refused (never received first home visit). HFA Retention Rates measure families who stayed in services (enrolled) compared to those who dropped out (terminated) of services. An analysis must include:

1. Data (both raw numbers and percentages) that depicts demographic, programmatic, and social factors, along with reasons why families refuse/drop-out of services;
2. A narrative that reflects informal findings from discussions with staff in team meetings or supervision sessions, advisory board conversations etc.; and
3. A narrative summary of the data that illustrates the patterns and trends, or in some cases the absence of patterns or trends among families. Patterns and trends are determined by comparing data across opposing groups (e.g., those accept compared to those who do not or families that stay compared to those that leave) over the same periods of time.

Below you will find suggestions of factors to use with regards to Acceptance and Retention analyses; however, sites may consider utilizing certain criteria for other analyses.

Please note: Not all factors listed below are required to be analyzed, however sites should review as many as possible in order to isolate those that may be impacting acceptance and retention rates most. At a minimum, sites need to analyze at least one factor within each of the three overall categories: demographic, programmatic and social. Doing so will increase the likelihood of improvement given that targeted strategies can be developed to address the most highly correlated factors.

PROGRAMMATIC FACTORS:
General site-related factors that impact service planning and delivery. Below are some suggested factors that sites may consider using in the analysis. For ease with programmatic factors, they have been separated out with regards to acceptance and retention analyses.

Programmatic Factors to consider for Acceptance Analysis

- Target population
- Relationships with partner agencies or other community providers
- Referral sources
- Staffing issues (patterns & trends among Family Resource Specialists)
- Number of days between referral and assessment
- Screening or Assessment timeframe (e.g., prenatal, at birth within two weeks, more than two weeks)
- If a re-enrolled or transferred family
- Training of staff

Programmatic Factors to consider for Retention Analysis

- Target population
- Enrollment timeframe (e.g. enrolled prenatally, at birth, or at a later period)
- If a re-enrolled of transfer family
- Staffing issues (patterns and trends among Family Support Specialists) depending on site size Family Support Specialist trends can be evaluated by individual, by team and by satellite
- Current service level
- Length of time in services
- Age of target child(ren) at enrollment
- How policies impact what happens with families and site outcomes
- Relationships with partner agencies or other community providers
- Training of staff

DEMOGRAPHIC FACTORS:
General population characteristics. Below are some suggested demographic factors that sites may consider using in the analysis.

- Gender
- Age
- Race & ethnicity
- Marital status
- Education level (last grade completed)
- Primary Language
- Employment Status (not employed, employed part-time, full-time, or seasonally)
- Income level
- Location: urban, suburban, rural; and
- City/zip code, etc.

SOCIAL FACTORS:
The set of characteristics linked to a family's formal and informal support network that may contribute or influence human development, relationships, way of life, group dynamics, etc. Below are some suggested social factors that sites may consider using in the analysis.

- Screening or Assessment score (level of risk)
- Work or school issues (barriers to engaging or retaining due to HS or college schedule, work hours, significant commute, works night shift, etc.)

- Family or friend support
- Teen parent(s) living independently or with parents
- Grandparents raising target child
- Linkages to other community resources
- Religious affiliation
- Domestic/family violence
- Cognitively delayed parents
- Substance abusing parents
- Parents with mental health issues
- Heightened gang or other criminal activity, etc.

FORMAL AND INFORMAL DATA:
Sites are required to provide both formal and informal data when conducting an analysis. Formal data relates to data that can be numerically recorded, often regarded as "hard data". Demographic, programmatic and social factors can all be reported as formal data and both numbers and percentages are used. Informal data or "soft data" is anecdotal in nature and helps complete the story of what is impacting family acceptance or retention. Informal data is often gathered through discussions with staff or with advisory members.

REASONS WHY:
Staff will attempt to determine the reasons why a family did not want to accept services, or dropped out of services prior to completion. At times the specific details may not be available (i.e., a family said yes to Family Resource Specialist's offer, yet never received a first home visit or a family was on creative outreach and is eventually closed). In these instances, staff may draw upon anecdotal assumptions about the reasons why. Sites will summarize reasons why in their narrative and utilize this information when planning to improve acceptance or retention.

COMPREHENSIVE:
A comprehensive analysis is a thoughtful and intentional selection and examination of key programmatic, demographic and social factors that includes a combination of raw (numeric) and aggregate (percentage) formal data as well as informal (anecdotal) data, and how various factors may relate to and influence other factors. A comprehensive analysis also includes a narrative that summarizes the findings including any patterns or trends.

PLAN FOR INCREASING ACCEPTANCE RATES AND RETENTION RATES:
The plans developed by staff to increase the acceptance and retention rates will be directly linked to the patterns and trends identified in the analysis. Staff should utilize team meetings, supervision, advisory board meetings as venues to strategize ways to increase these rates. Additionally, staff should take sufficient time to implement the strategies, determine the effectiveness of a particular strategy, while working to improve rates over time.

Tables of Documentation

Summary and Guidance for Data Collection Timeframes

The Tables of Documentation provide a complete list of data requirements in the HFA Best Practice Standards (BPS). Also included is a column with recommended timeframes for ongoing monitoring and adherence to the standards, as it is helpful to have routine monitoring & measurement of these activities to represent continuous quality improvement. These recommended timeframes may also be helpful as you develop and follow-up on your site's Quality Assurance Plan (Standard GA-3.B). When a site finds that any of these QA activities are following below expectations stated in the standards the site is also encouraged to include these items on their site Goal/Benchmark Plan for ongoing monitoring and improvement.

Measuring/Monitoring/Reporting Timeframes

- Annual - Site selects the most recent 12 months, most recent calendar year, or most recent fiscal year
- Quarterly - Site selects the most recent three months, or most recent full quarter (Jan-Mar, Apr-Jun, Jul-Sept, Oct-Dec)

Standard	Required Timeframe	How to Measure **Please Note:** HFA Spreadsheets do these calculations	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
Before starting calculations within standard 1, define a cohort group year. The easiest way to define a cohort group is to pick a timeframe (ex: 1/1/2015-12/31/2015) and use those who were screened or identified within that timeframe as your cohort group. This number is the same number as (2) in the 1-1.C calculation.				
1-1.C Target Population Screened/ Referred	Annual	1. Determine total number in target population within defined timeframe (this may be an estimate based on community data from the past few years). 2. Count total number screened/referred within the same timeframe 3. Calculate: 2. (Number screened/referred) divided by 1. (Total in Target Population) 4. Provide report of number of screens by referrals source 5. Include strategies and indicate which are implemented	HFA Standard 1-1 to 1-4.A spreadsheet or local data report and strategies.	Update Monthly

1-2.C Eligibility Timeframe	Annual	1. For those within your cohort, determine total number of eligibility screens or assessments completed 2. Of those completed, how many were completed either prenatally or within 2 weeks of birth? 3. Calculate: 2. (Number completed prenatally or w/in 2 weeks of birth) divided by: 1. (total number eligibility screens or assessments completed for cohort group)	HFA Standard 1-1 to 1-4.A spreadsheet or local data report. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly
1-2.D Positive Screens Not Assessed or Not Offered and Strategies	Annual	1. Count number from cohort group that screened positive 2. Count number from cohort group that were either a) Not offered services (if a 1-step site), or b) Not offered the assessment/parent survey (if a 2-step site) 3: Calculate: 2. (number either not offered service or assessment) divided by 1. (number from cohort group that screened positive) 4. Include strategies developed and indicate which are implemented	HFA Standard 1-1 to 1-4.A spreadsheet or local data report and strategies.	Update Monthly
1-2.E Verbal Declines and Strategies	Annual	1. Count number from cohort group offered HF home visiting services 2. Count number from cohort group who verbally declined services 3. Calculate: 2. (number who declined) divided by 1. (number who were offered) 4. Include strategies developed and indicate which are implemented	HFA Standard 1-1 to 1-4.A spreadsheet or local data report and strategies.	Update Monthly

1-3.B First Home Visit	Annual	1. Count number from cohort group with a first home visit 2. Count number from cohort group with a first home visit either prenatally or within 3 months of birth 3. Calculate: 2. (number with first home visit prenatally or within 3 months) divided by 1. (number with a first home visit)	HFA Standard 1-1 to 1-4.A spreadsheet or local data report. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly
1-4.A Acceptance Rate	Annual	1. Count number from cohort group offered HF home visiting services (Yes, this is the same number as step 1 in 1-2.E) 2. Count number from cohort group with a first home visit (Yes, this is the same number as step 1 in 1-3.B) 3. Calculate: 2. (number with a first home visit) divided by 1. (number offered services)	HFA Standard 1-1 to 1-4.A spreadsheet or Acceptance Rate and description of methodology, if not using HFA spreadsheets or PIMS	Update Every Six Months
1-4.B&C Acceptance Analysis and Plan	Every other year	Analyze both formally and informally families who refused services in comparison to families who accept services. Analysis includes programmatic, demographic and social factors as well as the reason why families decline. Develop a plan to increase acceptance addressing any programmatic, demographic and social factors identified in the analysis. For smaller sites with less than 50 families offered services over a two year period, the site is required at a minimum to collect informal data and reasons why families are not accepting services, at least once every two years. The site will do a more comprehensive analysis when the sample size over a two-year period is 50 or more.	HFA Standard 1-4.B&C Acceptance Analysis and Plan or Comprehensive Acceptance Analysis and Plan for at least one cohort year. For sites with less than 50 families offered services over a two year period, narrative of informal data and reasons why families are not accepting services as well as strategies developed to increase acceptance and which have been implemented.	Update Annually

3-4.A Retention Rate	Annual	HFA methodology for calculating a site's retention rate is: 1. Select a specified time period, e.g., January 1, 2016 to December 31, 2016 – this is called a "volume year" and can be a calendar year or fiscal year 2. Count the number of families who received a first home visit during this time period 3. Count the number of families in this group that remained in services over specified periods of time (six months, 12 months, two years or more, etc.) 4. Divide this number by the total number in step 2 (that received a first home visit during the time period.) 5. For accuracy, a time period must be selected that ended at least one year ago for one year retention rate, two years ago for two year retention rate, three years ago for three year retention rate, and so on. This is to ensure all families beginning services during the specified time period have had the opportunity to stay for the full retention period. For example, a family enrolled in December 2016 could not be counted as retained for one year until December 2017.	HFA 3-4.A Retention Measurement Worksheet or Retention Rate and description of methodology, if not using HFA spreadsheets or PIMS	Update Every Six Months
3-4.B&C Retention Analysis and Plan	Every other year	Analyze both formally (numbers and percentages) and informally (anecdotal information from staff or advisory members), families who remain in services in comparison to families who leave. Analysis includes programmatic, demographic and social factors as well as the reason why families leave. Develop a plan to increase retention addressing any programmatic, demographic and social factors identified in the analysis.	HFA Standard 3-4.B&C Retention Analysis and Plan or Comprehensive Retention Analysis and Plan for at least one cohort year. For sites with less than 50 families offered services over a two year period, narrative of informal data and reasons why families are not accepting services as well as strategies developed to increase acceptance and which have been implemented.	Update Annually

4-1.B Level 1 for Six Months	Ongoing - All Active Families	1. Count total number active families who have been enrolled at least six months after the birth of the baby, or six months after enrollment (whichever is longer) 2. Count the number of these families who remained on level 1 (weekly visits) for a minimum of six months, excluding time on creative outreach. 3. Present number and calculate percentage: 2. (families who remained on level 1 according to standard) divided by 1. (total number of active families who have been enrolled for timeframes described).	HFA 4-1.B Weekly Home Visiting Spreadsheet or report reflecting all active families with a target child over 6 months indicating those who remained on Level 1 for six months. Include explanation for any families who did not remain on Level 1 for six months. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Quarterly

4-2.B Home Visit Completion	Quarterly	Report including: All active families by Family Support Specialist (FSS) including level of service, level changes that quarter, number of expected home visits that quarter and number of completed home visits that quarter. Home Visit completion calculation: 1. Determine for each family over the course of a quarter the expected number of home visits (based on level of service alone) 2. Count the number of completed visits (while family is on active service level) for each family during the quarter 3. For each family calculate: 2. (completed visits) divided by 1. (expected visits) 4. Count the total number of active families 5. Subtract from 4. (total active families) the number of families who were on creative outreach for the entire quarter 6. Count the number of active families who received at least 75% of expected home visits 7. Site HVC rate is calculated by taking 6. (number of active families who received 75%+ of visits) divided by 5. (total active families - minus CO entire quarter)	HFA 4-2.B Home Visit completion spreadsheet or local Home Visit completion reports by FSS and rolled-up by site for the *most recent quarter* *Note: The overall site level HVC is determined by taking the total number of families who completed at least 75% of the expected home visits based on their level of service, divided by the total number of families on active caseloads for the site (exclude families who were on creative outreach the entire quarter). It is NOT calculated by averaging the HVC for* all FSSs. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (75% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Quarterly
4-3.B Services minimum of three years	Annual	Local data.	Report indicating current number of families who have been enrolled for 3 or more years. If families graduate after three years of service, provide a report indicating all families who have graduated within the last year.	Update Annually
5-4.A Input from Staff & Families	Every other year	Input from families and staff regarding: 1) materials, 2) communication or linguistic factors, and 3) staff-family interaction. Input can be gathered through surveys, meetings, focus groups and/or supervision.	Aggregated Summary of staff and family input results. Sample staff and Family Surveys available	Update Annually

5-4.B Cultural Analysis and Plan (CAP)	Every other year	The CAP must include review of: 1) materials, 2) training, and 3) the service delivery system a. initial engagement b. home visiting c. supervision d. management 4) staff and families feedback on materials, communication or language factors and the staff-family interactions (5-4.A). Many sites also incorporate information gleaned from the acceptance analysis, retention analysis and staff satisfaction to inform the CAP.	Cultural Analysis and Plan (CAP) including all required components. HFA Cultural Humility Workbook available	Update Annually
6-3.D CHEERS Check-In (PCI Tool)	Annual	1. Count number of active families 2. County number of families who had a PCI tool administered in the year 3. Calculate: 2. (number with CHEERS Check-In) divided by 1. (the total number of active families)	HFA 6-3.D CHEERS Check-In spreadsheet or CHEERS Check-In (or other HFA approved PCI tool) tracking report.	Update Annually
6-5.B ASQ-3 Development Screening	Ongoing - All Active Target Children	Report indicating which target children received at least two a developmental screens per year (unless developmentally inappropriate) for children under the age of three and at least one screen per year for children ages three through five years and which did not. Include if delay was indicated and if a referral was made. Provide a summary of the total families (number and percent) who received the required screens divided by the total number of active families.	HFA 6-5.B ASQ Tracking Form or ASQ-3 Tracking Report including explanation of any missed screens. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly

6-5.C ASQ:SE-2 Social Emotional Screening	Ongoing - All Active Target Children	Report indicating which target children received at least one social emotional screen per year (unless developmentally inappropriate) for children birth through age five. Include if delay was indicated. Provide a summary of the total families (number and percent) who received the required screens divided by the total number of active families.	HFA 6-5.C ASQ Tracking Form or ASQ-SE-2 Tracking Report including explanation of any missed screens. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly
7-1.B Medical/Health Care Provider	Ongoing - All Active Target Children	Report reflecting: 1. List and count all active target children 2. List and count all active target children w/medical provider, include provider 3. Calculate: 2. (target children w/medical provider) divided by 1. (total number of target children)	Report detailing all active target children and their current medical/health care provider. Include a summary of the total number active target children who have a provider, divided by the total number of active target children.	Update Monthly
7-2.B Immunizations at 12 months	Ongoing - All Active Target Children	1. Count number of active target children between 12-23 mo. 2. Subtract from 1. (target children between 12-23 months) those who are excused from receiving immunizations according to allowable reasons described in BPS. 3. Of these children (determined in step 2), count how many are fully up to date with all immunizations through 6 mo. 4. Report number and calculate: 3. (those up to date) divided by 2. (number between 12-23 months minus those excluded from count).	HFA 7-2.B Immunization Tracker or local data report.	Update Every Six Months

7-2.C Immunizations at 24 months	Ongoing - All Active Target Children	1. Count number of active target children older than 24 mo. 2. Subtract from 1. (target children over 24 mo.) those who are excused from receiving immunizations according to allowable reasons described in BPS 3. Of these children (determined in step 2), count how many are fully up to date with all immunizations through 18 mo. 4. Report number & calculate: 3. (those up to date) divided by 2. (number over 24 mo. minus those excluded from count)	HFA 7-2.B Immunization Tracker or local data report.	Update Every Six Months
7-4.B Prenatal Depression screening	Ongoing - All Active Families	1) Report families enrolled prenatally: a. enrollment date b. date of birth of target child c. Prenatal screening date(s) d. date of birth & screen dates for subsequent births 2) Count number of families enrolled prenatally 3) Count number of families screened prenatally b. Divide 3. (screened prenatally) by 2. (enrolled prenatally) 4) Provide an explanation of any missed screens	HFA 7-4.B&C Depression Screening Spreadsheet or local data report.	Update Monthly
7-4.C Postnatal Depression screening	Ongoing - All Active Families	1) Report families enrolled postnatally: a. enrollment date b. date of birth of target child c. Postnatal screening date(s) d. date of birth & screen date for subsequent births 2) Using information above, count number of families enrolled before the baby was 3 months old a. of those families, count the number screened postnatally before the baby was 3 months old b. divide 3a. (screened) within 3 months by 3. (enrolled before baby was 3 months old) 3) Count number of families enrolled after 3 mo. a. of these families, count the number screened within 3 mo. of enrollment b. divide 4a. (screened postnatally) within 3 mo. of enrollment by 4. (enrolled after 3 mo. of age)	HFA 7-4.B&C Depression Screening Spreadsheet or local data report.	Update Monthly

		4) Provide a summary of this information 5) Provide an explanation of any missed screens		
8-1.B Caseload monitoring	Ongoing - All Active Families	Report indicating the active caseload for all current FSS over the past 12 months . Include each FSS's full time equivalency, the number of families assigned to him or her, and the level/intensity of service each family is receiving.	HFA 8-1&8-2 Weighted Caseload Tool or local data report.	Update Monthly
9-4 Staff Satisfaction and Retention	Every other year	1. For staff retention, include data of staff who have left. Include staff (by position title) who left during the timeframe (12 months for new sites, 24 months for all others), their hire date, termination date, reason why they left; and any other pertinent characteristics. 2. For staff satisfaction include a summary of staff satisfaction input in regard to work conditions that contribute both negatively and positively to job satisfaction (typically aggregated survey results) for those currently employed with the HFA site. Agency-wide staff satisfaction surveys, if used, must be filtered and reported for HFA staff only. 3. Include strategies developed for staff retention based on what was learned from retention and satisfaction data.	Narrative reflecting factors associated with staff turnover along with satisfaction feedback from existing HFA staff utilized to develop staff retention strategies. Include which strategies have been implemented.	Update Annually
10-1 Orientation Training	Ongoing - All Current Staff	Training Logs including hire date and date of all training topics received for all current HFA staff (Family Resource Specialists (FRS), Family Support Specialists (FSS), supervisors and program manager).	HFA Training Log or local training report.	Update Monthly
10-2 Stop-Gap Training	Ongoing - All Current Staff	Training Logs including hire date and date of all training topics received for all current HFA staff (FRS, FSS, supervisors and program manager).	HFA Training Log or local training report.	Update Monthly
10-3 HFA Core Training	Ongoing - All Current Staff	Training Logs including hire date and date of all training topics received for all current HFA staff (FRS, FSS, supervisors and program manager).	HFA Training Log or local training report.	Update Monthly

11-2 thru 11-4 Wrap Around Training	Ongoing - All Current Staff	Training Logs including hire date and date of all training topics received for all current HFA staff (FRS, FSS, supervisors and program manager).	HFA Training Log or local training report.	Update Monthly
11-5 Ongoing Training	Ongoing - All Current Staff	Training Logs including hire date and date of all training topics received for all current HFA staff (FRS, FSS, supervisors and program manager).	HFA Training Log or local training report.	Update Monthly
12-1.B Frequency and Duration of Supervision	Quarterly	1. Determine for each direct service staff member needed frequency and duration of supervision per FTE guidelines within BPS. 2. Determine number of expected supervision sessions for each staff member for one quarter. 3. Subtract from 2. (expected sessions) excused sessions within guidelines provided by BPS. 4. Count number of supervision sessions that occurred within proper timeframes and for expected duration. Divide 4. (number of supervision sessions at required duration) by 3. (expected sessions minus those excused). 5. Create report reflecting findings for each staff member.	HFA 12-1.B Supervision Spreadsheet or local data report.	Update Monthly
GA-3.A Goals	Annually	Site Goals/Benchmarks	Site goals/benchmarks with outcomes, follow up and mechanisms for improvement.	Update Quarterly
GA-3.B QA Plan	Annually	Quality Assurance Plan with outcomes, follow up and mechanisms for improvement.	Sample HFA QA Plan Template or local QA Plan.	Update Quarterly

1. Initiate services prenatally or at birth.

Standard 1 Intent: ***The overall intent of the standards in this section is to ensure the site has a well-thought out mechanism for the early identification and engagement of families who could benefit from services.***

1-1. The site has a description of its target population and the community partnerships in place to ensure it identifies and initiates services with families in the target population during pregnancy or at the birth of the baby.

1-1.A The site has a description of its target population and how the current target population definition was decided upon. The description includes data collected from one or more sources, e.g. a community needs assessment, state rankings, census.gov, etc.

Intent: *Communities choose to implement the HFA model as a mechanism to improve family and child outcomes and do so because there is local, state and/or federal interest in providing supportive home visiting services to parents, infants and young children who reside in at-risk communities or segments of a community where families or children may be experiencing increased stress. It is therefore vitally important site leadership has the data upon which to base target population decisions and can utilize it to ensure a systematic process for identifying families is in place. Demographic data which quantifies (as closely as possible) the volume of potential families (as defined by its target population) is gathered. This data is specific to the families actually giving birth within the identified target population.* ***Target populations can be defined by factors such as: maternal age, Medicaid eligibility, geographical area, first time pregnancy, etc. Some cities have multiple HFA sites working together by serving different target populations.*** *A site can potentially access data regarding community need from kidscount.org, census.gov, or state and local health departments. When compiling demographic data to quantify information about the target population, data pertinent to the risk factors associated with families who might benefit most from long-term, intensive home visiting services are used.*

The site's target population is reviewed periodically and updated as changes in funding, site structure or community demographics warrant. A site's target population describes the characteristics and total number (or close approximate) of all potential families. Each site defines its own target population in order to meet the unique needs of the community.

For example, I work with my community advisory board to determine the target population we intend to serve with HFA is teen parents, because teen parents are an underserved demographic in our area and there are very few existing services in our community to support them. We know from the Kids Count Data Center (kidscount.org), in the most recent year data is available, a total of 1,000 women under the age of 20 gave birth in our area. We also know 780 women under the age of 20 gave birth our city's largest birthing hospital last year. We therefore define our target population as pregnant or parenting teens (with an infant less than 3 months old), who reside in Babyville County. Data obtained from Kids Count indicates approximately 1,000 families annually meet our target population criteria.

1-1.A RATING INDICATORS

3 - The site has a description of its target population including community data (include source and year) used in the decision-making. Both the description and data utilized **have been updated within the last two years**.

2 - The site has a description of its target population including the community data (include source and year) used in the decision-making; and the description or data utilized **have been updated within the last four years.**

1 - The site does not yet have a description of its target population; or community data was not used, when deciding on its current target population or source was not indicated; or data is older than four years.

☺ Tip: Sites are encouraged to identify target populations that are realistic to reach. For example, while it is commendable to want to reach out to all families giving birth in a given year, fiscal capacity or limited staffing capacity may make this goal unrealistic, not to mention, not all families will necessarily need or benefit from intensive, long-term home visiting.

1-1.B The site identifies places where the target population is found, and the site has established organizational relationships with these entities for purposes of screening families and obtaining referrals (e.g., local hospitals, prenatal clinics, high schools, centralized intake systems, etc.).

Intent: *In addition to the site's target population definition/description of families it intends to serve, the site will also indicate the community partners which will enable the site access to families. Sites are encouraged to focus on building these relationships with other community entities to help ensure the target population is well defined and easy to access. In order for sites to access families within the target population, it is essential to create relationships with community entities that come into contact with potential families within the target population. In some cases these community partnerships may require formal Memorandums of Understanding/Agreement (MOU/MOA), and in other cases these relationships may be verbal agreements or informal in nature. In either case, it is important these relationships allow site staff to connect with families in the target population. These connections may include the agencies providing referrals/screens or contact information to the HFA site for the purpose of assessing families to determine eligibility.*

Continuing with the example in 1-1.A for Babyville County, the HFA site there reaches out to the largest birthing hospital where 780 births to women under the age of 20 occurred last year. We establish a Memorandum of Agreement with the hospital's social work department to identify and refer teen parents to our HFA site. We engage the hospital's Social Work Dept. director to participate on our Community Advisory Board to ensure ongoing communication, and we coordinate in-service meetings with key hospital unit staff to provide them with materials and information about our HFA site. Similarly, we engage our local WIC provider, though in a less formal way (without a MOA) so they too are aware they can refer teen parents who meet our criteria (pregnant or with a newborn, and living in Babyville County). We track each month how many referrals are coming in from each referral partner and from any other sources.

1-1.B		RATING INDICATORS
3	-	No 3 rating indicator for 1-1.B.
2	-	The site identifies organizations within the community in which the target population can be found, and agreements (either formal or informal) are in place.
1	-	The site does not yet identify organizations within the community in which the target population can be found, or the site has not yet initiated relationships with identified referral organizations.

☺ Tip: The site can decide if a formal MOU would be beneficial with some of its referral sources. Some sites may have only formal MOUs in place, while others will have only informal (verbal) agreements in place, and others still may have a mix of both formal and informal.

1-1.C The site measures the number of families in the target population *screened/referred* for Healthy Families services through its system of organizational relationships and develops improvement strategies. Please Note: Sites can use the Standard 1 Spreadsheet to calculate the percentage of the target population being screened/referred.

Intent: *Measuring the percentage of families in the target population being reached allows the site to utilize data effectively to advocate for families in the community whose needs may go unmet. For example, there may be many more potential families in the target population than can be served owing to the site's current capacity. Measuring the data in this case provides the site with valuable information to support a funding request to increase staffing. In other cases, the site might be reaching the vast majority of its target population yet staff caseloads are not filled. The data can then help the site determine whether its current target population definition is too restrictive.*

*Monitoring the system of organizational relationships is a key component to understanding how more families might be reached. The site will also use this data to develop strategies for how the screening/referral process might be improved (e.g., strategies to form new relationships, provide in-service training for referral agencies, create more effective ways to screen/identify families in the target area, etc**.).***

*Demographic data quantifying (as closely as possible) the volume of potential families (as defined by its target population) is gathered. This data is specific to the families actually giving birth within the identified target population. To measure the percentage of the target population screened/referred for HFA services, a site starts with this total potential number of families in the service area over an upcoming 12 month period which meet its target population descriptor(s). This does not have to be an exact number and can be informed by both formal and informal data sources. At the end of the 12 month period the site totals the number actually screened/referred for services who met target population descriptor(s). The **actual number** screened/referred divided by the **potential number** x 100 = the percentage screened/referred.*

For example in Babyville, the most recent Kids Count data shows 1000 teens gave birth in that area over a one year period, and so 1000 is the potential target population. Over the past year, the Babyville HFA site received a total of 550 referrals from the birthing hospital, WIC, a local food pantry agency and even some self-referrals, however 50 of these referrals did not meet target population criteria as they resided outside the county or were not teens. As a result, five hundred (500) referrals received in the past year met target population criteria. Therefore the calculation is 500/1000 x 100 = 50% of the target population was screened/referred.

1-1.C		RATING INDICATORS

3 - The site measures annually (as described in the intent) the percentage of families from the target population screened/referred to Healthy Families services, and includes the source of referrals into the program. The site has also **implemented** strategies to:
- increase the percentage screened/referred, or
- increase access to services when at capacity (via referrals to other community services or expansion of existing HFA services when feasible), or
- sustain/strengthen relationships with referral sources.

2 - The site measures annually (as described in the intent) the percentage of families from the target population that were screened/referred to Healthy Families services, and includes the source of referrals into the program, and has **developed**, but not yet implemented strategies to:
- increase the percentage screened/referred, or
- increase access to services when at capacity (via referrals to other community services or expansion of existing HFA services when feasible), or
- sustain/strengthen relationships with referral sources.

1 - Any of the following: the site has not yet measured at least annually (as described in the intent) the percentage of the target population being reached; the site does not yet identify the referral source; or has not yet developed any improvement strategies.

☺ Tip: When working in partnership with an external entity providing centralized intake, it will be important to have an MOU/MOA in place allowing reciprocal sharing of aggregate data. This includes how many within the target population are being screened/referred (by centralized intake) and how many are connecting to services (by the HFA site).

1-2. The site ensures screening/assessment processes for all referrals are tracked and monitored from initial referral to the offer of services.

1-2.A The site has policy and procedures regarding its screening/assessment processes and mechanisms to ensure timely determination of eligibility. Policy and procedures also include the site's tracking and monitoring requirements.

1-2.A RATING INDICATORS

3 - No 3 rating indicator for standard 1-2.A.

2 - The site's policy and procedures include the following information:
- Screening process (for one-step and two-step)
- Parent Survey process (when Parent Survey is used for eligibility – two step)
- Mechanisms to ensure timely determination of eligibility, including timeframes between receipt of a referral/screen to the completion of the Parent Survey or other HFA approved tool (when used for eligibility), to the offer of services; and the site's tracking and monitoring requirements.

1 - The site does not yet have policy and procedures; or the policy and procedures do not yet address the requirements listed in the 2 rating.

☺ Tip: It is recommended sites utilize the following timeframes:
- For one-step where positive screen determines eligibility: assign Family Support Specialist and offer HFA services within 1-2 business day of receiving a positive screen.

- For two-step where positive screen and positive assessment determines eligibility: administer the Parent Survey within one week of a positive screen, complete Parent Survey narrative and scoring within 1-2 business days of Parent Survey visit, finalize scoring and offer to those eligible within 3-4 business days of Parent Survey visit (this could be longer if a follow-up visit is scheduled for purposes of offering service), and assign to Family Support Specialist within 1 business day of family verbally accepting if not earlier.

1-2.B The site implements its screening process and utilizes a systematic process for receiving referrals and screening families in a timely manner.

1-2.B		RATING INDICATORS
3	-	The site utilizes a systematic process for receiving referrals and screening families.
2	-	Past instances may have occurred when the site did not utilize a systematic process for receiving referrals and screening families; however **recent practice** indicates this is now occurring.
1	-	The site does not yet utilize a systematic process for receiving referrals and screening families.

☺ Tip: Sites are encouraged to follow-up with referring entities to provide information regarding the outcome of their referral(s) including when the initial contact with the family is not completed.

1-2.C Determination of eligibility for services occurs either prenatally or within the first two weeks after the birth of the baby.

Intent: *HFA allows sites to choose between a one-step and a two-step process to determine eligibility. For sites using a one-step process, a positive screen determines eligibility. For sites using a two-step process, a positive screen is followed by a more comprehensive Parent Survey (or other HFA approved tool) to determine family eligibility. For sites providing "universal" home visiting services (where all families are considered eligible to participate in services), the "universal" status is considered a positive screen (and therefore a one-step process). Regardless of whether using a one-step or two-step process, sites are required to calculate annually the percentage of families the site determined eligible prenatally and within two weeks of birth.* ***Please Note:*** *For sites working with a centralized intake system, the site determines eligibility after it receives the referral and confirms target population criteria are met.*
Please Note: *Sites are encouraged to accept transfers from other sites whenever appropriate and to re-enroll families with the same target child that may have been previously closed from services. Any transfers or re-enrollments when the child is already 2 weeks old or older will be exempted from this calculation. The exemption from the calculation ensures the receiving site is not held accountable for eligibility determination originally completed at the sending site.*

1-2.C		RATING INDICATORS
3	-	**Ninety-five percent (95%) through one hundred percent (100%)** of eligibility screenings (one-step) or Parent Survey assessments or other HFA approved tool (two-step) occur prenatally or within the first two weeks after the birth of the baby.
2	-	**Eighty percent (80%) through ninety-four percent (94%)** of all eligibility screenings (one-step) or Parent Survey assessments or other HFA approved tool (two-step) occur either prenatally or within the first two weeks after the birth of the baby.
1	-	Less than eighty percent (80%) of all eligibility screenings (one-step) or Parent Survey assessments or other HFA approved tool (two step) occur either prenatally or within the first two weeks after the birth of the baby.

☺ Tip: Sites are encouraged to establish systems allowing the connection with families to occur as early as possible, ideally during the prenatal period.

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when rates fall below the 80% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

1-2.D The site monitors and addresses families who screen positive but were either 1.) not offered services when the site offers services universally or uses a positive screen to determine eligibility or 2.) not offered Parent Survey/assessment when the site uses a positive Parent Survey/assessment to determine eligibility.

Intent: *Many potential families miss the opportunity to participate in services because site staff is unable, for a variety of reasons, to maintain contact with them subsequent to the initial screening process. Therefore, sites are to monitor the screening/referral process in order to develop strategies for increasing the capacity of the site to connect with the target population. The depth of the monitoring will depend on the amount of information gathered through the screening/referral process, but at a minimum must include the number of families over the course of a year who screen positive and either were not offered service (for sites using a 1-step eligibility process), or not assessed with the Parent Survey or other HFA approved tool (when using a 2-step process).* ***Please Note:*** *For sites working with a centralized intake system that offers Healthy Families (HF) services to families, the site will consider the offer of services to occur when the site receives the referral and contacts the family themselves to offer services.*

1-2.D RATING INDICATORS

3 - The site monitors at least annually the screening process particularly as it relates to any families who screen positive and then are not offered services (when screen is used to determine eligibility – one step), or screen positive and are not assessed using the Parent Survey or other HFA approved tool (when assessment is used to determine eligibility – two step), and has developed and **implemented strategies** to address any issues. **Or** 100% of families were offered services or received assessment, in which case strategies do not need to be developed.

2 - The site monitors at least annually the screening process particularly as it relates to any families who screen positive and then are not offered services (when screen is used to determine eligibility – one step), or screen positive and are not assessed using the Parent Survey or other HFA approved tool (when assessment is used to determine eligibility – two step), and has **developed strategies** to address any issues.

1 - Any of the following: the site has not yet monitored, at least annually, the screening process as it relates to families who screen positive and then are not offered services (when screen is used to determine eligibility), or screen positive and are not assessed using the Parent Survey or other HFA approved tool (when assessment is used to determine eligibility); or has not yet developed strategies to address issues.

1-2.E The site monitors families who verbally accepted versus declined the offer of services subsequent to either, 1.) a positive screen when used to determine eligibility, or 2.) a positive Parent Survey when the site uses assessment to determine eligibility. The site also identifies strategies to address any issues.

Intent: *Sites are to monitor families who verbally accept and decline the site's offer of services after being determined eligible in an effort to develop strategies for increasing the ability to connect with, engage and enroll families. By monitoring those who verbally accept and those who verbally decline, sites will also know how many of those who verbally accept end up following through with a first home visit subsequent to the offer of service.* ***Please Note:*** *For sites working with a centralized intake system, sites will monitor the number of families who accept versus decline the site's offer of services, and not those who accept versus decline an offer of service made by the centralized intake system.*

1-2.E RATING INDICATORS

3 - The site monitors families who verbally accept versus decline the site's offer of services after a positive screen (one-step) or after a positive Parent Survey or other HFA approved tool (two-step); and has **implemented strategies** to address any issues; or ninety to one hundred percent (90-100%) of families offered services verbally accept, in which case improvement strategies do not need to be developed or implemented.

2 - The site monitors families who verbally accept versus decline the site's offer of services after a positive screen (one-step) or after a positive Parent Survey or other HFA approved tool (two-step); and has **developed strategies** to address any issues; however, these strategies have **not yet been implemented**.

1 - The site has not yet monitored families who verbally accept versus decline the site's offer of services, or has not yet developed strategies to address issues.

1-3. The site ensures the first home visit occurs within three months after the birth of the baby.

Intent: *HFA research, as well as significant anecdotal evidence, points clearly to a site's ability to achieve improved outcomes the earlier services are initiated. This is owing to multiple variables including:*

- *The particular vulnerability of the infant during the prenatal and newborn period, and an opportunity to help shape better health, nutrition and lifestyle practices that can impact the infant during this particularly sensitive period*
- *The patterns of the parent-infant relationship, including parental responsiveness and interpretation of infant behavior begin during this period as well, and strategies employed by Family Support Specialists can promote healthier bonding and attachment*
- *And especially for families with limited exposure to healthy, trusting relationships during their life, the ability to form a trusting relationship with a Family Support Specialist requires time*

Therefore, the earlier the alliance between Family Support Specialist and parent is formed, the greater the likelihood of increased family retention.

1-3.A The site has policy and procedures stating, for families who accept services, the first home visit occurs prenatally or within the first three months after the birth of the baby (i.e. up until the baby turns 3 months of age), and includes tracking and monitoring requirements.

1-3.A	RATING INDICATORS
3 -	No 3 rating indicator for standard 1-3.A.
2 -	The site's policy and procedures clearly indicate the following: the first home visit occurs prenatally or within the first three months after the birth of the baby; and detail the site's tracking and monitoring requirements.
1 -	The site does not yet have policy and procedures, or the policy and procedures do not yet address the requirements listed in the 2 rating.

1-3. B The site's practices ensure, for families who accept services, the first home visit occurs prenatally or within the first three months after the birth of the baby. Please Note: When infants begin life with an extended hospital stay in the NICU, it may not be possible to begin home visits until after 3 months. These situations must be documented clearly and will be exempted from the requirements of this standard. Please Note: Sites are encouraged to accept transfers from other sites whenever appropriate and to re-enroll families with the same target child that may have been previously closed from services, and any transfers or re-enrollments when the child is already 3 months old or older will be exempted from this calculation.

1-3.B	RATING INDICATORS
3 -	**Ninety-five percent (95%) through one hundred percent (100%)** of first home visits occur prenatally or within the first three months after the birth of the baby.
2 -	**Eighty percent (80%) through ninety-four percent (94%)** of first home visits occur prenatally or within the first three months after the birth of the baby.
1 -	Less than eighty percent (80%) of first home visits occur prenatally or within the first three months after the birth of the baby.

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when rates fall below the 80% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

☺ Tip: During times when HFA caseloads are at capacity, sites are discouraged from maintaining families on a waitlist. Telling eligible families they are on a waitlist conveys a promise of eventual enrollment the family, which may not be possible. The child may age out before an opening occurs, and urgent or immediate needs the family may have would go unattended, potentially at dire consequence to the family or child, bringing a liability risk to the HFA host agency. In such situations, a referral to other community services is preferred to wait-listing the family. Most often, the reason sites use a waitlist is to ensure caseload capacity can be maintained should a family leave services early, and while this may be in service to the agency to ensure consistent billing, it is not in service to the family, and also limits enrollment of new prenatal and newborn families.

1-4. The site measures, analyzes, and addresses how it might increase the acceptance rate of families into services on a regular basis and in a consistent manner.

1-4.A The site measures annually (with 12 consecutive months of data) the acceptance rate of families offered services using HFA methodology (based on receipt of first home visit and using both numbers and percentages). Please see measuring acceptance rates on page 22. When measuring and analyzing sites can use the Standard 1 Spreadsheet.

Intent: *Calculating the rate of families accepting services is a critical quality improvement measure. Sites are to look at the total number of families offered services over the course of a year and what number and percent of those families accepted site services (as demonstrated by completion of a first home visit after the offer was made). To ensure uniformity in measurement, HFA requires sites to track the acceptance rate of families based on acceptance of the first home visit, regardless of how a site may define its enrollment date. Sites can measure rates at additional intervals if desired.* ***Please Note:*** *As stated in the glossary, the first home visit is the first visit completed by the assigned Family Support Specialist after eligibility has been determined, where rights and confidentiality forms are signed (unless already signed), where CHEERS is observed, and at least one focus area (see glossary for home visit definition) occurs. The visit is documented on a home visit record.*

1-4.A		RATING INDICATORS
3	-	The site measures its acceptance rate of families (using HFA methodology) into services and acceptance rates are being **measured more than once a year.**
2	-	The site measures its acceptance rate of families (using HFA methodology) into services and acceptance rates are being **measured annually.**
1	-	The site is not yet measuring its acceptance rate using HFA methodology at least annually.

1-4.B For sites with 50 or more families offered Healthy Families services over a two year period, the site comprehensively analyzes at least once every two years (e.g., both formally, through data collection of demographic, programmatic and social factors, and informally through discussions with staff and others involved in the screening and assessment process), families who accept services compared to those who do not accept (refused **)**services among those determined to be eligible for services and the site also analyzes the reasons why families choose not to accept services. Please see common terms associated with analyses. Sites can use Standard 1 Spreadsheet.

For smaller sites with less than 50 families offered services over a two year period, the site is required at a minimum to collect informal data and reasons why families are not accepting services, at least once every two years. The site will do a more comprehensive analysis when the sample size over a two-year period is 50 or more.

Intent: *Sites are to measure acceptance data at least annually (as indicated in standard 1-4.A) and conduct a thorough analysis once every two years to determine patterns or trends; the analysis compares families who accept site services with those who refuse site services, and identifies potential improvement strategies to increase site acceptance, based on the analysis. When looking at demographic, programmatic and social factors, the site will be sure to look at all options associated with that factor (e.g. if looking at marital status as a demographic factor, the site will look at the number and percent of single, married, separated, divorced, and widowed individuals vs only looking at number of single parents).* ***Please Note:*** *Sites may analyze data more frequently than every other year if patterns or volume suggest this need, however at minimum one full year of data must be used.* ***Please Note:*** *New sites without 2 full years since home visiting services began will complete a first analysis with one year of data instead of two. If the site is both new and small (25 families or fewer offered services over one year or 50 over two years), they will report on informal information and reasons why for families who have left services.*

1-4.B RATING INDICATORS

3 - The site uses both formal (with numbers and percentages) and informal data to analyze, at least once every two years, families who refused services and why. This analysis is comprehensive, addressing **multiple factors in each of the 3 categories**, 1) programmatic, 2) demographic, and 3) social, and compares these factors for those who accept and those who decline during the same time period;

or at least ninety percent (90%) of families offered services over a two year timeframe accepted services by receiving a first home visit, in which case an analysis is not required (new sites not yet in operation for two full years with an acceptance rate of 100% during the first year are also exempt from completing an analysis).

2 - The site uses both formal (with numbers and percentages) and informal data to analyze, at least once every two years, families who refused services and why. This analysis compares those who accept with those who declined during the same time period, and addresses **at least one factor in each of the 3 categories**, 1) programmatic, 2) demographic, and 3) social.

Sites with fewer than 50 families offered services over a two year period have collected informal data and reasons why families are not accepting services.

1 - Any one of the following:
1) the site does not yet have an analysis of who refused services and why;
2) the analysis does not yet include both formal and informal data;
3) the analysis does not yet include at least one factor from each of the three categories, (programmatic, demographic, and social);
4) the analysis does not yet include a comparison of those who accept and those who decline during the same time period;
5) the analysis is not yet conducted at least once every two years; or
6) if a smaller site, the site has not yet, at a minimum, collected informal data and reasons why families are not accepting.

NA - The site did not offer HFA services to any new families in the last two years.

☺ Tip: For those whose acceptance rate has remained 90% or more over a 2 year period (3 rating) the site is encouraged to collect informal data, along with reasons why a families might not be accepting services.

1-4.C The site addresses how it might increase its acceptance rate based on its analysis of those refusing services in comparison to those accepting services. Sites can use Standard 1 Spreadsheet.

1-4.C		RATING INDICATORS
3	-	Based on the analysis, the site **has implemented a plan** for increasing its acceptance rate among the individuals who are not currently choosing to participate in services. The plan addresses programmatic, demographic, or social factors identified within the analysis; **or** at least ninety percent (90%) of individuals offered services over the two-year timeframe accepted services, in which case an analysis and plan is not required. Smaller sites have implemented a plan based on the review of informal data and reasons why.
2	-	Based on the analysis, the site has a plan for increasing its acceptance rate among the individuals who are not currently choosing to participate in services. The plan addresses the programmatic, demographic, or social factors identified within the analysis; however, **the plan has not yet been implemented**. For smaller sites, a plan to increase acceptance has been developed but not yet implemented based on informal data collected and reasons why.
1	-	Any of the following: the site does not yet have a plan; the plan is not yet based on the analysis; does not yet address programmatic, demographic, and social factors identified within the analysis; or does not yet address how it might increase its acceptance rate.
NA	-	The site did not offer HFA services to any new families in the past two years.

Tables of Documentation			
*Note: See Link for Self Study Face Sheet in Glossary section to submit with Self Study			
1. Initiate services prenatally or at birth			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study**	**Site Visit Activities**
Before starting calculations within standard 1, define a cohort group year. The easiest way to define a cohort group is to pick a timeframe (ex: 1/1/2015-12/31/2015) and use those who were screened or identified within that timeframe as your cohort group. This number is the same number as (2) in the 1-1.C calculation.			
1-1.A Target Population		Submit a narrative definition of the current target population (who the site intends to serve) including how the current target population was decided upon and the relevant and up-to-date (within the last four years) community data (include data source) used in the decision-making. Please note: HFA Standard 1-1 to 1-4.A spreadsheet available	**Interview:** * Program Manager **Review:** * formal and/or informal agreements with referring agencies * updated reports showing recent improvements, if needed * Advisory Group Survey
1-1.B Referring Organizations		Submit narrative indicating where the target population is found (e.g., local hospitals, prenatal clinics, high schools, etc.) and the type of organizational relationship (formal or informal agreement) in place with each entity. Please note: HFA Standard 1-1 to 1-4.A spreadsheet available	
1-1.C Monitoring Screens		Submit report reflecting families screened/referred in the target population in the most recent calendar or fiscal year: 1. Determine total number in target population within defined timeframe (this may be an estimate based on community data from the past few years). 2. Count total number screened/referred within the same timeframe 3. Calculate: 2. (Number screened/referred) divided by 1. (Total in Target Population) 4. Provide report of number of screens by referrals source 5. Include strategies developed and indicate which are implemented Please note: HFA Standard 1-1 to 1-4.A spreadsheet available	
1-2.A Policy - Screening/ Assessment Process	Eligibility process, timely determination of eligibility, and tracking and monitoring mechanisms	Submit Policy Please note: HFA Policy and Procedure Template including sample policy language is available, as well as Policy and Procedure Checklist to ensure all required components of all policy standards are included.	
1-2.B Screening Process		No documentation required pre-site	**Interview:** * Program Manager * FRS supervisor * FRS

1-2.C Screening Timeframe		Submit a report reflecting the number of screens or assessments (whichever is used to determine eligibility) which occurred prenatally or within the first two weeks of the birth of the baby, and more than two weeks after the birth of the baby in the most recent calendar or fiscal year: 1. For your cohort group, determine total number of eligibility screens or assessments completed 2. Of those completed, how many were completed either prenatally or within 2 weeks of birth? 3. Calculate 2. (Number completed prenatally or w/in 2 weeks of birth) divided by: 1. (total number eligibility screens or assessments completed for cohort group) Please note: HFA Standard 1-1 to 1-4.A spreadsheet available This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	**Review:** * Screening tracking system (Data system or Binder) * updated reports showing recent improvements, if needed * Advisory Group Survey
1-2.D Not Offered Assessment or Services		Submit a report reflecting the number of families who 1.) were not offered home visiting services (when the site offers services universally or uses a positive screen to determine eligibility - one-step), or 2.) were not assessed (when a positive assessment is used to determine eligibility - two-step) in the most recent calendar or fiscal year. 1. Count number from cohort group that screened positive 2. Count number from cohort group that were either a) Not offered services (if a 1-step site), or b) Not offered the assessment/parent survey (if a 2-step site) 3: Calculate: 2. (number either not offered service or assessment) divided by 1. (number from cohort group that screened positive) 4. Include strategies developed and indicate which **are implemented** Please note: sites may submit the HFA Standard 1 Spreadsheet	
1-2.E Monitor and Address Declines		Submit a report reflecting the number of families who verbally declined further involvement subsequent to either, 1.) the offer of services (when a positive screen is used to determine eligibility or offers services universally - 1-step), or 2. a positive assessment (when the assessment is used to determine eligibility - 2-step), or 2.) in the most recent calendar or fiscal year. 1. Count number from cohort group offered HF home visiting services 2. Count number from cohort group who verbally declined services 3. Calculate: 2 (number who declined) divided by 1 (number who were offered) 4. Include strategies developed and **indicate which** are implemented Please note: HFA Standard 1-1 to 1-4.A spreadsheet available	

1-3.A Policy - First Home Visit within 3 months	The process and timeframe for initiating home visiting services prenatally or within the first 3 months, and tracking and monitoring requirements	Submit Policy	
1-3.B First Home Visit within 3 months		Submit a report reflecting the number of first home visits occurring prenatally or within the first three months after the birth of the baby in the most recent calendar or fiscal year. 1. Count number from cohort group with a first home visit 2. Count number from cohort group who had their first home visit either prenatally or within 3 months of birth 3. Calculate: 2. (number with first home visit prenatally or within 3 months) divided by 1. (number who had a first home visit) Please note: HFA Standard 1-1 to 1-4.A spreadsheet available This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	
1-4.A Measure Acceptance Rate		Submit a narrative describing the site's definition of acceptance rate and method for calculation (unless using HFA spreadsheet) and the current acceptance rate. 1. Count number from cohort group offered HF home visiting services (Yes, this is the same number as step 1 in 1-2.E). 2. Count number from cohort group with a first home visit (Yes, this is the same number as step 1 in 1-3.B) 3. Calculate: 2. (number with a first home visit) divided by 1. (number **offered services)**. Please note: HFA Standard 1-1 to 1-4.A spreadsheet available	**Interview:** * Program Manager * Supervisors **Review:** * Staff Survey * Advisory Group Survey
1-4.B Acceptance Analysis		Analyze both formally and informally families who refused services in comparison to families who accept services. Analysis includes programmatic, demographic and social factors as well as the reason why families decline. Please note: HFA Standard 1-4.B&C Acceptance Analysis and Plan available For smaller sites with less than 50 families offered services over a two year period, the site is required at a minimum to collect informal data and reasons why families are not accepting services, at least once every two years. The site will do a more comprehensive analysis when the sample size over a two-year period is 50 or more.	
1-4.C Plan to Increase Acceptance		Submit the most recent plan to increase the acceptance rate based on the comprehensive analysis from standard 1-4.B. Include which strategies have been implemented. Please note: HFA Standard 1-4.B&C Acceptance Analysis and Plan available	

2. Use standardized screening and assessment tools to systematically identify and assess families most in need of services. The Parent Survey or other HFA approved tool is used to assess the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences.

Standard 2 Intent: ***The overall intent of the standards in this section is to ensure the site has an objective, standardized process for identifying and assessing the strengths and needs of families at the onset of services.***

2-1. The site has clearly defined eligibility requirements for families offered services.

2-1.A The site has policy and procedures which clearly define the eligibility requirements, including scoring criteria, for families offered services.

Intent: *When developing policy, consider whether the site extends eligibility universally (meaning all families are eligible), or if eligibility is based on a positive screen, or if eligibility is based on a positive Parent Survey. The policy describes what a positive screen or a positive Parent Survey means, i.e. is it considered positive based on a particular score, a certain number of items found to be true, etc.*

2-1.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 2-1.A.
2	-	The site has policy and procedures which clearly define eligibility requirements, including scoring criteria (i.e. what constitutes a positive screen or positive assessment), for families offered services.
1	-	The site does not yet have policy and procedures; or the policy and procedures do not yet clearly define eligibility requirements or scoring criteria for families offered services.

2-1.B The site follows its policy and procedures regarding eligibility requirements for families offered services.

2-1.B		RATING INDICATORS
3	-	The site follows its policy and procedures regarding eligibility requirements for families offered services.
2	-	Past instances may have occurred when the site did not follow its policy and procedures regarding eligibility requirements for families offered services; however, **recent practice** indicates this is now occurring.
1	-	Any of the following: the site does not yet have policy and procedures; the site does not yet follow its policy and procedures regarding eligibility requirements for families in the target population; or the policy and procedures do not yet clearly define eligibility requirements for families offered services.

2-2. The site is required to use the *Parent Survey* or other HFA approved tool to initially assess for the presence of factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences.

Intent: *No single factor is sufficient to predict who faces the high levels of stress that may lead a parent to abuse or neglect a child. It is also not possible for a single factor to predict when a child is at risk for developmental delays, poor childhood outcomes or adverse childhood experiences. Therefore, sites will use the Parent Survey or other HFA approved tool to determine family strengths and needs.*

2-2.A The site has policy and procedures requiring the Parent Survey (or other HFA approved tool) be administered to assess for *risk factors* that could contribute to increased risk for child maltreatment or other adverse childhood experiences. The policy and procedures also require documentation of these risk factors be completed in *narrative* format that fully describes the concerns/needs and strengths expressed by the parent(s) during the Parent Survey/assessment conversation, and all items are scored in accordance with the guidelines of the tool. The policy and procedures identify who is responsible for administering the tool, the timeframe for completing the narrative, including supervisor review.

Intent: *Site policy and procedures ensure all staff involved in the Parent Survey assessment process provide such service objectively and reliably, so all families are assessed in the same way among all staff who administer the Parent Survey (or other HFA approved tool). Site policy also includes expectations for the documentation of the Parent Survey narrative to ensure it conveys accurately what each family shared in regard to strengths, risk factors and needs. Consistent documentation in this way provides Family Support Specialists with an understanding of each family, and affords the opportunity to provide individualized service building upon family strengths and is specific to their unique needs.*

Sites are also encouraged to highlight/document specific conversations indicating a parent(s) motivation for change (e.g. statements such as "I don't want to parent the same way as my parents", "I really want to finish school", "I want to learn everything I can to meet my baby's needs", "I want to stay clean for my baby," or "I am not going to use a belt to discipline my baby"). Statements like these assist home visiting staff in identifying potential starting points for home visit activities and can facilitate connections with families. The ongoing use of this assessment documentation becomes the basis for standards 6-1.A, 6-1.B and 6-1.C.

Please note: *If services are offered based on a positive screen or universally to all families in the* ***target population****, The Parent Survey (or other HFA approved tool – see glossary – Assessment Tool) is to be completed at the onset of services (within first 30 days of first home visit) to provide Family Support Specialists and supervisors with an understanding of the unique strengths, risk factors, and needs of a family, such that interventions uniquely tailored to the family can be planned.*

2-2.A		RATING INDICATORS
3	-	The site policy and procedures require the Parent Survey (or other HFA approved tool) is: 1) administered in its entirety in **one visit**, 2) administered prior to the first home visit if used to determine eligibility and if not used to determine eligibility, within **15 days** of the first home visit, 3) documented in narrative format detailing the presence of factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences, 4) scored in all domains (as 0, 5, 10 or U) including expectations related to scoring both parents (or partner/significant other), 5) identifies the timeframe for completing the narrative documentation and scoring, and 6) the process and timeframe for supervisor review and feedback.
2	-	The site policy and procedures require the Parent Survey (or other HFA approved tool) is: 1) administered in its entirety in no more than **two visits**, 2) administered prior to the first home visit if used to determine eligibility and if not used to determine eligibility within **30 days** of the first home visit, 3) documented in narrative format detailing the presence of factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences, 4) scored in all domains (as 0, 5, 10 or U), including expectations related to scoring both parents (or partner/significant other), 5) identifies the timeframe for completing the narrative documentation and scoring, and 6) the process and timeframe for supervisor review and feedback.
1	-	The site does not yet have policy and procedures including the detail listed in the 2 rating.

2-2.B The Parent Survey or other HFA approved tool is documented uniformly and in accordance with site policy and procedures.

2-2.B		RATING INDICATORS
3	-	The *Parent Survey* or other HFA approved tool is documented uniformly in accordance with site policy and procedures.
2	-	Past instances may have occurred when the site did not document the *Parent Survey* (or other HFA approved tool) uniformly and in accordance with site policy and procedures; however, **recent practice** indicates this is now occurring.
1	-	The site does not yet document the *Parent Survey* (or other HFA approved tool) uniformly in accordance with site policy and procedures.

2-2.C (NEW) The Parent Survey or other HFA approved tool is administered within the timeframe identified in the site's policy and procedures.

2-2.C		RATING INDICATORS
3	-	The *Parent Survey* or other HFA approved tool is administered within the timeframe identified in the site's policy and procedures.
2	-	Past instances may have occurred when the site did not administer the *Parent Survey* (or other HFA approved tool) within the timeframe identified in the site's policy and procedures; however, **recent practice** indicates this is now occurring.
1	-	The site does not yet administer the *Parent Survey* (or other HFA approved tool) uniformly within the timeframe identified in its policy and procedures.

2-2.D (NEW) Supervisors review and provide feedback to staff who administer the Parent Survey or other HFA approved tool to ensure consistent quality of scoring and documentation.

2-2.D		RATING INDICATORS
3	-	Supervisors review and provide feedback to staff each time the tool is administered to ensure documentation is complete and scoring is accurate.
2	-	Past instances may have occurred when the supervisor did not review and provide feedback to staff each time the tool is administered; however, **recent practice** indicates this is now occurring.
1	-	Supervisors do not yet review and provide feedback to staff each time the tool is administered.

Tip ☺: When staff attend Parent Survey training, supervisors are encouraged to complete post training inter-rater reliability activities with staff. Doing so helps to develop a process for ongoing review and feedback.
Tip ☺: At the time of a site visit, a supervisor's initials or signature on the Parent Survey, along with notes in the staff Supervision binder can be used to indicate the review and feedback process. Supervisors may choose to save the initial draft of the Parent Survey narrative, with comments they provided or suggestions for alternate scoring. This could be used as well, though is not required.
Tip ☺: Supervisors are strongly encouraged to review the Parent Survey within one week of administration to ensure higher risk issues and urgent needs can be discussed with staff.

Tables of Documentation			
2. Use standardized screening and assessment tools to systematically identify and assess families most in need of services. The Parent Survey or other HFA approved tool is used to assess the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study**	**Site Visit Activities**
2-1.A Policy- Eligibility	Eligibility requirements with scoring criteria	Please Submit Policy	**Interview:** * Program Manager * FRS Supervisors * FRS **Review:** * Family Files * Advisory Group Survey
2-1.B Eligibility Policy Followed		No documentation required pre-site	
2-2.A Policy - Parent Survey/Assessment	Assessment criteria as outlined in the standard	Please Submit Policy. If site uses an approved tool other than the Parent Survey, also submit approval letter from HFA National Accreditation Panel.	**Interview:** * Program Manager * FRS Supervisors * FRS **Review:** * Family Files * Staff Survey
2-2.B Parent Survey/Assessment Uniformity		No documentation required pre-site	
2-2.C Parent Survey/Assessment Timeframes		No documentation required pre-site	
2-2.D Parent Survey/Assessment Supervision		No documentation required pre-site	

3. Offer services voluntarily and use positive, persistent outreach efforts to build family trust.

***Standard 3 Intent:* The overall intent of the standards in this section is to ensure the site has a process for reaching out to and engaging families initially, as well as attempting to stay connected with and re-engaging families who may have more barriers to accepting and maintaining services.**

3-1. The site's policy, procedures and practices ensure services are offered to families on a *voluntary* basis.

Intent: *Offering services voluntarily (allowing families to choose to participate) increases trust and receptivity. Research suggests an important reason for voluntary services is mandatory services shift emphasis from one of social support to one of social control (Daro, 1988). Home visiting services must be voluntary, such that the entire context and tone is one of respect for families – their desires and their strengths (Gomby, 1993).*

3-1.A The site has policy and procedures stating services are *voluntary* and include how this information is shared with families. Please Note: See Standard GA-5.B regarding the need to have a written Family Rights form which includes but is not limited to the voluntary nature of services and a family's right to refuse service**.**

3-1.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 3-1.A.
2	-	The site has policy and procedures regarding the voluntary nature of site services, including how this information is shared with families.
1	-	The site does not yet have policy and procedures regarding the voluntary nature of services including how this information is shared with families.

3-1.B The site's practices ensure services are offered to families on a *voluntary* basis.

Intent: *While HFA is very clear services to families are offered voluntarily, there may be some external agencies who require HFA as part of mandated treatment or service plans (e.g., child welfare, court systems, substance abuse treatment facilities, etc.). HFA does not have authority to prevent this type of referral, however must be certain to clarify with families that regardless of the intent of the referral entity, HFA services are voluntary and families may end services at any time.*

Additionally, when the site enrolls families already open and active with child welfare (CPS), HFA staff are not to monitor family's progress on behalf of CPS or the court. Sharing of family service information with child welfare or the court system is bound by the confidentiality requirements of HFA and informed consent (unless subpoenaed) which indicates precisely what information is to be shared. Additionally, it may be important to inform families that sharing such information may not always be helpful to the family's situation.

3-1.B		RATING INDICATORS
3	-	The site practice clearly indicates services are offered to all families solely on a voluntary basis.
2	-	Past instances may have occurred when services were not provided voluntarily to all families; however, **recent practice** indicates services are now offered to families solely on a voluntary basis.
1	-	There are instances in which services are not yet provided voluntarily.

3-2. Staff utilizes positive methods to build family trust and engage/enroll new families.

3-2.A The site has policy and procedures specifying a variety of positive methods to build family trust and engage new families in services.

Intent: *This standard reflects the need for staff to reach out to families and utilize trust-building methods and tools, including supervision support, when establishing relationships with families. When parents have experienced unresolved early childhood trauma, their sense of whether people are safe, predictable, and pleasurable may be compromised. As a result, families may be reluctant to accept services and may struggle to develop healthy, trusting relationships. Therefore, site staff must identify positive ways to establish a relationship with a family. Utilizing a family centered approach allows staff to focus on what is important to the family. Supervision is an excellent place to strategize ways to build trust and engage families.* ***Please note:*** *This standard applies to families who have not yet received a first home visit (i.e., subsequent to the site offering services), and is not to be confused with creative outreach expectations which occur after the family has received a first home visit (Standard 3-3).*

3-2.A		RATING INDICATORS
3	-	No 3 rating indicator for 3-2.A.
2	-	The site has policy and procedures specifying a variety of positive methods (e.g., telephone calls, visits, mailings, parenting groups, family-centered practices, etc.) to build family trust and engage/enroll new families in services.
1	-	The site does not yet have policy and procedures or the policy and procedures do not yet address the requirements in a 2 rating.

☺ Tip: While there is no requirement for the amount of time staff will spend trying to initially engage families, it is recommended the pre-engagement outreach (outreach services provided prior to the first home visit) concludes within 30-45 days of the first attempted contact with the family subsequent to their verbal acceptance. For early prenatal referrals or when sites are working to build caseloads, pre-engagement outreach may extend longer.

3-2.B Staff utilize positive methods to build family trust and engage/enroll them in services.

Intent: *Staff utilize a variety of strategies to engage/enroll families in services. Research indicates families who have experienced generational abuse are at greater risk for difficulty in developing healthy relationships with others and are often reluctant to accept a partnership with Family Support Specialists (Fraiberg, 1975). Staff will develop unique ways to connect with families. Sample strategies to use with all families, including those who have experienced generational abuse, may include:*

- *Warm telephone calls focused on the family's well being*
- *Creative and upbeat notes which encourage parents to want to participate*
- *Drop by visits (exercising safety) and leaving a card when families are not home*
- *Texting when approved by site policy*
- *Anchoring conversations with families to their interests and need,*
- *Encouraging self-care practices, and*
- *Personalizing engagement efforts*

Please note: *If there are safety concerns based upon the initial screen or assessment, supervisors and staff use caution when considering unplanned visits.*

3-2.B RATING INDICATORS

3 - Site staff uses positive methods to build family trust when enrolling and engaging families in services.

2 - Past instances may have occurred when positive methods were not used; however, **recent practice** indicates the site now uses positive methods to build family trust when enrolling and engaging families in services.

1 - The site does not yet use positive methods to build family trust when enrolling and engaging families in services.

3-3. The site offers creative outreach under specified circumstances for a minimum of three months before discontinuing services for families that have had at least one home visit subsequent to the offer of services.

3-3.A The site policy and procedures specifies when families are placed on creative outreach, the activities to be carried out while the family is on creative outreach, that creative outreach is continued for families for at least three months and is only concluded prior to three months when families have (re)engaged in services, refused services, have moved from the area, have closed due to other allowable reasons (bolded below in the intent), or (in the case of Level TR (temporary re-assignment) permanent staff assignment has been reestablished.

Intent: *It is the site's responsibility to reach out to families who have received a first home visit, yet for a variety of reasons, may not be comfortable receiving ongoing home visits in a consistent manner. Often, families who have experienced trauma in their own childhood histories find it difficult to openly trust and welcome others into their homes. Additionally, families in crisis may find it difficult to continue participation due to a variety of factors.*

Please keep in mind services are to be uniquely tailored to the individual family. Activities are to be focused on strategies that demonstrate to the family the Family Support Specialist is genuinely interested in them and willing to continue to offer services. Creative activities designed to reach out to families occur throughout the full three-month timeframe. Sites are advised to avoid correspondence that threatens or demands the family to contact the site, lest they be terminated from services. While services may in all likelihood be terminated after the three-month timeframe, correspondence indicating that plan will likely add to the feelings of alienation and lack of trust families have. Personalized, handwritten notes may be more effective in establishing a trusting relationship.

The three-month creative outreach timeframe applies to families who have received a first home visit subsequent to the offer and acceptance of services. Sample strategies to use with families while on creative outreach are similar to those identified above (3-2.B) when working to initially engage families and may include:

- *Warm telephone calls focused on the family's well being*
- *Creative and upbeat notes encouraging parents to want to participate*
- *Drop by visits (exercising safety) and leaving a card when families are not home*
- *Texting when approved by site policy*
- *Anchoring conversations with families to their interests and needs*
- *Demonstrating joy in being with the parent(s)*
- *Offering playful/fun activities*
- *Encouraging parent's self-care*
- *Utilizing music and art in initial interactions, and*
- *Personalizing engagement efforts*

Site policy will include criteria for closing prior to three months only if family re-engages in service, refuses services, moves out of the service area, or other allowable reasons for ending services

(parent no longer has custody, pregnancy ended in miscarriage, target child or primary care provider is deceased, significant staff safety issues, or transferred to another program).

Please Note: *Families placed on Level TR (Temporary Re-assignment) during a staff leave of absence or turnover, will receive creative outreach service similar to families placed on Level CO (Creative Outreach) as described on HFA Level Change forms, until staff returns from leave or there is a permanent reassignment.*

3-3.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 3-3.A.
2	-	The policy and procedures specify: - when families will be placed on Creative Outreach using HFA Level Change form; - the activities to be carried out and documented during the course of Creative Outreach; - creative outreach is continued to families for a minimum of 3 months, and is only concluded prior to 3 months when families have engaged in services, **refused services**, the family has moved from the service area, other allowable reasons (parent no longer has custody, pregnancy ended in miscarriage, target child or primary care provider is deceased, significant staff safety issues, or transferred to another program), or permanent staff assignment has been reestablished.
1	-	The site does not yet have policy and procedures; or the policy and procedures do not yet address all points required in the 2 rating.

☺ Tip: It is not unusual for families to go on and off creative outreach several times, particularly when the parent has a history of past relationships that have been unsafe, unstable or unpredictable. Reluctance to engage may be a form of self and family protection to avoid repeating a pattern of being hurt or victimized by others. Reluctance to engage might be one of few mechanisms a parent feels able to use in order to establish some amount of control over their lives. When the Family Support Specialist offers positive, attentive creative outreach activities, it demonstrates to the parent the genuine caring we have for the family. Some of the most poignant and powerful stories of family outcomes are with families who were very hard to engage and were on and off creative outreach initially. Some sites have reported as many as 40% of families re-engage from creative outreach, which is tremendous. When considering the high-risk circumstances of families' lives and the vulnerability of babies, re-engaging just one family is a huge success.

☺ Tip: Sites are encouraged to consider placing a family on creative outreach when a scheduled visit results in a "no show", followed by a consecutive rescheduled visit also resulting in a no-show, or an unsuccessful attempt to reschedule (i.e. parent cannot be located). When moving to Level CO, the date of the first "no-show" visit can be used as the date CO began). When returning a family to their previous service level, and to avoid frequent back and forth placement from Level CO to an active service level, it may be beneficial to do so once the family has received at least 75% of expected visits for the month (when returning to Level 1). For families returning to Level 2 or 3, the date of transition back to these levels will be based on supervisor and FSS consideration of family's re-engagement.

☺ Tip: Supervisors may use their discretion to determine family situations warranting a creative outreach period longer than three months, and this should be documented in supervision notes.

☺ Tip: It is recommended Family Support Specialist s check in with families regularly to obtain new or additional emergency contacts. Having updated secondary contact information can make a significant difference in maintaining connections with families over the course of service delivery.

3-3.B The site places families on creative outreach and continues creative outreach for at least three months, only concluding creative outreach services prior to three months when families have (re)engaged in services, refused services or moved from the area.

3-3.B		RATING INDICATORS
3	-	The site places families on creative outreach appropriately, conducts the activities to be carried out during the course of creative outreach and continues creative outreach for at least three months. The only instances found when outreach was concluded prior to three months occurred when the families (re)engaged in services, refused services, moved from the area, or other allowable reasons (parent no longer has custody, pregnancy ended in miscarriage, target child or primary care provider is deceased, significant staff safety issues, or transferred to another program) or permanent staff assignment has been (re)established.
2	-	Past instances may have occurred when families were not placed on outreach appropriately; however, **recent practice** indicates the site places families on creative outreach, conducts the activities to be carried out during the course of creative outreach and continues outreach for at least three months. The only instances found when creative outreach was concluded prior to three months occurred when the families (re)engaged in services, refused services, moved from the area, or other allowable reasons (parent no longer has custody, pregnancy ended in miscarriage, target child or primary care provider is deceased, significant staff safety issues, or transferred to another program) or permanent staff assignment has been (re)established.
1	-	Any of the following: the site does not yet place families on creative outreach appropriately; does not yet conduct the activities to be carried out during the course of creative outreach; or does not yet continue creative outreach services for at least three months.

3-4. The site measures, analyzes and addresses how it might increase the retention rate of families in a consistent manner and on a regular basis.

3-4.A The site measures its retention rate using HFA approved methodology - first and last home visit of all who enrolled in a particular calendar or fiscal year – (please see measuring retention rates). Other methodologies may be used in addition. 3-4 Retention Worksheet

Intent: *Calculating the length of time families are retained in services is a critical quality improvement measure. Sites are to look at the length of time families remain in services and identify patterns and trends associated with families dropping out of services at specified intervals. Comparing retention rates across different cohort groups (e.g. all families enrolled in 2015 with all families enrolled in 2016) allows sites to determine if improvement strategies employed one year are having impact the next, or if there have been significant demographic or programmatic shifts that have impacted retention from year to year.* ***Please Note: New sites without 2 full years since home visiting services began will complete an annual measurement of retention based on 6-month retention data.***

3-4.A RATING INDICATORS

3 - The site measures the retention rate of families in services using HFA methodology at various intervals (e.g. 6 month, 12 month and 24 month, etc.) across **multiple cohort groups** (e.g. families enrolled in 2015 and 2016) and retention rates for each group are being measured at least annually.

2 - The site measures its retention rate using HFA methodology at various intervals (e.g. 6 month and 12 month, etc.) for **one cohort group** (e.g. 2015 only) and retention rates are measured at least annually.

1 - The site is not yet measuring its retention rate using HFA methodology at least annually.

For example, if you want to measure retention for the cohort of families that enrolled in calendar year 2015, you would first record each family enrolled between January 1, 2015 and December 31, 2015 with the date of each family's first home visit. And then for any of these families that have left services you will also record the date of their last home visit. Families that remain open (including those still on creative outreach) will only have the first home visit date recorded.

Then, six months after the 2015 enrollment year ends (i.e. July 1, 2016) you are able to calculate a valid 6 month retention rate, looking at the percentage of families who remain in services as of that date. Similarly, twelve months after the 2015 enrollment period ends (i.e. January 1, 2017) you are able to calculate a valid 12 month retention rate looking at the percentage of families remaining in services out of all those enrolled in 2015. And twenty-four months after the 2015 enrollment period ends (i.e. January 1, 2018) you will be able to calculate a valid 2 year retention rate.

Calculating retention at these various intervals for 2015 families (or any other enrollment year) will result in a 2 rating for this standard. Calculating retention for two different enrollment years (let's say 6 mo, 12 mo, and 24 mo retention rates for 2015 families and 6 mo and 12 mo retention rates for 2016 families) will result in 3 rating.

3-4.B Average and large sites with more than 50 active families at any one time over the last two years, will comprehensively analyze at least once every two years (i.e., both formally through data collection of demographic, programmatic and social factors, and informally through discussions with staff and others involved in site services) families no longer receiving services in comparison to families remaining in services. Please see common terms associated with analyses. Sites can use 3-4 Retention Worksheet

Intent: *Sites are required to measure family retention annually and conduct a thorough analysis once every two years to determine patterns or trends, comparing families who remain enrolled with those who are no longer enrolled services, and to identify improvement strategies to increase family retention. Sites may choose to analyze data more often if patterns or volume suggest this need.*

For smaller sites with 50 or fewer active families in services at any one time over a two year period, the site is required at a minimum to collect informal data and reasons why families are leaving services, and to do a more comprehensive analysis when active families at any one time exceeds 50 or more over a two year period.

Please note: *While sites will measure retention (3-4.A) over various intervals (6 months, 12 months, 24 months, 36 months, etc.) and across different cohort groups (e.g. those who enroll in 2015, in 2016, in 2017, etc.), the analysis of families who stay compared to those who leave (3-4.B and C) needs only to be based on one cohort group of families who enrolled in services within a defined year. In addition, sites should choose just one interval (suggested interval: 12 months) in order to clearly distinguish similarities and differences between those who were retained vs those who leave services (e.g. How are families that were enrolled in 2016 and retained for at least 12 months similar and different from families that enrolled in 2016 and left services before the 12 month mark?).*

When a site is only able to run this analysis every other year, sites may choose to widen their cohort group to include two years of families (e.g. instead of choosing to analyze families that enroll in 2016 only, sites could choose to analyze families that enroll in 2015 AND 2016). In this case, the measurement (3-4.A) and the analysis (3-4.B) will in all likelihood reflect different data sets and this is perfectly acceptable.

Please Note: *Sites or multi-site systems with capacity and desire to conduct a more rigorous retention analysis are welcome to do so.*

Please Note: *New sites without 2 full years since home visiting services began will complete a first analysis with one year of data instead of two. If the site is both new and small (25 active families or fewer over one year, or 50 or fewer over two years), they will report on informal data and reasons why for families who have left services.*

3-4.B RATING INDICATORS

3 The site uses both formal and informal data to analyze, at least once every two years, families who leave services and reasons why. This analysis is comprehensive, addressing **multiple factors within each of the 3 categories**, 1) programmatic, 2) demographic, and 3) social, and compares these factors for those who remain in services with those who left services during the same time period; **OR no families have left services prior to service completion in the past two years**.

2 - The site uses both formal and informal data to analyze, at least once every two years, families who leave services and reasons why. This analysis compares those who remained in service with those who dropped out during the same time period, and addresses **at least one factor within each of the 3 categories**, 1) programmatic, 2) demographic, and 3) social. For smaller sites with 50 or fewer families active in services at any one time over a two year period (or for new sites without two years of data, fewer than 25 active families over one year), the site has at a minimum collected informal data and reasons why families have left services.

1 - Any of the following:
1) the site does not yet have an analysis of families who dropped out of services and reasons why;
2) does not yet include both informal and formal data;
3) the analysis does not yet include at least one factor from each of the three categories, programmatic, demographic, or social;
4) the analysis does not yet include a comparison of those who remained in service with those who dropped out during the same time period;
5) the analysis is not yet conducted at least once every two years, or
6) if a smaller site, the site has not yet, at a minimum, collected informal data and reasons why families have left services.

3-4.C The site has a plan to address how it might increase its retention rate based on its analysis of families who dropped out of services, at what point in services, and the reasons why. Sites can use 3-4 Retention Worksheet.

Intent: *Some reasons for ending services are not factors that can typically be influenced by developing retention strategies and therefore do not need to be included in the plan for increasing retention. Though sites will be expected to capture all reasons why families are discontinuing services earlier than expected, reasons not requiring improvement strategies include parent no longer has custody, pregnancy ended in miscarriage, target child or primary care provider is deceased, staff safety issues, transferred to another program, or family moved out of service area. Sites will clearly connect the patterns or trends learned from the analysis to strategies identified in the plan.*

3-4.C		RATING INDICATORS
3	-	Based on the analysis, the site **has implemented a plan** for increasing its retention rate among the families currently dropping out of services. The plan addresses programmatic, demographic, or social factors based upon the trends identified in the analysis. **Or no families dropped out of the site in the past two years**. Smaller sites have implemented a plan based on the review of informal data and reasons why.
2	-	Based on the analysis, the site has developed a plan for increasing its retention rate among the families currently dropping out of services. The plan addresses programmatic, demographic, or social factors based upon the trends identified in the analysis; however, **the plan has not yet been implemented**. For smaller sites, a plan to increase retention has been developed but not yet implemented based on informal data collected and reasons why.
1	-	Any of the following: the site does not yet have a plan; the plan is not yet based on the analysis; does not yet address programmatic, demographic, and social factors; or does not yet address how it might increase its retention rate.

Tables of Documentation			
3. Offer services voluntarily and use positive, persistent outreach efforts to build family trust			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study**	**Site Visit Activities**
3-1.A Policy - Voluntary Services	The voluntary nature of services and how families are made aware services are voluntary	Submit Policy	**Interview:** * Program Manager * Supervisors * FRS * FSS * Families **Review:** * Materials/Forms Indicating services are voluntary * Family Files * Staff Surveys
3-1.B Services are Voluntary		No documentation required pre-site	
3-2.A Policy - Trust Building	The methods use to establish and build trusting relationships with families	Submit Policy	**Interview:** * FSS Supervisors * FSS * Families **Review:** * Family Files * Staff Surveys
3-2.B Trust Building		No documentation required pre-site	
3-3.A Policy - Creative Outreach	The process for creative outreach services specifying the criteria indicated in the standard	Submit Policy	**Interview:** * FSS Supervisors * FSS * Families **Review:** * Closed Family Files
3-3.B Creative Outreach		No documentation required pre-site	

3-4.A Measure Retention		Please submit the site's definition of family retention and method for calculating (unless using HFA spreadsheet) and minimum of 12 month retention calculation. HFA methodology for calculating a site's retention rate is: 1. Select a specified time period, e.g., January 1, 2016 to December 31, 2016 – this is called a "volume year" and can be a calendar year or fiscal year. 2. Count the number of families who received a first home visit during this time period, 3. Count the number of families in this group that remained in services over specified periods of time (six months, 12 months, two years or more, etc.); 4. Divide this number by the total number of families defined in step 2 (that received a first home visit during the time period.) 5. For accuracy, a time period must be selected that ended at least one year ago for one year retention rate, two years ago for two year retention rate, three years ago for three year retention rate, and so on. This is to ensure that all families beginning services during the specified time period have had the opportunity to stay for the full retention period being measured. For example, a family enrolled in December 2016 could not be counted as retained for one year until December 2017. Please note: HFA 3-4.A Retention Measurement Worksheet available	**Interview:** * Program Manager * FSS Supervisors * FSS **Review:** * Staff & Advisory Surveys
3-4.B Retention Analysis		Analyze both formally and informally families who remain in services in comparison to families who leave. Analysis includes programmatic, demographic and social factors as well as the reason why families leave. Develop a plan to increase retention addressing any programmatic, demographic and social factors identified in the analysis. Please note: HFA Standard 3-4.B&C Retention Analysis and Plan available For sites with less than 50 families offered services over a two year period, narrative of informal data and reasons why families are not accepting services as well as strategies developed to increase acceptance and which have been implemented.	
3-4.C Plan to Increase Retention		Please submit the most recent plan to increase retention based on the comprehensive analysis in 3-4.B. Include which strategies have been implemented. Please note: HFA Standard 3-4.B&C Retention Analysis and Plan available	

4. Offer services intensely and over the long term, with well-defined criteria and a process for increasing or decreasing intensity of service.

***Standard 4 Intent:** The overall intent of the standards in this section is to ensure the site is providing services intensively after the birth of the baby (weekly) and to ensure services are offered until the child is a minimum of three years and up to five years of age. Additionally, the site must have a well-thought out process for determining the intensity/frequency of home visits consistent with the needs and the progress of each family.*

4-1. The site offers home visiting services intensively after the birth of the baby.

4-1.A The site's policy and procedures state families are offered weekly home visits for a *minimum* of six months after the birth of the baby or six months after enrollment (whichever is longer), excluding time on creative outreach.

Intent: *The first 6 months of involvement with a family, after a baby has been born, is critical for many reasons including: parent-infant relationship development, newborn care and safety, and adjustment to parenthood. While respecting the family's schedule, weekly visits during this time are essential. This standard does not require all families receive weekly visits during this time period, but is intended to ensure weekly services are offered during this time.*

Policy regarding families being offered weekly home visits for 6 months after the birth of the baby can provide exception for isolated instances (up to 10% of active caseload) due to family school or work restrictions. However, when families request a less frequent home visiting schedule during this timeframe, sites are encouraged to keep the family on level one, continue to offer weekly visits as the family's school or work situation may change. This also ensures the Family Support Specialist's caseload weight is safeguarded to allow for weekly home visits to resume under those circumstances. This does not mean the Family Support Specialist must continually try to schedule or engage the family into a weekly visiting schedule, but they clearly indicate to the family the availability of this weekly schedule. This also ensures that movement to Level 2 is based on family progress vs family availability.

In some situations, families may enter services when the baby is older than 1 month, or some families may have periods of being on creative outreach during the first six months, therefore it is important to establish policy clearly indicating the time frame to offer weekly service is intended as a full six month period of active family engagement versus until the baby is six months old. This six month period also excludes time while on creative outreach (this includes Levels CO, TO, and TR). The HFA 4-1.B Tracking Form (or equivalent) assists site in monitoring this. ***Please Note:*** *Families whose infant is hospitalized in NICU after birth will not be placed on Level 1 until the baby comes home from the hospital, unless the parents want weekly visits during that time. Otherwise, the family will be on level CO or TO while in NICU and weekly visits will be offered once the baby comes home for six months or longer (as specified in the standard).*

4-1.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 4-1.A.
2	-	The site's policy and procedures state the minimum length of time for offering weekly home visits is at least six months after the birth of the baby or six months after enrollment (whichever is longer), excluding time on creative outreach (Levels CO, TO and TR), unless family qualifies for HFA Accelerated (both parents score at low-risk, 20 or less, per initial assessment using the Parent Survey).
1	-	The site's policy and procedures state the minimum length of time for offering weekly home visits is less than six months, or minimum length of time for weekly visits is not yet indicated in site policy and procedures.

4-1.B The site ensures families remain on a weekly home visiting level for a minimum of six months after the birth of the baby, and develops strategies to improve if the rate less than 90%.4-1.B Tracking Form**.**

Intent: *The site is expected to measure its rate of home visit intensity using the 4-1.B spreadsheet. If using a data system report instead, it must apply the same HFA methodology in its calculation. The site will need to be sure it aggregates and summarizes its data and develop improvement strategies if the rate is below 90%.*

It is important when a family's immediate work/school schedule precludes the offer of weekly home visits, or when a family enters moves to creative outreach during the 6 month period, their service level returns to weekly as soon as the family's schedule permits. It is not intended for families in these situations to automatically be moved to Level 2, as progression to less intense services is based on indicators of increased family stability and parent-child well-being as identified in level change ***criteria*** *versus scheduling conflicts.*
Please Note: *When calculating the percent of families who remained on Level 1 for six months or longer, sites will exempt from the data calculation any family that re-enrolled after previously being closed to services or that* ***transferred*** *into HFA services from another site when the transfer or re-enrollment occurred postnatally after the baby is 3 months old. Families who* ***transferred*** *or re-enrolled prenatally or prior to the baby turning 3 months old will be included in the calculation.*
Please Note: *Families are also excluded from the 4-1.B calculation who meet the criteria for HFA Accelerated - where both parents score 20 or less on the Parent Survey (when both parents have been scored), or the primary caregiver scores 20 or less (when only one parent is scored) AND meet progress criteria to move to Level 2 sooner than six months.*

4-1.B RATING INDICATORS

3 - **At least ninety percent (90%) of families remain on a weekly home visiting level for a minimum of six months** after the birth of the baby or six months after enrollment (whichever is longer), excluding time on creative outreach.

2 - Past instances may have occurred when less than 90% of families remained on a weekly home visiting level for a minimum of six months after the birth of the baby or six months after enrollment (whichever is longer), excluding time on creative outreach; however, improvement strategies have been developed and **the most recent level changes from Level 1 to Level 2 indicates at least ninety percent (90%) of families remain on a weekly home visiting level for a minimum of six months** after the birth of the baby or six months after enrollment (whichever is longer), excluding time on creative outreach.

1 - Less than 90% of families remain on a weekly home visiting level for a minimum of six months after the birth of the baby or six months after enrollment (whichever is longer), excluding time on creative outreach; or improvement strategies have not yet been developed.

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when home visit intensity rates (families staying on Level 1 for at least 6 months) fall below the 90% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

4-2. The site utilizes a well-thought-out system for managing the intensity/frequency of home visiting services.

4-2.A (MERGED 4-2.D) The site has policy and procedures clearly defining the levels of service (i.e. visit frequency - weekly, bi-weekly, monthly, etc., and corresponding case weight at the various levels). The site's policy and procedures also includes the process for reviewing progress and achievements made by families are involved in the level change decision. Please download HFA Level Change Forms and Documents.

Intent: *As a family-centered model, HFA endorses the use of a "level system" for managing the intensity of services. A well-thought out system is sensitive to the needs of each family, the changes in family needs and competencies over time, and the responsibilities of the Family Support Specialist. Clearly defined levels reflect in measurable ways the capacity of the family, such that families with higher needs are able to receive more intensive services, while less intensive services are provided as stability and progress increases. Not only does an effective "level system" allow for individualized service delivery, it also provides sites a mechanism to monitor more effectively caseload capacity, thus promoting higher quality services. It is important for Family Support Specialists to know where to locate information regarding levels of service and to be familiar with the process of how a family progresses from one level to another. Because changes to visit frequency are based on progress, the age of the child or the length of time on a particular level are never the sole basis for level change decisions. HFA has the following levels and associated case weights are provided below:*

Level 2P = 2 points - every other week visits when enrolled during first or second trimester of pregnancy (0-27 weeks gestation). Weekly visits to start for purposes of establishing the relationship may be considered followed by every other week visits until birth. 2pts ensures space is retained to allow move to Level 1

Level 1P= 2 points - weekly visits when enrolled in third trimester of pregnancy (28 weeks gestation and later), or earlier based on need

Level 1 =	*2 points - weekly visits*
Level 2 =	*1 point - every other week visits*
Level 3 =	*.5 point - monthly visits*
Level SS =	*additional 1 point added to Level 1, 2 or 3 weight during temporary periods of intense crisis*
Level 4 =	*.25 point – quarterly visits*
Level CO =	*.5 point - 2 points*
formerly Level X	*Sites maintain a family's case weight while on Level CO equal to the family's level prior to being placed on creative outreach to ensure space is retained to move family back to that level if re-engaged*
Level TO =	*.5 point - 2 points - temporarily out of area for up to 3 months* *Sites maintain a family's case weight while on Level TO equal to the family's level prior to being placed on creative outreach to ensure space is retained to move family back to that level if re-engaged*
Level TR =	*.5 point - temporary re-assignment to another staff person during extended staff leave or turnover up to 3 months, when family is not receptive or able to continue receiving services at the frequency associated with previous level. When family is receptive and able to continue receiving home visits consistent with previous level then they should remain on that level and weight versus moving to TR.*

This standard also relates to the process a site utilizes to ensure families, Family Support Specialists, and Supervisors are all involved in the level-change decision. Therefore, supervisors document conversations they have with Family Support Specialists about potential level changes during routine supervision sessions where family progress is discussed (this can be done using the Level Change form by checking off expectations met and including the date discussed). Likewise, Family Support Specialists are to document conversations they have with families about family progress and any change made to home visit frequency. If sites use HFA Celebration forms (giving copy to the family and keeping a copy in the file with the date shared with the family) additional documentation in the home visit record is not needed, ***Please Note:*** *Level change decisions based on family progress are specifically tied to when families move from one active service level to another (i.e. Level 1 to Level 2, Level 2 to Level 3, and Level 3 to Level 4). It does not apply to moving families to Level CO, TO or TR or from Level 2P to Level 1P or from Level 1P to Level 1.*

4-2.A RATING INDICATORS

3 - No 3 rating indicator for standard 4-2.A.

2 - The site's policy and procedures:
- define levels of service,
- describe the process for reviewing progress and achievements made by families using HFA Level Change Forms,
- include the involvement of the Family Support Specialist, the family, and the supervisor in making level change decisions based on family progress.

1 - The site does not yet have policy and procedures; or the policy and procedures do not yet address the requirements listed in the 2 rating.

☺ Tip: When making decisions about frequency of visits prenatally, sites should keep in mind that Healthy Families research has demonstrated higher rates of positive birth outcome when visits are initiated as early in the pregnancy as possible, and no later than 31 weeks gestation with a minimum of 7 visits received prior to birth. (Lee, E., et al, 2009. *Reducing low birth weight through home visitation: A randomized controlled trial*. American Journal of Preventive Medicine 36; 2: 154-160). For sites using doulas, see 4-2.B regarding use of multi-disciplinary staff to provide home visits.

☺ Tip: When families exit services and later express interest in re-enrolling, sites can use their discretion about whether to do so, and will want to consider whether space is available to re-enroll. When a family has been discharged for longer than 6 months, a site should also consider whether a brand new service record should be established, including obtaining updates on the Parent Survey and other intake information. The site may also want to establish initial assignment at Level 1 until progress criteria to move to Level 2 is demonstrated (which could potentially happen sooner than six months on Level 1).

4-2.B Families at the various levels of service (e.g., weekly visits, bi-weekly visits, monthly visits, etc.) offered by the site receive the appropriate number of home visits, based upon the level of service to which they are assigned. **Sites can use Home Visit Completion and Caseload Management worksheet.**

Intent: *Home visits (taking place where the family resides) provide the opportunity to experience the family's living environment, to develop first-hand knowledge of the strengths and stresses of the home environment, to implement home safety assessments with the family, and to engage the family on "their turf". It is acknowledged not all visits will occur in the home. When the home environment is overly chaotic or unstable, or when social isolation impedes the family's interaction with the larger community, or when visits happen in conjunction with transporting to medical appointments, etc., these visits occurring outside the home can be beneficial and are permissible (at Supervisors discretion). These visits can count as a home visit, but only when the content of the visit matches the goal of a home visit and can be documented as such, including documentation of CHEERS. The goal of a home visit is to promote positive parent-child interaction, healthy childhood growth and development, and enhance family functioning. Typically, a home visit lasts a minimum of an hour and the child is present.*

For those families assigned to a weekly level of service, one parent group meeting per month may be counted as a home visit if documented individually on a home visit record in the family file. The home visit documentation of the group meeting must be documented by an HFA trained staff (does not have to be the assigned Family Support Specialist) and includes CHEERS observations when the group includes parent child interaction time.

Some sites work in collaboration with other multi-disciplinary team members, such as doulas, lactation consultants, child development specialists, mental health therapists, etc. The site may count one home visit per month conducted by these team members if the provider has received HFA Integrated Strategies core training, documents the visit on the site's home visit record, including observation of CHEERS, and receives supervision in accordance with standards 12-1 and 12-2.

Please note: *The HFA 4-2.B form (or an equivalent database report) measures home visit completion rates over a period of three consecutive months (one quarter).*

The home visit completion percentages detailed in the rating indicators are designed to account for situations when staff or family may not be available due to illness, vacation, training, etc.

4-2.B RATING INDICATORS

3 - **Ninety percent (90%) of families receive at least seventy-five (75%)** percent of the appropriate number of home visits based upon the individual level of service to which they are assigned.

2 - **Seventy-five percent (75%) of families receive at least seventy-five (75%)** percent of the appropriate number of home visits based upon the individual level of service to which they are assigned.

1 - Less than seventy-five percent (75%) of families receive at least seventy-five (75%) percent of the appropriate number of home visits based upon the individual level of service to which they are assigned.

Note: This is a Sentinel Standard

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when home visit completion rates fall below the 75% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase completion rates.

☺ Tip: When home visiting staff are away from the office for a period of longer than one week, families should be provided with contact information of who to contact in their absence, if needed. When extended absences occur i.e. due to family or medical leave, a more formal coverage plan should be in place, so families receive necessary support and services.

4-2.C The site monitors and addresses annually how it might increase its home visit completion rate.

Intent: *The HFA 4-2.B Tracking Form (or equivalent database report) along with supervision provides a format for monitoring home visit completion rates for each Family Support Specialist , and ultimately for the site as a whole. When tracking data over multiple quarters, determination of patterns and trends related to home visit completion rates can be identified. Strategies to improve home visit completion rates, based on information from site monitoring over four consecutive quarters are to be developed annually. This in no way precludes a site from taking earlier and more timely action when needed to correct a staffing or policy issue, or other situation requiring immediate action.* ***Please note: You can find a definition for*** *Monitors and Addresses in the glossary.*

4-2.C RATING INDICATORS

3 - Based on the most recent year of quarterly monitoring (four consecutive quarters), **strategies have been implemented** for increasing its home visit completion rate; or all staff for each of the last four quarters has achieved a rate of 90% of the families receiving 75% of their home visits (in which case no strategies are required).

2 - Based on the most recent year of quarterly monitoring (four consecutive quarters), strategies addressing issues and how the site might increase its home visit completion rate have been **developed, but have not yet been implemented.**

1 - Any of the following: the site either has not yet monitored home visit completion rates over the most recent year; or does not yet have strategies for how it might increase home visit rates; or site's strategies do not yet address a significant issue identified through monitoring.

☺ Tip: Sites are encouraged to consider its review of home visit completion rates with similar rigor as standards which require analysis. This would involve to the greatest extent possible consideration of any demographic, programmatic or social factors which could be contributing to lower home visit completion rates.

4-2.D Each family's progress (as identified on HFA Level Change forms) to a new level of service is reviewed by the Family Support Specialist and Supervisor and the family's progress serves as the basis for the decision to move the family from one level of service to another.

Intent: *Family progress is reviewed in an ongoing fashion as often as needed (whether semi-annually, quarterly or more frequently) based on the needs of the family and the current home visit frequency. The decision to change to a new level of service needs to be based on family progress, which is most often outlined on level change forms. Level change decisions are not made based on site needs, personnel issues, or the age of the child.*

4-2.D		RATING INDICATORS
3	-	Each family's progress (as identified on HFA Level Change forms) to a new level of service is reviewed by the Family Support Specialist and supervisor and serves as the basis for the decision to move the family from one level of service to another.
2	-	Past instances may have occurred when families moved from one level of service to another in absence of HFA Level Change forms or a review of family progress by the Family Support Specialist and supervisor; however, **recent practice** indicates the Family Support Specialist and supervisor review the appropriate Level Change form and base level change decisions on progress made by families.
1	-	Families are moved from one level of service to another in absence of HFA Level Change forms and a review of family progress by the supervisor and Family Support Specialist.

4-2.E **(SPLIT)** Once the supervisor and the Family Support Specialist agree a family's progress indicates readiness for movement to a less intensive service level, the Family Support Specialist reviews this progress and achievements with the family and serves as the basis for the decision to move the family from one level of service to another.

Intent: *Family progress and achievements are acknowledged with the family an ongoing fashion The decision to change to less frequent home visits is based on family progress, as outlined on level change forms. The conversation with families when moving to less frequent visits is to be used as a time to celebrate with the family their progress and achievements. HFA has sample celebration forms that can be used with families for this purpose.*

4-2.E		RATING INDICATORS
3	-	Each family's progress (as identified on level change forms) to a new level of service is reviewed by the family and Family Support Specialist and serves as the basis for the decision to move the family from one level of service to another.
2	-	Past instances may have occurred when families moved from one level of service to another in absence of a review of family progress, between the Family Support Specialist and family; however, **recent practice** indicates the Family Support Specialist and family review and base level change decisions on progress made by families.
1	-	Families are moved from one level of service to another in absence of a review of family progress, or the Family Support Specialist and family were not involved with the level change decision.

4-3. The site offers traditional HFA services to families for a minimum of three years (or through age five when sites are funded to do so), after the birth of the baby.

4-3.A The site has policy and procedures specifying traditional HFA services are offered for a minimum of three years after the birth of the baby.

4-3.A	RATING INDICATORS
3 -	No 3 rating indicator for standard 4-3.A.
2 -	The site policy and procedures specify traditional HFA services are offered for a minimum of three years after the birth of the baby.
1 -	The site does not yet have policy and procedures, or the policy and procedures do not yet address the requirements listed in the 2 rating.

☺Tip: Sites are encouraged to continue services beyond age 3, and through age 5, whenever family needs warrant, funding permits and transition to other services (e.g., Head Start, kindergarten) is not possible.

☺Tip: Service length may also be extended beyond the norm on occasions where Level 3 or 4 families nearing service completion experience a crisis warranting a temporary return to more intensive services. Normative situations, like a healthy subsequent birth, are not reason to extend service length beyond what would be expected based on age of target child, nor is it recommended sites restart services with the subsequent birth as a new target child, unless the subsequent birth adds substantial risk to the functioning of the family.

☺Tip: Sites who enroll families scoring at low-risk (both parents score 20 or less on the Parent Survey), may have families successfully complete progress criteria and conclude services prior to three years (HFA Accelerated).

4-3.B Services are offered to families for a minimum of three years after the birth of the baby.

4-3.B	RATING INDICATORS
3 -	Services are offered for a minimum of three years after the birth of the baby.
2 -	Services are offered for a minimum of three years after the birth of the baby. Past instances may have occurred when the site did not offer services to families for at least a minimum of three years; however, **recent practice** indicates the site is offering services for a minimum of three years; or the site has not yet been in operation for 3 years.
1 -	Site is not yet offering services for a minimum of three years.
Note:	**This is a Sentinel Standard**

4-4. The site ensures families planning to discontinue or close from services have a well thought out transition plan.

Intent: *When a family prepares to terminate services (whether due to HFA service completion, graduation, transition to a different service provider in the community, planned move out of the service area, etc.), transition planning efforts involving the family, Family Support Specialist , and Supervisors, will be made to ensure a successful transition.* ***Please note:*** *All parties do not have to be present at the same time to develop the plan. While the decision to develop a transition plan is based on the wishes of the family (the family may decline), the site is expected to be strongly proactive with respect to transition planning. To increase the likelihood needed supports and services will be accessed after service closure, the site takes the initiative to explore suitable resources, contact service providers, and follow-up on the transition plan, as appropriate, when possible, and with the permission of the family, ensuring appropriate informed consents are signed. Whenever possible, sites are to allow for sufficient time to ensure needed services will be planned for and accessed after HFA services end. Typically, this process may take 3-6 months prior to the transition.*

4-4.A The site has policy and procedures specifying the activities related to service closure and transition planning for families who have a planned closure and provide notice of such to the Family Support Specialist at least three months prior to closure (circumstances leading to an unplanned or unexpected closure, or a planned closure with less than three months' notice would not be held to the standard, though the site is encouraged to provide as much support as possible in these situations). The activities include the following:

- documentation of a transition plan includes reason for planned closure and date the discussion was initiated with the family,
- the family, the Family Support Specialist , and the *Supervisors* are involved, though not required to be present at the same time,
- sufficient time is allotted to conduct the plan (typically 3-6 months prior to transition),
- resources or services needed or desired by the family are identified,
- steps are outlined to obtain any identified resources or services,
- Prior to closure the site or family (based on family preference) follows-up with identified resources to determine availability and assist with successful case closing transition.

4-4.A		RATING INDICATORS
3	-	No 3 rating indicator for 4-4.A
2	-	The site has policy and procedures specifying the process for service closure and transition planning, including all components identified in the standard.
1	-	The site does not yet have policy and procedures, or the policy and procedures do not yet include the components outlined in the standard.

☺Tip: Sites are encouraged to incorporate transition planning into the Family Goal process if families choose to do so.

☺Tip: Site should begin transition planning with families when the child is 30 months of age (when length of service is 3 years) or 54 months (when length of service is 5 years). Following initial discussion, the topic of transition planning should be included in most discussions with the family at subsequent home visits, including identification of available resources/services needed or desired.

☺Tip: As it relates to families who decline a transition plan, it will be useful for the site to document or obtain a signature indicating the family has declined.

4-4.B The site utilizes transition planning, to support families with a planned discharge from services. Download HFA Sample Transition Plan in English and Spanish.

4-4.B		RATING INDICATORS
3	-	The site conducts transition planning with families when there is a planned closure, and activities include all items included in the standard.
2	-	Past instances may have occurred when transition planning activities as outlined in the standard were not conducted; however, **recent practice** indicates the site conducts transition planning according to the standard; or there have been no planned closures yet, or families with planned closure declined a transition plan.
1	-	A transition plan for families with a planned closure is not yet offered or does not yet include all components identified in the standard.

Tables of Documentation			
4. Offer services intensely and over the long term, with well-defined criteria and a process for increasing or decreasing intensity of service			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study**	**Site Visit Activities**
4-1.A Policy - Weekly Visits Six Months	The minimum length of time families remain on level one with criteria as specified in the standard	Please Submit Policy	**Interview:** * Supervisors and FSSs, if needed **Review:** * Family Files * Supervision Records
4-1.B Measuring Home Visit Intensity		Submit report showing the total number of families who have been enrolled at least six months after the birth of the baby, or six months after enrollment (whichever is longer) and the number (and percent) of those families who remained on level 1 (weekly visits) for a minimum of six months, excluding time on creative outreach. 1. Count total number active families who have been enrolled at least six months after the birth of the baby, or six months after enrollment (whichever is longer) 2. Count the number of these families who remained on level 1 (weekly visits) for a minimum of six months, excluding time on creative outreach. 3. Present number and calculate percentage: 2. (families who remained on level 1 according to standard) divided by 1. (total number of active families who have been enrolled for timeframes described). Please Note: HFA 4-1.B Weekly Home Visiting Spreadsheet available This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	
4-2.A Policy - Levels of service	Levels changes including use of HFA Level Change Forms and review of family progress and involvement of family, FSS and supervisor in level change decisions	Submit Policy	

4-2.B **Home visit Completion Rate** ***Sentinel Standard***		Submit home visit completion report which includes: All active families by FSS including level of service, level changes that quarter, number of expected home visits that quarter and number of completed home visits that quarter. To calculate home visit completion: 1. Determine for each family over the course of a quarter the expected number of home visits (based on level of service alone). 2. Count the number of completed visits (while family is on active service level) for each family during the quarter. 3. For each family calculate: 2. (completed visits) divided by 1. (expected visits). 4. Count the total number of active families. 5. Subtract from 4. (total active families) the number of families who were on creative outreach for the entire quarter. 6. Count the number of active families who received at least 75% of expected home visits. 7. Program HVC rate is calculated by taking 6. (number of active families who received 75%+ of visits) divided by 5. (active families - minus CO entire quarter). Please Note: HFA 4-2.B Home Visit completion spreadsheet available This is a threshold standard, meaning to be in adherence a minimum threshold has been established (75% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	**Interview:** * FSS Supervisors * FSS * Families **Review:** * Family Files * Supervision Records * Staff Surveys
4-2.C Monitor Home Visit Completion and Plan to Increase		Please submit most recent four quarters of HVC data and strategies to address issues. **Please Note:** The HFA HVC strategies handout available	
4-2.D Level Changes in Supervision		No documentation required pre-site	
4-2.E Level Changes with Families		No documentation required pre-site	

4-3.APolicy - Services for Minimum of Three Years	The length of time families remain services, minimum of three years after birth of the baby	Please Submit Policy	**Interview:*** FSS Supervisors* FSS**Review:*** Family Files* Supervision Records
4-3.B Services provided for 3-5 years *Sentinel Standard*		Submit a report indicating the current number of families who have been enrolled for 3 or more years. If families graduate after three years of service, provide a report indicating all families who have graduated within the last year.	
4-4.A Policy - Transition Planning	Process for service closure and transition planning including components in the standard	Please Submit Policy	**Interview:** * FSS Supervisors * FSS **Review:** * Family Files * Supervision Records
4-4.B Transition Planning		No documentation required pre-site	

5. Services take into account the culture of families such that staff understands, acknowledges, and respects cultural differences of families; staff and materials used by the site reflect to the greatest extent possible the cultural, language, geographic, racial and ethnic diversity of the population served.

Standard 5 Intent: *The overall intent of the standards in this section is to ensure the site is* ***culturally respectful*** *to each family's unique characteristics and views each family's culture broadly beyond just race, ethnicity, or heritage. For services to be effective it is imperative cultural context be incorporated into service design and delivery. There are two underlying assumptions to this statement: 1) the diversity of families is of great significance to service delivery; and 2) services may be provided by persons whose culture differs from that of the participating family. Thus, in developing home visiting programs, it is important to consider:*

- *Family needs, health beliefs, coping mechanisms and child rearing practices vary individually and by population - thus, service delivery is uniquely tailored to reflect this variation;*
- *Valuing the culture of families and their traditions (e.g., cultural, language, racial, religious, geographic and ethnic) allows a Family Support Specialist to establish quality relationships with families; and*
- *A Family Support Specialist's ability to establish strong relationships with families based on mutual respect and understanding will enhance the opportunity for providers and families to work together.*

Cultural humility is not what one knows of another person's culture, though a certain level of foundational knowledge can be helpful. It is instead how we are in allowing another person to share their own story which reflects their identity, experiences, background, values and beliefs. Allowing parents to teach us of their culture, and being observant and accepting of behaviors, attitudes, and beliefs that may be different from our own reduces the risk of making faulty assumptions, and helps us evolve our own humanness. Conversations and observations of culture are always done sensitively, respectfully, non-judgmentally and with humility. Cultural humility is one construct for understanding and developing a process-oriented approach to competency and sensitivity. Hook, Davis, Owen, Worthington and Utsey (2013) conceptualize Cultural humility as the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to that person".

Successful home visiting programs provide services with cultural humility so new skills and ideas being shared with the family are respectful of each family's values and decision-making systems. Providing services with cultural understanding and humility requires knowledge of diversity be applied to policy and practice. Family Support Specialists facilitate the family's consideration of how new perspectives fit into their lives. This practice allows families and Family Support Specialists to work together to craft positive family development strategies.

Families vary in many ways, so it is important Family Support Specialists understand differences among them. Cultural groups may define "family" differently, which affects the audience for services. Family Support Specialists observe cultural differences and use them as a springboard for inquiry and understanding, asking families about particular behaviors and practices. Family background and ethnicity influence value systems, how people seek and receive assistance, and communication practices (e.g., native language, slang, body-language), among other things. When Family Support Specialists express curiosity with open-ended questions, ~~and~~ are non-judgmental, and refrain from imparting their own belief and value systems, families have an opportunity to reflect and share. In order to strengthen families' coping abilities and independence, HFA staff respect differences among families.

References:

Hook, J. N., Davis, D. E., Owen, J., Worthington Jr., E. L., & Utsey, S. O. (2013). Cultural Humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*®.

☺ Tip: The HFA National Office has produced **Cultural Humility Workbook**; a workbook to assist sites with these standards.

5-1. The site has a description of the *cultural characteristics* of its current *service population* which includes data (numbers and percentages) and narrative detail.

Intent: *The description of the service population is specific to the families who have accepted services. The description includes race, ethnicity, language and other cultural and demographic characteristics such as the customs, values, age, gender, military service, religion, sexual orientation, social class, and geographic origin among others determined to be most relevant by the site. Additionally, sites are encouraged to look at other factors such as: intimate partner violence, substance abuse, parent mental health or cognitive abilities, criminal history, and physical disabilities as it relates to the unique culture of families being served.*

5-1. RATING INDICATORS

3 - No 3 rating indicator for standard 5-1.

2 - The description (narrative with numbers and percentages) of the cultural characteristics of the service population addresses all of the following:

→ ethnic or racial characteristics
→ language characteristics, and
→ other cultural and demographic characteristics (see 5-1 intent)

1 - The site does not yet have a description of the service population, or the description does not yet address all characteristics as stated above.

☺ Tip: Sites are encouraged to update the description of the cultural characteristics of the service population every time the *Cultural Analysis and Plan (CAP)* is completed. Ideally, sites update it annually to identify necessary training for staff as required in 5-3.

5-2. The site demonstrates respect for the culture of families by ensuring cultural characteristics are reflected in all aspects of its service delivery.

5-2.A The site has the capacity to provide *family-centered and culturally respectful* (e.g., photos reflective of diversity of population, materials available in *major* languages spoken by target population, materials reflect literacy level of *families*, etc.) services to the *major* group(s) within the *service population*.

Intent: *Racial and ethnic minorities often face barriers in receiving adequate services within their communities. These include language barriers, marginalization, isolation, and other challenges related to socio-economic status, and encounters with service providers lacking knowledge of the family's culture. Family Support Specialists have an opportunity to provide a voice for families who may not be represented fairly.*

Sites identify strategies or practices to ensure families feel comfortable, respected and represented in site services. It is the site's responsibility to identify major cultural groups within the service population and determine groups currently under-served. In addition to hiring staff who may represent the major groups (through a variety of characteristics), sites are encouraged to provide training through other community entities or other means in an effort to increase staff's ability to meet the cultural and language needs of families. This is an ongoing process for all staff.

Sites will also want to make sure that in addition to staff, any materials, literature; brochures, etc. reflect the diversity in the community.

5-2.A RATING INDICATORS

3 - The site **has the appropriate staff, materials** (e.g., annual report, brochures, site specific materials such as curricula, etc.), and community partners to meet the cultural and language needs of the major population groups within the service population.

2 - While the site **may not currently have all of the appropriate staff, materials** (e.g., annual report, brochures, site specific materials such as curricula, etc.), and community partners to meet the cultural and language needs of the major population groups within the service population, it **has developed strategies** to address these needs.

1 - The site does not yet have the appropriate staff, materials (e.g., annual report, brochures, site specific materials such as curricula, etc.), and community partners to meet the cultural and language needs of the major population groups within the service population, and has not yet developed strategies to address these needs..

☺ Tip: Incorporate any gaps related to staff and materials when considering professional development for staff (standard 5-3). Typically the unique characteristics identified as gaps in service delivery will correspond with the site providing training on these topics to staff at least annually.

5-2.B Ethnic, racial, language, demographic, and other cultural characteristics identified by the site are taken into account in overseeing staff-family interactions.

Intent: *In order to ensure staff are best equipped to connect with and relate to the unique characteristics of families, sites are encouraged to utilize training, supervision, or development plans, etc. to assist staff in supporting and respecting the family's cultural, racial/ethnic, and language characteristics. It is also important to support Family Resource Specialists during the oversight of staff-family interactions, because they are often a family's first experience with the site and set the tone for participating in services. These activities can be linked to standards 5-2.A and 5-3.*

5-2.B RATING INDICATORS

3 - The site takes into account ethnic, racial, language, demographic, and other cultural characteristics identified by the site during oversight of staff-family interactions by ensuring the worker supports and respects each family's cultural, racial/ethnic, and language characteristics.

2 - Past instances may have occurred when the site did not take into account ethnic, racial, language, demographic, and other cultural characteristics identified by the site during oversight of staff-family interactions by ensuring the worker supports and respects each family's cultural, racial/ethnic, and language characteristics; however, **recent practice** indicates this is now occurring.

1 - Either the site does not yet take into account ethnic, racial, language, demographic, and other cultural characteristics identified by the site during oversight of staff-family interactions or it does not yet ensure the worker supports and respects ethnic, racial, language, demographic, and other cultural characteristics identified by the site.

☺ Tip: Supervision is the ideal opportunity to monitor Family Support Specialist -family interactions, not only during ongoing case review, but also during shadowing of home visits. It is an opportunity to ensure staff is respecting a family's cultural values and beliefs based on ethnic, racial, language, demographic, and other cultural characteristics. Additionally, through the use of reflective practice, it provides an opportunity to support staff and strategize new ways to relate to the family based on their unique characteristics.

☺ Tip: These activities may be challenging to document and illustrate through written documentation; however, sites are encouraged to ensure staff is aware of the activities and

link them back to staff-family interaction.

5-3. The site ensures staff receives annual training designed to increase understanding of the unique characteristics of the *service population*. Please Note: During the first year of hire, standard 11-4.E. (The Role of Culture in Parenting), may be used to satisfy this standard. In the second year of hire and every year thereafter, all staff (program managers, *Supervisors*, Family Resource Specialists and Family Support Specialists) receive at least one training related to characteristics of the population being served (all staff do not have to attend the same training and in some years the training may be broader in scope, such as training and reflection to increase one's ability to practice Cultural humility).

Intent: *Staff are better prepared to serve and interact with families when they have increased understanding of **cultural** practices linked to the family's unique characteristics and values. Sites are encouraged to reflect on a broad definition of culture and identify training related to characteristics beyond race and ethnicity and use the information gathered in 5-1 to identify training based on the unique characteristics of the service population. This could include a variety of training topics such as the cultural dynamics of substance-abusing parents, or parenting in households where there is intimate partner violence. It could also include topics such as working with military families, immigrant families, grandparents raising grandchildren, etc. Essentially, helping staff develop and enhance skills to allow them to work most effectively with families being served.*

5-3.		RATING INDICATORS
3	-	All staff receives training related to the unique characteristics of the service population at least annually.
2	-	Past instances may have occurred when an annual training related to the unique characteristics of the service population was not received; however, **recent practice** indicates the site is now ensuring all staff receives training annually.
1	-	Staff do not yet complete training related to the service population on an annual basis.

5-4. The site analyzes the extent to which all aspects of its service delivery system (initial engagement, home visiting, supervision and management) take into account the culture of families.

5-4.A (old 5-4.B) The site has obtained family and staff input regarding the site's ability to provide culturally respectful services.

Intent: *The site obtains feedback from both families and staff related to:*

- *the materials (brochures, flyers, curriculum, videos, etc.) used by the site,*
- *communication and language factors (language spoken and written, reading level, etc.), and*
- *culturally respectful interaction between staff and families (i.e. working with families in a manner that is individualized and tailored to the unique strengths and needs of each family and is respectful of family traditions, religious beliefs, values, norms, parenting styles).*

*The feedback can be gathered in various forms (e.g., surveys/questionnaires, interviews, family advisory committees, focus groups, supervision, etc.). **Please Note:** When using surveys with staff, be sure that they are HFA staff specific vs staff from throughout the agency. Sites prepare a descriptive narrative summarizing patterns and trends, strengths and areas to address, based on the feedback from families and staff.*

5-4.A RATING INDICATORS

3 - No 3 rating indicator for standard 5-4.A.

2 - The site has obtained direct input, within the last 2 years, from the families and staff on the following **culturally sensitive** practices:
- site materials,
- communication and language factors and
- interaction between staff and families,

and the site has compiled a summary of all responses including a description of strengths, and any areas to address.

1 - The site has not yet obtained, within the last 2 years, family or staff input as described in the 2 rating.

☺ Tip: Sample surveys developed by HFA can be used.
☺ Tip: Sites are encouraged to include questions on their satisfaction survey related to culture. Be sure to include questions that link back to the screening and assessment process, or even referral process, if appropriate.
☺ Tip: Staff surveys should be offered to all site staff, and ideally responses should be obtained by all, protecting worker anonymity so as to encourage candid feedback without repercussion.

5-4.B (old 5-4.A) The *Cultural Analysis and Plan (CAP)* is completed at least every other year and it addresses the following components: materials, training and the service delivery system, and integrates input obtained from families and staff (see Standard 5-4.A).

Intent: *A Cultural Analysis and Plan (CAP) allows a site to continually modify or tailor its system of service delivery based on the cultural characteristics of families being served. The analysis is in narrative format and includes information about the site's materials, training, and all aspects of the delivery system (initial engagement, home visiting, supervision and management). It also includes summarized input from families and staff and identify patterns and trends related to site strengths as well as areas to improve upon.* ***Please Note: New sites without 2 full years since home visiting services began will complete its first Cultural Analysis and Plan (CAP) with one year of data instead of two.***

5-4.B RATING INDICATORS

3 - The *Cultural Analysis and Plan (CAP)* is completed at least every other year and includes:
- a narrative summary of input obtained from families and staff (5-4.A) and
- a comprehensive review of
  - materials,
  - training, and
  - all components of the service delivery system (initial engagement, home visiting, supervision, and management). This includes looking at more than one factor associated with each component.

2 - The *Cultural Analysis and Plan (CAP)* is completed at least every other year and addresses all the items listed in a 3 rating, but could be more comprehensive (a minimum of one factor included for each component of the service delivery system).

1 - Any of the following: there is no *Cultural Analysis and Plan (CAP);* it does not yet address the components listed above; or it is not yet completed at least every two years.

☺ Tip: Sites are encouraged to reference the HFA Cultural Humility Workbook for guidance on all required components of the *Cultural Analysis and Plan (CAP).*

5-4.C The *Cultural Analysis and Plan (CAP)* is reported to the advisory/governance group and strategies for growth are identified or discussed.

Intent: *A site continually modifies or tailors its service delivery system by integrating information learned in order to be sensitive to the cultural characteristics in the service population. It can be difficult to self-identify gaps and determine strategies. This is why it is important to seek the perspective and assistance from the site's advisory/governance group. The advisory/governance group may help to determine the necessary action to take. It is the expectation each site will have at least one improvement strategy in order to increase the site's ability to be culturally humble, and reflect the culture of families within services.*

5-4.C		RATING INDICATORS
3	-	The *Cultural Analysis and Plan (CAP)* is reported at least once every two years to the advisory/governance group. Strengths and strategies for growth are identified, discussed and implemented.
2	-	The *Cultural Analysis and Plan (CAP)* is reported at least once every two years to the advisory/governance group. Strengths and strategies for growth are identified and discussed.
1	-	Any of the following: the *Cultural Analysis and Plan (CAP)* is not yet reported at least once every two years to the advisory/governance group; there is no *Cultural Analysis and Plan (CAP);* or strengths and strategies for growth were not yet identified and discussed with the advisory group.

Tables of Documentation			
5. Services take into account the culture of families such that staff understands, acknowledges, and respects cultural differences of families; staff and materials used by the site reflect to the greatest extent possible the cultural, language, geographic, racial and ethnic diversity of the population served			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study** **Please Note: HFA Cultural Humility Workbook is available to assist with these standards**	**Site Visit Activities**
5-1 Service Population	Policy not required **Please note:** sites may have Policy and Procedures related to these standards and may submit them for the benefit of the peer review team; however, they are not required.	Please submit a narrative description of the cultural characteristics of the service population (including numbers and percentages). Ensure the description addresses ethnic or racial characteristics, language characteristics, and other cultural and demographic characteristics.	**Interview:** * Program Manager * Staff Surveys * Advisory Group Surveys
5-2.A Appropriate Staff, Materials & Community Partnerships		If not already included in the Cultural Analysis & Plan (5-4-B), submit a narrative describing how the site ensures it has the appropriate staff, materials (e.g., annual report, brochures, site specific materials such as curricula, etc.), and community partners to meet the cultural and linguistic needs of the major population groups within the service population.	**Interview:** * Program Manager * Supervisors * Direct Service Staff * Families **Review:** * Supervision Documentation * All relevant materials for service and target populations, (eg., annual report, brochures, flyers curriculum, etc) * Staff & Advisory Surveys
5-2.B Cultural Characteristics Considered When Overseeing Staff-Family Interactions		If not already included in the Cultural Analysis & Plan (5-4-B), submit a narrative describing how the site takes into account ethnic, racial, linguistic, demographic, and other cultural characteristics identified by the site in overseeing staff-family interactions.	
5-3 Training on Unique Characteristics of Service Population		Submit a narrative describing the training offered to staff related to the unique characteristics of the service population for the most recent year. Be sure to link the training to the characteristics identified in 5-1. Please submit training logs or a list of all staff in attendance at the training(s), and date trainings were completed for the most recent year.	**Interview:** * Program Manager * Supervisors * Direct Service Staff **Review:** * Additional training logs, if necessary * Staff Surveys

5-4.A Family & Staff Input		Please submit a narrative describing the ways the site obtains input from families and staff regarding culture. If surveys are used to obtain input, please submit an aggregated summary of the feedback including questions asked. Input from families and staff must include: 1) materials, 2) communication or linguistic factors, and 3) staff-family interaction. Input can be gathered through surveys, meetings, focus groups and/or supervision. **Please note:** Sample Staff and Family Surveys available	**Interview:** * Program Manager* Supervisors* Direct Service Staff* Advisory Members* Families**Review:** * Team & Advisory Meeting Minutes* Staff & Advisory Surveys
5-4.B Cultural Analysis & Plan		Please submit the most recent Cultural Analysis & Plan which must include review of: 1) materials, 2) training, and 3) the service delivery system a. Initial engagement b. home visiting c. supervision d. management 4) staff and families feedback on materials, communication or language factors and the staff-family interactions (5-4.A). Many sites also incorporate information gleaned from the acceptance analysis, retention analysis and staff satisfaction to inform the CAP. **Please note:** HFA Cultural Humility Workbook available	
5-4.C Advisory Input Regarding CAP		Please submit advisory/governing group meeting minutes to illustrate review of the Cultural Analysis & Plan. Please highlight strategies for improvement and strengths noted by this group. If identified strategies & strengths are documented elsewhere, submit relevant supplemental documentation.	

6. Services focus on supporting the parent(s) as well as the child by cultivating the growth of nurturing, responsive parent-child relationships and promoting healthy childhood growth and development.

Standard 6 Intent: *The overall intent of the standards in this section is to reduce risk factors and build protective factors ensuring site staff provide services which are family-centered, process oriented, support parents in nurturing their children and in setting meaningful goals, enhancing family functioning, and sharing child development information.*

*HFA employs an infant mental health approach in which services are relationship focused, strength-based (building on parental competencies), **culturally sensitive**, and are anchored to the parallel process during interactions with families. HFA Family Support Specialists develop healthy relationships with families and an alliance with parents to support them in responding sensitively and in a nurturing manner with their young children.*

6-1. (old 6-1 and 7-4 are now merged) Risk factors and stressors identified from the Parent Survey (or other HFA approved tool), as well as risk factors that emerge later in the course of services (when not disclosed or present initially) are addressed during the course of services utilizing a HFA Service Plan. The HFA Service Plan is developed by the supervisor and Family Support Specialist and includes a focus on building protective factors. Practice demonstrates the Service Plan is being implemented.
Download the HFA Service Plan and HFA Service Plan Instructions. See glossary term for HFA Service Plan.

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Intent: *Healthy Families sites serve many families who are struggling with issues including substance abuse, intimate partner violence, developmental delay in parents, depression, and other mental health challenges some of which may be an effect of early childhood trauma, along with multiple other stressors in their lives such as financial, housing, lack of education, and poor self-esteem to list a few. In order to address these challenges, site staff: 1) form healthy relationships with parents, 2) apply a strength-based empowerment approach that includes being honest when parents are responding to their environment in ways that may cause harm to themselves and their children, 3) accept families where they are, without judgment or bias, 4) build on parental competencies and 5) focus on the experience versus trying to establish "right or wrong". These principles are core HFA components.*

Family Support Specialists are not counselors or therapists. Their most important role as it relates to substance abuse, intimate partner violence, and mental health challenges is to support the parent(s) to become "treatment ready" by:

- *Providing honest feedback with parents' permission*
- *Pointing out discrepancies between stated values and actual behavior*
- *Providing an atmosphere of safety and acceptance*
- *Encouraging forward thinking (i.e. assist parent in developing a vision of what they want)*
- *Providing information and referrals*
- *Using motivational interviewing (when trained on this technique)*
- *Utilizing reflective supervision to receive support and prevent burnout*

It is important for Family Support Specialists to help parents recognize the importance of the parent-child relationships and the impact of untreated depression or other mental health issues. Research clearly demonstrates untreated disorders and past trauma can have serious consequences for early learning, social competence and lifelong health.

6-1.A The site has policy and procedures regarding the review of each family's risk factors and stressors (as identified in the Parent Survey or other HFA approved tool), as well as parent-child interaction/attachment concerns and risk factors/challenging issues identified subsequent to administration of the Parent Survey, (i.e. substance abuse, intimate partner violence, parent's cognitive impairment, and mental health concerns), that includes the Supervisor and Family Support Specialist working together to develop a HFA Service Plan with activities to address

these issues, and build protective factors. Procedures guide staff in the implementation of these activities during home visits with the family, initially and during the course of services.
Download the HFA Service Plan and HFA Service Plan Instructions. See glossary term for HFA Service Plan.

6-1.A		RATING INDICATORS
3	-	No 3 rating for 6-1.A.
2	-	The site has policy and procedures regarding the review of each family's risk factors and stressors as identified in the Parent Survey (or other HFA approved tool), as well as parent(s) risk factors/challenging issues (i.e. substance abuse, intimate partner violence, cognitive impairment and mental health issues) identified subsequent to the administration of the Parent Survey, including 1) the supervisor and Family Support Specialist working together to develop a HFA Service Plan which includes activities to address identified issues and build protective factors, 2) the prioritization/pacing of such activities, and 3) the Family Support Specialist and family working together on the implementation of these the activities during home visits initially and during the course of services.
1	-	The site does not yet have policy and procedures, or the policy and procedures do not yet address all the requirements listed in the 2 rating.

☺ Tip: For sites using the Parent Survey to determine eligibility, when initially developing a family's HFA Service Plan, a joint conversation between the Family Resource Specialist, Family Support Specialist and Supervisor can be beneficial as a "warm hand off" to guide activities and an approach to service delivery the family will be most receptive to. The supervisor is generally responsible for documenting the Service Plan in the Supervision binder, with Family Support Specialists maintaining a copy in their "working folder", and both are updated together throughout the course of services.

☺ Tip: Often when helping families move toward "treatment readiness", the first step is to implement a screening/assessment process using the Parent Survey, along with depression screening tools, substance use screening tools, etc. to determine when outside services are necessary. Many sites utilize components of motivational interviewing, anchor to parents' values and dreams for their children, build on parental strengths, offer decision matrices (pros and cons regarding making decisions), and other strategies to support families in making healthy decisions about lifestyle. Staff are encouraged to also access free online Protective Factors training made available by the National Alliance of Children's Trust and Prevention Funds.

6-1.B The Supervisors and Family Support Specialist review each family's risk factors and stressors as identified in the Parent Survey (or other HFA approved tool), as well as parent-child interaction/attachment concerns, parent(s) risk factors/challenging issues (i.e. substance abuse, intimate partner violence, cognitive impairment or mental health issues) identified subsequent to the administration of the Parent Survey and develop a HFA Service Plan with activities to address risk and build protective factors, including plans to prioritize/pace these activities, initially and during the course of services.

Intent: *Supervisors and Family Support Specialists will develop a HFA Service Plan based on all risk factors identified in the initial assessment/Parent Survey. The Service Plan will list all risk factors plus activities to support the family and build protective factors. To support the family and Family Support Specialist there will also be planning for the appropriate prioritization and pacing of activities. Supervisors and Family Support Specialists will refer back to the Parent Survey (or other HFA approved tool), during the course of services to update the Service Plan and clarify how the issues that place families at-risk for poor childhood outcomes are addressed over time. The frequency of the update to the HFA Service Plan depends on the complexity of each family's situation, including risk factors and challenging issues (i.e. substance abuse, intimate partner violence, cognitive*

impairment, and mental health issues) that may emerge subsequent to the initial administration of the Parent Survey, all of which will be incorporated into the HFA Service Plan.

Additionally, the supervisor and Family Support Specialist plan how to discuss information from the Parent Survey (or other HFA approved tool) with families. The activities the supervisor and the Family Support Specialist discuss are dynamic, incorporating input Family Support Specialists receive from families and acknowledgement of changing family dynamics over time. Activities reflect a thoughtful, purposeful discussion that assists the Family Support Specialist in understanding how early childhood trauma and the stressors experienced by the family impact parenting. Discussions acknowledge and build on family strengths (protective factors), guide the Family Support Specialist's work with the family and are briefly notated and dated on the HFA Service Plan (with more detail documented in supervision notes and home visit records when needed. Sites may also use HFA's optional Mapping Complex Issues form to document additional service planning details). Clear documentation of these supervision discussions ensures continuation of services should there be any staff changes.

For sites using a screening tool to determine eligibility of home visiting services, the Parent Survey (or other HFA approved assessment tool) is conducted as part of early home visits once the family is enrolled.

6-1.B RATING INDICATORS

3 - The supervisor and Family Support Specialist review all the risk factors and stressors identified in the Parent Survey (or other HFA approved tool), as well as parent(s) risk factors/challenging issues (i.e. substance abuse, intimate partner violence, cognitive impairment or mental health issues) identified subsequent to the administration of the Parent Survey and discuss activities to address them and build protective factors with families initially and during the course of services which are documented in a HFA Service Plan.

2 - Past instances may have occurred when the supervisor and Family Support Specialist did not review all the risk factors and stressors identified in the Parent Survey (or other HFA approved tool), as well as parent(s) risk factors/challenging issues (i.e. substance abuse, intimate partner violence, cognitive impairment or mental health issues) identified subsequent to the administration of the Parent Survey or discuss activities to address them and build protective factors with families initially and during the course of services; or document these activities in a HFA Service Plan however **recent practice** indicates this is now occurring.

1 - Either the supervisor and Family Support Specialist do not yet review all the risk factors and stressors identified in the Parent Survey (or other HFA approved tool), or parent(s) risk factors/challenging issues (i.e. substance abuse, intimate partner violence, cognitive impairment or mental health issues) identified subsequent to the administration of the Parent Survey; or do not yet discuss activities to address risk factors and build protective factors with families initially and during the course of services; or have not yet documented activities in a HFA Service Plan.

☺ Tip: Activities to address risk factors can be linked to the empowerment strategies covered in the HFA Core training for Family Support Specialists along with intentional promotion of the protective factors.

☺ Tip: It is recommended that the Supervisor and FSS review and update each family's Service Plan once monthly for families on Level 1, 1P or SS, less frequently for families on the other levels of service.

6-1.C The Family Support Specialist implements with the family over the course of services, the activities and strategies identified on the HFA Service Plan in an effort to build protective factors and to address the risk factors and stressors identified in the Parent Survey (or other HFA

approved tools), as well as parent(s) risk factors/challenging issues (i.e. substance abuse, intimate partner violence, cognitive impairment or mental health issues) identified subsequent to the administration of the Parent Survey.

Intent: *The Family Support Specialist addresses with families the risk factors and stressors identified in the Parent Survey over the course of a family's enrollment in home visiting services, ensuring families are offered ongoing opportunities and support to make positive healthy changes in their lives. Utilizing an HFA Service Plan ensures services are family driven and tailored to each family's unique needs, based on the concerns, stresses and priorities articulated by the family.*

Please Note: *it is not expected a Family Support Specialist discuss with the family all of the risk factors and stressors at one time, or that the Family Support Specialist "enforce" behavior-change or issue-resolution prior to a family's readiness to do so. The HFA Service Plan serves as a road map for the Family Support Specialist to help guide and address the issues presented by the family over the course of services. Implementation of the HFA Service Plan is collaborative in nature (meaning family input and changing family dynamics are incorporated), and discussions/activities are documented in the family file. Many families enrolled in HFA have and are experiencing challenging issues such as alcohol and substance abuse, intimate partner violence, depression and other mental health issues. As such, staff do need to become comfortable in addressing these issues while supporting the parent through the process. HFA staff are not licensed clinicians nor should they counsel families on these issues. Their role is to support parents in becoming treatment ready as well as to ensure children are in safe environments. The supervisor's role is essential in supporting staff when these conversations take place. Reflective supervision is critical in assisting staff when these challenging issues arise over the course of service delivery.* ***Note:*** *HFA has developed a document, "Procedures: Working with Families in Acute Crisis" which may be helpful in clarifying staff roles and responsibilities. Additionally, HFA has incorporated triage criteria for serving families experiencing these challenging issues when a Family Support Specialist is on leave and families are placed on "Temporary Re-Assignment" (TR).*

6-1.C RATING INDICATORS

3 - The Family Support Specialist implements with families activities/strategies documented in a HFA Service Plan developed to build protective factors and address issues identified in the Parent Survey (or other HFA approved tool), as well as parent(s) risk factors/challenging issues (i.e. substance abuse, intimate partner violence, cognitive impairment or mental health issues) identified subsequent to the administration of the Parent Survey during the course of service.

2 - Past instances may have occurred when the Family Support Specialist did not implement with families activities/strategies documented in a HFA Service Plan developed to build protective factors and to address issues identified in the Parent Survey (or other approved tool), as well as parent(s) risk factors/challenging issues (i.e. substance abuse, intimate partner violence, cognitive impairment or mental health issues) identified subsequent to the administration of the Parent Survey during the course of service; however, **recent practice** indicates this is now occurring.

1 - The Family Support Specialist did not yet implement with families activities/strategies documented in a HFA Service Plan developed to build protective factors and to address all issues identified in the Parent Survey (or other approved tool) as well as parent(s) risk factors/challenging issues (i.e. substance abuse, intimate partner violence, cognitive impairment or mental health issues) identified subsequent to the administration of the Parent Survey during the course of services.

☺ Tip: Sites are also encouraged to have their staff access free online Protective Factors training made available by the National Alliance of Children's Trust and Prevention Funds.

6-2. Family goals assist in the development of home visit activities, the identification of resources, and the successful achievements to build a family's resiliency and promote protective factors. The process of developing family goals utilizes family-centered practices.

Intent: *Goal setting is designed to be a collaborative process between parents and the Family Support Specialist. Supervision supports the development and completion of goals by helping Family Support Specialists identify and resolve barriers families may be experiencing, and acknowledging progress made. The process of developing goals is an essential part of HFA's infant mental health approach. Supporting parents in achieving success changes the way parents view the world, increases self-efficacy, enhances internal motivation and builds protective factors. As a result families feel less like victims and more in control of their lives.*

Parents, whose needs were not met in infancy or who were raised with early childhood trauma-may be more focused on survival and may have a distorted perception of what they can accomplish in their lives. This can limit their ability to think about the future and impact their feelings of self-worth. Therefore a family's ability to develop and achieve goals can be life altering. The process is more important than the product which means the role of the Family Support Specialist and the supervisor in the goal setting and achievement process is critical to family success.

6-2.A The site has policy and procedures regarding the process of developing family goals, such that families have at least one active goal, and includes the development of goals that are meaningful to the family; including the target dates for achieving the goal, how goals are developed, periodically reviewed and updated, and what resources are used. Policy also addresses how strengths are identified to support goal achievement, and that the family goal process is supported through supervision.

6-2.A RATING INDICATORS

3 - No 3 rating for 6-2.A.

2 - The site has policy and procedures regarding the development and review of meaningful family goals including:
- families have an active goal at all times once initial goal is established
- how often goals are developed and updated with the family,
- target dates for accomplishing the goal,
- family strengths to support goal achievement are identified,
- how goal achievement is celebrated, and
- how the family goal process is supported through supervision.

1 - The site does not yet have policy and procedures, or policy and procedures do not yet address the requirements listed in the 2 rating.

6-2.B The Family Support Specialist supports the family in setting goals that are meaningful to the parent. The Family Support Specialist also helps the parent develop specific objectives (steps) to achieve the goal taking into consideration family needs, cultural ideologies and concerns. Once the goal is developed, the family and Family Support Specialist identify family strengths and resources specifically related to supporting parents in accomplishing their goal. The Family Support Specialist helps build on these strengths to support the parent in overcoming barriers that may arise, and celebrates parent successes along the way. The Family Support Specialist helps the family establish new goals as previous goals are achieved or retired. Please Note: It may take some time after the initiation of home visiting services for a family to be ready to set a goal, however once an initial goal has been set (generally within 3 months of the first home visit, unless on creative outreach during that period) families will then have an active goal at all times throughout the course of services.

Intent: *The family and Family Support Specialist work together to develop goals and break those goals into meaningful and manageable steps/objectives. There is a clear conversation and partnering between the parent and Family Support Specialist to support parents in feeling competent, capable, and hopeful in being able to make positive changes in their own lives. Breaking larger goals into small steps assists parents in developing problem solving skills, increases their sense of power over their situations, and supports adult brain development. Steps are incremental, measurable, and functional for the family. The focus is not so much about how many goals families accomplish, rather it is entirely related to the skills parents build in the process of developing and working on goals. The goal setting process is 100% based upon what families want, need, or dream about rather than site needs. The process also supports parental empowerment, enhances family functioning, and builds protective factors. The more success a family has the more they change their world-view. Families experience the greatest success when their Family Support Specialist clearly understands the family's values and works within a* ***culturally sensitive*** *and trauma-informed framework to assist families in developing functional goals.*

Interacting with families to identify what strengths and competencies they have to address their needs develops critical thinking and problem solving skills and promotes protective factors. Family Support Specialist will document conversations regarding the family goal in home visit notes. Notes detail the content of these discussions including review of current goals, any revisions to plans that may be developed and successes celebrated. As each specific objective or step is accomplished, Family Support Specialists are encouraged to record the "date accomplished" on the family goal sheet indicating ongoing review of progress. Staff are required to complete Family Goal training (see Standard 11-2.F) and can utilize the HFA Family Goal webinar and related resources for this purpose.

6-2.B RATING INDICATORS

3 - The Family Support Specialist supports the family to have at least one active goal at all times (broken into smaller steps) with a target date for accomplishing the goal. Once the goal is developed, the Family Support Specialist and family identify family strengths and resources specifically related to supporting parents in accomplishing the goal developed. Family Support Specialists support families in achieving their goals, celebrate successes and help parent(s) develop new goals when the previous goal is accomplished or when a goal may no longer be relevant to the family.

2 - Past instances were found when the Family Support Specialist did not support the family to have at least one active goal at all times (broken down into smaller steps) with a target date for accomplishing the goal, or did not identify family strengths and resources; or did not support families in achieving their goals, celebrate successes and help parent(s) develop new goals when the previous goal are accomplished or when a goal may no longer be relevant to the family; however, **recent practice** indicates the site is now consistently applying these practices.

1 - Any of the following: the Family Support Specialist does not yet support the family to have an active goal at all times; or does not yet identify family strengths and resources specifically related to supporting parents in accomplishing the goals and objectives developed; or does not yet support the family in achieving their goals, celebrate successes and help parent(s) develop new goals when previous goals are accomplished or when goals may no longer be relevant to the family.

☺ Tip: The goal setting process takes time. Sites may use more than one tool or strategy to develop goals and steps to achieve the goals.

☺ Tip: Staff are encouraged to access free online Protective Factors training made available by the National Alliance of Children's Trust and Prevention Funds.

☺ Tip: Identification of strengths and needs may be ongoing. Documentation of these conversations may be found in home visit notes, or in the tools each site uses to "think about" strengths and needs with families (including tools provided in HFA Core training such as the Values Clarification activity or What I'd Like for My Child), or in actual family goal sheets. Sites are encouraged to articulate in their policy and procedures which tools are used to identify strengths. Exploring the parent's values assists parents in identifying what they want for their family and increases motivation for change. Additionally, sites offer families an opportunity to explore their strengths and consider how these strengths can support parent goals.

☺ Tip: For families with a planned closure (see standard 4-4), the required transition plan may be accomplished on the same form used to document a family's goal. In this case the goal would be related to what the parent would like to see happen for themselves and their child subsequent to the closure.

6-2.C The Family Support Specialist and Supervisors review family goal progress on an ongoing basis.

Intent: *In order to support growth in families, supervisors and Family Support Specialists review the progress families are making towards the achievement of their goals. The supervisor and Family Support Specialist collaborate to ensure the goals for families are current, challenges to achieving goals are addressed, and accomplishment of each step/objective is celebrated. Additionally, the supervisor brainstorms with the Family Support Specialist any barriers being faced regarding development of family goals with families and supports the Family Support Specialist in increasing the quality of the family goal process.*

6-2.C		RATING INDICATORS
3	-	The Family Support Specialist and supervisor review family goal progress on an ongoing basis, ensuring families have a current/active goal, Family Support Specialists are supported to help problem-solve any challenges and successes are celebrated.
2	-	Past instances were found when the Family Support Specialist and supervisor did not review family goal progress on an ongoing basis; however, **recent practice** indicates the site now ensures this occurs, families are with active goals, Family Support Specialists receive support to help problem-solve any challenges, and successes are celebrated.
1	-	The Family Support Specialist and supervisor do not yet review family goal progress as indicated in the 2 rating.

☺ Tip: Intervals for reviewing the family goal progress during supervision may be adjusted based upon the level of service (i.e., weekly, biweekly, monthly or quarterly) the family is currently on and the target date for goal completion.

6-3. The site assesses, addresses, and promotes positive parent-child interaction, attachment, and bonding and the development of nurturing parent-child relationships.

Intent: *The promotion of parent-child relationships is a primary HFA goal. Many parents in HFA have experienced significant early childhood trauma that can impact their ability to be emotionally present for their children. Parents who themselves have experienced early childhood trauma often struggle in being responsive and available to their children, distort emotional content in their relationships with others and have a restricted ability to utilize cognitive reasoning until their own basic needs for safety and trust are met. HFA Family Support Specialists are trained to use an infant mental health approach which supports the formation of a dyadic alliance between the parents and the Family Support Specialist and provides an effective strategy to mediate successful parenting. This parent-worker alliance provides the parent with an experience of a strong and healthy relationship, and facilitates the strengthening of the parent-child relationship through the parallel process. Utilizing an infant mental health approach reinforces that child development occurs within the context of the parent-child relationship. Parent-child relationships and child development are different frameworks (parent-child relationships focus on attachment; child development focuses on developing cognitive, language/communication, social-emotional, fine and gross motor & self-help skills).*

6-3.A The site has policy and procedures requiring the use of CHEERS and indicate how the staff will assess (either informally or formally), address, and promote parent-child interaction, attachment, and bonding. Site policy also includes the role of supervisors to support Family Support Specialists in the use of CHEERS, and that a validated Parent Child Interaction (PCI) tool will be administered at least once annually.

Intent: *Sites develop clear policy and procedures for how Family Support Specialists will assess parent-child relationships using CHEERS and how Family Support Specialists will partner with supervisors to develop plans for increasing positive parent-child interactions which strengthen the parent-child relationship, beginning prenatally (when services are initiated prior to birth). Policy and procedures include the use of the strength-based reflective strategies introduced in HFA's role-specific **Core training.** Policy also includes expectations related to documenting CHEERS on each home visit, using a validated PCI tool at least once annually, plus the reflective strategies used or curriculum material shared to address concerns and promote positive PCI. It is expected the parent-child relationship is observed each visit in which the parent and the child are both present, and the child is awake for at least some portion of the visit.*

6-3.A	RATING INDICATORS

3 - No 3 rating indicator for standard 6-3.A.

2 - The site has policy and procedures regarding the use of CHEERS including when and how Family Support Specialists will assess, address concerning parent-child interaction and promote positive parent-child interaction (through use of reflective strategies and curriculum material). Site policy also includes the use of a validated PCI tool at least once annually, and the role of the supervisor to support Family Support Specialists with CHEERS assessments and interventions.

1 - Any of the following: the site does not yet have policy and procedures; or the policy and procedures do not yet require the use of CHEERS including when and how Family Support Specialists assess, address concerning parent-child interaction and promote positive parent-child interaction (through use of reflective strategies and curriculum material); or the policy does not yet include the use of a validated PCI tool at least once annually, or the role of the supervisor to support Family Support Specialists with CHEERS assessments and interventions.

☺**Tip:** HFA recommends the use of a validated parent-child interaction observation tool such as the CHEERS Check-In twice a year beginning at 4 months until age of 3.

6-3.B The site assesses parent-child interaction, attachment, and bonding with all families, utilizing CHEERS on all home visits. CHEERS webinar and related resources may be helpful.

Intent: *HFA requires CHEERS be used as a parent-child observation strategy during each home visit (with exception of when it is documented that the child is not present or not awake, when the Parent Survey is being administered, or when a separate Parent Child Interaction (PCI) tool is being used during that particular visit, i.e. CHEERS Check-In, KIPS, NCAST or PICCOLO). CHEERS is also documented prenatally in the second trimester beginning at 24 weeks gestation, (one domain of CHEERS) and two domains are documented in the third trimester beginning at 31 weeks as discussed in* ***HFA Core training for Family Support Specialists****. It is also expected that any group session being counted as a home visit (1/month allowed while a family is on Level 1 or 1P) also include some documentation of CHEERS if there is parent-child interaction time during the group. In both situations (prenatal and groups), not all aspects of CHEERS are required to be documented. In all other situations all components of CHEERS are to be observed and documented.*

HFA supports the concept of the strength-based approach with families, however because of the strong relationships staff develop with families, the intent of "strength-based" may be distorted. This can lead to only positive interactions being recorded in documentation. In addition to seeing the strengths, capacities, and resources of parents related to attachment, observations and documentation must also be honest, and reflect the experience of the full home visit. Therefore, parent-child interaction observations and documentation through CHEERS reflect both positive and challenging parental responses. Without being able to identify where a Family Support Specialist may be able to support parents in developing healthier ways to interact with their children, a FSS's capacity to have an impact in creating nurturing attachment relationships is limited.

Supporting the use of CHEERS is analogous to supporting use of the Ages and Stages Questionnaire (ASQ-3). Staff would not record a child being able to accomplish a developmental task just because he is really trying hard or when a skill is emerging. Instead, the staff would support the parent in offering more practice, sharing child development information/curriculum or refer for early intervention services. The same is true about PCI. When a parent is not able to respond to their child in a consistently safe, predictable, comfortable, or pleasurable manner, supporting parent-child connections by using a reflective strategy is critical. When reflective strategies are used well, parents feel positive,

empowered, and competent.

6-3.B RATING INDICATORS

3 - Family Support Specialists assess parent-child interaction, attachment, and bonding with all families, utilizing CHEERS on all home visits, with the exception of home visits where the child is not present or asleep throughout visit, the Parent Survey, or another PCI tool is used on a particular visit. At least one domain of CHEERS is documented beginning in the second trimester, two domains of CHEERS are documented in the third trimester, and all domains are documented beginning at birth).

2 - Past instances were found when the Family Support Specialist did not assess parent-child interaction, attachment and bonding with all families utilizing CHEERS; however, **recent practice** indicates this is now occurring (including at least one domain of CHEERS for prenatal families in the second trimester, two domains of CHEERS for prenatal families in the third trimester, and all domains of CHEERS for postnatal families), with the exception of home visits where the child is not present or asleep throughout visit, or the Parent Survey, or another PCI tool is used on a particular visit.

1 - Family Support Specialists do not yet assess parent-child interaction, attachment and bonding with all families utilizing CHEERS on all home visits.

NOTE: This is a Sentinel Standard

☺ Tip: Promotion of the parent-child relationship begins prenatally, and the use of the HFA's *Great Beginnings Start Before Birth* prenatal training and parenting materials is encouraged.

6-3.C The site addresses concerning parent-child interaction and promotes positive parent-child interaction, attachment, and bonding with all families based on observations made using CHEERS.

Intent: *Sites are to document observations of parent-child interaction and how they used these observations to develop and implement home visit activities and strength-based interventions to promote positive parent-child interaction. It is helpful for staff to document how they build on parental competences and promote healthy relationships in a thoughtful way using teachable moments (e.g. if parents struggle to understand what their baby is communicating to them, the Family Support Specialist might identify when they observe the parent being empathic, thereby building the parents' skills). Other sites may incorporate videotaping to promote parental sensitivity, understanding, and a secure attachment. As above, it is important to document parental competencies and struggles and what the Family Support Specialist is doing (i.e. through use of reflective strategies, use of curriculum activities, etc.) to promote and support the parent-child relationship. ATP is used for promotion of parent-child interaction; the other reflective strategies are used to address concerning parent-child interactions.*

6-3.C	RATING INDICATORS
3 -	Family Support Specialists address PCI concerns and promote positive parent-child interaction, attachment, and bonding with all families based on CHEERS observations.
2 -	Past instances were found when the Family Support Specialist did not address PCI concerns and promote positive parent-child interaction, attachment and bonding with all families utilizing CHEERS; however, **recent practice** indicates this is now occurring.
1 -	Family Support Specialists do not yet address PCI concerns and promote positive parent-child interaction, attachment and bonding with all families utilizing CHEERS.
NOTE:	**This is a Sentinel Standard**

6-3.D **(NEW)** The site utilizes a validated Parent-Child Interaction Tool at least once annually.
Please Note: *In the next update of the BPS, this standard will require all sites to use the CHEERS Check-In tool. Sites are therefore encouraged to plan accordingly if currently using a different tool to allow for a smooth transition. Sites can use HFA PCI Tracker.*
Download CHEERS Check-In Training Package.

6-3.D	RATING INDICATORS
3 -	The site uses **the validated CHEERS Check-In tool** with at least 90% of target children (including each child when multiples), a minimum of once per year during the first three years of the child's life. The CCI tool is validated at intervals from 2 months to 49 months. Beginning 1/1/18, children 4-12 months receive at least one CCI, children ages 13-24 months receive at least one CCI and children ages 25-36 months receive at least one CCI.
2 -	The site uses **any validated PCI tool** other than the CHEERS Check-In tool with at least 90% of target children ages 4-36 months as of 1/1/18, a minimum of once each year of the child's life from birth to age three.
1 -	Beginning 1/1/18, less than 90% of target children ages 4-36 months have had a validated PCI screening tool used at least once in each year of the child's life.

☺Tip: HFA recommends the use of a validated parent-child interaction observation tool such as the CHEERS Check-In twice a year beginning at 4 months until age 3, though it can be used beyond age 3 as well. Training on the CHEERS Check-In (CCI) is available on the Network Resources page of the HFA website.

6-3.E **(NEW)** Supervisors support home visiting staff in the assessing (through use of CHEERS and a validated PCI tool), addressing concerning parent-child interactions, and promoting parent-child interactions, attachment, and the development of nurturing parent-child relationships, and support.

Intent: *Supervisors are critical in developing and maintaining a clear focus on parent-child interaction and attachment. It is the supervisor's role to partner with staff to ensure CHEERS and a validated PCI tool are used to develop reflective strategies to increase positive attachment experiences during weekly supervision.*

6-3.E		RATING INDICATORS
3	-	Supervisors support staff in assessing PCI, addressing concerning parent child interactions and promoting positive parent-child interaction, attachment, and bonding with all families utilizing CHEERS and a validated PCI tool.
2	-	Past instances were found when the supervisor did not support staff in assessing PCI, addressing concerning parent-child interaction, and promoting positive parent-child interaction, attachment and bonding with all families utilizing CHEERS and a validated PCI tool; however, **recent practice** indicates this is now occurring.
1	-	Supervisors do not yet support staff in assessing PCI, addressing concerning parent-child interactions, and promoting positive parent-child interaction, attachment and bonding with all families utilizing CHEERS or a validated PCI tool.

NOTE: This is a Sentinel Standard

☺ Tip: It can be supportive to Family Support Specialists for supervisors to write-up CHEERS with staff immediately following a shadowed home visit, providing feedback on observations and what to include in each domain (helping to discern facts, feelings and interpretations and focus on the facts of the observation).

☺ Tip: Using and becoming adept in the use of the Reflective Strategies as a supervisor will support staff in using reflective strategies effectively with families.

☺ Tip: Supervisors are encouraged to note any concerns identified from the PCI assessment on the HFA Service Plan, with planned interventions/activities to address and track progress.

6-4. (old 6-4 and 6-5 now merged as 6-4) The site promotes healthy child development, parenting skills, and health and safety practices with families, and provides parenting materials on these topics utilizing evidence-informed curricula. Please note: More than one curriculum can be used.

Intent: *Curricula materials are to be used in conjunction with teachable moments, parental interest, and shared with parents using a strength-based approach building on parental capacity (e.g. emergent curriculum use). The curriculum helps Family Support Specialists provide anticipatory guidance and supports parents in thinking about what their baby's next phase of development will be, and how they can support this development.*

When a parent has endured early childhood trauma, it is important the Family Support Specialist spend time with the parent to listen to what the parent is thinking, feeling and experiencing before presenting the curriculum. It is only when the parent feels safe and supported that he or she can begin to concentrate on handouts and curriculum activities. Including parents in the discovery of their child's development by asking parents what they have noticed about their baby as related to the specific child development topics, before teaching specific lessons or modules is highly recommended.

*The key to successful use of curriculum is tied most closely to how the materials are used with families versus what the materials are, though always be **culturally respectful** and supported by research. With any choice of curriculum, sites are cautioned the curriculum not become the primary focus of each home visit. Curriculum represents just one piece of a comprehensive approach to working with families. The primary focus of each visit is on the relationship between parents and child. Over-reliance on parenting materials distracts from this primary focus and from the ability to be fully observant, attuned and responsive to these relationship dynamics. Therefore, sites should be cautious about requiring curriculum use each visit.*

Curricula will contain a variety of components which include:

- *Information on how to promote nurturing parent-child relationships (e.g., gives parents a positive sense of their new role, makes mom or dad unique to this baby, supports the*

development of empathy, focuses on experience versus what is "right or wrong", anchors baby's current behavior to future development, builds parental self-esteem, encourages parents to have fun playing with their baby)

- *Child development information and how to share this in a strength-based manner (e.g., build on parental competencies, take advantage of teachable moments, engage parents' critical thinking skills, identify emerging skills, address language use and literacy, include all developmental domains, incorporates the use of developmental screens)*
- *Content that is developmental in nature*
- *Strategies that strengthen families and their relationships*
- *Health and safety information such as safe sleep, breastfeeding, pre and postnatal health care, well-child care, dental and oral health, and lead exposure.*
- *A facilitator's manual (ideally) and family materials/manual (required)*

6-4.A The site has policy and procedures regarding the promotion of child development, parenting skills, and health and safety practices with families and the policy specifies which evidence-informed curriculum is used and how often this information is to be shared with families.

Intent: *Sites develop policy and procedures regarding the Family Support Specialist's role in using evidence-informed curricula materials to promote child development, parenting skills, and health and safety.*

6-4.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 6-4.A.
2	-	The site has policy and procedures regarding the Family Support Specialist's role in promoting child development, parenting skills, and health and safety practices with families. The policy specifies use of an evidence-informed curricula and how often this information is expected to be shared with families.
1	-	Any of the following: the site does not yet have policy and procedures; the policy and procedures do not yet cover promotion of child development, parenting skills, and health and safety related issues; or the policy does not yet specify use of evidence-informed curricula materials or how often this information is expected to be shared with families.

6-4.B Family Support Specialists build skills and shares information with families on appropriate activities designed to promote healthy child development and parenting skills.

Intent: *Family Support Specialists observe, build skills, and share information regarding healthy child development and parenting with families based upon naturally occurring experiences as well as through curriculum and other resources. Parenting skills, such as guidance and discipline, toilet training, weaning from the breast, etc., are included as child development activities and occur within the context of parent-child interaction. A parent who has the ability to understand what their child is able to do developmentally and the intent of the baby's behavior will be much more likely to have empathy within the relationship. Child development activities are designed to promote the parent-child interaction thereby impacting the relationship established over time between the parent and child. Whenever possible, Family Support Specialists are encouraged to organize child development information into activities in which the parent is encouraged to play with the child while the Family Support Specialist shares the developmental stimulation the baby is receiving. Family Support Specialists are encouraged to take advantage of "teachable moments" and share appropriate information with families when it is most meaningful (emergent curriculum).* ***Please Note:*** *Documentation in the home visit note includes what material/information is shared on a particular visit.*

6-4.B	RATING INDICATORS
3 -	The Family Support Specialist shares information with all families on appropriate activities designed to promote healthy child development and parenting skills.
2 -	Past instances were found when the Family Support Specialist did not share information with all families on appropriate activities designed to promote healthy child development and parenting skills; however, **recent practice** indicates this is now occurring.
1 -	The Family Support Specialist does not yet share information with all families on appropriate activities designed to promote healthy child development and parenting skills.

☺ Tip: Sites are encouraged to document observations of child development, including not only what the child is able to do, but also how the parent responds and what the Family Support Specialist does to take advantage of teachable moments to increase parents' knowledge It is helpful for staff to document how they build on parental competencies and promote child development and parenting skills in a thoughtful way (e.g. if parents struggle to understand what their baby is communicating to them, the Family Support Specialist might ask parents what they think the baby might be communicating, explore what parents already know about their child and anchor the conversation to what children are able to do within a particular developmental age).

6-4.C The Family Support Specialist shares curricula information with families designed to promote positive health and safety practices.

Intent: *Health and safety practices include sharing prevention strategies as well as addressing any health and safety issues observed in the home. Content shared with families may include smoking cessation, safe sleep, SIDS, "shaken baby" strategies, baby-proofing, feeding and nutrition, dental and oral health, selection of child care providers or alternative caretakers, in addition to any culturally based safety issues. It is expected Family Support Specialists will address any health or safety concerns that could be detrimental to parents and their children. Additionally, Family Support Specialists support the development of a healthy and stimulating home environment.*

6-4.C	RATING INDICATORS
3 -	The Family Support Specialist shares information with all families designed to promote positive health and safety practices.
2 -	Past instances were found when the Family Support Specialist did not share information with all families designed to promote positive health and safety practices; however **recent practice** indicates this is now occurring.
1 -	The Family Support Specialist does not yet share information with all families designed to promote positive health and safety practices.

☺ Tip: Sites will have mechanisms for insuring how Family Support Specialists use safety checklists or share information with families. Staff is encouraged to document the content of health and safety discussions in home visit notes.

6-5. **(OLD 6-6)** The site monitors the development of participating infants and children with the ASQ-3 (Ages and Stages Questionnaire) and ASQ: SE-2 (Social Emotional).

6-5.A **(OLD 6-6.A)** The site has policy and procedures for administration of the ASQ-3 and ASQ: SE-2 including the frequency of administration and specifies these tools are to be used with all target children participating in services, unless developmentally inappropriate, and requires all staff who administer the tool are trained prior to use. Sites can use the HFA ASQ SE Form.

Intent: *The policy and procedures indicates the ASQ-3 and ASQ: SE-2 are used with all target children during home visits unless developmentally inappropriate (e.g. when enrolled in Early Intervention or with permanent health condition impacting development), and in accordance with established tool guidelines; revising the screening schedule based on prematurity, and specifying which intervals the site requires staff to administer. At a minimum, sites are to screen all target children using the ASQ-3 a minimum of twice per year for children under the age of three and annually for children ages three through five years. The ASQ:SE-2 is to be administered with all target children a minimum of once per year.*

Additionally, the policy must specify instances when the site would not be administering the ASQ-3 or ASQ: SE-2 (i.e., developmentally inappropriate, receiving early intervention services). Sites are expected to maintain Level CO and TR families on their ASQ-3 and ASQ: SE-2 data reports (and to note time period they were on Level CO or TR).

Finally the policy and procedures also require staff and their supervisors be trained on the administration of the ASQ-3 and ASQ:SE-2 prior to first use.

6-5.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 6-5.A.
2	-	The site has policy and procedures for administration of the ASQ-3 and ASQ: SE-2 that require at a minimum: 1) the ASQ-3 and ASQ: SE-2 are used with all target children, unless developmentally inappropriate, 2) the ASQ-3 is administered at least twice per year for children under the age of three, and annually for children ages three through five years (for sites serving children ages three - five), and 3) the ASQ:SE-2 is administered at least once annually, 4) the training of staff and supervisors on administration of the ASQ-3 and ASQ: SE-2 prior to first use (unless already included in the site's training plan/policy – standard 10-1).
1	-	Any of the following: 1) the site does not yet have policy and procedures to administer the ASQ-3 and ASQ: SE-2; 2) the policy and procedures do not yet specify when the tools are to be used with all target children, unless developmentally inappropriate; 3) the policy and procedures do not yet require use of the ASQ-3 for children under the age of three at least twice per year, and at least once annually for children ages three through five years (for sites serving children ages three - five), and 4) the policy and procedures do not yet require use of annual administration of the ASQ;SE-2; or 5) the policy does not yet require the training of staff on administration of the ASQ:3 and ASQ: SE-2 prior to first use (here or in the site's training plan/policy 10-1).

☺Tip: Sites are encouraged to screen more frequently than the minimum required in the standard.
☺ Tip: Supervisors are encouraged to note any concerns identified from the developmental screens on the HFA Service Plan, with planned interventions/activities to address and track progress.

6-5.B **(OLD 6-6.B)** The site ensures the ASQ-3 (Ages and Stages Questionnaire) is used during home visits to monitor child development at specified intervals, unless developmentally inappropriate, and is administered according to the developers' instructions to ensure valid results (i.e. administered during the specified window of time). 6-5.B HFA ASQ-3 Tracking Form

Intent: *All target children are screened for potential developmental delays. Staff are not required to screen children who are enrolled in early intervention services (special needs) and are receiving in-depth developmental assessments. Please Note (was a Tip): Sites are to indicate in the family files when a child has a revised screening schedule due to premature birth or other reasons, when screens are missed due to families being on creative outreach or when families decline the opportunity to screen the child.*

6-5.B		RATING INDICATORS
3	-	The site uses the ASQ-3 during home visits and **at least 90%** of target children (excluding those when developmentally inappropriate) are screened a minimum of twice per year for children under the age of three and annually for children ages three through five years.
2	-	Past instances were found when the site did not use the ASQ-3 with at least 90% of target children (excluding those when developmentally inappropriate) a minimum of twice per year for children under the age of three and annually for children ages three through five years; however, this is now occurring during home visits and **90% of target children have completed screens due in the last six months**.
1	-	Any of the following: the site does not yet use the ASQ-3 during home visits; the site does not yet use the ASQ-3 at the specified intervals to ensure all target children in the site (excluding those when developmentally inappropriate) were screened a minimum of twice per year for children under the age of three and annually for children ages three through five years, or less than 90% of target children have completed ASQ-3 screens due in the last six months.

Note: **This is a Sentinel Standard**

☺ Tip: The site is encouraged to make the ASQ-3 tool available to parents for subsequent births. With subsequent births, the ASQ-3 can be provided to the parent for self-administration, or it may be administered by Healthy Families staff. If administered by staff, the dates and results should be recorded in the family file.

☺ Tip: When a child is receiving early intervention services, it is recommended sites request a copy of the developmental assessment from the family or from the early intervention service provider with permission from the family so the home visiting site can support the developmental activities of the early intervention team.

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when rates fall below the 90% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

6-5.C **(NEW)** The site ensures the ASQ: SE-2 (Ages and Stages Questionnaire – Social Emotional) is used during home visits, unless developmentally inappropriate, and is administered according to the developers' instructions to ensure valid results. 6-5.C HFA ASQ-SE Tracking Form

6-5.C		RATING INDICATORS
3	-	The site uses the ASQ: SE-2 during home visits at specified intervals, and ensures **at least 90%** of target children (excluding those when developmentally inappropriate) are screened a minimum of once per year of the child's life, for children birth to age five.
2	-	Past instances were found when the site did not use the ASQ: SE-2 with at least 90% of target children (excluding those when developmentally inappropriate) a minimum of once per year of the child's life, for children birth through age five; however, this is now occurring during home visits and **at least 90% of target children have completed screens due in the last twelve months**.
1	-	Any of the following: the site does not yet use the ASQ: SE-2 during home visits; the site does not yet use the ASQ: SE-2 a minimum of once per year for target children birth to age five, or less than 90% of target children have completed ASQ: SE-2 screens due in the last twelve months.

☺ Tip: The site is encouraged to make the ASQ: SE-2 intervals available to parents for subsequent births. If administered by site staff, the dates and findings should be recorded in the family file.

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when rates fall below the 90% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

6-5.D **(OLD 6-6.C)** Those who administer the ASQ-3 have been trained in the use of the tool before administering it, and supervisors also receive this training.

Intent: *Staff must be trained before administering the ASQ-3. Ideally, this training is conducted by an individual who understands the use of the tool in a home visit setting. When possible, this training includes information detailing the critical function behind each of the developmental questions. ASQ-3 training received prior to HFA hire date is acceptable if the staff person has been using the tool consistently (without lapse) since receipt of training.*

6-5.D		RATING INDICATORS
3	-	All staff, and their supervisors, hired in the past five years, who use the ASQ-3 are trained in its use prior to administering the tool. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have occurred after first use. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
2	-	Past instances were found when staff hired in the past five years did not receive training on the ASQ-3 prior to administering the tool; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Staff administer the ASQ-3 prior to being trained, or supervisors have not yet received the training.

6-5.E **(NEW)** Those who administer the ASQ:SE-2 have been trained in the use of the tool before administering it, and supervisors also receive this training.

Intent: *Staff must be trained before administering the ASQ:SE-2. Ideally, this training is conducted by an individual who understands the use of the tool in a home visit setting. When possible, this training includes information detailing the critical function behind each of the questions. ASQ:SE-2 training received prior to HFA hire date is acceptable if there has been no gap in use of the tool.*

6-5.E		RATING INDICATORS
3	-	All staff using the ASQ: SE-2, and their supervisors, have been trained in its use prior to administering.
2	-	Past instances were found when training of direct service staff and supervisors was not received until after staff had administered the ASQ: SE-2, these staff have since been trained, and **recent practice** indicates the site is now ensuring all staff receive training prior to their first administration.
1	-	Staff administer the ASQ: SE-2 prior to being trained or supervisors have not yet received this training.

6-6. (OLD 6-7) The site tracks target children who are suspected of having a developmental delay and follows through with appropriate referrals and follow-up, as needed.

6-6.A (OLD 6-7.A) The site has policy and procedures which address how it tracks target children who are suspected of having a developmental delay and how it follows through with appropriate referrals and follow-up, as needed.

Intent: *Site staff know who to refer a family to when the ASQ-3 or ASQ:SE-2 screen indicates the child may have a developmental delay. This determination is developed with the supervisor and may include referring the family to their primary care physician or medical provider. In most instances, sites refer to the early intervention experts within the community. Many early intervention systems are complicated with numerous requirements and a variety of agencies that provide different services to families. Families frequently have difficulty keeping track of various appointments and schedules or may be reluctant to access these services. The site's policy and procedures will require Family Support Specialists to track children suspected of having a developmental delay and require staff to follow-up with all referrals made. Follow-up supports the family's access to and utilization of developmental resources, services and intervention.*

6-6.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 6-6.A.
2	-	The site's policy and procedures address how it tracks target children who are suspected of having a developmental delay and how it follows through with appropriate referrals and follow-up, as needed.
1	-	The site does not yet have policy and procedures which address how it tracks target children who are suspected of having a developmental delay and how it follows through with appropriate referrals and follow-up, as needed.

☺ Tip: Be sure the policy and procedures are clear regarding when and how to make a referral, whom to make the referral to, how to determine the outcome of the referral, and how to participate in the process so staff can support families and greatly facilitate the tracking process to ensure families receive appropriate services in a timely manner.

☺ Tip: Sites are encouraged to contact early intervention services in their community to assist in the development of policy and procedures regarding the referral and tracking process for children suspected of having a delay. Families enrolled in early intervention services will have an IFSP process. It is recommended collaboration occur in the development of an IFSP with both early intervention and HFA sites. Staff is encouraged to continue collaboration with early intervention services when child is dually enrolled.

6-6.B **(OLD 6-7.B)** The site tracks target children suspected of having a developmental delay and follows through with appropriate referrals and follow-up, as needed.

Intent*: Sites are encouraged to collaborate with early intervention services for children who are dually enrolled in HFA and early intervention to avoid duplication of services and to encourage consistency. Early intervention services can be difficult for parents to understand. The Family Support Specialist can be a great liaison for the family into various services offered through early intervention. If a family declines early intervention services, be sure to document this in the family's file, as well as the Family Support Specialist's continuous efforts to advocate for early intervention services. Be sure to document any contacts with EI for updates, or joint meetings attended, and any referrals Family Support Specialists made to support parents.*

It is critical to support parents by tracking referrals and supporting the parent in following-through with in-depth evaluations and therapy. It is recommended screens and

developmental assessments administered by early intervention services be kept in the family files (however, this is not a requirement). At the site level the program manager/supervisor is aware of any challenges with referral sources for early intervention services and assists by advocating with referral entities/partners to reduce these barriers.

6-6.B RATING INDICATORS

3 - Site tracks target children suspected of having a delay and follows through with appropriate referrals and follow-up, as needed.

2 - Past instances were found when the site did not track target children suspected of having a delay and follow through with appropriate referrals and follow-up, as needed; however, **recent practice** indicates this is now occurring.

1 - Site does not yet track target children suspected of having a developmental delay or ensure appropriate referrals and follow-up, as needed.

NA - No children identified with a developmental delay.

Note: This is a Sentinel Standard

☺ Tip: The site is encouraged to track any referrals made regarding developmental delay for non-target children residing in the home, and obtain signed consent when making the referral on behalf of the family.

Tables of Documentation			
6. Services focus on supporting the parent(s) as well as the child by cultivating the growth of nurturing, responsive parent-child relationships and promoting healthy childhood growth and development			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study**	**Site Visit Activities**
6-1.A Policy - HFA Service Plan Addressing Risk Factors from Parent Survey and other Challenging Issues	Supervisor, Family Support Specialist (FSS) & family plan to address risk factors identified in the Parent Survey & other challenging issues, including how the Supervisor and FSS work together to develop a HFA Service Plan and how the FSS and family work together on implementing the activities initially and during the course of services.	Please Submit Policy	**Interview:** * FSS Supervisors * FSS * Families **Review:** * Supervision documentation * Family Files * HFA Service Plans * Staff Surveys
6-1.B Sup & HV Developing and Utilizing HFA Service Plan		No documentation required pre-site	
6-1.C HV & family Implementing HFA Service Plan	-	No documentation required pre-site	
6-2.A Policy - Development of Family Goals	The development of family goals including how often goals are developed and updated with the family, target dates for accomplishing the goal, family strengths to support goal attainment, how goal achievement is celebrated and how the family goal process is supported through supervision.	Please Submit Policy	Interview**:** * FSS Supervisors * FSS * Families **Review:** * Supervision documentation * Family Files * Staff Surveys
6-2.B Family Goal Development		No documentation required pre-site	

6-2.C Sup & HV Review of Family Goals			
6-3.A Policy - CHEERS	Use of CHEERS including how staff will assess, address, and promote parent-child interaction, attachment, and bonding. Policy also includes the role of supervisors to support FSS in the use of CHEERS, and use of a validated Parent Child Interaction (PCI) tool at least once annually. Policy and procedures include the use of the strength-based reflective strategies introduced in HFA's role-specific Core training.	Please Submit Policy	Interview: * FSS Supervisors * FSS * Families **Review:** * Family Files * Supervision Records * CHEERS Check-In Validated Tool * Staff Surveys
6-3.B PCI Assessed/CHEERS Sentinel Standard		No documentation required pre-site	
6-3.C PCI Addressed/Promoted Sentinel Standard			
6-3.D Parent Child Interaction Tool Annually		Submit report reflecting the use of CHEERS Check-In with all active families in the most recent calendar or fiscal year: 1. Count number of active families 2. County number of families who had a PCI tool administered in the year 3. Calculate: 2. (number with CHEERS Check-In) divided by 1. (the total number of active families) **Please Note:** HFA 6-3.D CHEERS Check-In Tracking spreadsheet available	

6-3.E Supervision Support in Assessing, Addressing and **Promoting PCI (through use of CHEERS and validated PCI tool)** ***Sentinel Standard***			
6-4.A Policy - Child Development, Parenting Skills, Safety & Curriculum	The FSS's role in promoting child development, parenting skills, and health and safety practices with families. The policy specifies use of an evidence-informed curricula and how often curriculum information is expected to be shared with families	Please Submit Policy	Interview**:** * FSS Supervisors * FSS * Families **Review:** * Family Files * Supervision Records * Staff Surveys
6-4.B Promote Child Dev and Parenting Skills		No documentation required pre-site	
6-4.C Promote Health and Safety		No documentation required pre-site	
6-5.A Policy - ASQ-3 and ASQ-SE-2 Screens	Administration of developmental & social-emotional screening (ASQ-3 and ASQ:SE-2) with specified intervals of administration, unless developmentally inappropriate) and staff are trained prior to use	Please Submit Policy	Interview**:** * FSS Supervisors * FSS * Families **Review:** * Family Files * Supervision Records * ASQ and ASQ-SE Tracking Tool
6-5.B ASQ-3 Developmental Screening Sentinel Standard		Please submit a report indicating which active target children received at least two a developmental screens per year (unless developmentally inappropriate) for children under the age of three and at least one screen per year for children ages three through five years and which did not. Include if delay was indicated and if a referral was made. Provide a summary of the total active families (number and percent) who received the required screens divided by the total number of active families. Please note: Sites may submit the HFA ASQ Tracking Form	

		This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	
6-5.C. ASQ:SE-2 Social Emotional Screening		Please submit a report indicating which active target children received at least one social emotional screen per year (unless developmentally inappropriate) for children birth through age five. Include if delay was indicated. Provide a summary of the total active families (number and percent) who received the required screens divided by the total number of active families. Please note: Sites may submit the HFA ASQ: SE-2 Tracking form	
6-5.D Staff trained on ASQ-3 developmental screen prior to administering		Please submit a list of all staff, date received ASQ-3 training and date first administered the tool Please note: Sites may submit HFAs Training Log	
6-5.E Staff trained on ASQ: SE-2 social emotional screen prior to administering		Please submit a list of all staff, date received ASQ: SE-2 training and date first administered the tool Please note: Sites may submit HFAs Training Log	
6-6.A Policy - Tracking and Follow Through with suspected Developmental Delay	Tracking and follow-up of suspected developmental delays	Please Submit Policy	Interview**:** * FSS Supervisors * FSS * Families **Review:** * Family Files with delay indicated * Related supervision records
6-6.B Developmental Delays Tracked and Followed Through ***Sentinel Standard***		No documentation required pre-site	

7. At a minimum, all families are linked to a medical provider to ensure optimal health and development. Depending on the family's needs, they may also be linked to additional services related to: finances, food, housing assistance, school readiness, child care, job training, family support, substance abuse treatment, mental health treatment, and domestic violence resources.

Standard 7 Intent: *The overall intent of the standards in this section is to ensure site staff link families to providers for preventative health care and timely receipt of immunizations and appropriately refer families to additional community services based on each family's unique needs.*

HFA alone may not be able to provide all the resources a family might need to become strong, so encouraging parents to access a variety of community resources is an essential part of our work. It is important to consider many parents may not have been protected by their parents when they were children This may result in parents not knowing how to protect their own children. Empowering families to take action and advocate on behalf of themselves and their children in incremental steps based on parental capacity is critically important. Staff must strike a delicate balance between doing too little and doing too much for families, lest they prevent families from learning how to successfully advocate for themselves (hence, the long standing philosophy of HFA, "Do For, Do With, Cheer On" as it relates to connecting to community resources). Additionally, staff is expected to both refer and follow-up to ensure families are able to access needed services.

7-1. Participating Target Children have a medical/health care provider to ensure optimal health and development.

7-1.A The site has policy and procedures for linking all target children to *medical/health care provider(s)*.

Intent: *It is important for each target child to have a medical home (a partnership between the family and the child's primary health care professional) and to utilize preventative health care practices for children. The site is to have a process for informing and connecting target children to* ***medical/health care provider****(s) 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.*

7-1.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 7-1.A.
2	-	The site has policy and procedures for linking all target children to medical/health care providers and supporting parents in utilizing health care appropriately for their child(ren).
1	-	The site does not yet have policy and procedures to link all target children to medical/health care providers or policy does not yet include how parents will be supported in utilizing health care for their child(ren).

☺ Tip: Supervisors are encouraged to note any concerns related to linkages to a medical home on a family's HFA Service Plan, with planned interventions/activities to address and track progress.

7-1.B Target children have a medical/health care provider.

Intent: *A medical home is crucial to the health and optimal development of the child. In addition to being a vital resource for ongoing preventive health and wellness guidance, and medical interventions as needed, a medical home plays a crucial role in child abuse prevention as it allows another professional consistent access to the family to provide support and monitoring for the well-being of the child. Sites can use 7-1.B,7-2.B,7-2.C Medical Home & Imm Tracker.*

7-1.B		RATING INDICATORS
3	-	Ninety-five percent **(95%) through one hundred percent (100%)** of target children have a medical/health care provider.
2	-	Eighty percent (**80%) through ninety-four percent (94%)** of target children have a medical/health care provider.
1	-	Less than eighty percent (80%) of target children have a medical/health care provider.

☺ Tip: For target children who currently do not have a medical/health care provider, be sure to indicate the reasons why and clearly document attempts/steps taken to link these children.

☺ Tip: It is also important to indicate if families are on Creative Outreach and current information is unavailable.

☺ Tip: Sites are also encouraged to document the current medical/health care provider for all participating family members (children other than target children and adults) – see standard 7-3.

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when rates fall below the 80% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-2. The Family Support Specialist promotes and educates families regarding the importance of immunizing their children, tracks the receipt of immunizations, and follows-up with parents when immunization appointments are missed. Participating Target Children are up-to-date on immunizations.

7-2.A The site has policy and procedures to ensure the Family Support Specialist shares information with families designed to promote and educate families on the importance of immunizations, tracks the receipt of immunizations, and follows-up with parents when immunization appointments are missed.

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 diseases 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 (German measles), mumps, tetanus, and Haemophilus influenzae type b (Hib). While the US currently has near record low cases of vaccine-preventable diseases, the viruses and bacteria which cause them still exist. Vaccines prevent disease in the people who receive them and protect those who come into contact with unvaccinated individuals (aap.org).

7-2.A		RATING INDICATORS
3	-	No 3 rating indicator for 7-2.A.
2	-	The site has policy and procedures including all of the following: - Family Support Specialists will share information with all families designed to promote and educate families on the importance of immunizations - how Family Support Specialists will obtain and track information regarding the receipt of immunizations - Family Support Specialists will follow-up when immunization appointments are missed
1	-	The site does not yet have policy and procedures, or policy and procedures do not yet include all items listed in the 2 rating.

7-2.B The site ensures immunizations are up-to-date for target children at one year of age. Please note: the percentage does not include children whose permanent health conditions or family beliefs preclude immunizations; however, explanation of these exceptions must be documented in the family file. *Sites can use 7-1.B,7-2.B,7-2.C Medical Home & Imm Tracker*.

Intent: *All children are immunized at regular health care visits, beginning at birth. Some children may be ill or have other reasons preventing them from receiving immunizations according to the identified immunization schedule (if a site does not have access to a local or state identified immunization schedule that specifies recommended immunizations for infants from birth through eighteen months, the CDC guidelines are recommended for this purpose). Therefore, children may not necessarily receive their immunizations on time; however, it is essential to keep them up-to-date.*

Sites track immunization information differently. Some choose to collect the information from the parent/care giver and document it on the site's tracking sheets, and others obtain (with consent) periodic updates from the medical provider or from a statewide electronic immunization system indicating whether or not the child is up-to-date or current. Therefore, sites are encouraged to clearly indicate how they obtain information on which immunizations have been administered to determine if target children are up-to-date.

Please Note: *When calculating up-to-date immunization rates at one year of age, the site will look at all enrolled target children ages 12-23 months (including those on creative outreach), and the number of those children who received all immunizations recommended for infants birth through six months. For example, if at the end of one fiscal year there are 25 enrolled target children who are ages 12-23 months, and 20 of them received all immunizations expected through 6 months of age, the rate for this age group is 20/25 x100 = 80%.*

7-2.B		RATING INDICATORS
3	-	Ninety percent (**90%) through one hundred percent (100%)** of target children have up-to-date immunizations at one year of age.
2	-	Eighty percent (**80%) through eighty-nine percent (89%)** of target children have up-to-date immunizations at one year of age.
1	-	Less than eighty percent (80%) of target children have up-to-date immunizations at one year of age.

☺ Tip: For target children, who are not currently up-to-date, be sure to indicate the reasons why and clearly document attempts/steps taken to obtain immunizations for these children.

☺ Tip: The Center for Disease Control has an interactive immunization scheduler available online.

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when rates fall below the 80% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-2.C **(old 7-2.B was split into 7-2.B and 7-2.C)** The site ensures immunizations are up-to-date for target children at two years of age. Please note: the percentage does not include children whose permanent health conditions or family beliefs preclude immunizations; however, explanation of these exceptions must be documented in the family file. ***Sites can use 7-1.B,7-2.B,7-2.C Medical Home & Imm Tracker.***

Intent: *See intent for 7-2.B.**Please Note:** When calculating up-to-date immunization rates at two years of age, the site will look at all enrolled target children 24 months and older (including those on creative outreach), and the number of those children who received all immunizations expected through 18 months. For example, if at the end of one fiscal year there are 10 enrolled target children who are 24 months old and older and 9 of those children received all the immunizations expected for children through 18 months of age, the rate for this age group is 9/10 x 100 = 90%.*

7-2.C		RATING INDICATORS
3	-	Ninety percent (**90%) through one hundred percent (100%**) of target children have up-to-date immunizations at two years of age.
2	-	Eighty percent (**80%) through eighty-nine percent (89%**) of target children have up-to-date immunizations at two years of age.
1	-	Less than eighty percent (80%) of target children have up-to-date immunizations at two years of age.

☺ Tip: For target children, who are not currently up-to-date, be sure to indicate the reasons why and clearly document attempts/steps taken to obtain immunizations for these children.

☺ Tip: The Center for Disease Control has an interactive immunization scheduler available online.

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when rates fall below the 80% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-3. Families are connected to services in the community on an as needed basis.

7-3.A The site has policy and procedures describing how direct service staff will provide information, referrals, and linkages to available health care, health care resources and community resources for all participating family members. The policy includes the follow-up mechanism to determine whether parents receive the services they were referred to.

7-3.A RATING INDICATORS

3 - No 3 rating for standard 7-3.A.

2 - The site has policy and procedures describing the process for direct service staff to provide information, referrals and linkages to available health care, health care resources, and community resources for all participating family members. The policy and procedures includes follow-up mechanisms to determine whether parents receive the services they were referred to.

1 - The site does not yet have policy and procedures; or the policy and procedures do not yet address the requirements listed in the 2 rating.

7-3.B Direct service staff provide information, referrals, and linkages to available health care and health care resources for all participating family members.

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 clinics, 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 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 a medical care provider). Therefore if a family is currently receiving necessary services/care, there may be no need for further provision of the above-mentioned services.*

7-3.B RATING INDICATORS

3 - Direct service staff provide information, referrals and linkages to all participating family members on available health care and health care resources, when necessary.

2 - Past instances were found when direct service staff did not provide information, referrals and linkages to all participating family members on available health care and health care resources, when necessary; however, **recent practice** indicates this is occurring.

1 - Direct service staff are not yet providing information, referrals and linkages to all participating family members on available health care and health care resources, when necessary.

☺ Tip: Sites may want to consider documenting health care resource referrals associated with this standard, in the same way other community resource referrals are documented for standards 7-3.C and 7-3.D.

7-3.C The site connects families to appropriate community providers for additional services and resources as needed.

Intent: *Families benefit by accessing community agencies and services to support the family in accomplishing goals or overcoming challenges they may be experiencing. Families may be reluctant to access additional services, and Family Support Specialists are one way to bridge the gap. Site staff are familiar with the community agencies and the services they provide to be sure families are referred appropriately. Sites are encouraged to provide referrals as often as needed.*

Additionally, while there may be services to refer the family to within the community, it does not mean they are necessarily appropriate or needed by the family. Sites stay up-to-date on existing resources in the community so referrals can be provided appropriately when needed.

7-3.C		RATING INDICATORS
3	-	Families are linked to additional services in the community when needed.
2	-	Past instances were found when families needing additional services were not connected to appropriate services (when resources exist in the community); however, **recent practice** indicates this is now occurring.
1	-	Families are not yet linked to additional services in the community on an as needed basis.

7-3.D The site tracks and follows up with the family, or service provider (if appropriate) to determine if the family received needed services. Follow-up with referral sources will require signed informed consent (see GA-5.C).

7-3.D		RATING INDICATORS
3	-	The site has a method for tracking and following-up on referrals of families to other community services as needed and the site is tracking and following up on referrals.
2	-	Past instances were found when tracking and follow-up did not occur; however, **recent practice** indicates this is now occurring.
1	-	Either the site does not yet have a method or the site has a method but is not yet tracking and following-up.

☺ Tip: Sites are encouraged to track all of the referral resources provided and the family's utilization of those services in one place for easy monitoring.

☺ Tip: Periodically, sites may want to review any trends pertaining to families' ability to access particular services in the community. Doing so can assist with the ongoing assessment of community needs and identification of gaps in service availability.

7-4. (old 7-5) The site conducts depression screening with all families using a standardized instrument.

Intent: *Many of the items on the Family Stress Checklist/Parent Survey are precursors for depression. Add to that the extreme stress families experience and the likelihood for depression is extremely high. When parents are depressed, there are significant impacts for the parent-child relationship such as the inability for the parent to be emotionally available to their infant, assist with physical and emotional regulation (read cues and respond in a timely and sensitive manner) and provide intellectual stimulation.*

Screening for depression during the prenatal and postnatal periods allows Family Support Specialists to assist parents in becoming aware of the depression, and determining if there are depressive issues needing to be addressed by a clinician. Administering a depression screen requires both knowledge of how to administer the screen and what to do if the screen has positive results. Staff training includes the following:

- *Administration guidelines*
- *Ways to talk with parents about depression*
- *Community resource information*
- *Activities Family Support Specialists can do with families to reduce stress and increase serotonin*
- *Ways to support parents in meeting their child's physical and emotional development*

Additional training opportunities include:

- *Review of the HFA online depression training module*
- *Access to the free online course through the National Child Traumatic Stress Network (Psychological First Aid – http://www.nctsn.org/sites/default/files/pfa/english/1-psyfirstaid_final_complete_manual.pdf)*

Although staff are not therapists, it is critical for Family Support Specialists to support parents in alleviating their depression while a parent is awaiting treatment or while considering treatment options. A sample of activities Family Support Specialists may engage parents in include:

- *Providing linkages and referrals to appropriate resources*
- *Providing referrals for mental health consultation (when available)*
- *Using motivational interviewing (when trained) to assist parents in accepting resources, treatment*
- *Utilizing supervision to assist staff in discussing depression with parents*
- *Getting parents out in the sunshine (which increases serotonin)*
- *Encouraging parents to walk, exercise, or engage in other forms of physical movement*
- *Encouraging parents to smile (even a "practice" smile increases serotonin)*
- *Encouraging parents to keep hydrated (hydration increases brain functioning)*
- *Encouraging self-care*
- *Practicing gratitude*
- *Using healthy strategies that have worked for the parent in the past*
- *Utilizing* Procedures for Working with Families in Acute Crisis
- *Encouraging parents to meet their baby's physical and emotional needs*
- *And using other strategies/activities identified locally*

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

7-4.A (old 7-5.A) The site has policy and procedures for administration of a standardized depression screening tool specifying when (at least once prenatally, and at least once within three months after birth, or within 3 months of enrollment if enrolled postnatally, and at least once within 3 months of all subsequent births) the tool is to be used with the primary caregiver of all enrolled families and ensures all staff who administer the tool are fully trained, and staff understand what constitutes a positive screen, and steps to take when the screen is positive. As indicated in the glossary, the primary caregiver is the individual with whom the baby lives and receives primary care from. This individual is generally, though not always, a parent, and is the primary point of contact for the Family Support Specialist when conducting home visits and observing PCI. In co-parenting or multi-generational parenting families, one person will be identified within the system as the primary caregiver. Depression screens are only required with this person.

7-4.A		RATING INDICATORS
3	-	No 3 rating for standard 7-4.A.
2	-	The site has policy and procedures for administration of the depression screening tool and specifies the following: is to be used with the primary caregiver of all enrolled families: - what tool is used for depression screening - the frequency of screening: at least once prenatally and at least once within three months of birth OR within 3 months of enrollment when enrolled after birth, AND at least once within 3 months of all subsequent births (born 1/1/18 or later). - what score constitutes a positive screen, - referral and follow-up expectations with elevated screens, and - activities appropriate for Family Support Specialists to do with families - the policy also requires all staff receive training on how to administer the tool prior to first use (unless already included in the site's training plan/policy – standard 10-1).
1	-	The site does not yet have policy and procedures, or policy and procedures do not yet include all components in the 2 rating.

☺ Tip: Sites may choose to administer the depression screen during the assessment process.
☺ Tip: Sites may consider conducting the depression screen with other caregivers, in addition to the primary caregiver.
☺ Tip: Research has shown pre and postnatal depression is not exclusive to mothers. Paternal depression is of concern as well with first births and subsequent births.

7-4.B **(old 7-5.C)** The site conducts depression screening with the primary caregiver of all enrolled families. If enrolled prenatally the screening will be completed at least once during the prenatal period. Please note the following limited exception criteria: If the primary caregiver refuses the screen, they are not counted within the cohort, and the refusal must be noted on the tracking form.

Intent: *Depression screening is conducted prenatally and postnatally. Depression screens are completed even when families are in treatment to ensure treatment is meeting the needs of the family. Sites are expected to include Level CO families on their depression screening data reports (and to note time period the family was on Level CO), and to track receipt of depression screening during times the family is not on Level CO.* ***Please note:*** *Sites can use the 7-4.B & C Depression Screening Form to track depression screens.*

7-4.B		RATING INDICATORS
3	-	**At least 95%** of primary caregivers are screened using a standardized and validated depression screening tool at least once prenatally (when enrolled prenatally).
2	-	**80% - 94%** of primary caregivers are screened using a standardized and validated depression screening tool at least once prenatally (when enrolled prenatally).
1	-	Any of the following: the site does not yet use a standardized depression screening tool; or less than 80% of primary caregivers are screened prenatally.
NA	-	The site does not enroll families prenatally.
Note:		**This is a Sentinel Standard**

☺Tip: According to several *Perinatal Care Position Statements,* depression screening is recommended to occur twice during the prenatal period (when families are enrolled in services early in their pregnancy).

☺Tip: Ideally, if multiple providers are involved, Family Support Specialists will coordinate with others to reduce duplicate screening. In such cases, a written consent must be on file in the participant record and the site must be in receipt of a copy to show the screening was done. Even more importantly, the site needs copy on file in order to make and track any necessary follow-up referrals/interventions for the family.

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when rates fall below the 80% "on-time" threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-4.C **(split old 7-5.B)** The site conducts postnatal depression screening with the primary caregiver of all enrolled families at a minimum of at least once postnatally before the baby is 3 months of age (when enrolled prenatally) and within 3 months of enrollment (when enrolled postnatally). Please note the following limited exception criteria: If the primary caregiver refuses the screen, they are not counted within the cohort, and the refusal must be noted on the tracking form.

Intent: *Depression screens are completed even when families are in treatment to ensure treatment is meeting the needs of the family. Sites are expected to include Level CO families on their depression screening data reports (and to note time period the family was on Level CO), and to track receipt of depression screening during times the family is not on Level CO.*
Please note: *Sites can use the 7-4.B&C Depression Screening Form to track depression screens.*

7-4.C		RATING INDICATORS
3	-	**At least 95%** of primary caregivers are screened using a standardized and validated depression screening tool at least once postnatally within 3 months of the baby's birth (for those enrolled prenatally), or within 3 months of enrollment for those enrolled postnatally. 100% have been screened at least once within 6 months postnatally or post-enrollment (unless caregiver refused the screen).
2	-	**80% - 94%** of primary caregivers are screened using a standardized and validated depression screening tool at least once postnatally within 3 months of the baby' birth (when enrolled prenatally), or within 3 months of enrollment (for those enrolled postnatally). 100% have a have been screened at least once within 6 months postnatally or post-enrollment (unless the caregiver refused the screen).
1	-	Any of the following: the site does not yet use a standardized depression screening tool; or less than 80% of primary caregivers are screened within 3 months as described in the 2 rating: or less than 100% have a depression screen within 6 months of enrollment.
Note:		**This is a Sentinel Standard**

☺Tip: According to several *Perinatal Care Position Statements,* depression screening is recommended postnatally at 6 weeks, 3 months, and 1 year following the birth of the baby.

☺Tip: Ideally, if multiple providers are involved, Family Support Specialists will coordinate with others to reduce duplicate screening. In such cases, a written consent must be on file in the participant record and the site must be in receipt of a copy to show the screening was done. Even more importantly, the site needs copy on file in order to make and track any necessary follow-up referrals/interventions for the family.

☺ Tip: Even if the site obtains copies of screens done at birth by another provider, re-screening is strongly recommended. Best practice would be to re-screen at 6 weeks and 3 months postpartum.

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when rates fall below the 80% "on-time" threshold or the 100% within 6 months threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-4.D **(NEW)** The site conducts postnatal depression screening with the primary caregiver of all enrolled families with a subsequent birth at a minimum of at least once postnatally within 3 months of the subsequent birth. Please note the following limited exception criteria: If the primary caregiver refuses the screen, they are not counted within the cohort, and the refusal must be noted on the tracking form.

Intent: *Postpartum depression is estimated to affect more than 5 percent of all women following childbirth, making it the most common postnatal complication of childbearing. The risk of recurrence is also known to be high, and given the impact of depression on maternal and child health, HFA sites are required to screen all subsequent births to ensure appropriate supports are provided when indicated. In a new study, researchers analyzed data on 457,317 women who had a first child (and subsequent births) between 1996 and 2013 and had no prior psychiatric hospital contacts or use of antidepressants. Postpartum affective disorder (which included postpartum depression) was defined as an antidepressant prescription fill or hospital contact for depression within six months after birth.*

In the cohort, 0.6% of all childbirths among women with no history of psychiatric disease led to postpartum affective disorder. A year after their first treatment, 27.9% of these women were still in treatment; after four years, that number was 5.4%. For women with a hospital contact for depression after a first birth, the risk of postpartum affective disorder recurrence was 21%; the recurrence was 15% for women who took antidepressants after a first birth. These rates mean that, compared to women without history of affective disorder, it is 46 and 27 times higher in subsequent births for women with postpartum affective disorder after their first birth.
"These population-based figures provide valuable guidance to physicians treating women with PPD," the authors say. "It underlines the seriousness of single initial episodes and highlights the necessity of both primary and secondary preventive measures of which several exist." Rasmussen M-LH, Strøm M, Wohlfahrt J, Videbech P, Melbye M (2017) Risk, treatment duration, and recurrence risk of postpartum affective disorder in women with no prior psychiatric history: A population-based cohort study. PLoS Med 14(9): e1002392. ***Please note:*** *Sites can use the 7-4.B-D Depression Screening Form to track depression screens.*

7-4.D		RATING INDICATORS
3	-	**At least 95%** of primary caregivers are screened using a standardized and validated depression screening tool at least once postnatally within 3 months of a subsequent birth (born 1/1/18 or later).
2	-	**80% - 94%** of primary caregivers are screened using a standardized and validated depression screening tool at least once postnatally within 3 months of a subsequent birth (born 1/1/18 or later); or there have been no subsequent births.
1	-	Any of the following: the site does not yet use a standardized depression screening tool; or less than 80% of primary caregivers are screened within 3 months of a subsequent birth (born 1/1/18 or later).

☺Tip: Ideally, if multiple providers are involved, Family Support Specialists will coordinate with others to reduce duplicate screening. In such cases, a written consent must be on file in the participant record and the site must be in receipt of a copy to show the screening was done. Even more importantly, the site needs copy on file in order to make and track any necessary follow-up referrals/interventions for the family.

☺ Tip: Even if the site obtains copies of screens done at birth by another provider, re-screening is strongly recommended. Best practice would be to re-screen at 6 weeks and 3 months postpartum.

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when rates fall below the 80% "on-time" threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-4.E (**old 7-5.C**) Family Support Specialists provide activities to support primary caregivers whose depression screening scores are elevated and considered to be at-risk of depression, including items listed at the bottom of the 7-4 intent (*Providing linkages and referrals to appropriate resources, Providing referrals for mental health consultation, using motivational interviewing (when trained) to assist parents in accepting resources, treatment, utilizing supervision to assist staff in discussing depression with parents, getting parents out in the sunshine, encouraging parents to walk,, exercise, or engage in other forms of physical movement, encouraging parents to smile (even a "practice" smile increases serotonin), encouraging parents to keep hydrated (hydration increases brain functioning), encouraging self-care, practicing gratitude, using healthy strategies that have worked for the parent in the past, utilizing* Procedures for Working with Families in Acute Crisis, *encouraging parents to meet their baby's physical and emotional needs, and using other strategies/activities identified locally)* in addition to referral and follow-up on referrals, unless already involved in treatment, or treatment resources do not exist in the community. Please Note: when caregivers are already involved in treatment or treatment resources do not exist in the community, these situations are noted in the tracking report.

7-4.E		RATING INDICATORS
3	-	Primary caregivers with an elevated depression screening score are supported with appropriate activities by the Family Support Specialist and are referred (with consent when needed) for further evaluation/treatment and follow-up unless already involved in treatment, or treatment resources do not exist in the community.
2	-	Past instances were found when the site did not ensure all primary caregivers with an elevated depression screening score were supported with appropriate activities by the Family Support Specialist and referred (with consent when needed) for further evaluation/treatment and follow-up unless already involved in treatment or treatment resources do not exist in the community; however, **recent practice** indicates this is now occurring. Or there have been no elevated depression screens for currently enrolled families.
1	-	Any of the following: primary caregivers with an elevated depression screening score are not yet supported with appropriate activities by the Family Support Specialists; or are not yet referred for further evaluation/treatment, or there is no follow-up on those who are referred.

☺ Tip: Supervisors are encouraged to note any concerns identified from the depression screen on the family's HFA Service Plan, with planned interventions/activities to address and track progress.

7-4.F **(old 7-5.D)** Those who administer the depression screen/tool have been trained in the use of the tool before administering it, including ways to talk with parents about depression, and Supervisors also receive this training.

Intent: *All staff who administer the depression screening tool, and their supervisors, receive training on the use of the tool prior to first use.* ***Please Note:*** *When a collaborative partnership results in another provider completing the depression screen and providing copy to the Healthy Families provider, the HFA site does not need to monitor training of non-HFA staff in administering the screen. However, HFA sites are required in these situations to ensure HFA staff receive depression screen training to ensure understanding of administration guidelines and referral procedures*

regardless of whether they administer the screen or not, as they need to be able to interpret and act on the results.

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7-4.F		RATING INDICATORS
3	-	All staff, and their supervisors, hired in the past five years, who use the depression screening tool are trained in its use prior to administering it. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have occurred after first use. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
2	-	Past instances were found when staff hired in the past five years did not receive training on the depression screening tool prior to administering it; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Staff administer the tool prior to being trained, or supervisors have not yet received the training.

Tables of Documentation			
7. At a minimum, all families are linked to a medical provider to ensure optimal health and development. Depending on the family's needs, they may also be linked to additional services related to: finances, food, housing assistance, school readiness, child care, job training, family support, substance abuse treatment, mental health treatment, and domestic violence resources			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study**	**Site Visit Activities**
7-1.A Policy - Medical Providers for Target Children	Linkage of target children to medical/health care providers	Please Submit Policy	**Interview if needed:** * FSS Supervisors * FSS * Families
7-1.B Target Children with Health Care Provider		Report detailing all active target children and their current medical/health care provider. Include a summary of the total number active target children who have a provider, divided by the total number of active target children.	
7-2.A Policy - Timely Receipt of Immunizations	Family Support Specialist (FSS) routinely share information designed to promote and educate families on the importance of immunizations, how immunizations are tracked and follow-up procedures	Please Submit Policy	**Interview if needed:** * FSS Supervisors * FSS * Families
7-2.B Measure Immunization Rates at 1yr		Please submit the site's immunization schedule. Also submit a report reflecting immunization rates for all active target children ages 12-23 months (including those on Creative Outreach). 1. Count number of target children currently between 12-23 months 2. Subtract from 1. (target children between 12-23 months) those who are excused from receiving immunizations according to allowable reasons in BPS 3. Of these children (determined in step 2), count how many are fully up to date with all immunizations expected through 6 months 4. Report number and calculate: 3. (those up to date) divided by 2. (number between 12-23 months minus those excluded from count) Please Note: HFA 7-2.B Immunization Tracker available	

7-2.C. Measure Immunization Rates at 2yr		Submit a report reflecting immunization rates for all active target children 24 months and older (including those on creative outreach). 1. Count number of target children currently older than 24 months 2. Subtract from 1. (target children over 24 months) those who are excused from receiving immunizations according to allowable reasons in BPS 3. Of these children (determined in step 2), count how many are fully up to date with all immunizations expected through 18 months 4. Report number and calculate: 3. (those up to date) divided by 2. (number over 24 months minus those excluded from count) Please Note: HFA 7-2.B Immunization Tracker available	
7-3.A Policy - Health Care and Community Referrals and Follow-up	How FSSs will provide information, referrals and linkages to available health care, health care resources and community resources as well as method for tracking and follow-up of referrals	Please Submit Policy	**Interview if needed:** * FSS Supervisors * FSS * Families **Review:** * Family Files * Supervision Records * Staff Surveys
7-3.B Health Care Referrals		No documentation required pre-site	
7-3.C Community Resource Referrals			
7-3.D Referral Follow-up			
7-4.A Policy - Administration of Standardized Depression Screen/Tool	- Screening tool used - frequency of screening (at least once prenatally (if served prenatally) & at least once within three mo. of birth OR within 3 mo. of enrollment if over 3 mo.) - what score constitutes a positive screen - referral & follow-up expectations - activities appropriate for FSSs to do with families	Please Submit Policy	**Interview:** * FSS Supervisors * FSS * Families **Review:** * Family Files/Referral Tracking for families with elevated screens * Supervision Records * Training Logs * Depression Resources/Materials

	- all staff receive training on the tool prior to first use		
7-4.B **Prenatal Screening Primary Care Giver for Depression** ***Sentinel Standard***		Submit report, depression screening for all active families enrolled prenatally: 1) Report families enrolled prenatally: a. enrollment date b. date of birth of target child c. Prenatal screening date(s) d. date of birth and date of screens for subsequent children 2) Count number of **families** enrolled prenatally 3) Count number of families screened prenatally b. Divide 3. (screened prenatally) by 2. (enrolled **prenatally)** **4**) Provide an explanation of any missed screens **Please Note:** HFA 7-4.B&C Depression Screening Spreadsheet available	
7-4.C **Postnatal Screening Primary Care Giver for Depression** ***Sentinel Standard***		Submit report, depression screening for all active families enrolled postnatally: 1) Report families enrolled postnatally: a. enrollment date b. date of birth of target child c. Postnatal screening date(s) d. date of birth and date of screens for subsequent children 2) Using information above, count number of families who were enrolled before the baby was 3 months old (this will include all families from (2) plus other who enrolled between birth and 3 months) a. of those families, count the number of families who were screened postnatally before the baby was 3 months old b. Divide 3a.) families screened postnatally within 3 months) by 3. (families enrolled before baby was 3 months old) 3) Count the number of families who were enrolled after 3 months of age a. of these families, count the number of families who were screened within 3 months of enrollment b. divide 4a. (families screened postnatally) within 3 months of enrollment by 4. (families enrolled after 3 months of age) 4) Provide a summary of all of this information 5) Provide an explanation of any missed screens **Please Note:** HFA 7-4.B&C Depression Screening Spreadsheet available	
7-4.D Referral and Follow up for Primary Care		No documentation required pre-site	

Giver with Elevated Screens			
7-4.E Training Prior to Administering		Submit a list of all staff indicating the date they were trained on the screening tool and the date they first administered the tool. Please Note: HFA training log available	

8. Services are provided by staff in accordance with principles of ethical practice and with limited caseloads to ensure Family Support Specialists have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future *activities.*

Standard 8 Intent: ***The overall intent of the standards in this section is to ensure site staff have limited caseloads to allow them the necessary time with families to build trusting, nurturing relationships.***

8-1. Services are provided by staff with limited caseloads to ensure Family Support Specialists have an adequate amount of time to spend with each family to meet their needs and plan for future activities.

Intent: *The importance of a manageable caseload size ensures families will be afforded the time, energy and resources necessary to help build protective factors, reduce risk and impact positive change. Caseload size provides the maximum number of families and maximum case weight that can be carried by a full-time Family Support Specialist. HFA allows sites to factor in circumstances that will weigh more heavily for many families, including high risk issues, extensive travel, multiple births, translation needs, etc. HFA's Workload Justification provides additional detail further supporting the need to maintain a manageable caseload size. Guidance regarding assigning case weight based on level of service (frequency of home visits) can be referenced in standard 4-2.A, and in HFA's Level Change forms.*

When setting caseload size, it is also important to know the maximum is established based on a full-time schedule of 40 hours worked per week. Should an organization employ full-time staff at less than 40 hours per week, the maximum caseload size will need to be prorated accordingly, and the proration calculation grid (below) can be used to determine maximum case weight.

8-1.A The site's policy and procedures regarding caseload size is no more than fifteen (15) families at the most intensive level, and no more than twenty-five (25) families at any combination of service levels, and a maximum case weight of thirty (30) points, per full-time (40 hours/week) Family Support Specialist.

8-1.A		RATING INDICATORS
3	-	The site's policy and procedures regarding maximum caseload size is no more than 12 families (when all are at the most intensive level of service) and 20 families (when at a variety of levels), with a maximum **case weight of 24 points per full-time Family Support Specialist** (40 hrs/wk).
2	-	The site's policy and procedures states maximum caseload size is no more than15 families (when all are at the most intensive level of service) and 25 families (when at a variety of levels), with a maximum **case weight of 30 points** per full time Family Support Specialist (40hr/wk). The only exception to the maximum number of 25 families is when a FSS's total case weight with 25 families is 15 points or less (which can happen if a FSS caseload is largely comprised of Level 3 and 4 families).
1	-	The site does not yet have policy and procedures regarding caseload size, or the site's policy states **caseload** size exceeds the maximums identified in the 2 rating per full time Family Support Specialist (40 hrs/wk).

☺Tip: Supervisors are encouraged to monitor caseload size closely, beginning with gradual increases to a FSS caseload when staff are newly hired and trained, and setting an expectation for all staff of an average caseload size vs an expectation that all staff carry the maximum number allowed.

For a 2 rating	Max weight	Max # of families		For a 3 rating	Max weight	Max # of families	
formula	.75 x number of hours per week	.375 x #hrs/wk	.625 x #hrs/wk	formula	.6 x number of hours per week	.3 x #hrs/wk	.5 x #hrs/wk
40 hour week	**30 max weight**	**15 when all L1**	**25 when at a variety of levels**	40 hour week	**24 max weight**	**12 when all L1**	**20 when at a variety of levels**
37.5 hour week	**28 max weight**	**14**	**23**	37.5 hour week	**22 max weight**	**11**	**18**
35 hour week	**26 max weight**	**13**	**21**	35 hour week	**21max weight**	**10**	**17**
20 hour week	**15 max weight**	**7**	**12**	20 hour week	**12 max weight**	**6**	**10**

8-1.B (old 8-1.C) Family Support Specialists are within the caseload ranges, as stated in standard 8-1.A Sites can use Home Visit Completion and Caseload Management worksheet.

Intent: *Circumstances may arise when staff exceed caseload size (e.g., a Family Support Specialist leaves and the caseload is dispersed among existing Family Support Specialists, etc.). This practice is temporary (3 consecutive months or less) and sites are to clearly document the reasons why the caseload has exceeded the limit and the duration of this deviation.*

8-1.B RATING INDICATORS

3 - Within the last twelve (12) months **no Family Support Specialist exceeds the maximum case weight**, as stated in standards 8-1.A.

2 - Instances were found when **Family Support Specialists exceeded the maximum case weight** as stated in 8-1.A, however **any deviation in the past twelve (12) months was temporary (3 consecutive months or less**).

1 - In the past twelve (12) months Family Support Specialists have exceeded the caseload sizes as stated in 8-1.A. for periods longer than 3 consecutive months; or data regarding caseload sizes has not been maintained for the past 12 months

8-2. The site's caseload system ensures Supervisors have procedures to apply when assigning families and when managing caseloads, including principles of ethical practice.

Intent: *The primary intent of HFA's Level Change System (including case weights for each level) is focused on ensuring staff have sufficient time to support the needs of families during home visits (as well as time needed prior to home visits when planning for the visit as well as after the visit to conduct follow-up). There are also other circumstances that impact caseload size. Staff who are new to HFA need time to integrate the essential components of HFA's approach including:*

- *an understanding of trauma-informed care (recognizing that "teaching" or "coaching" families without establishing a relationship can re-traumatize the parent),*
- *the power of healthy relationships (beginning with the very first relationship – that with a parent), and*

- *the importance of reflection (the capacity to think about one's own experiences and how they could be impacting the work).*

Additionally, developing relationships with families who have lost their previous Family Support Specialist may require additional creative support to maintain engagement in services since there may be an additional sense of loss. And consideration when assigning families will need to factor in any potential boundary issues or conflicts to ensure staff avoid these situations. Other considerations include the length of time to travel to and from family homes especially for rural or remote areas where travel time may exceed the norm. Weather complications may further impact travel times. Considerations are also made when there are multiple births (see guidelines in HFA's Level System).

8-2.A The site has policy and procedures for assigning and managing its caseloads.

8-2.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 8-2.A.
2	-	The site's policy and procedures include all of the following criteria: - experience and skill level of the Family Support Specialist assigned, - nature and difficulty of the problems encountered with families, - work and time required to serve each family, - avoiding potential worker conflict or boundary challenge owing to an existing personal relationship, - number of families per service provider which involve more intensive intervention, - travel and other non-direct service time required to fulfill the service providers' responsibilities, - extent of other resources available in the community to meet family needs, and - other assigned duties.
1	-	The site does not yet have policy and procedures, or the policy and procedures do not yet include all the criteria listed above in the 2 rating.

☺ Tip: Sites are encouraged to utilize a Code of Ethics, whether one established through professional organizations for nurses, social workers, early childhood professionals, or a multi-disciplinary *Code of Ethics for Human Service Professionals*.

8-2.B The site uses the criteria identified above in 8-2.A. to assign and manage its caseloads.

8-2.B		RATING INDICATORS
3	-	The site assigns and manages its caseload sizes utilizing criteria identified in 8-2.A and outlined in the policy and procedures.
2	-	Past instances were found when caseloads were not assigned or managed according to the criteria identified in 8-2.A; however, **recent practice** indicates this is now occurring.
1	-	The site does not yet assign or manage its caseloads utilizing criteria identified in 8-2.A.

Tables of Documentation			
8. Services are provided by staff in accordance with principles of ethical practice and with limited caseloads to ensure Family Support Specialists (FSS) have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study**	**Site Visit Activities**
8-1.A Policy - Caseload Size	Caseload size is no more than a maximum case weight of 30 points per full time FSS (40hr/wk).	Please Submit Policy	**Interview:** * FSS Supervisors * FSS * Families **Review:** * Caseload documentation * Family Files * Supervision Records
8-1.B Monitoring Caseloads		Please submit a report indicating the active caseload for all current FSSs over the past 12 months. Include each FSS's full time equivalency, the number of families assigned to him or her, and the level/intensity of service each family is receiving. Please Note: HFA 8-1&8-2 Weighted Caseload Tool available	
8-2.A Policy - Managing Caseloads	How caseloads are managed including all criteria listed in the standard	Please Submit Policy	
8-2.B Caseload Management		No documentation required pre-site	

9. Service providers are selected because of their personal characteristics, their willingness to work in or their experience working with culturally diverse communities, and their knowledge and skills to do the job.

Standard 9 Intent: The intent of the standards in this section is to ensure staff are selected because they possess characteristics necessary to build trusting, nurturing relationships and work with families with different cultural values and beliefs than their own.

Please Note: Program managers and Supervisors hired prior to July 1, 2014 will need to demonstrate at least a Bachelor's degree. criteria underlined below will be applied to staff hired July 1, 2014 or after. Also, a staff development plan can be developed and implemented to support any experiential gaps at the time of hire, however it cannot compensate for education. The minimum education requirement must be met. Experiential criteria includes all items bulleted in 9-1.B-D that are not educational requirements.

Download Sample Staff Development Plan

This standard has many components that pertain to the staff roles of: Family Resource Specialist, Family Support Specialist, Supervisors, and Program Managers. Please utilize the hyperlinks provided here to seek clarity on these roles as defined in the Glossary section.

9-1. Service providers and site management staff are selected because of a combination of personal characteristics, experiential, and educational qualifications, and the site's hiring system includes processes to ensure this can happen.

9-1.A The site's system for hiring new staff includes the following:

- Job descriptions which include at least the minimum criteria indicated in standard 9-1.B-D for the positions of Program Manager, Supervisor and direct service staff;
- Standardized interview questions appropriate to each role including questions to screen for an applicant's reflective capacity; and
- Policy requiring at least two reference checks and a criminal background check.

9-1.A		RATING INDICATORS
3	-	No 3 rating for standard 9-1.A.
2	-	The site's system for screening and selection of new staff includes: 1) job descriptions with at least the minimum criteria listed for program managers, supervisors and direct service staff (see standards 9-1.B-D), 2) standardized interview questions appropriate to each role and include questions to assess each applicant's reflective capacity, and 3) policy regarding two reference checks and a criminal background check being complete prior to hire.
1	-	The site's system for screening and selection of new staff does not yet include all components listed in the 2 rating.

☺ Tip: Please see the glossary definition of reflective capacity and the next link to interview questions when considering an applicant's **Reflective Capacity**.

9-1.B (old 9-1.A) Screening and selection of program managers includes consideration of characteristics including, but not limited to:

- A solid understanding of and experience in managing staff;

- Administrative experience in human service or related field including experience in quality assurance/improvement and site development;
- Master's degree in public health or human services administration or fields related to working with children and families, or Bachelor's degree in these fields with 3 years of relevant experience.
- Infant mental health endorsement preferred (if available in the state; if unsure you can find out here)

9-1.B		RATING INDICATORS
3	-	The site's program manager **meets all of the criteria** listed in the standard.
2	-	The site's program manager **meets the educational criteria but at the time of hire did not meet all the experiential criteria, however a staff development plan for managers is in place and has been acted upon.**
1	-	Any of the following: 1) program managers do not yet meet the educational criteria stated in the standard; 2) the program managers do not yet meet all the experiential criteria and there is no development plan to compensate for experiential gaps; or 3) the development plan has not yet been acted upon.

☺ Tip: There may be circumstances when the most appropriate and best suited candidate for a program manager or supervisor role does not possess the required educational background identified in the standard. While HFA encourages hiring the individual who is the best fit for the role, this standard will be rated out of adherence. However, given that sites are not required to have 100% of standards in adherence to be accredited, this alone will not impact a site's ability to be accredited and should therefore not be used as the sole basis for employee selection or termination.

9-1.C (old 9-1.B) Screening and selection of supervisors includes all of the following, but is not limited to:

- Master's degree in human services or fields related to working with children and families, or Bachelor's degree in these fields with 3 years of relevant experience.
- A solid understanding of or experience in supervising and motivating staff, as well as providing support to staff in stressful work environments
- Knowledge of infant and child development and parent-child attachment
- Experience with family services which embrace the concepts of family-centered and strength-based service provision
- Knowledge of maternal-infant health and dynamics of child abuse and neglect
- Experience in providing services to culturally diverse communities/families
- Experience in home visiting with a strong background in prevention services to the 0-3 age population
- Infant mental health endorsement preferred (if available in the state; if unsure you can find out here)
- Experience with reflective practice preferred (see standard 12-2.B for more detail)

9-1.C		RATING INDICATORS
3	-	The site's supervisors **meet all of the** criteria listed in the standard.
2	-	The site's **supervisors meet the educational criteria but at the time of hire did not meet all the experiential criteria, however a staff development plan for supervisors is in place and has been acted upon.**
1	-	Any of the following: 1) supervisors do not yet meet the educational criteria stated in the standard; 2) supervisors do not yet meet all the experiential criteria and there is no development plan to compensate for experiential gaps; or 3) the development plan has not yet been acted upon.

☺ Tip: There may be circumstances when the most appropriate and best suited candidate for a program manager or supervisor role does not possess the required educational background identified in the standard. While HFA encourages hiring the individual who is the best fit for the role, this standard will be rated out of adherence. However, given that sites are not required to have 100% of standards in adherence to be accredited, this alone will not impact a site's ability to be accredited and should therefore never be used as the sole basis for employee selection or termination.

9-1.D (old 9-1.C) Screening and selection of direct service staff, volunteers, and interns (performing the same function) include consideration of personal characteristics, including but not limited to:

- Minimum of a high school diploma or equivalent, college coursework preferred
- Experience in working with or providing services to children and families
- An ability to establish trusting relationships
- Acceptance of individual differences
- Experience and willingness to work with the culturally diverse populations present among the site's target population
- Knowledge of infant and child development
- Open to reflective practice (i.e. has capacity for introspection, communicates awareness of self in relation to others, recognizes value of supervision, etc.)
- Infant mental health endorsement preferred (if available in the state)

9-1.D		RATING INDICATORS
3	-	The site's direct service staff **meets all of the criteria** listed in the standard.
2	-	The site's direct service staff **meets the educational criteria but at the time of hire did not meet all the experiential criteria, however a staff development plan for direct service staff is in place and has been acted upon.**
1	-	Any of the following: 1) direct service staff do not yet meet the educational criteria stated in the standard; 2) direct service staff do not yet meet all the experiential criteria and there is no development plan to compensate for experiential gaps; or 3) the development plan has not yet been acted upon.

9-2. The site actively recruits, employs, and promotes qualified personnel and administers its personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, handicap, sexual orientation, or religion of the individual under consideration.

9-2. RATING INDICATORS

3 - The site:
- is in compliance with the Equal Opportunity Act in the United States, and communicates its equal opportunity practices in recruitment, employment, transfer and promotion of employees,
- informs staff of the equal opportunity practices
- uses recruitment materials which specify the non-discriminatory nature of the site's employment practices
- h**as no administrative findings or court rulings against the site** in this respect, and
-no known violations of equal employment opportunity.

2 - **Status is under review and pending final determination; no major difficulties have been identified in the process of a review conducted by a regulatory authority**; EEO practices do not include all areas of personnel administration and there are no known violations of equal employment opportunity; **the site uses limited means of communicating information on its non-discriminatory hiring practices**.

1 - Any of the following: the site is not yet in compliance with the applicable law and has not yet begun corrective action; or the site has violated its equal opportunity policy; or the site does not yet disseminate information internally on its position on equal opportunity.

9-3. The site's recruitment and selection practices ensure its human resource needs are met.

9-3.A The site's recruitment and selection practices are in compliance with applicable law or regulation and include:

- utilization of standardized interview questions that comply with employment and labor laws and interview responses or summaries maintained for selected and currently employed staff, and
- verification of 2 references or letters of recommendation. If hired from within the organization, performance appraisals can suffice.

Please Note: *If Human Resources policy does not permit interview responses/summary or reference checks to be maintained in personnel files, the program manager or supervisor is expected to maintain copies in their own staff files.*

9-3.A RATING INDICATORS

3 - The site's recruitment and selection practices contain all practices identified in the standard for both staff and volunteers.

2 - Past instances were found where the site's recruitment and selection practices did not contain all practices identified in the standard for both staff and volunteers; however, **recent practice** (through new hires) indicates this is now occurring.

1 - The site's recruitment and selection practices consistently do not yet include all practices identified in the standard for both staff and volunteers.

☺ Tip: It is recommended practice that when posting for available positions, the job listing is posted internally before posting externally,
☺ Tip: Contact HFA for sample interview questions if needed.

9-3.B The agency conducts appropriate, legally permissible, and mandated inquiries (as allowed within the state or province) of state or provincial criminal history records on all employees, subcontractors and volunteers who will have direct contact with children or access to data involving children.

Intent: *Sites must ensure the safety of the families and children it serves by conducting criminal background checks on all employees who will come in contact with them, e.g., Family Resource Specialists, Family Support Specialists, supervisors and program managers. Even in cases when the State does not mandate criminal background checks for HFA staff, sites are expected to check legally permissible criminal history records. At a minimum, sites are to conduct legally permissible background checks (at any point during employment) in order to be in adherence to the standard. While inquiries made to civil child abuse and neglect registries are highly recommended, they are not always legally permissible or readily available to sites.*

Criminal history records should not be used to deny employment of qualified individuals unless the nature of the conviction is related to the specific job duties. Legal counsel should be consulted with regard to appropriate use of background checks.

The site is not required to conduct background checks for licensed staff if the site has verified that background checks, or FBI fingerprinting are part of the licensing process, and staff reporting to be licensed have a valid and current license on file in the personnel record.

Please Note: *If Human Resources policy does not permit criminal background checks to be maintained in personnel files, the head of Human Resources will need to provide a signed letter on agency letterhead indicating each employee's first and last name, the date of hire and the date the results of the criminal background check were received.*

9-3.B		RATING INDICATORS
3	-	All currently employed site staff have had legally permissible criminal background checks completed **at the time of employment**. State child abuse and neglect registries may have been checked in addition.
2	-	All currently employed staff have had criminal background checks completed **at any point during employment**. State child abuse registries may have been checked in addition.
1	-	The site has conducted legally permissible background checks on some but not all currently employed staff; or does not yet conduct criminal background checks.

Note: This is a Safety Standard

☺ Tip: Sites are encouraged to re-screen employees at various time intervals and conduct background checks not only at the time of hire but also during the course of an employment (e.g. once every five years) or if transferring within the agency..

9-4. The site evaluates and reports on personnel satisfaction and turnover at least once every two years and addresses how it may increase staff retention.

Intent: *A stable, qualified workforce is known to contribute to improved participant outcomes, with families more likely to be retained in services when staff are retained. Therefore, site management evaluates factors associated with staff turnover. By understanding the circumstances and characteristics of staff who leave, along with input from those who stay, strategies to increase retention can be developed (based on the data) and implemented with a greater likelihood of success.* ***Please Note:*** *While the site will want to include in their report all the reasons contributing to staff turnover, strategies for improvement do not need to be developed when reasons pertain to personal growth opportunities that could not have been fulfilled on the job, i.e. returning to school, job promotion, etc.* ***Please note:*** *New sites without two full years since home*

visiting services began will monitor staff retention and satisfaction with one year of data. ***Please note:*** *If there has been no turnover in the last two years, the site will still monitor staff satisfaction among employed staff.*
Download Sample Staff Satisfaction and Retention Template

9-4. RATING INDICATORS

3 - The site evaluates and reports on staff turnover and satisfaction at least once every two years, and has developed and **implemented strategies** to address any issues identified from compiled satisfaction surveys responses of current staff, as well as issues that impacted staff who left employment,

2 - The site evaluates and reports on staff retention and satisfaction at least once every two years, and has developed strategies to address any issues identified from compiled satisfaction surveys responses of current staff, as well as issues that impacted staff who left employment, though **strategies have not yet been implemented**.

1 - The site has not yet evaluated staff turnover or satisfaction at least once every two years, or has not yet developed strategies to address issues.

☺ Tip: When sites obtain feedback from currently employed staff related to job satisfaction and retention, they are encouraged to consider factors such as: job category, staff demographics, role clarity, acknowledgement of work performed, satisfaction with salary and benefits, reasonable workload, autonomy, opportunities for advancement and career development.

Tables of Documentation			
9. Service providers are selected because of their personal characteristics, their willingness to work in or their experience working with culturally diverse communities, and their knowledge and skills to do the job			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study**	**Site Visit Activities**
9-1.A Site's System and Policy for Screening and Selection of New Staff	Policy requiring at least two reference checks, the use of standardized interview questions, job descriptions and a criminal background check	Staff are selected because of a combination of personal characteristics, experiential, and educational qualifications, and the site's hiring system includes processes to ensure this can happen. Please submit: 1) Site's policy requiring at least two reference checks and a criminal background check prior to hire, 2) Job descriptions with at least the minimum criteria listed for program managers, supervisors and direct service staff (see standards 9-1.B-D), 3) Standardized interview questions appropriate to each role and include questions to assess each applicant's reflective capacity.	**Interview:** * Program Manager * Human Resources, if applicable * Other staff as needed **Review:** * Personnel Files * Staff Development Plans, if needed * Staff Surveys
9-1.B Screening & Selection of Program Managers	-	Please submit resumes for all current staff. Staff development plans should be submitted for any staff who did not meet the minimum experiential criteria.	
9-1.C Screening & Selection of Supervisors	-		
9-1.D Screening & Selection of Direct Service Staff	-		
9-2 Equal Opportunity Employment (EOE)	-	Please provide a narrative description of the organization's current status with regard to EOE, whether under current review, in remediation, or with a history of previous findings. Please also provide any HR policy or protocols or other descriptive documentation specific to how the organization applies EOE laws.	**Interview:** * Program Manager * Human Resources, if applicable **Review:** * Materials which indicate EOE * Staff Surveys

9-3.A Job Postings, Interviews & references **9.3.B** **Legally Permissible Background Checks** ***Safety Standard***	-	Personnel files will be reviewed onsite. If peers are not permitted access to personnel files, a letter on agency letterhead signed by HR director can be provided verifying internal review of personnel records. If providing a letter, it must include the names of all current HFA staff, date of hire, and confirmation that each of the following exist in the personnel record:- Completed use of standardized interview questions (reflecting answers/summary to the questions, typically hand written)- Dates of two completed reference checks & name of individual who obtained the references- Date criminal background check was completed - If utilized, date of state child abuse registry check (optional - 3 rating)	**Interview:** * Program Manager* Human Resources, if applicable**Review:** * Personnel Files
9-4 Staff Retention and Satisfaction	-	Submit narrative reflecting factors associated with staff turnover along with satisfaction feedback from existing HFA staff utilized to develop staff retention strategies. Include which strategies have been implemented. 1. For staff retention, include data of staff who have left. Include staff (by position title) who left during the timeframe (12 months for new sites, 24 months for all others), their hire date, termination date, reason why they left; and any other pertinent characteristics. 2. For staff satisfaction include a summary of staff satisfaction input in regard to work conditions that contribute both negatively and positively to job satisfaction (typically aggregated survey results) for those currently employed with the HFA site. Agency-wide staff satisfaction surveys, if used, must be filtered and reported for HFA staff only. 3. Include strategies developed for staff retention based on what was learned from retention and satisfaction data. **Please note:** Sample staff Survey available	**Interview:** * Program Manager * Supervisors * Direct Service Staff **Review:** * Staff & Advisory Surveys

10. Service providers receive intensive training specific to their role to understand the essential components of family assessment, home visiting and supervision.

Standard 10 Intent: The overall intent of the standards in this section is to ensure staff receive training specific to their role. HFA Core training is required for all Family Support Specialists, Family Resource Specialists, supervisors, and program managers within six months of hire. This training must be provided by a nationally certified HFA Core trainer. Stop-gap training is provided when staff begin providing direct services prior to receiving Core training. In addition, there are seven orientation training topics required to be received by staff prior to work with families. ***Please Note:*** *For training standards (10 & 11) where "recent practice" is indicated for a 2 rating, at the time of the accreditation site visit, the site's most recent hire (whose hire date has allowed sufficient time to receive training) plus any staff hired three months prior to the most recent hire, will demonstrate training was received in accordance with the standard, specific to content and timeframe requirements, unless extenuating circumstances warrant contextual decision-making.*

This standard has many components that pertain to the staff roles of: Family Resource Specialist, Family Support Specialist, Supervisors, and Program Managers. Please utilize the hyperlinks provided here to seek clarity on these roles as defined in the Glossary section.

10-1. **(old 11-1)** The site has a comprehensive training plan/policy detailing all required trainings listed below for staff (Family Support Specialists, Family Resource Specialists, supervisors and program managers), including: 1) topics and subtopics, 2) the method for obtaining training, and 3)the timeframe for each.

- orientation (10-2.A-G)
- stop-gap training (10-3.A-D) when HFA Core is received after first direct service
- intensive role specific (HFA Core) training (10-4.A-C)
- implementation training (10-5). Program managers or designee only
- wrap-around training topics within 3 months of hire (11-1.A-C)
- wrap-around training topics within 6 months of hire (11-2.A-F)
- wrap-around training topics within 12 months of hire (11-3.A-E) and 11-3.F for sites in multi-site systems
- annual ongoing training and child abuse and neglect update training (11-4.A-B)
- cultural humility (5-3)
- ASQ-3 and ASQ: SE-2 (6-5.D and E) for staff who administer the tool and their supervisors
- depression screens (7-4.D) for staff who administer the tool and their supervisors
- any other evaluation tools or screening/assessment instruments (such as PCI tool) used by the site

Please note: All interns and volunteers who perform the same duties as Family Resource Specialists, Family Support Specialists and supervisors receive the same type of training as paid staff.

Standard 10-1 Intent: *The training plan/policy addresses all topics and subtopics included in standards 10 and 11, as listed above. The plan/policy guides the site toward achieving the training in a timely manner (by the specified timeframes) and clearly identifies:*

- *how the training is provided and by whom (e.g., site manager/supervisor, community agency, HFA online training modules, video, reading materials, etc.),*
- *topics covered by each session, and*

Training logs include supervision verification the training was received. ***Please Note:*** *Sites using the HFA Learning Center (TLC) for wrap-around training can simply state this in conjunction with each subtopic. For sites who do not use the TLC, the site will create a crosswalk between each of the required subtopic area and the training title and training provider/method used to cover each subtopic. Sites can track training using the* HFA Log of Required Trainings.

10-1.		RATING INDICATORS
3	-	No 3 rating for standard 10-1.
2	-	The site has a comprehensive training plan/policy including all required trainings and the method and timeframe for receipt of all trainings.
1	-	Any of the following: there is no training plan/policy; the training plan/policy is not yet comprehensive (does not list all required topics, subtopics, method for receipt of training (e.g. e-learning, TLC, onsite, etc.); or does not yet include timeframe for receipt of all training.

☺ Tip: The tracking form should include date of hire to HFA, date of 1st direct service contact provided (home visit, assessment, supervision etc.).

☺ Tip: Sites should be sure to track training even when training was received outside of the required timeframe.

10-2. (old 10-1) Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers), receive orientation training (separate from intensive role specific training) subsequent to HFA hire date and prior to direct work with families to familiarize them with the functions of the site. Program managers hired July 1, 2014 or later will receive orientation training within 3 months of hire. Program managers hired prior to July 1, 2014 are grandfathered and not required to document receipt of orientation topics.

Intent: *When staff are hired, they often begin their work with families prior to receiving role specific **HFA Core training**. Therefore, it is essential staff have been oriented to topics which will directly impact their immediate work with families or with direct service staff (for supervisors). Typically, these orientation trainings are designed and provided by the site and will reflect the resources, laws and requirements specific to the host organization, local community or state. Site administrators ensure these orientation topics are comprehensive and support the staff to succeed in their roles during this early part of employment. All of these training topics must be covered prior to direct contact with participants and prior to direct supervision of staff. **Please note:** In the event staff did not receive these trainings within the required timeframes, for accreditation purposes it is expected all staff will receive the training regardless of the timeframe. **Please Note:** When a site is newly established, the program manager or supervisor may be involved in the writing of policy and procedure, and the development of orientation procedures for staff. These activities, with documented dates relative to each orientation topic can be referenced as completion of orientation for program managers or supervisors.*

10-2.A Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) are oriented to their roles as they relate to 1) the HFA goals and services, 2) the philosophy of home visiting/family support, and 3) the principles of ethical practice, subsequent to HFA hire date and prior to direct work with families or supervision of staff.

10-2.A		RATING INDICATORS
3	-	All staff hired in the past five years are oriented to their roles as they relate to HFA goals and services, the philosophy of home visiting/family support, and the principles of ethical practice subsequent to HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have occurred after first direct service. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
2	-	Past instances were found when staff hired in the past five years were not oriented to their roles as they relate to HFA goals and services, the philosophy of home visiting/family support, and the principles of ethical practice subsequent to HFA hire date and prior to direct work with families or supervision with staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Staff are not yet oriented to their roles as they relate to HFA goals and services, the philosophy of home visiting/family support, and the principles of ethical practice subsequent to HFA hire date and prior to direct work with families or providing supervision to staff.

☺ Tip: Sites are encouraged to include shadowing experiences with other direct service staff to assist new staff in becoming familiar with their role.

☺ Tip: Sites are encouraged to utilize a Code of Ethics, whether one established through professional organizations for nurses, social workers, early childhood professionals, or a multi-disciplinary *Code of Ethics for Human Service Professionals*.

10-2.B (old 10-1.A split into 10-2.A and 10-2.B) Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) are oriented to their roles as they relate to 1) the site's curriculum materials, 2) policy and operating procedures, and 3) data collection forms and processes, subsequent to HFA hire date and prior to direct work with families or supervision of staff.

10-2.B		RATING INDICATORS
3	-	All staff are oriented to their roles as they relate to the site's curriculum materials, policy and operating procedures, and data collection forms and processes, subsequent to HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have occurred after first direct service. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
2	-	Past instances were found when staff were not oriented to their roles as they relate to the site's curriculum materials, policy and operating procedures, and data collection forms and processes, subsequent to HFA hire date and prior to direct work with families or supervision with staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Staff are not yet oriented to their roles as they relate to the site's curriculum materials, policy and operating procedures, and data collection forms and processes, subsequent to HFA hire date and prior to direct work with families or providing supervision to staff.

10-2.C (old 10-1.B) Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) are oriented to the site's relationship with other community resources subsequent to HFA hire date and prior to direct work with families.

10-2.C		RATING INDICATORS
3	-	All staff are oriented to the site's relationship with other community resources (e.g., organizations in the community with which the site has working relationships) subsequent to HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been occurred after first direct service. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
2	-	Past instances were found when staff were not oriented to the site's relationship with other community resources subsequent to HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Staff are not yet oriented to the site's relationship with other community resources subsequent to HFA hire date and prior to direct work with families or supervision of staff.

10-2.D **(old 10-1.C)** Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) are oriented to 1) child abuse and neglect indicators and 2) reporting requirements subsequent to HFA hire date and prior to direct work with families.

Please note: To be accredited, sites must be sure all staff have been oriented to child abuse and neglect indicators.

10-2.D		RATING INDICATORS
3	-	All staff are oriented to child abuse and neglect indicators and reporting requirements subsequent to HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been occurred after first direct service. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
2	-	Past instances were found when staff were not oriented to child abuse and neglect indicators and reporting requirements subsequent to HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Staff are not yet oriented to child abuse and neglect indicators and reporting requirements subsequent to HFA hire date and prior to direct work with families or supervision of staff.
Note:		**This is a Safety Standard**

10-2.E (old 10-1.D) Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) are oriented to issues of confidentiality prior to direct work with families.

10-2.E		RATING INDICATORS
3	-	All staff are oriented to issues of confidentiality subsequent to HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have occurred after first direct service. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
2	-	Past instances were found when staff were not oriented to confidentiality subsequent to HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Staff are not yet oriented to issues of confidentiality subsequent to HFA hire date and prior to direct work with families or supervision of staff.

10-2.F **(old 10-1.E)** Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) are oriented to issues related to boundaries subsequent to HFA hire date and prior to direct work with families.

10-2.F		RATING INDICATORS
3	-	All staff are oriented to issues related to boundaries subsequent to HFA hire date and prior to direct work with families or supervision of staff. For sites in their first

		accreditation cycle, staff hired more than five years ago have received the training but may have occurred after first direct service. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
2	-	Past instances were found when staff were not oriented to issues related to boundaries subsequent to HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Staff are not yet oriented to issues related to boundaries subsequent to HFA hire date and prior to direct work with families or supervision of staff.

10-2.G (old 10-1.F) Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) are oriented to issues related to staff safety subsequent to HFA hire date and prior to direct work with families.

10-2.G		RATING INDICATORS
3	-	All staff are oriented to issues related to staff safety subsequent to HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have occurred after first direct service. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
2	-	Past instances were found when staff were not oriented to issues related to staff safety subsequent to HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Staff are not yet oriented to issues related to staff safety subsequent to HFA hire date and prior to direct work with families or supervision of staff.

10-3. **(old 10-2)** Supervisors, Family Resource Specialists and Family Support Specialists who begin direct service or supervision work prior to receipt of role-specific HFA Core training, must receive "stop-gap" training. Stop-gap training does not need to be conducted by a certified trainer; however it must be conducted by someone who has been intensively trained in the role they are providing stop-gap training for. Stop-gap training does not replace the requirement to attend HFA Core training.

Intent: *When staff begin* direct service or supervision work *prior to the receipt of role-specific **HFA Core training**, the site must have a policy for the provision of stop-gap training. Stop-gap training is defined as: customized role-specific training provided as-needed to meet an individual's urgent need for training in the skills necessary to perform their work, prior to the receipt of HFA Core training. HFA has developed a series of stop-gap training webinars to be used in conjunction with on-site activities designed to set staff on a positive trajectory for their work with families. Stop-gap on-site activities do not need to be conducted by a certified trainer; however it must be conducted by someone who has been intensively trained in the role. Stop-gap training does not replace the requirement to attend HFA Core training.*

For established sites, all new staff will complete stop-gap training in order to begin their work with families when waiting to attend HFA Core training, unless the site's policy requires HFA Core

Training is received prior to direct service. Stop gap training including on-site activities have been developed by HFA and may be conducted by the site supervisor or program manager. HFA stop-gap training includes:

- *A clear description of the "HFA Advantage" (what makes HFA unique including trauma-informed practice, the power of relationships/attachment, and reflective capacity).*
- *Shadowing of other staff in a similar role*
- *Training on forms used by individuals in that role*
- *Hands-on practice (with observation and feedback)*
- *Inter-rater reliability related to documentation (Family Support Specialist, Family Resource Specialist, or supervisor)*
- *Use of a strengths-based approach when working with others*

***Please Note:** For brand new sites where there is currently no one on staff who has received HFA Core Training or there is not a neighboring site with which to connect with, the HFA National Office can provide support allowing families to begin receiving services. Please contact your HFA Implementation Specialist for more details.*

10-3.A (old 10-2.A) The site has policy and procedures for providing stop-gap training to staff (Family Resource Specialists, Family Support Specialists and supervisors) when they will begin their work prior to the receipt of HFA Core training to ensure the worker has adequate understanding and knowledge of their role. The training must include the bulleted components described in the intent.

10-3.A.		RATING INDICATORS
3	-	No 3 rating for 10-3.A.
2	-	The site has policy and procedures for providing stop-gap training to Family Resource Specialists, Family Support Specialists and supervisors who will begin their work prior to the receipt of HFA Core training. Stop-gap training includes all bulleted components described in the intent.
1	-	The site does not yet have policy and procedures for training Family Resource Specialists, Family Support Specialists and supervisors who will begin their work prior to the receipt of HFA Core training, or the policy and procedures does not yet specify the training include all bulleted components described in the intent.
NA	-	The site's policy requires that HFA Core training be received prior to providing direct service.

10-3.B (old 10-2.B) Family Resource Specialists and Family Support Specialists who administer the Parent Survey (or other HFA approved assessment tool) prior to completion of HFA Core Training, and their supervisor, have received stop-gap training to ensure the worker and/or supervisor have adequate understanding and knowledge of his/her role.

10-3.B		RATING INDICATORS
3	-	Staff receive assessment stop-gap training prior to administering the tool and/or supervising administration of the tool which includes all required components. For sites in their first accreditation cycle, staff hired more than five years ago have received training though may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired more than five years ago is not required.
2	-	Past instances occurred when stop-gap training was not received prior to administering the tool and/or supervising administration of the tool, or some of the required components were not included; however, **recent practice** indicates this now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Site staff do not yet receive stop-gap training prior to administering the tool and/or supervising administration of the tool, or the training does not yet include all required components.
NA	-	Per site policy, all staff have received HFA Core training prior to providing direct service.

10-3.C (old 10-2.C) Family Support Specialists who begin conducting home visits prior to completion of HFA Core Training, and their supervisor, have received stop-gap training to ensure the worker and/or supervisor have adequate understanding and knowledge of his/her role.

10-3.C		RATING INDICATORS
3	-	Staff receive Family Support Specialist stop-gap training prior to conducting home visits and/or supervising home visits which includes all required components. For sites in their first accreditation cycle, staff hired more than five years ago have received training though may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired more than five years ago is not required.
2	-	Past instances may have occurred when stop-gap training was not received prior to conducting home visits and/or supervising home visits, or some of the required components were not included; however, **recent practice** indicates this now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Site staff do not yet receive stop-gap training prior to conducting home visits and/or supervising home visits, or the training does not yet include the required components.
NA	-	Per site policy, all staff have received HFA Core training prior to providing direct service.

10-3.D (old 10-2.D) Supervisors who begin providing supervision prior to completion of HFA Core Training have received stop-gap training to ensure the supervisor has adequate understanding and knowledge of his/her role.

10-3.D		RATING INDICATORS
3	-	Supervisors receive supervisor stop-gap training including all required components prior to conducting supervision sessions. For sites in their first accreditation cycle, staff hired more than five years ago have received training though may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired more than five years ago is not required.
2	-	Past instances may have occurred when training was not received prior to conducting supervision sessions or some of the required components were not included; however, **recent practice** indicates this now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Supervisors do not yet receive training prior to conducting supervision sessions, or the training does not yet include all of the required components.
NA	-	Per site policy, all supervisors have received HFA Core Supervisor training (day 5 of PSCO and day 5 of Foundations for Family Support, formerly ISHV) prior to supervising staff.

10-4. **(old 10-3)** Staff (Family Resource Specialists, Family Support Specialists and supervisors) receive role-specific HFA Core training from a HFA certified trainer within six months of date of hire. Program Managers who do not supervise any direct service staff receive HFA Core training within 18 months of hire.

Intent: *Intensive training develops **the** knowledge and skills necessary to achieve site goals. It prepares staff to assess family needs, assist with parent-child interaction, strengthen family functioning, provide appropriate information, connect families with appropriate resources, and meet the expected standards of service delivery. Furthermore, intensive training allows staff to link theory to practice by developing and implementing practical approaches to real-life situations and to share information and experiences, and to learn from one another.*

Please Note: *All Program Managers hired prior to July 1, 2014 are strongly encouraged to attend HFA Core training if they have not already, though Program Managers hired prior to July 1, 2014 will be "grandfathered" and not be required to demonstrate receipt of HFA Core training, unless the Program Manager also supervises direct service staff or the Program Manager supervises a supervisor carrying a caseload of 4 or more families. Program managers hired after July 1, 2014 must attend all HFA Core trainings.*

Please Note*: Supervisors hired prior to July 1, 2014 must, at minimum, attend HFA Core Training for all roles they directly supervise. Supervisors hired after July 1, 2014 are required to attend both Family Support Specialist and Family Resource Specialists Core trainings plus the supervisor day attached to each, to further ground them in the model, and to ensure they are able to effectively support staff to implement assessment and home visiting skills learned in training.* ***Exception:*** *Supervisors who supervise a team of FRSs only (i.e. do not supervise anyone in a Family Support Specialist role) are exempt from attending HFA Foundations for Family Support core training and day 5 for Supervisors (formerly ISHV).*

Please note: *In the event staff did not receive HFA Core training within the required timeframes, it is required all staff will receive the training regardless of the timeframe.*

When staff either move from one role to another (e.g., Family Support Specialist becomes Family Resource Specialist), or at some point are cross-trained (e.g., start as Family Resource Specialists

and later serve as assessment and home visit staff), it is required additional core training to the new or added role will occur within 6 months from date of position change.

Please Note: *When a staff member who has received Core training is re-hired for the same position, whether at the same site or at a different site, re-taking of HFA Core training is required if the staff person has not worked for HFA in three or more years.*

10-4.A (old 10-3.A) All staff conducting assessments and all supervisors receive intensive *HFA Core Assessment training,* by a HFA certified trainer, within six months of date of hire to understand the essential components of the Family Resource Specialist role. *Program Managers* receive HFA Core training (PSCO) within eighteen months of hire.

10-4.A		RATING INDICATORS
3	-	All staff conducting assessments, and all supervisors receive intensive role specific assessment training, by a HFA certified trainer, on the essential components of family assessment within six months of the date of hire or position change, and within eighteen months for program managers. For sites in their first accreditation cycle, staff hired more than five years ago have received the training though may have been received later than within six months of hire. For sites in a reaccreditation cycle, training data for staff hired more than five years ago not required.
2	-	Past instances were found when staff or supervisors did not receive intensive role specific assessment training, by a HFA certified trainer, within six months after hire or position change, or within eighteen months for program managers; however, **recent practice** indicates this now occurring and all staff (if site is in its first accreditation cycle) have received role-specific training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Staff conducting assessments or supervisors and program managers, do not yet receive intensive role specific training within the specified time frames, or training was not conducted by a HFA certified trainer.
Note:		**This is a Sentinel Standard**

☺ Tip: Post-training inter-rater reliability activities (as discussed during core training) are very important to knowledge and skill acquisition, and direct service staff and supervisors who attend PSCO training are strongly encouraged to complete these.

☺ Tip: When HFA Core training materials and content are significantly revised by the HFA National Office, staff are encouraged to attend refresher training.

10-4.B (old 10-3.B) Family Support Specialists and their supervisors have received intensive *HFA Core* Integrated Strategies for *Family Support Specialist training*, by a HFA certified trainer, within six months of date of hire to understand the essential components of the Family Support Specialist role. Program Managers receive HFA Foundations for Family Support Core training (formerly ISHV) within eighteen months of hire.

Please Note: Supervisors who supervise a larger centralized intake system responsible for completing the Parent Survey, or part of a larger site supervising a separate assessment "unit" and therefore without involvement in supervising the home visiting component of services are exempt from the requirement that all supervisors receive both tracks of HFA Core training. Supervisors with these larger assessment units are required to complete Core Assessment Training (PSCO) and are recommended but not required to complete Integrated Strategies.

10-4.B	RATING INDICATORS

3	-	All Family Support Specialists and their supervisors receive intensive role specific Family Support Specialist training, by a HFA certified trainer, on the essential components of home visiting within six months of the date of hire or position change and within eighteen months for program managers. For sites in their first accreditation cycle, staff hired more than five years ago have received the training though may have been received later than within six months of hire. For sites in a reaccreditation cycle, training data for staff hired more than five years ago not required.
2	-	Past instances were found when staff or supervisors and program managers did not receive intensive role specific Family Support Specialist training, by a HFA certified trainer, within six months after hire or position change or within eighteen months for program managers; however, **recent practice** indicates this is now occurring, and all staff (if site is in its first accreditation cycle) have received role specific training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Family Support Specialists or their supervisor and program manager do not yet receive such training within the specified time frames, or the training was not conducted by a HFA certified trainer.

Note: **This is a Sentinel Standard**

☺ Tip: When staff have been cross-trained, but have not performed the duties of this additional role within one year of original training, it is recommended they receive comprehensive refresher training or retraining within 6 months of assuming these duties. This refresher training can be conducted by a program manager or supervisor (who have completed the training) or certified trainer.

☺ Tip: Post-training certification activities (as discussed during core training) are very important to knowledge and skill acquisition, and supervisors are strongly encouraged to have staff complete these for additional certification.

10-4.C **(old 10-3.C)** Supervisors have received intensive *HFA Core Supervision training*, by a HFA certified trainer, within six months of date of hire to understand the essential components of his/her role as a supervisor, as well as the role of Family Resource Specialists and Family Support Specialists. Program Managers receive this training within eighteen months of hire. HFA Core Supervision training involves attending the "day 5 Supervisors training" of both Foundations for Family Support (formerly ISHV) training and Parent Survey (PSCO) training, unless within a multi-site system that has developed a separate intensive Supervisor Core.

10-4.C		RATING INDICATORS
3	-	All supervisors receive intensive role specific supervision training, by a HFA certified trainer, on the essential components of supervision, within six months of the date of hire or position change, and within eighteen months of hire for program managers. For sites in their first accreditation cycle, staff hired more than five years ago have received the training though may have been received later than within six months of hire. For sites in a reaccreditation cycle, training data for staff hired more than five years ago not required.
2	-	Past instances were found when supervisors did not receive intensive role specific supervision training, by a HFA certified trainer, within six months after hire or position change or within eighteen months for program managers; however, **recent practice** indicates this is now occurring and all supervisors and program managers (if site is in its first accreditation cycle) have now received both supervisor trainings regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	Supervisors and /program managers do not yet receive training specific to their role within the specified time frames, or training was not conducted by a HFA certified trainer.

Note: **This is a Sentinel Standard**

☺ Tip: Subsequent to receiving HFA Core Supervisor training, all supervisors are strongly encouraged to also obtain HFA's Advanced Supervision training.

10-5. **(new)** All Program Managers hired to HFA on or after January 1, 2018 receive *HFA Implementation training* from the HFA National Office within eighteen months of date of hire, to understand the essential components of implementing the HFA model. HFA Implementation training is strongly encouraged and optional for program managers hired prior to January 1, 2018. Program managers who have attended Implementation training prior to January 1, 2018 do not need to re-take the training. Please note: **In situations where the program manager's time commitment to the site is extremely limited or divided among different individuals, the program manager may designate another staff person to attend instead. This happens infrequently and so must be discussed with an HFA Implementation Specialist for approval.**

10-5		RATING INDICATORS
3	-	All program managers hired to HFA on or after January 1, 2018 receive intensive HFA Implementation training, by National Office staff, on the essential components of implementing the HFA model, within twelve months of the date of hire or position change; or program managers hired prior to 1/1/18 completed HFA Implementation Training.
2	-	All program managers hired on or after January 1, 2018 receive intensive HFA Implementation training, by National Office staff, within eighteen months after hire or position change.
1	-	Program managers hired on or after January 1, 2018 have not yet received HFA Implementation training from National Office staff within eighteen months of hire or position change.
N/A	-	The site's program manager was hired prior to 1/1/18 and is exempt from completing Implementation Training.

Tables of Documentation			
10. Service providers receive intensive training specific to their role to understand the essential components of family assessment, home visiting and supervision			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study**	**Site Visit Activities**
10-1 Training Plan/Policy	Training provided, tracked and monitored	Please submit training plan/policy including: all required topics, subtopics, method for receipt of training (i.e. e-learning, TLC, onsite, etc.); and timeframe for receipt.	**Interviews:** * As needed **Review:** ***** Training documentation * Staff Surveys
10-2.A-G Orientation Training ***10-2.D*** **-** Safety ***Standard***		Please submit documentation indicating the date each staff person (program managers (PM), family support specialists (FSS), family resource specialists (FRS), supervisors (SUP)) completed each of the orientation topics (10-1.A-G), including the date of hire and the date staff person began providing direct service or supervision. Please note: HFA Training Log available	
10-3.A Policy for Stop-Gap Training	Stop-gap training in accordance with standard requirements for staff (program managers, FSS, FRS, supervisors) when they will begin their work prior to receipt of HFA Core Training	Please Submit Policy	
10-3.B-D Stop-Gap provided when needed		Submit documentation indicating of Stop-Gap training (if used) including the date each training topic completed, as well as the date of hire for each staff (PM, FSS, FRS, SUP). Please note: HFA Training Log available	
10-4.A **HFA Parent Survey Training** ***Sentinel Standard***		Submit documentation indicating the date each staff person completed Core training (program managers, FSS, FRS, supervisors) and include the staff date of hire. Documentation can be recorded in a training log with supervisor signature, or training certificates may be submitted. Please note: HFA Training Log available	
10-4.B **HFA Integrated Strategies Training** ***Sentinel Standard***			
10-4.C **HFA Supervisor** ***Sentinel Standard***			

10-5 HFA Implementation training for Program Managers		Please submit documentation indicating the date of hire for the Program Manager (or designee) and the date HFA Implementation training was completed.	

11. Service providers have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers receive basic training in areas such as culture, reporting child abuse, determining the safety of the home, managing crisis situations, and responding to mental health, substance abuse, or intimate partner violence issues, drug-exposed infants, and services in their community.

Standard 11 Intent: *The overall intent of the standards in this section is to ensure staff receive the training support and have the skill set necessary to fulfill their job functions and achieve the site's goals with families. Training is geared to the unique aspects of services with which staff are engaged, and is* ***culturally*** *respectful, taking into account each staff member's skills and needs. Training can be received through a variety of methods including, but not limited to the following: lecture or interactive presentations by individuals with particular expertise in an area, workshops, college coursework, multi-disciplinary clinical consultations, training presentations by staff members, and self-study with supervision follow-up.*

This standard has many components that pertain to the staff roles of: Family Resource Specialist, Family Support Specialist, Supervisors, and Program Managers. Please utilize the hyperlinks provided here to seek clarity on these roles as defined in the Glossary section.

Intent 11-1, 11-2, and 11-3:
Training that is specific and relevant to the field of home visiting and can translate to the work of HFA staff is critical in the first year of employment. It is intended for staff to receive training in all of the topics and subtopics outlined within the rating indicators. It is a site's responsibility to ensure competency of staff, and determine their need for additional training beyond the required topics outlined in these standards. The intent of training is to provide staff with the knowledge and skills necessary to assess issues and concerns with families and to facilitate the development of healthy families.

Several formats are acceptable to accomplish training in each of the specified areas below and can include: attendance at trainings/workshops/in-services, HFA's on-line Learning Center (TLC), other online training, formal education, certification, licensure, and competency-based testing (a tool, often paper and pencil or measured through observation of skills and abilities, which tests an individual's knowledge level on a given topic). Professional experience and previous formal education can qualify as training when coupled with competency based testing or supervision follow-up to ensure successful knowledge acquisition and understanding of concepts or materials. Formal education, previous training and previous experience must have occurred within three years prior to hire in the Healthy Families role and directly apply to the topics identified in order to be counted. Supervisors must determine how experience or education received prior to working in a Healthy Families role is appropriate to the staff person's work as a Family Resource Specialist, Family Support Specialist, or supervisor or if additional training in this topic might be beneficial. Learning objectives for all required 11-1, 11-2, and 11-3 trainings are located within the Healthy Families America Core Supervisor Manual should sites want to provide this training face-to-face.

Please Note:
1. *Supervisors, Family Support Specialists and Family Resource Specialists hired to their HFA role prior to July 1, 2014 must receive at least a* ***majority*** *of the topics listed in the 11-1, 11-2 and 11-3 standards.* ***All*** *staff, including program managers, hired on or following July 1, 2014, must receive* ***all*** *of the training topics listed in the 11-1, 11-2 and 11-3 standards. Program Managers hired to their HFA role prior to July 1, 2014 are grandfathered and not required to show wrap-around training topics were received. It is recommended however they obtain and document this training, even if received outside the required timeframes.*
2. *All staff at affiliated HFA sites may use the* ***HFA Learning Center (TLC)*** *to obtain all of the 11-1, 11-2 and 11-3 training topics online. Each online course is accompanied by a post-training assessment which must be passed successfully in order to fulfill the training requirement for the standard. Reports printed from the TLC demonstrating all staff successfully completed each module will satisfy requirements for these standards. If not using the TLC, staff must maintain copies of course completion records or training agendas, certifications, etc. clearly indicating all subtopics were received to demonstrate adherence.*

3. *HFA Core training (standards 10-4.B-D) cannot be used to satisfy the 3, 6 and 12 month training requirements.*
4. *The purpose for specifying in the rating indicators a five year timeframe is to allow sites that have been in existence more than five years to demonstrate their current capacity to achieve a 3 rating, rather than being hindered by practice that may have occurred prior to its last accreditation site visit.*
5. *For training standards (10 & 11) where "recent practice" is indicated for a 2 rating, at the time of the accreditation site visit, the site's most recent hire (whose hire date has allowed sufficient time to receive training) plus any staff hired three months prior to the most recent hire, will demonstrate training was received in accordance with the standard, specific to content and timeframe requirements, unless extenuating circumstances warrant contextual decision-making.*

☺ Tips: (for 11-1, 11-2 and 11-3):

- Sites should have mechanisms for ensuring staff training needs are being met and the trainings are of high quality (e.g. post-training surveys, or input obtained during supervision or team meeting).
- When circumstances prevent staff from attending a required training in a timely way it is recommended sites document the circumstances that led to staff missing the training, so peer reviewers can take this information into consideration when assigning a rating.
- When staff complete the TLC modules very quickly after hire, they are encouraged to revisit the TLC as a refresher at a later point once they begin to increase their experiences working with families. This will assist with the transfer of knowledge to practice, as training done very early or too quickly may not be readily applied if they have not yet begun serving families.

11-1. **(old 11-2)** Staff (Family Resource Specialists, Family Support Specialists, and supervisors) receive training on a variety of topics necessary for effectively working with families and children within three months of hire and within eighteen months for Program Managers.

11-1.A (old 11-2.A) Staff (Family Resource Specialists, Family Support Specialists, and supervisors) receive training on all topic areas of Infant Care within three months of the date of hire, and within eighteen months for Program Managers.

11-1.A		RATING INDICATORS
3-	-	All staff hired within the past five years received training on Infant Care within three months of hire (eighteen months for program managers). Staff hired more than five years ago have received the training but may have been later than three months after hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than three months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Sleeping - Feeding/Breastfeeding - Physical care of the baby - Crying and comforting the baby
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Infant Care within three months of hire (eighteen months for program managers); however with the most recent hire(s), practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Infant Care topics within three months of hire (eighteen months for program managers), or there are site staff who have not yet received training on all the content areas identified above regardless of timeframe.

11-1.B (old 11-2.B) Staff (Family Resource Specialists, Family Support Specialists, supervisors and Program Managers) receive training on all topic areas of Child Health and Safety within three months of the date of hire and within eighteen months for program managers.

11-1.B		RATING INDICATORS
3	-	All staff hired within the past five years received training on all topic areas of Child Health and Safety within three months of hire (eighteen months for program managers). Staff hired more than five years ago have received the training but may have been later than three months after hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than three months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Home safety (e.g., fire, child supervision, water temperature, pools, falls, etc.) - Shaken baby syndrome - SIDS - Seeking medical care - Well-child visits/immunizations - Seeking appropriate child care - Car seat safety - Failure to thrive
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Child Health and Safety within three months of hire (eighteen months for program managers); however with the most recent hire(s), practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Child Health and Safety topics within three months of hire (eighteen months for program managers), or there are site staff who have not yet received training on all of the content areas identified above regardless of timeframe.

11-1.C (old 11-2.C) Staff (Family Resource Specialists, Family Support Specialists, supervisors and Program Managers) receive training on all topic areas of Maternal and Family Health within three months of the date of hire and within eighteen months for Program Managers.

11-1.C		RATING INDICATORS
3	-	All staff hired within the past five years received training on Maternal and Family Health within three months of hire (eighteen months for program managers). Staff hired more than five years ago have received the training but may have been later than three months after hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than three months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Family Planning - Nutrition - Pre-natal/Post-natal healthcare - Pre-natal/Post-Partum Depression - Warning signs for when to call the doctor
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Maternal and Family Health within three months of hire (eighteen months for program managers); however with the most recent hire(s), practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Maternal and Family Health topics within three months of hire (eighteen months for program managers), or there are site staff who have not yet received training on all of the content areas identified above regardless of timeframe.

11-2. **(old 11-3)** Staff (Family Resource Specialists, Family Support Specialists, supervisors and *Program Managers*) receive training on a variety of topics necessary for effectively working with families and children within six-months of hire and within eighteen months for program managers.

11-2.A **(old 11-3.A)** Staff (Family Resource Specialists, Family Support Specialists, supervisors and Program Managers) receive training on all topic areas of Infant and Child Development within six months of the date of hire and within eighteen months for program managers.

11-2.A		RATING INDICATORS
3	-	All staff hired within the past five years received training on Infant and Child Development within six months of hire (eighteen months for program managers). For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than six months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Language and literacy development - Physical and emotional development - Identifying developmental delays - Brain development
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Infant and Child Development within six months of hire (eighteen months for program managers); however for the most recent hire(s), practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Child Development topics within six months of hire (eighteen months for program managers), or there are site staff hired in the past five years who have not yet received training on all of the content areas identified above regardless of timeframe.

11-2.B (old 11-3.B) Staff (Family Resource Specialists, Family Support Specialists, supervisors and Program Managers) receive training on all topic areas of Supporting the Parent-Child Relationship within six months of the date of hire and within eighteen months for program managers.

11-2.B		RATING INDICATORS
3	-	All staff hired within the past five years received training on Supporting the Parent-Child Relationship within six months of hire (eighteen months for program managers). For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than six months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Supporting attachment - Positive parenting strategies - Discipline - Parent-Child interactions - Observing parent-child interactions - Strategies for working with difficult relationships
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Supporting the Parent-Child Relationship within six months of hire (eighteen months for program managers); however with the most recent hire(s), practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Supporting the Parent-Child Relationship topics within six months of hire (eighteen months for program managers), or there are site staff who have not yet received training on all of the content areas identified above regardless of timeframe.

11-2.C (old 11-3.C) Staff (Family Resource Specialists, Family Support Specialists, supervisors and Program Managers) receive training on all topic areas of Staff Related Issues within six months of the date of hire and within eighteen months for program managers.

11-2.C		RATING INDICATORS
3	-	All staff hired within the past five years received training on Staff Related Issues within six months of hire (eighteen months for program managers). Staff hired more than five years ago have received the training but may have been later than six months after hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than six months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Stress and time management - Burnout prevention - Personal safety of staff - Ethics - Crisis intervention - Emergency procedures
2	-	Past instances were found when staff hired with the past five years did not receive training on all of the topics related to Staff Related Issues within six months of hire (eighteen months for program managers); however with the most recent hire(s), practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Staff Related Issues topics within six months of hire (eighteen months for program managers), or there are site staff who have not yet received training on all of the content areas identified above regardless of timeframe.

11-2.D (old 11-3.D) Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) receive training on all topic areas of Mental Health within six months of the date of hire and within eighteen months for program managers.

11-2.D		RATING INDICATORS
3	-	All staff hired within the past five years received training on Mental Health within six months of hire (eighteen months for program managers). Staff hired more than five years ago have received the training but may have been later than six months after hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than six months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Promotion of positive mental health - Behavioral signs of mental health issues - Depression - Strategies for working with families with mental health issues - Referral resources for mental health
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Mental Health within six months of hire (eighteen months for program managers); however with the most recent hire(s), practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Mental Health topics within six months of hire (eighteen months for program managers), or there are site staff who have not yet received training on all of the content areas identified above regardless of timeframe.

11-2.E (old 11-5.B) Staff (Family Resource Specialists, Family Support Specialists, and supervisors) receive Prenatal specific training within six months of hire when the site serves families prenatally and within eighteen months for program managers. HFA Prenatal training webinar and related resources and the expectation of this standard. Attendance at HFA's Great Beginnings Start Before Birth training is a 3 rating.

Intent: *The site ensures staff receive Prenatal Training when the site is serving prenatal families. The prenatal period affords sites the opportunity to:*

- *Improve pregnancy and birth outcomes*
- *Establish the Family Support Specialist-parent relationship*
- *Identify and address challenges earlier*
- *Promote reflective function*
- *Promote the parent-child relationship*

11-2.E		RATING INDICATORS
3	-	All staff have attended HFA's Great Beginnings Start Before Birth training or have received Prenatal Training within six months of hire (eighteen months for program managers). For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than six months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Fetal growth & development during each trimester - Warning signs: when to call the doctor - Activities to promote the parenting role, and the parent-child relationship during pregnancy - Preparing for the baby - Promoting parental awareness of what the baby is experiencing with a connection to what the parent is doing (reflection)
2	-	Past instances were found when staff received Prenatal Training later than six months after hire (eighteen months for program managers); however with the most recent hire(s), practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Prenatal topics within six months of hire (eighteen months for program managers), or there are site staff who have not yet received training on all of the prenatal content areas identified above regardless of the timeframe.
NA	-	The site does not serve families prenatally.

11-2.F **(old 11-5.C)** Home visiting staff and their supervisor receive training on all topic areas of the Family Goal process within six months of hire and within eighteen months for program managers.
HFA Family Goal Process webinar and related resources

Intent: *The purpose of the **Family Goal** process is to amplify parents' problem solving skills, support their ability to develop and implement options to improve their situation, and celebrate with them their successes in achieving goals and objectives. The Family Goal process sets the framework for Family Support Specialists to:*

- *Offer the concept that change can happen and the family can have an impact creating their future*
- *Help the family identify what they want to accomplish and the mechanism(s) by which the Family Support Specialist can assist*
- *Develop opportunities for the family to experience success*
- *Assist the family to identify and acknowledge their strengths*
- *Work together with the family to develop goals and break those goals into meaningful steps to ensure success for each family. This includes a clear conversation and partnering between the Family Support Specialist and parent that supports growth in families*
- *Celebrate success with the family*

11-2.F		RATING INDICATORS
3	-	Family Support Specialists and their supervisors and program manager receive training on all the topics in the family goal process within six months of hire (eighteen months for program managers). For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than six months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Purpose and importance of the family goal process in HFA services - Working with families to identify strengths and needs - Supporting the family's role in setting and achieving meaningful goals to assist families in taking charge of their lives - Development of family goals based upon the Family Support Specialist's knowledge about the family, as well as tools completed with the family. - Practice writing family goals in ways that help families create measurable goals
2	-	Past instances were found when staff received training on the family goal process later than six months after hire (eighteen months for program managers); however, **recent practice** indicates this is now occurring and all staff (if in a first accreditation cycle) have received the training listed in the 3 rating regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
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1	-	The site's most recent hire(s) have not yet received all Family Goal topics within six months of hire (eighteen months for program managers), or there are site staff who have not yet received training on all of the family goal topics identified above regardless of the timeframe.

☺ Tip: HFA's Family Goal webinar builds on information provided initially during HFA Core training for Family Support Specialists (10-4.B), and therefore it is recommended the webinar be viewed after staff receive Core, unless Core is received so close to the 6 month due date, waiting would put staff past 6 months for receipt of 11-2.F.

11-3. **(old 11-4)** Staff (Family Resource Specialists, Family Support Specialists, and supervisors) received training on a variety of topics necessary for effectively working with families and children within twelve-months of hire and within eighteen months for program managers.

11-3.A (old 11-4.A) Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) receive training on all topic areas of Child Abuse and Neglect within twelve months of the date of hire and within eighteen months for program managers.

11-3.A		RATING INDICATORS
3	-	All staff hired within the past five years received training on Child Abuse and Neglect within twelve months of hire (eighteen months for program managers). Staff hired more than five years ago have received the training but may have been later than twelve months after hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than twelve months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Etiology of child abuse and neglect - Working with survivors of abuse
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Child Abuse and Neglect within twelve months of hire (eighteen months for program managers); however with the most recent hire(s), practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Child Abuse and Neglect topics within twelve months of hire (eighteen months for program managers), or there are site staff who have not yet received training on all of the content areas identified above regardless of timeframe.

11-3.B (old 11-4.B) Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) receive training on all topic areas of Intimate Partner Violence within twelve months of the date of hire and within eighteen months for program managers.

11-3.B		RATING INDICATORS
3	-	All staff hired within the past five years received training on Intimate Partner Violence within twelve months of hire (eighteen months for program managers). Staff hired more than five years ago have received the training but may have been later than twelve months after hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than twelve months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Indicators of Intimate Partner violence - Dynamics of Intimate Partner violence - Intervention procedures - Strategies for working with families with Intimate Partner violence issues - Effects on children - Referral resources for family violence
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Intimate Partner Violence within twelve months of hire (eighteen months for program managers); however with the most recent hire(s), practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Intimate Partner Violence topics within twelve months of hire (eighteen months for program managers), or there are site staff who have not yet received training on all of the content areas identified above regardless of timeframe.

11-3.C (old 11-4.C) Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) received training on all topic areas of Substance Abuse within twelve months of the date of hire and within eighteen months for program managers.

11-3.C		RATING INDICATORS
3	-	All staff hired within the past five years received training on Substance Abuse within twelve months of hire (eighteen months for program managers). Staff hired more than five years ago have received the training but may have been later than twelve months after hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than twelve months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Etiology of substance abuse - Culture of drug use - Strategies for working with families with substance abuse issues - Smoking cessation - Alcohol use/abuse - Fetal Alcohol Spectrum Disorders - Street drugs - Referral resources for substance abuse
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Substance Abuse within twelve months of hire (eighteen months for program managers); with the most recent hire(s), practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Substance Abuse topics within twelve months of hire (eighteen months for program managers), or there are site staff have who not yet received training on all of the content areas identified above regardless of timeframe.

11-3.D (old 11-4.D) Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) receive training on all topic areas of Family Issues within twelve months of the date of hire and within eighteen months for program managers.

11-3.D		RATING INDICATORS
3	-	All staff hired within the past five years received training on Family Issues within twelve months of hire (eighteen months for program managers). Staff hired more than five years ago have received the training but may have been later than twelve months after hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than twelve months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Life skills management - Engaging fathers - Multi-generational families - Teen parents - Relationships - HIV and AIDS
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Family Issues within twelve months of hire (eighteen months for program managers); however with the most recent hires, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Family Issues topics within 12 months of hire (eighteen months for program managers), or there are site staff who have not yet received training on all of the content areas identified above regardless of timeframe.

11-3.E (old 11-4.E) Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) receive training on all topic areas of the Role of Culture in Parenting within twelve months of the date of hire and within eighteen months for program managers.

11-3.E		RATING INDICATORS
3	-	All staff hired within the past five years have received training on the Role of Culture in Parenting within twelve months of hire (eighteen months for program managers). Staff hired more than five years ago have received the training but may have been later than twelve months after hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but may have been later than twelve months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required. Topics include: - Working with diverse cultures/populations (age, religion, gender, sexuality, ethnicity, poverty, dads, teens, gangs, disabled populations, etc.) - Culture of poverty - Values clarification
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Role of Culture in Parenting within twelve months of hire (eighteen months for program managers); however with the most recent hire(s), practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training on all topics regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.
1	-	The site's most recent hire(s) have not yet received all Role of Culture topics within twelve months of hire (eighteen months for program managers), or there are site staff who have not yet received training on all of the content areas identified above regardless of timeframe.

11-3.F **(new)** Staff (Family Resource Specialists, Family Support Specialists, supervisors and program managers) who work at a site that is part of a HFA Multi-Site System are oriented to the Multi-Site System, including the goals, objectives, policies and functions of the Multi-Site System and Central Administration. Please Note: though this has existed as a Central Admin standard for several years, because it is new to the BPS, staff hired January 1, 2018 and later will be required to document the dates this training is received. Staff hired prior to January 1, 2018 are encouraged to have this documented as well, though not required.

11-3.F		RATING INDICATORS
3	-	All staff hired since January 1, 2018 are oriented to the Multi-Site System, including the goals, objectives, policies and functions of the Multi-Site System and Central Administration within twelve months of hire.
2	-	Past instances were found when staff hired since January 1, 2018 were not oriented to the Multi-Site System, including the goals, objectives, policies and functions of the Multi-Site System and Central Administration within twelve months of hire; however, **recent practice** indicates this is now occurring and all staff have received the orientation training regardless of the timeframe.
1	-	Staff hired since January 1, 2018 are not yet oriented to the Multi-Site System, including the goals, objectives, policies and functions of the Multi-Site System and Central Administration within twelve months of hire.
NA	-	No new hires since January 1, 2018; or the site is not part of a HFA Multi-Site System.

11-4. **(old 11-5)** The site ensures Family Resource Specialists, Family Support Specialists, supervisors and program managers receive ongoing training which takes into account the individual's knowledge and staff also receive annual child abuse and neglect training.

11-4.A (old 11-5.A) The site ensures Family Resource Specialists, Family Support Specialists, supervisors and program managers hired more than twelve months receive *ongoing training* on an annual basis which takes into account the individual's knowledge and skill base. Please Note: In the second year of hire and every year thereafter, all staff (program managers, supervisors, Family Resource Specialists and Family Support Specialists) receive ongoing training to support ongoing professional development (all staff do not have to attend the same training).

Intent: *The worker and supervisor identify individual training needs and determine what additional training topics would be most beneficial in enhancing job performance. This determination would be based upon worker knowledge, skill base and interest.*

11-4.A		RATING INDICATORS
3	-	The site ensures staff hired to Healthy Families for more than twelve months receive ongoing training on an annual basis, beyond the trainings identified in the 10-2, 10-3, 10-4, 11-1, 11-2 and 11-3 standards. Staff are offered and participate in ongoing training.
2	-	Past instances were found when staff hired more than twelve months did not receive ongoing training on an annual basis, beyond the trainings identified in the 10-2, 10-3, 10-4, 11-1, 11-2 and 11-3 standards; however, **recent practice** indicates this is now occurring.
1	-	The site does not yet ensure staff hired more than twelve months receive ongoing training on an annual basis, or staff does not yet participate in ongoing training opportunities.

☺ Tip: It is recommended supervisors assist staff in identifying relevant training opportunities to meet each staff person's unique needs and all staff receive a minimum of fifteen (15) hours of ongoing training each year after the first year of hire to remain energized, enthused and up-to-date on recent advances in the field.

☺ Tip: Direct service staff and supervisors are encouraged to attend HFA's Facilitating Change training to meet ongoing training requirements for one year.

11-4.B (old 11-5.D) All staff hired more than twelve months receive training annually related to child abuse and neglect in order to stay updated on current child welfare policies, practices, and trends in their community. Please Note: During the first year of hire, standard 11-3.A. (Child Abuse and Neglect), may be used to satisfy this standard. In the second year of hire and every year thereafter, all staff (program managers, supervisors, Family Resource Specialists and Family Support Specialists) receive at least one training related to child abuse and neglect updates (all staff do not have to attend the same training).

Intent: Self-study training applies for this standard with appropriate documentation (e.g., reading manuals or literature, watching videos, listening to tapes, etc.), Remote training, e.g. webinars produced by the state and updated regularly can also be used to satisfy requirements of this standard, or professional experience when face-to-face training is not available.

11-4.B		RATING INDICATORS
3	-	All staff hired more than twelve months receive annual training related to child abuse and neglect including updates on current child welfare policies, practices, and trends in the community.
2	-	Past instances were found when staff hired more than twelve months did not receive annual training related to child abuse and neglect including updates on current child welfare policies, practices, and trends in the community, however, **recent practice** indicates this is now occurring and all staff received the training regardless of the timeframe.
1	-	All staff hired more than twelve months have not yet received annual training on all of the content areas identified above.

Tables of Documentation			
11. Service providers have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers receive basic training in areas such as cultural competency, reporting child abuse, determining the safety of the home, managing crisis situations, responding to mental health, substance abuse, or domestic violence issues, drug-exposed infants, and services in their community			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study**	**Site Visit Activities**
11-1.A-C Three month wraparound training		Please submit for all current staff (program managers, family support specialists (FSS), family resource specialists (FRS), supervisors): Training logs indicating date of hire and list what, when and how the training covers each topic and subtopic listed in the wraparound training standards has been received. For staff utilizing formal education, previous training, and/or previous professional experience to satisfy the 3, 6 & 12 month training requirements, please include a narrative indicating any competency based testing and/or supervision follow-up to assure successful knowledge acquisition and understanding of concepts and/or materials provided to assure knowledge of the topics was satisfied. PMs will have 18 months to complete the wrap around training. Please note: HFA Training Log available	
11-2.A-F Six month wraparound training			
11-3.A-F Twelve month wraparound training			
11-4.A Ongoing Training		Please submit a list of all staff and the ongoing training(s) completed (this can be in the form of a training log or database printout). **Please note:** HFA Training Log available	
11-4.B Annual Child Abuse and Neglect Training		Please submit documentation indicating the date each staff person (program managers, FSS, FRS, and supervisors) completed annual child abuse and neglect training. **Please note:** HFA Training Log available	

12. Service providers receive ongoing, effective supervision so they are able to develop realistic and effective plans to empower families.

Standard 12 Intent: *The overall intent of the standards in this section is to ensure direct service staff and supervisors collaborate effectively to facilitate healthy growth in families through the professional relationships staff have with families, as well as reduce burnout and increase staff retention. A supervisor's primary role is to create an environment that encourages staff to grow and change, provide motivation and support, maintain ideals, standards, quality assurance and safety, and facilitate open, clear communication. To accomplish this, supervision is provided with protected time each week, utilizing reflection in order to enable staff to develop self-awareness in increasing measure, identify and build on parental competencies, become more effective in their interactions with families, and to become more familiar with their own feelings and values, understanding how these impact their work.*

There are three components of supervision required by supervisors at HFA sites; administrative, clinical, and reflective. Administrative supervision relates to the oversight of policies, rules and procedures, and adherence to the Best Practice Standards. Examples of administrative supervision are:

- *Hiring*
- *Training, educating*
- *Overseeing paperwork*
- *Writing reports*
- *Monitoring productivity, and*
- *Explaining rules, policies and procedures*

Clinical supervision is focused on the family, collaborative in nature, and revolves around developing intervention or home visit activities based upon the needs of the families, the challenges families face, and builds upon family competencies. Examples of clinical supervision are:

- *Reviewing the staff members work with families*
- *Discussing the potential actions and home visit strategies used by staff*
- *Developing a plan of action*
- *Reviewing and evaluating progress, and*
- *Providing guidance and coaching*
- *Anticipating and responding to challenging situations*

Reflective supervision focuses primarily on the parallel process involving the relationships between the staff member and the parent, the parent and the baby, and the supervisor and the staff member. It explores how these relationships and the interactions within them may elicit strong feelings. Reflective supervision provides a safe space for staff to explore the roots of these feelings, knowing that not only is it possible for relationships alone to elicit a strong emotional response, but that past experiences – positive and traumatic alike - can affect our emotional interpretations. Reflection and reflective supervision considers that relationships require an emotional investment, and as a result, home visiting work will inherently take an emotional toll. Reflective supervision strives to attend to the emotional content itself and hold the staff member's reactions to these emotions. Examples of reflective supervision are:

- *Asking questions to encourage details about the emerging relationships between the infant, parent and staff member*
- *Listening and holding the space for/allowing inward reflection*
- *Remaining emotionally present*
- *Observing for emotional reactions, energy shifts*
- *Encouraging the staff member to explore thoughts and feelings the he/she has about the work*
- *Maintaining a balance of attention on the infant, parent, and staff member*
- *Maintain a neutral stance*

*Please note: All three components of supervision are often **integrated** and part of the same conversation on a particular topic. For example, some questions from each of the three components of supervision apply to the development of family goals: **Administrative**: Are the family goals developed and reviewed during home visits? **Clinical**: How is the Family Support Specialist facilitating the family goal setting process? What tools are used (motivational interviewing, solution-focused questions)? How are goals broken down into achievable steps? **Reflective**: How does it impact the Family Support Specialist when families are not achieving their goals? How does the Family Support Specialist feel when families choose a goal that is not meaningful to the Family Support Specialist?*

This standard has many components that pertain to the staff roles of: Family Resource Specialist, Family Support Specialist, Supervisors, and Program Managers. Please utilize the hyperlinks provided here to seek clarity on these roles as defined in the Glossary section.

12-1. The site ensures direct service staff receive weekly and ongoing supervision.

Intent: *Providing weekly scheduled supervision helps direct service staff maintain perspective, evaluate their own performance, encourages personal and professional development, helps them learn new strategies to effectively work with families, and ultimately enhances the quality of services families receive. Additionally, supervision promotes both staff and site accountability and reduces staff burnout and turnover by providing much needed support. Supervisors must ensure they have adequate time to spend with each staff person, therefore the frequency and duration of supervision is monitored closely. Additionally, supervisors need to have a limited number of staff to supervisor to ensure they can fulfill the necessary activities in 12-2.*

Policy and procedures clearly define the frequency (weekly for anyone .25 FTE and above) and duration requirements for individual supervision of each direct service staff. Supervision is not to be split into more than two sessions per week.

With regard to duration: For all full-time and part-time staff who are .75 FTE to 1.0 FTE, the requirements are 1.5 to 2 hours weekly. For part-time staff who are .25 FTE to .74 FTE, the requirements are 1 hour weekly. For staff or contractors working less than .25 FTE, supervision may be provided according to occurrence of services.
For example:
1) Family Resource Specialists discuss all of the assessments completed in a given week; however this may not take the full hour of discussion.
2) Part-time staff with three or fewer families may have supervision discussions at a frequency based on the level of service the families are on.
3) Supervisors make sure the requirements of the 12-2 standards are being carried out throughout the shortened sessions.

For full-time staff who serve in more than one role (e.g., position is split with Family Resource Specialist time at 30% and Family Support Specialist time at 70%) 1.5 hours per week is the expectation to meet the supervision requirements of both roles and documentation clearly indicates both roles are being addressed.

12-1.A The site's policy states individual supervision is provided to all direct service staff (e.g., Family Resource Specialists and Family Support Specialists) and volunteers and interns (performing the same function) at the frequency and duration required within the standards.

Intent: *All full-time direct service staff (Family Resource Specialists and Family Support Specialists) receive weekly individual supervision for 1.5 to 2 hours and part-time staff receive at least 1 to 1.5 hours as described above in the 12-1 intent. Supervision sessions must be received individually each week, unless excused owing to the FSS or FRS not working the entire week. **Please note**: For sites using reflective consultation groups, one session per month may apply towards the*

weekly supervision rates, when done in accordance with the expectations outlined in standard 12-1.C.

12-1.A		RATING INDICATORS
3	-	The site policy and procedures specify all .75 - 1.0 FTE direct service staff receive a minimum of **2 hours** per week of scheduled individual supervision and part-time staff employed .25 - .74 FTE receive a prorated amount of supervision as defined in the intent, and staff less than .25 receive supervision based on occurrence of service. The site's policy also indicates supervision can be divided into no more than two sessions per week, and reflective supervision groups (if used) count for 1 session per month if conducted by a qualified individual and only for direct service staff who have been in their role for at least 12 months and who have demonstrated proficiency in their role (as determined by the site and based on supervisor judgment). Finally, the policy specifies the ratio of supervisors to direct service staff is **1:5**.
2	-	The site policy and procedures specifies all .75-1.0 FTE direct service staff receive a minimum of **1 ½ hours** per week of scheduled individual supervision and part-time staff employed .25 - .74 FTE receive a prorated amount of supervision as defined in the intent, and staff less than .25 receive supervision based on occurrence of service. The site's policy also indicates supervision sessions can be divided into no more than two sessions per week, and reflective supervision groups (if used) count for 1 session per month if conducted by a qualified individual and only for direct service staff who have been in their role for at least 12 months and who have demonstrated proficiency in their role (as determined by the site and based on supervisor judgment). Finally, the policy specifies the ratio of supervisors to direct service staff is **1:6**.
1	-	The site does not yet have policy and procedures, or the policy and procedures does not yet meet the requirements of the 2 rating.

☺ Tip: It is critical staff have access to supervisors at all times when they are in the field. Sites must have a plan in place to cover supervision in the case of supervisor absences.

12-1.B The site ensures weekly individual supervision is received by all direct service staff and any volunteers and interns who provide direct services to families independently in the role of a Family Support Specialist. Please Note: Volunteers or interns who perform supportive functions to assist direct service staff (e.g. assist with parent groups, data entry, accompanying a Family Support Specialist on home visits, etc.) are exempt from the supervision and training requirements of the standards. 12-1.B Tracking Form

Intent: The critical importance of Supervision is emphasized in the HFA model, and particularly the role it plays in supporting the overall performance and functioning of individual staff and the site as a whole. It is understood that staff bring various experiences and educational backgrounds to their work, however all staff have in common the need for regular supervision to obtain guidance and support in regard to the complex challenges many families present and the impact the work has on the worker. It is therefore required sites track and monitor in an ongoing way the receipt of weekly supervision for each staff. ***Please Note:*** *When sites exist in rural or frontier areas, and the Family Support Specialists work in remote or off-site locations from the "main office" where the supervisor is located, the use of Skype or the telephone can suffice for weekly supervision, however at least one in-person monthly supervision is required.* ***Please Note:*** *Direct service staff who are new to their role or are without full caseloads are still expected to receive the required amount of*

weekly supervision. In these situations, supervision may be more focused on skill development than family discussion ***Please Note:*** *When supervisors are on leave, direct service staff will have a back-up supervisor they can obtain support from. If the supervisor's leave is for two weeks or less, the back-up supervisor does not have to have HFA Core training, though it would be preferred. However, if the Supervisor's leave is for longer than two consecutive weeks, the back-up supervisor must have received HFA Core training, as required of all supervisors. Sites may want to consider establishing a "team lead" role, as a career ladder opportunity for a direct service staff person with capacity to perform as back-up supervisor, and to have that person obtain supervision training as well.*

12-1.B		RATING INDICATORS
3	-	All direct service staff receive 90% of required weekly individual supervision for a minimum of 1.5 - 2 hours (excluding weeks when FSS is out all week). Supervision sessions are not split into more than two scheduled meetings and less than .75 FTE staff receive a prorated amount of supervision as defined in the intent above.
2	-	All direct service staff receive **75% of** required weekly individual supervision for a minimum of 1.5 hours – 2 hours (excluding weeks when FSS is out all week). Supervision sessions are not split into more than two scheduled meetings and less than .75 FTE staff receive a prorated amount of supervision as defined in the intent above.
1	-	The site is not yet following the guidelines as outlined in 2 rating above.
Note:		**This is a Safety Standard**

☺ Tip: Frequency and duration of supervision sessions are most effective when viewed over time versus monthly to account for times when staff are in training, on vacation or for seasonal fluctuations in service delivery. Semi-annual and annual supervision rate reviews are recommended in addition to quarterly monitoring.

☺ Tip: Although the individual supervision sessions for Family Resource Specialists may be divided into more frequent sessions, supervisors are still held accountable for achieving the 12-2 standards. Family Resource Specialist supervisors are encouraged to ensure at least one of the weekly supervision sessions enables them to provide their staff with skill development and professional support.

☺ Tip: Sites are encouraged to set goals/benchmarks (for Standard GA-3.A) when rates fall below the 75% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

12-1.C When the site provides *reflective consultation groups*, they must be implemented with the same degree of preparation, and documentation (must include who attended and content topics covered), and must be facilitated by a qualified individual.

Intent: *Typically, these sessions last two or more hours. Reflective consultation groups include but are not limited to:*

- *Family presentation,*
- *Focus on holding the space that encourages self-reflection and self-regulation for staff, both physically and emotionally,*
- *Observation of the staff member's internal responses to the work including parallels between what might be going on for the worker as well as how that might impact the work,*
- *Focus on the parallel process; expanding to what might be going on for the staff in conjunction with what the family and the baby might be experiencing,*
- *Considering what the supervisor might do differently for the next supervision, developing a plan with the Family Support Specialist for work going forward,*
- *Opportunities for participants in the group to reflect on the group session they just observed.*

Supervision sessions must be received individually each week for a minimum of 12 months after initial hire to HFA role for all staff. Subsequent to that time, and with demonstrated staff proficiency, one reflective consultation group per month may substitute for one individual weekly supervision session. ***Please Note:*** *Staff not yet with the site for at least 12 months or longer would still be encouraged to attend and benefit from group supervision (if held), however attendance cannot be counted toward the required weekly individual sessions expected of staff during that time period.*

Please Note: *If group reflective consultation is done, there are specific documented qualifications the reflective practice consultant must have:*

- *IMH Endorsement at Level III or Level IV or Master's degree in counseling or related field,*
- *two years post-graduate work experience providing* ***culturally sensitive****, relationship-focused infant mental health services with infants and toddlers and their families, and*
- *has also been recipient of reflective supervision.*

This person may be sub-contracted by the agency. If reflective consultation is conducted by a contractor, the supervisor attends in order to support staff with recommended action steps pertaining to the family discussed during group.

12-1.C		RATING INDICATORS
3	-	The site provides *reflective consultation groups* that include case presentation, and is conducted according to the guidelines listed in the intent. Group reflective consultation is counted for no more than one session per month only for staff who have demonstrated **proficiency in their role** and have been with the site for 12 months. Group reflective consultation is provided by a qualified individual.
2	-	Past instances occurred when the site provided group reflective consultation not conducted according to the guidelines listed in the intent; however **recent practice** indicates this is now occurring.
1	-	Any of the following: the site does not yet provide group reflective consultation according to the guidelines listed in the intent; or is not yet conducted by a qualified individual; or group reflective consultation is counted for more than one weekly individual supervision rate per month.
NA	-	Site does not use *reflective consultation groups*.

12-1.D The ratio of supervisors to direct service staff and volunteers and interns (performing the same function) is sufficient to allow regular, ongoing, and effective supervision to occur.

Intent: *It is critical supervisors have the time to prepare for supervision as well as complete all of the requirements of the site and host organization. It is estimated each direct service staff member requires approximately 8 hours per week of supervision time including the actual supervision session, as well as the supervision activities outside of the session including internal quality management activities, administrative work, and arranging training staff meetings, etc. Part time staff require nearly the same amount of supervision time, therefore the ratio for a staff of all part time direct service providers is limited to a maximum of 8 to each full-time supervisor.* ***Please Note:*** *full-time equates to a 40 hour work week. Therefore, sites that employ staff considered full-time but working less than 40 hours per week must prorate staffing ratios accordingly. See the proration calculation grid below for guidance.* ***Please Note:*** *In the event the Supervisor is not full time in their role (e.g., is hired 75%, or is hired full-time, but a portion of that time is as a part-time Family Resource Specialists, or is a Program Manager also providing supervision to direct service staff, or is full-time to the agency but only part-time to Healthy Families, etc.) they are to indicate the amount of time spent in their Healthy Families supervision role and calculate the ratio of direct service staff based on the percentage of time spent in the supervision role. For example: a*

supervisor who is 75% supervisor and 25% Family Resource Specialist would have a ratio of .75 FTE supervisor: 4.5 FTE direct service staff. This is calculated by taking .75 (% FTE) X 6 (as allowed in a 2 rating) equals 4.5 FTE. This formula can be used to determine the ratio of supervisors to direct service staff regardless of the percentage of time.

12-1.D		RATING INDICATORS
3	-	The ratio of supervisors to direct service staff is one (1) full time supervisor to five (5) full time direct service staff. The site is consistently following this standard.
2	-	The ratio of supervisors to direct service staff is one (1) full time supervisor to six (6) full time direct service staff (or 8 part-time staff as indicated in the intent). The site is consistently following this standard.
1	-	The site ratio of supervisors to direct service staff has more than six (6) full time direct service staff (or more than 8 part-time staff) to one (1) full time supervisor or the site is not yet following the standard as outlined in 2 rating above.

☺ Tip: It is recommended that sites whose staff have caseloads largely comprised of families scoring 40 or above on the Parent Survey maintain a 1:5 supervisor to direct service staff ratio.

2 rating	**supervisor ratio**	**3 rating**	**supervisor ratio**
formula	**.15** x number of hours per week	formula	**.125** x number of hours per week
40 hour week	6 staff supervised	40 hour week	5 staff supervised
37.5 hour week	5 staff supervised	37.5 hour week	4 staff supervised
35 hour week	5 staff supervised	35 hour week	4 staff supervised
20 hour week	3 staff supervised	20 hour week	2.5 staff supervised

The above calculation grid can also be used in reverse to determine how many hours and FTE of supervisor time is needed based on number of direct service staff.
For example, for a site with 1 FTE direct service staff, the minimum number of hours per week required for a supervisor is 6.7hrs. (1 divided by .15 = 6.7), and to determine amount supervisor FTE, divide 6.7 by 40 = .17 FTE. This would equate to a 2 rating.
A site with 2.5 FTE direct service staff would be 2.5 divided by .15= 16.7hrs/wk and 16.7 divided by 40= .42 FTE. Again, for a 2 rating.

12-2. Direct service staff (e.g., Family Resource Specialists and Family Support Specialists) and volunteers and interns (performing the same function) are provided with professional support and supervision including administrative, clinical and reflective components.

12-2.A The site has supervision policy and procedures to ensure all direct service staff (e.g., Family Resource Specialists and Family Support Specialists) and volunteers and interns (performing the same function) are provided with professional support and supervision including administrative, clinical, and reflective components.

Intent: *Supervisors represent several roles in the HFA site. As an administrator, supervisors evaluate the performance of the staff and shadow assessments and home visits. In doing so, they provide feedback which encourages the staff's professional development. As the teacher/collaborator, supervisors add to the knowledge of direct service staff, discuss how to work with challenging families and enhance their abilities. Supervisors ensure the training staff receives is incorporated into their work. Working with overburdened families is a high stress job, and as a result, supervisors have a critical role of offering guidance, emotional support and insight into the*

impact of the work on the worker. Ultimately providing staff with this kind of support allows for congruency between the staff person's expectations of the family and the site's expectations of the visitor, which ensures site quality. 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.

12-2.A RATING INDICATORS

3 - No 3 rating indicator for standard 12-2.A.

2 - The site has supervision policy and procedures which ensure supervisors are responsible for providing all direct service staff with professional support and supervision which includes administrative, clinical, and reflective components in order to continuously improve the quality of their performance. Any activity a supervisor engages in with staff can and probably will have aspects of administrative, clinical, and reflective supervision. The following supervision practices have been grouped by the type of supervision most often, but not exclusively, associated with each task. The site's procedures include the following mechanisms:

Within supervision sessions (12-2.B practice)

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 and updating Service Plan activities to address assessment issues/**risk factors** and challenging issues
- supporting Parent-Child Interaction work and **CHEERS** observations
- guiding **culturally respectful** 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
- sharing of information related to community resources
- integrating policy changes into practice

Reflective:

- exploring/reflecting on of impact of the work on the worker
- coaching and providing feedback on strength-based approaches, **reflective strategies**, and interventions used (e.g. motivational interviewing or use of change talk)
- encouraging self-care
- guiding **culturally respectful** practice

- identifying areas for growth
- identifying and reflecting on potential boundary issues
- discussing ongoing worker safety

Outside of supervision sessions (12-2.C practice):

Administrative:

- reading home visit narratives & Family Stress Checklist/Parent Surveys - 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:

- shadowing full time direct service staff at least twice annually, and at least once annually for part-time staff
- providing multi-disciplinary teams
- assuring on-call availability to service providers

Reflective:

- creating a nurturing work environment that provides opportunities for respite
- assuring an open door policy with supervisors

1 - The site does not yet have policy and procedures, or the policy and procedures do not yet include the administrative, clinical and reflective components described in the 2 rating.

☺Tip: While it is not possible to engage in reflective conversation pertaining to each family each week, supervisors are encouraged to have reflective conversation for each Level 1, P or SS family on a Family Support Specialist's caseload a minimum of one time per month.

☺Tip: Download Sample Supervision Tickler

12-2.B The site ensures all direct service staff (e.g., Family Resource Specialists and Family Support Specialists) and volunteers and interns (performing the same function) are provided with supervision including administrative, clinical, and reflective components to continuously improve the quality of their performance.

12-2.B		RATING INDICATORS
3	-	The site ensures all direct service staff are provided with supervision including administrative, clinical, and reflective components to continuously improve the quality of their performance. Practice includes the mechanisms listed in the 12-2.A standard under *Within the Supervision Sessions*.
2	-	Past instances were found when staff did not receive supervision including administrative, clinical, and reflective components to continuously improve the quality of their performance; however, **recent practice** indicates this is now occurring for all direct service staff.
1	-	Staff do not yet receive supervision including administrative, clinical, and reflective

components.

Note: **This is a Sentinel Standard**

12-2.C The site implements supervision policy and procedures to ensure all direct service staff (i.e., Family Resource Specialists and Family Support Specialists) and volunteers and interns (performing the same function) are provided with professional support to continuously improve the quality of their performance.

Intent: *The site's practice ensures all direct service staff have ongoing professional support and a positive working environment that is nurturing and conducive to productivity. Many sites utilize multi-disciplinary teams to support staff in the field and these are included in the concept of professional support.*

12-2.C		RATING INDICATORS
3	-	All direct service staff (i.e., Family Resource Specialists and Family Support Specialists) and volunteers and interns (performing the same function) are provided with professional support to continuously improve the quality of their performance. Practice includes a variety of the mechanisms listed in the 12-2.A standard under *Outside of Supervision Sessions.*
2	-	Past instances were found when the direct service staff did not receive professional support; however, **recent practice** indicates this is now occurring and practice includes a variety of the mechanisms listed in the 12-2.A standard under *Outside of Supervision Sessions*.
1	-	Staff do not yet receive receives professional support via any of the mechanisms listed in the 12-2.A standard under *Outside of Supervision Sessions*.

☺ Tip: Sites are encouraged to keep agendas or minutes of team meetings including content and who was present.

12-3. Supervisors receive regular, ongoing supervision which holds them accountable for the quality of their work and provides them with skill development and professional support.

12-3.A The site has policy and procedures to ensure supervisors are held accountable for the quality of their work, receive skill development and professional support through regular and ongoing supervision.

Intent: *Supervisors must receive professional support and skill development on a regular basis. Sites are to have clear policy and procedures regarding the frequency of supervision for supervisors, including the professional support, skill development and accountability measures in place to support supervisors Policy and procedures clearly describe which mechanisms from the items listed in the rating indicators are used by the site.*

It is recommended supervisors receive individual supervision every other week, however the minimum requirement is monthly. Supervision of the supervisors can occur face-to face or via the telephone. Supervision sessions are regularly scheduled to ensure the supervisor has the support they need to ensure quality at the staff and direct service level.

Please Note: *For supervisors carrying small caseloads (1-3 families) on a permanent basis, or carry a larger caseload, but on a temporary basis (when families are temporarily re-assigned due to staff leave or turnover), or conduct occasional assessments (as a back-up):*

- *The person providing supervision does not have to be trained as an HFA supervisor. It is preferred but not required.*

- *The supervision session can occur based on the frequency of contact and does not have to occur weekly.*
- *If the person providing the supervision is not trained as a supervisor in HFA, the supervisor can maintain the supervision notes based on the discussions being conducted.*

Please note: *For supervisors carrying larger caseloads (i.e. 4 or more families on an ongoing basis), or routine completion of Parent Surveys:*

- *The ratio of supervisor to staff (12-1.C) is to be taken into account based on the percentage of time the supervisor is providing direct services.*
- Supervisors must receive supervision in accordance with the 12-1 and 12-2 standards.
- And the individual providing supervision to the supervisor must have received all HFA required training as outlined in Standards 10 and 11.

12-3.A		RATING INDICATORS
3	-	Policy and procedures includes a requirement that in addition to all components described in the 2 rating, supervisors also will receive reflective supervision from a qualified individual (as required to facilitate reflective consultation groups 12-1.C: - IMH Endorsement at Level III or Level IV or Master's degree in counseling or related field, - two years post-graduate work experience providing culturally sensitive, relationship-focused infant mental health services with infants and toddlers and their families, and - has also been recipient of reflective supervision.).
2	-	The site has policy and procedures which specify supervisors receive a minimum of once monthly individual supervision and are held accountable for the quality of their work, receive skill development and professional support. Procedures include a variety of mechanisms such as: - Addressing personnel issues, - Feedback/reflection to supervisors regarding team development and agency issues, - Review of site documentation including monthly or quarterly reports, - Site statistics (screening and initial engagement, home visit rates, content of home visits, quality assurance mechanisms, etc.), - Review of progress towards meeting site goals and objectives, - Strategies to promote professional development/growth, and - Quality oversight that could include shadowing of the supervisor.
1	-	The site does not yet have policy and procedures, or the policy does not yet meet the requirements specified in the 2 rating.

12-3.B The site's practice ensures supervisors receive regularly scheduled supervision, are held accountable for the quality of their work, receive skill development and professional support.

12-3.B.		RATING INDICATORS
3	-	Site ensures supervisors receive at least monthly supervision and are held accountable for the quality of their work, receive skill development and professional support. Supervisors are also in receipt of reflective supervision.
2	-	Past instances were found when the site did not ensure supervisors received at least monthly supervision or were held accountable for their work, received skill development or professional support; however, **recent practice** indicates this is now occurring.
1	-	Any of the following: supervision of supervisors is not yet occurring at least monthly; or supervisors are not yet held accountable for the quality of their work, receive skill development or professional support; or this supervision is not yet documented.

12-4. Program managers are held accountable for the quality of their work and are provided with skill development and professional support.

12-4.A The site has policy and procedures to ensure program managers are held accountable for the quality of their work, receive skill development and professional support.

Intent: *Program Managers are provided with skill development, professional support and are held accountable for the quality of their work. This can happen through accountability with quarterly 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 training.*

12-4.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 12-4.A.
2	-	The site has policy and procedures ensuring program managers are held accountable for the quality of their work, receive skill development and professional support.
1	-	The site does not yet have policy and procedures, or the policy does not yet meet the requirements specified in the 2 rating.

☺ Tip: The program manager role is distinct from that of program supervisor, and while both roles can be assumed by the same person, FTE status of both roles must be protected to ensure sustainable program leadership and adequate support to staff being supervised. HFA recommends a minimum program manager FTE of .17 for very small sites (2.0 FTE direct service staff or less) which increases as site size increases.

12-4.B The site ensures Program Managers are held accountable for the quality of their work, receive skill development and professional support.

12-4.B		RATING INDICATORS
3	-	Site ensures program managers are held accountable for the quality of their work, receive skill development and professional support.
2	-	Past instances were found when programs managers were not held accountable, receiving skill development or professional support; however, **recent practice** indicates this is now occurring.
1	-	Program managers are not yet held accountable for the quality of their work, receive skill development or professional support.

Tables of Documentation			
12. Service providers receive ongoing, effective supervision so they are able to develop realistic and effective plans to empower families			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study**	**Site Visit Activities**
12-1.A Policy for Frequency & Duration	Supervision of all direct service staff specifying frequency and duration	Please Submit Policy	**Interview:** * Program Manager * Supervisors * Direct Service Staff **Review:** * Content of Reflective Consultation Groups, if utilized * Supervision Logs * Staff Surveys
12-1.B **Measure supervision frequency and duration** ***Safety Standard***		Please submit a report indicating the frequency and duration of supervision sessions for the most recent quarter. 1. Determine needed frequency and duration of supervision per FTE guidelines within BPS for each direct service staff 2. Determine number of expected supervision sessions for each staff member for one quarter 3. Subtract from 2. (expected sessions) excused sessions within guidelines provided by BPS 4. Count number of supervision sessions that occurred within proper timeframes and for expected duration 5 Divide 4. (number of supervision sessions at required duration) by 3. (expected sessions minus those excused) 6. Create report to communicate findings for each staff member **Please note:** HFA 12-1.B Supervision Spreadsheet available This is a threshold standard, meaning to be in adherence a minimum threshold has been established (75% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	
12-1.C Reflective Consultation Group		Please submit a report indicating the date, time and attendees of group reflective consultation groups (if utilized) for the most recent quarter. Also, please submit the qualifications of the individual facilitating groups.	
12-1.D Ratio of Supervisors to staff		Please submit the HFA FaceSheet indicating each supervisor, their full time equivalency (FTE), percentage of time spent in each role, and the staff he/she supervises (with FTE for each position). Be sure to capture FTE for each role each staff person has, if applicable.	

12-2.A Policy - Administrative, Clinical and Reflective Supervision and Professional Support	Supervisors are responsible for providing all direct service staff with professional support and supervision including administrative, clinical and reflective components to support improvement in the quality of their performance	Please Submit Policy	
12-2.B Reflective, Clinical and Admin Sup provided ***Sentinel Standard***		No documentation required pre-site	**Interview:** * Supervisors * Direct Service Staff **Review:** * Supervision records reflecting skill development, accountability and professional support, including administrative, clinical and reflective components * Staff Surveys
12-2.C Professional Support Provided		No documentation required pre-site	
12-3.A Policy - Supervision of Supervisor	Supervisors are held accountable for the quality of their work, receive skill development and professional support at least monthly	Please Submit Policy	**Interview:** * Supervisors of supervisors * Supervisors **Review:** * Supervision records reflecting skill development, accountability and professional support * Staff Surveys
12-3.B Supervision of the Supervisor Received		No documentation required pre-site	
12-4.A Policy - Program Manager Accountability	Accountability, skill development and professional support processes for program managers	Please Submit Policy	
12-4.B Program Manager Supervision Received		No documentation required pre-site	**Interview:** * Supervisor of Program Manager * Program **Manager** **Review**: * Supervision records * Staff Surveys

GOVERNANCE AND ADMINISTRATION

The site is governed and administered in accordance with principles of effective management and of ethical practice. Please note: GA is not a Critical Element

Governance and Administration Standards Intent: *The overall intent of the standards in this section is to ensure the site has feedback and oversight mechanisms to ensure high quality services to families. These practices include effective advisory group operation, evaluation/review of site quality, handling of family grievances, utilization of informed consent, protection for families related to research conducted, and appropriate reporting of child abuse and neglect.*

GA-1. The site has an advisory/governing group which serves in an advisory or governing capacity in the planning, implementation, and assessment of site related activities.

Intent: *Advisory/governing groups serve an important function in community-based agencies in that they can be advocates for the site in the community, representing the site and agency in other venues and settings, which can bring more recognition and visibility. Community advisory/governing group members can bring to the site different skills and perspectives than might be present within site staff. Members can share strategies, brainstorming ideas that might arise and facilitate growth for the site. Additionally, members often have access to resources to strengthen the site or agency. It is important the group has the community connections to understand the needs of the participant population.*

Some HFA sites fulfill the need for the functions outlined in the Standards below by having two different groups they report to. This happens most often when HFA sites function as part of a larger agency, which has its own governing board. The agency board, typically having many other functions outside of Healthy Families, usually does not have the capacity to serve in all the ways the Standards require – but may be involved in making key decisions about the site and its financial provisions.

Regardless of whether HFA sites have this larger agency board or not, sites will need to create and maintain an advisory group with the primary function of advising in the planning, implementation, and evaluation of site related activities. Many times the host agency governing board will have final say, but the advisory group can provide input to the Program Managers (or other site representative) who can provide the information to the agency board. ***Please note:*** *Frequency of meetings may vary depending on the duties assigned to the advisory/governing group, activities carried out by any subcommittees and age/longevity of the site. A minimum of quarterly meetings are maintained.*

GA-1.A The site's advisory/governing group meets at least quarterly and is an effectively organized, active body advising/governing the functions specified in GA-1.

GA-1.A		RATING INDICATORS
3	-	The site's advisory/governing group is an organized, active body, which meets at least quarterly and advises/governs the activities of planning, implementation and assessment of site services.
2	-	Past instances occurred when the advisory group did not meet quarterly, however **recent practice** indicates this is now occurring. The site's advisory/governing group advises/governs the specified functions, but could be more active in one area of functioning.
1	-	Any of the following: the site's advisory/governing group meets less than quarterly; or is not yet active; or is not advising/governing on planning, implementation and assessment.

☺ Tip: Advisory group involvement may be more intense during the start-up phase when community leadership is critical to the launch of the site, however well-established sites

benefit tremendously from advisory group involvement as well. Over time a well-formed advisory committee with strong member relationships is a huge asset to the continuation of a shared vision and the realization of intended impacts.

GA-1.B The advisory/governing group has a wide range of needed skills and abilities and includes representatives with a heterogeneous mix in terms of skills, strengths, community knowledge, professions, and cultural diversity, allowing it to effectively serve the interests of the community and advocate on behalf of the diverse needs of site participants.

GA-1.B		RATING INDICATORS
3	-	The advisory/governing group has a **wide range of skills, abilities, and provides a heterogeneous mix in terms of skills, strengths, community knowledge, professions and cultural characteristics** (as determined by the site to represent the diverse needs of site participants).
2	-	The advisory/governing group's membership has **some of the representative skills, knowledge, interests and cultural characteristics** (as determined by the site to represent the diverse needs of site participants) necessary to represent the community.
1	-	The advisory/governing group's membership does not yet represent the skills, knowledge, interests and cultural characteristics (as determined by the site to represent the diverse needs of site participants) of the population it serves.

GA-1.C The site manager (or other site representative) and the advisory/governing group work as an effective team with information, coordination, staffing, and assistance provided by the site manager.

GA-1.C		RATING INDICATORS
3	-	The site manager (or other site representative) and the advisory/governing group **work as an effective team**.
2	-	The site manager (or other site representative) and the advisory/governing group plan and consult with one another, but the **advisory group could be more fully involved**.
1	-	The site manager and the advisory/governing group do not yet work as a team.

GA-2. Sites offer families opportunities to provide feedback to the site, through the use of formal mechanisms.

GA-2.A The site has policy and procedures regarding the mechanisms available for families to provide feedback about their experiences with services. Policy and procedures include at minimum, the mechanism(s) used to obtain satisfaction feedback at least once every other year.

GA-2.A		RATING INDICATORS
3	-	No 3 rating indicator for standard GA-2.A.
2	-	The site (or the host agency) has policy and procedures regarding the mechanism(s) for families to provide satisfaction feedback to the site.
1	-	The site does not yet have policy and procedures related to the how families provide feedback.

GA-2.B The site has mechanisms in place for families (past or present families) to provide formalized input into services.

Intent: *It is critical for sites to receive and utilize feedback from families, in their efforts toward continuous quality improvement. When families provide their observations and experiences, it can illuminate areas in which staff would benefit from additional training or support, as well as highlight particular areas of strength or staff skill. Families may provide formal input into site operations through the use of satisfaction surveys, service on the advisory/governing group, family advisory committee, focus groups, etc. So as to not overwhelm families, the site may choose to seek input via the same survey used to obtain feedback from parents regarding the sites ability to be culturally relevant and respectful (standard 5-4.A), which is required at least once every other year. If doing so, the site will want to be sure satisfaction questions have been added to the survey beyond those focused on culture. The information may then be shared with the site staff and full advisory/governing board in a narrative format.*

GA-2.B		RATING INDICATORS
3	-	The site has formal mechanisms for families to provide input to the site. At least two **mechanisms** are used by the site to elicit input such as: participant satisfaction surveys, participant service on advisory/governing group or a family advisory committee, participant feedback through focus groups, etc. Input is sought at least once every other year.
2	-	The site has **at least one mechanism** for families to provide input to the site and input is sought at least once every other year.
1	-	There are no mechanisms for families to have input into services, or the site has not yet sought input at least once every other year.

☺ Tip: Parent satisfaction surveys are most helpful when recommendations for site improvement from parents are solicited and an analysis or summary in aggregate format is shared with the advisory/governing board.

☺ Tip: Sites are encouraged to provide training and support to parents and to board members re: board operation to ensure families are well-received and their skills used effectively (e.g., areas such as curriculum, outreach activities, Cultural humility, etc.).

GA-3. The site monitors and evaluates quality of services.

Intent: *The site uses a variety of methods to monitor the quality of all services offered to families. Monitoring activities include initial engagement, home visiting, supervision, and management. The Cultural Analysis and Plan (5-4 standards), family engagement/acceptance (1-2 standards) and family retention (3-4 standards) are mechanisms that can be included in evaluation of quality. Other methods include internal quality management strategies (periodic file review, shadowing of assessment, home visiting and supervision) and state or site level evaluation reports.*

GA-3.A The site annually establishes goals/benchmarks, *monitors* the progress toward its goals/benchmarks, and develops follow-up mechanisms to address identified areas of improvement.

Intent: *Each year the site identifies one or more benchmarks or goals it wants to focus on (such as increasing home visit completion 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 (CQI) expectations may also be established by an oversight entity or funder. However decided, once the site has articulated its goals, it should indicate what the baseline is (e.g. home visit completion is 42% at 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. Sites may use PDSA (Plan Do Study Act) cycles to illustrate their efforts to achieve identified goals/benchmarks.*
Download GA-3.A Sample Annual Goal-Benchmark Template

GA-3.A		RATING INDICATORS
3	-	Each year the site establishes one of more goals/benchmarks, **monitors progress** toward reaching its goals **at least quarterly**, and implements follow-up mechanisms to address areas of improvement.
2	-	Each year the site establishes one or more goals/benchmarks, **monitors progress** toward reaching its goals **at least annually**, and implements follow-up mechanisms to address areas of improvement.
1	-	Any of the following: the site does not yet establish goals/benchmarks; it is not yet conducted on an annual basis; progress is not yet monitored at least quarterly; or follow-up mechanisms have not yet been implemented.

☺ Tip: As sites focus on their follow-up mechanisms, all of these efforts should be integrated into the supervision of direct service staff.

GA-3.B 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: *Sites will develop a Quality Assurance plan that will include activities such as twice annual shadowing of direct service staff (assessment, home visiting), satisfaction surveys, annual file review, reports related to site activities, etc. These activities help ensure accountability, support and 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 .*Download Sample Quality Assurance Plan

GA-3.B		RATING INDICATORS
3	-	The site has a comprehensive quality assurance plan including all components of the service delivery system (initial engagement, home visiting, supervision and management) and **has implemented follow-up mechanisms** to address areas of improvement.
2	-	The site recently developed a comprehensive quality assurance plan including all components of the service delivery system (initial engagement, home visiting, supervision and management); and **follow-up mechanisms** to address areas for improvement have been developed but **not yet been implemented**.
1	-	Any of the following: the site either does not yet have a quality assurance plan; the quality assurance plan does not yet include all components of the service delivery system (initial engagement, home visiting, supervision and management); or the site has not yet developed follow-up mechanisms to address areas for improvement.

☺ Tip: Sites are encouraged to document areas of improvement and demonstrate improvements have been accomplished.

☺ Tip: Program managers are also encouraged to shadow supervisors and review supervision documentation.

GA-4. 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.

GA-4.A The site has policy and procedures for reviewing and recommending approval or denial of research proposals, whether internal or external, involving past or present families. The policy and procedures includes:

- a description of the group or body of people who would 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 National Office (via Implementation Specialist) regarding summary of research design and contact information for principal investigator.

Please Note: For individual sites, if your stance is not to accept any research proposals, indicate that as the basis of your policy statement. For sites within multi-site systems, if using the central office policy please describe how the site would proceed when receiving an individual request.

Intent: *The site's policy and procedures ensure a committee or defined group of people is available to make recommendations regarding the 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 many state systems the responsibility for the review of research proposals resides with the state entity or sponsoring organization, however, sites still must have policy about handling these types of requests (e.g., bring request to advisory group).* ***In cases when funder requires*** research ***as a condition of the funding, the need for policy and procedures still applies.***

GA-4.A		RATING INDICATORS
3	-	No 3 rating indicator for standard GA-4.A.
2	-	The site has policy and procedures for reviewing and recommending approval or denial on any research proposal involving past or present families or family information, and includes all items listed in the standard; or clearly states no research proposals will be accepted for review.
1	-	The site does not yet have policy and procedures regarding review and approval or denial of any research proposal, or the site's policy does not yet include all items listed in the standard.

☺ Tip: The Research Department at the National Office is able to provide guidance and support when a site is considering but has not yet approved a research proposal. Sites (or the central administration when part of a Multi-Site System) are strongly encouraged to reach out to the Research Department through their Implementation Specialist as early in the process as possible.

GA-4.B The site follows its policy and procedures for reviewing and recommending approval or denial of research proposals, whether internal of external, involving past or present families.

GA-4.B		RATING INDICATORS
3	-	The site has **followed its policy and procedures regarding the review and approval or denial of any research proposals** involving past or present families or family information.
2	-	Past instances may have occurred when the site did not follow its policy, however the **most recent research proposal** review now demonstrates the policy and procedures are being followed; or **no requests for research have been received to date.**
1	-	The site's policy and procedures are not yet being followed.

GA-4.C **(old GA-5.D)** The site implements the policy related to ensuring participant privacy and voluntary choice with regard to research conducted by or in cooperation with the site.

Intent: *A site that participates in or permits research conducted by an outside source involving service recipients establishes the right of individuals to refuse to participate without penalty and guarantees participants' confidentiality. All research involving service recipients must be conducted in accordance with applicable legal requirements. Research includes all forms of internal or external research involving service recipients.*

GA-4.C RATING INDICATORS

3 - The site ensures participant privacy and voluntary choice for all families with regard to research.

2 - Past instances may have occurred participant privacy and voluntary choice with regard to research was not ensured; however, **recent practice** indicates this is now occurring.

1 - Any of the following: individual researchers follow their own plans, and potential for disclosure of identity or violation of privacy is high; or families are not yet provided an opportunity to refuse disclosure.

NA - No research is currently being conducted by or in collaboration with the site.

GA-5. The site informs families of their rights and ensures confidentiality of information both during the intake process as well as during the course of services.

Intent: *HFA values a family-centered approach to service delivery which requires site practices that reflect a profound respect for personal dignity, confidentiality and privacy. This approach is in all services provided, and the standards in this section are devoted to preserving the rights and dignity of all service recipients. In addition to addressing legally protected family rights, the standards in this section also center on the professional ethics of service delivery and promote privacy, honesty and mutual respect.*

Research Note *(Client Rights: COA 8th Edition 2006): Ethics documents published by the National Association of Social Workers and the American Psychological Association. Both state an individual' right to privacy, confidentiality, and self-determination. Practitioners, while not always required by law, are ethically obligated to protect these rights for all individuals.*

GA-5.A (GA-2.A regarding family grievance policy merged with GA-5.A) The site has policy and procedures to inform families of their rights and confidentiality both at intake and during the course of services. The policy and procedures include how families are informed of the grievance procedures, including:

1. The specific steps for reviewing and acting on any grievances received,
2. The timeframe for addressing any grievances, and
3. The follow-up mechanisms used to address identified areas of improvement.

The Policy also includes the informed written consent by families when information is shared with an outside agency.

GA-5.A RATING INDICATORS

3 - No 3 rating for standard GA-5.A.

2 - The policy and procedures addresses rights and confidentiality, the procedures for addressing any grievances, and states the family is informed about their rights and confidentiality before or on the first home visit, including the right to file a grievance. The policy and procedures also state the family is informed and signs written consent every time information is to be shared with a new external agency.

1 - The site does not yet have policy and procedures addressing rights and confidentiality, on or before the first home visit, the procedures for addressing grievances, and the process for obtaining informed consent to release information.

GA-5.B **(now also includes old GA-2.C)** The site ensures all parents are notified and receive copy of family rights and confidentiality at the onset of services, both verbally and in writing.

Documentation that the rights and confidentiality assurances were reviewed with families is placed in the participant file, and a copy is provided for the family to keep. At a minimum these forms include the following:

Family Rights

- the right to refuse service (voluntary nature)
- the right to referral, as appropriate, to other service providers
- the right to participate in the planning of services to be provided
- the right to file a grievance/complaint and how to do so should the need arise including phone number or contact information

Confidentiality

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

Download Sample Rights and Confidentiality form in English and Spanish.

GA-5.B		RATING INDICATORS
3	-	Families are informed and receive copy of their family rights and confidentiality, on or before the first home visit, both verbally and in writing; plus any family grievances have been addressed in accordance with site policy, or no family grievances have been received.
2	-	Past instances were found when families were not being informed or provided copy of their rights and confidentiality on or before the first home visit; however, **recent practice** indicates this is now occurring; plus any family grievances have been addressed in accordance with site policy, or no family grievances have been received.
1	-	Any of the following: the forms do not yet include the criteria listed in the standard; families are not yet being informed about their family rights and confidentiality on or before the first home visit; the site does not protect family confidentiality and privacy; or family grievances were not addressed in accordance with site policy.

Note: This is a Sentinel Standard

☺ Tip: While the rights and confidentiality form is required to be completed only once at the initiation of services, sites are encouraged to consider renewing it annually with families as a best practice. Also, while the required components bulleted above pertaining to family rights and confidentiality can be addressed via more than one form, sites are strongly encouraged to utilize only one form so as not to overwhelm families with excessive paperwork. Sites are also encouraged to keep language family-friendly.

GA-5.C Parents are informed and sign a new consent form every time information is to be shared with a new external source or with the same source but for a subsequent time period. The consent includes the following, but is not limited to:

- a signature from the person whose information will be released or parent/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 (not to exceed 12 months)
- the name of person/agency to whom the information is to be released
- the name of the HFA site providing the confidential information
- a statement that the person/family may withdraw their authorization at any time

Download Sample Release of Information Form in English and Spanish

Intent: *When a site receives a request for confidential information about a family, or when a release of confidential information is necessary for the provision of services, the site must obtain the family's informed, written consent prior to releasing the information.* ***Please note:*** *Consent to release information forms will only list one (1) agency per form in order to maintain confidentiality related to the various services a family might receive. "Blanket" release of information forms, that list multiple entities on the same form, are not acceptable for use. All information on the form (including the specific information to be released, who it is being released to, the purpose for the sharing, etc.) must be filled in before parents sign the form. It is not permissible to have parents sign incomplete forms. Additionally, informed consents are time specific and do not include open-ended timeframes such as "during the course of services". Sites are to be as specific as possible about what is to be shared (e.g., home visit notes, developmental screen, assessment information, etc.) so families are very clear about what will be released. This consent may also apply to verbal sharing of information, and sufficient details about what staff may speak about must be clearly listed. Since a signed release form remains in effect for a maximum of 12 months, a new consent form will need to be signed annually when communication or sharing extends beyond the 12 month time period with the same external source.*

GA-5.C RATING INDICATORS

3 - Families provide written consent every time information is to be shared with a new external source or with the same source but for a subsequent time period.

2 - Past instances were found when families did not provide written consent for sharing of information or the consent did not include the criteria listed in the standard; however, **recent practice** indicates this is now occurring.

1 - Information is shared without the family's written consent, or the consent does not yet include all criteria listed in the standard.

Note: This is a Sentinel Standard

GA-6. The site reports suspected cases of child abuse and neglect to the appropriate authorities.

Intent: *Staff clearly understand how to identify child abuse and neglect indicators and the State's definitions of child abuse and neglect. This will assist them with knowing how and when to report. Additionally, it is important for staff to know who to contact for support when abuse or neglect is suspected. It is the intent site leadership be notified in advance of a CPS report being made, however imminent child safety concerns are of higher priority. Therefore, staff also clearly understand that contacting Child Protective Services prior to immediate notification of the site manager or supervisor is appropriate ONLY IF waiting to contact site leadership may cause greater risk to the child(ren). Exceptions must be fully documented. These criteria and reporting procedures are clearly outlined in the orientation training staff receive prior to their work with families (10-2.C) and reviewed annually throughout employment (11-4.B).*

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 Child Protective Service, without risk or jeopardy, even in situations where site leadership may not agree with the need to report.

GA-6.A The site has policy and procedures to report suspected cases of child abuse and neglect.

Intent: *The site must have policy and procedures to effectively guide staff in situations where abuse or neglect is suspected so appropriate and timely action can be taken. Sites may choose to reiterate information from the State's Children's Code, agency-wide policy, or training materials indicating the child abuse and neglect criteria and reporting requirements. At a minimum, these materials must be referenced in policy so staff know where to locate them.*

GA-6.A		RATING INDICATORS
3	-	No 3 rating indicator for standard GA-6.A.
2	-	The site has policy and procedures that are in accordance with all applicable laws and specify the following: - *criteria* used to identify and determine when to report suspected child abuse and neglect (or at a minimum, policy must indicate where these criteria can be found), and - immediate notification of the site manager or supervisor when abuse or neglect is suspected.
1	-	The site does not yet have policy and procedures specifying the criteria (or the location of the criteria) used to identify and report cases of suspected child abuse/neglect, or the policy and procedures do not yet specify immediate notification of the site manager or supervisor.
Note:		**This is a Safety Standard**

GA-6.B The staff notifies Supervisors or site manager immediately in situations involving suspected abuse or neglect, and reports suspected cases of child abuse and neglect to the proper authorities.

GA-6.B		RATING INDICATORS
3	-	Staff report all suspected cases of child abuse and neglect and immediate notification of site manager or supervisor occurs.
2	-	Past instances were found when staff did not report suspected cases of child abuse and neglect, or immediate notification of the supervisor did not occur; however **recent practice** indicates all suspected child abuse and neglect situations are reported, and immediate notification of the supervisor or site manager occurs; **or there have been no reports made to CPS by currently employed staff to illustrate implementation and follow-through.**
1	-	The site's does not yet report suspected abuse and neglect, or immediate notification of the supervisor or site manager does not yet occur.
Note:		**This is a Safety Standard**

GA-7. The site responds to support families and staff in situations involving participant death.

GA-7.A The site has policy and procedures specifying immediate notification of the site manager or supervisor in cases of participant death (other appropriate staff/supervisors within the site are notified as needed) and specify staff are offered grief counseling when a participant death occurs, and families are offered extended support as needed.

GA-7.A	RATING INDICATORS
3 -	No 3 rating for GA-7.A.
2 -	The site's policy and procedures specify immediate notification of the site manager or supervisor, and that staff are offered grief counseling when a death occurs, and extended support is offered to the family.
1 -	Any of the following: the site does not yet have policy and procedures; the site's policy and procedures do not yet specify immediate notification of site manager or supervisor; or policy and procedures do not yet indicate staff are offered counseling when a death occurs or do not yet indicate the family is offered extended support as needed.

GA-7.B The site responds in situations involving participant death to support family members and staff as needed. Program manager or supervisor is notified immediately.

Intent: *This standard ensures both staff and family members are supported through the grief process. 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. A death creates a deep sense of loss for families as well as staff, including Family Support Specialists, Supervisors and Family Resource Specialists with whom the family member had a relationship. At a minimum, reporting would occur if there is a death of a participating child or participating parent.*

GA-7.B	RATING INDICATORS
3 -	In situations involving participant death of a parent or target child, immediate notification of the site manager or supervisor occurs. Support is provided to families and staff when a death occurs.
2 -	Past instances were found when notification of program manager or supervisor did not occur immediately or staff or families were not offered support; however, **recent practice** indicates this is now occurring; or **there have been no participant deaths from a currently employed staff member's caseload to illustrate implementation and follow-through**.
1 -	Program manager or supervisor have not yet been notified immediately; or staff or families are not yet offered support when a death occurs.

GA-8. Updates to the site's Policy and Procedures Manual are communicated to all staff in a timely basis and staff have access to a copy of the Policy and Procedure Manual.

Intent: *It is critical for all staff to know and understand the policies and procedures which guide their work. It is not necessary for staff to have the Policy and Procedures manual memorized, but they will, at a minimum, know where to look when they have a policy or procedure question and are able to use it as a support to practice when needed. **Please Note:** Orientation to policy and procedures is required before contact with families as per standard 10-2.A. For additional guidance see* Policy and Procedure Checklist and Sample Policy and Procedure Template/Guide.

GA-8.	RATING INDICATORS
3 -	The site has a Policy and Procedures Manual, all staff have access to it, and

updates have been communicated to staff when they occur.

2 - The site has a Policy and Procedures Manual. Past instances were found when the site staff did not have access to it or receive communication when updates occurred, however all staff now have access to the Policy and Procedure Manual and **recent policy changes** were communicated to staff when they occurred.

1 - Any of the following: the site does not yet have a Policy and Procedures Manual; or all staff do not yet have access to it, or staff have not yet received communication when updates to policy occur.

☺ Tip: Staff receive orientation training to the site's policy and procedures (10-2.B). Communication with staff about policy updates can occur during supervision or team meetings with support provided to help staff understand and integrate policy changes into practice.

END OF HFA BEST PRACTICE STANDARDS

Prior to an accreditation decision, the HFA National Office will confirm the following are in adherence. A site is required to remedy any that are out of adherence before the accreditation award can be conferred.

GA-9. In accordance with HFA's Affiliation and Licensing Agreement, which grants sites the ability to implement the model and access it's intellectual property, affiliates are required to adhere to the responsibilities outlined therein, particularly those pertaining to data, fees and brand identity.

GA-9.A The site ensures that all HFA required data pertaining to site characteristics and outcomes is kept up-to-date, primarily though not exclusively, through HFAST (Healthy Families America Site Tracker).

Intent: *The HFAST system is used to maintain accurate demographic and programmatic details regarding all HFA sites. In order to accurately and effectively represent the entire HFA network it is imperative sites update the information stored on HFAST at least annually (more often when there are staffing changes). When all site data is recorded accurately and is up-to-date, we are best able to understand, reflect on, and articulate to the field and key stakeholders and decision-makers the collective impact the HFA model has.*

GA-9. RATING INDICATORS

3 - No 3 rating for GA-9.

2 - All HFA required data, including that entered into the HFAST system, is up-to-date consistent with expectations for all affiliated sites.

1 - Data required of all HFA affiliates is not yet currently up-to-date as required of all HFA affiliates.

Note: This is a National Office Requirement

GA-9.B The site is up-to-date with all fees owed to the HFA National Office.

Intent: *Sites must have any outstanding fees paid in full prior to accreditation.*

GA-9.B RATING INDICATORS

3 - No 3 rating for GA-9.B.

2 - The site has no outstanding fees owed to the National Office or has now paid any

		fees previously owed.
1	-	The site currently has overdue or unpaid fees.

Note: This is a National Office Requirement

GA-9.C The site utilizes the trademarked HFA name, logo and brand according to HFA graphic standards.

Intent: *The image and integrity of the HFA model is maintained through appropriate use of HFA graphics on all promotional materials and other documents and images shared publicly (electronically or in hard copy). Visual representation that is uniform across the HFA network conveys a stronger brand identity.*

GA-9.C		RATING INDICATORS
3	-	No 3 rating for GA-9.C.
2	-	The site utilizes HFA graphics (name, logo, etc.) in accordance with HFA graphic standards for site materials made available publicly.
1	-	The site is not yet utilizing HFA graphics (name, logo, etc.) in accordance with HFA graphic standards for site materials made available publicly.

Note: This is a National Office Requirement

Tables of Documentation			
GA - The site is governed and administered in accordance with principles of effective management and of ethical practice Please note: GA is not a Critical Element			
Standard	**Required Policy and Procedures**	**Pre-Site Documentation to include in Self Study**	**Site Visit Activities**
GA-1.A Organization of Advisory Group	Policy not required **Please note:** sites may have Policy related to these standards and may submit them for the benefit of the peer review team; however, they are not required.	Please submit a narrative (could be narrative, policy or bylaws) describing the advisory group 's role in advising with regards to planning, implementation, and evaluation of site activities.	**Interview:** * Advisory group members * Program Manager **Review:** * Board Meeting Minutes from Past Year * Advisory Group Surveys
GA-1.B Wide Range of Skills & Knowledge		Please submit a advisory group roster with affiliation and summary of skills, strengths, community knowledge, professions, and cultural diversity (as defined by the site); which qualify them to effectively serve the interests of the community and advocate on behalf of families.	
GA-1.C Program Manager & Advisory Group Work as Team		Please submit a narrative describing how the program manager (or Designee) and advisory group work as an effective team with information, coordination, staffing, and assistance provided by the program manager.	
GA-2.A Policy - Formalized Input from Families	How families provide feedback about their experiences with services	Submit Policy	**Interview:** * Program Manager * Supervisors * Direct Service Staff * Families
GA-2.B Formalized Input from Families		Please submit a narrative describing how input (include all mechanisms utilized) is obtained regarding services from families including a summary of results. Please note: Sample Family Survey available	
GA-3.A Review of Progress of Goals & Benchmarks		Please submit site goals and benchmarks including the progress toward reaching goals and follow-up mechanism to address areas of improvement.	**Interview:** * Program Manager * Supervisor * Direct Service Staff **Review:** * Completed QA forms/documentation - documentation may include: shadowing of staff, family file reviews, supervision reviews, review of evaluation results, etc.
GA-3.B Quality Assurance Plan		Please submit the site's Quality Assurance Plan including review of all aspects of site implementation (initial engagement, home visiting, supervision and management) and follow-up mechanisms to address identified areas of improvement. Please note: Sample Staff and Family Surveys and Sample HFA QA Plan Template available	

GA-4.A Policy - Research Proposals	Process and timing for reviewing and recommending approval or denial of research proposals, whether internal or external, which involve past or present families.	Please Submit Policy	**Interviews** if necessary Review: * Research proposals and outcome
GA-4.B Research Proposals		Pleases submit narrative describing all research proposals received by the site. Please explain the process and outcome from the proposals. Please indicate if no proposals have been received to date.	
GA-4.C Participant Privacy and Voluntary Choice in Research		Please submit copies of relevant forms related to protection of participant identify and privacy for research projects and the option not to participate in research.	
GA-5.A Policy - Family Rights & Confidentiality, Release of Information, and Families are Informed of Grievance Procedures	How families are informed about their right to confidentiality before or on the first home visit. Policy and procedures also state how families are informed and sign written consent every time information is to be shared with a new external source. In addition, how families are informed of the right to file a grievance and the procedures for addressing grievances.	Please Submit Policy	**Interview:** * Program Manager * Supervisor * Direct Service Staff * Families **Review:** * Family Files
GA-5.B **Family Rights & Confidentiality** ***Sentinel Standard***		Please submit sample of relevant form(s) related to confidentiality, informing families of their rights and informing families of the grievance procedures. Please provide a description of any grievances received during the past year and how these were handled by the site.	
GA-5.C **Informed & Signed Consent** ***Sentinel Standard***		Please submit sample of relevant form(s) related to informed consent when sharing information with other external sources (e.g., consent forms).	

GA-6.A Policy - Criteria to Identify Child Abuse & Neglect ***Safety Standard***	Immediate notification of program manager and/or supervisor when reporting suspected cases of child abuse and neglect, and the criteria for reporting Child Abuse and Neglect clearly outlined or referenced	Please submit policy	**Interview:** * Program Manager * Supervisor * Direct Service Staff **Review:** * Any Relevant Documentation * Staff Surveys
GA-6.B Child Abuse Reporting ***Safety Standard***		Please submit narrative (if not outlined in policy & procedures), describing the site's process for identifying and reporting child abuse and neglect and describe any reports that have occurred within the past year.	
GA-7.A Policy - Participant Death & Grief Counseling	Immediate notification of program manager and/or supervisor in the instance of a participant death, and provision of support to staff and family.	Please Submit Policy	**Interview:** * Program Manager * Supervisor * Direct Service Staff **Review:** * Any Relevant Documentation
GA-7.B Participant Death & Grief Counseling		Please submit narrative indicating any incidents of participant death that have occurred within the past year.	
GA-8 Policy & Procedure Manual		Please submit narrative describing how staff are updated on revised or new policies. Please note: HFA Policy and Procedure Template including sample policy language is **available,** as well as Policy and Procedure Checklist to ensure all required components of all policy standards are included	**Interview:** * Program Manager * Supervisor * Direct Service Staff **Review:** * Any Relevant Documentation * Staff & Advisory Surveys
GA-9 National Office Requirements		No documentation required pre-site	***National Office Staff Review:*** ** HFAST status* ** Payment status* **Appropriate use of HFA logo and name*