HEALTHY FAMILIES NEW YORK

POLICY MANUAL

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INTRODUCTION AND MISSION

Healthy Families New York Approach

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

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

Healthy Families America Mission Statement

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

Healthy Families New York Mission Statement

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

HEALTHY FAMILIES AMERICA GOALS

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

HFNY PROGRAM GOALS

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

GUIDE TO THE HFNY POLICIES AND PROCEDURES MANUAL

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

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

Each policy that has MIS evidence components, or supporting forms or documentation has these elements listed at the end of the policy.

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

Lastly, the HFNY PPM includes a glossary of important terms to ensure universal interpretation of the meaning of key terms and concepts used in the HFA model and HFNY state system.

HEALTHY FAMILIES NEW YORK STATE SYSTEM

Healthy Families New York (HFNY) is affiliated with Healthy Families America as an accredited Multi-Site System, and each program site in HFNY is an affiliated and accredited site as part of the Multi-Site System. HFNY is funded and managed by the New York State Office of Children and Family Services (OCFS). OCFS contracts with all funded programs to provide Healthy Families services. Each funded site was selected through a competitive Request for Proposal (RFP) process, which solicited proposals from agencies serving very high need areas. In addition to the strength of the proposal, funded programs were able to document the need in their target area as well as strong community collaboration. Funded programs are required to follow the Healthy Families America Best Practice Standards and participate in the accreditation process. These requirements are included in every contract between OCFS and HFNY sites. It is possible for HFNY sites to operate solely with local funding. These programs may be affiliated with HFNY provided they follow HFNY policies and standards.

OCFS has a Program Coordinator who oversees the Multi-Site System, and Program Contract Managers who manage the program sites and provide technical assistance and monitoring of sites.

OCFS is also responsible for overseeing the research and evaluation activities implemented by the Multi-site system. OCFS has a Senior Researcher who oversees all research and evaluation activities, and Junior Researchers who manage the day-to-day activities related to the system's research and evaluation work.

The benefits of a Multi-Site system include:

- Support to new and developing programs
- Data collection and analysis
- Staff training and professional development opportunities
- Information-sharing and networking support
- Assistance with HFA accreditation
- Access to educational resources
- Quality assurance
- Technical Assistance
- Monitoring

OCFS contracts with Prevent Child Abuse New York (PCANY) to conduct all basic training, advanced training on selected topics, and through our statewide Continuous Quality Improvement efforts, to visit each site on a regular basis to observe home visits, assessments and supervision, provide a variety of site support activities geared to the needs and requests of each program, and provide technical assistance visits as needed through the Training and Staff

Development Team (TSD). The TSD is part of the HFNY Central Administration, along with OCFS and the Center for Human Services Research (CHSR). The TSD has a Director of Training, an Associate Director, HFA certified core trainers, and Training and Staff Development Specialists. PCANY also publishes *the Link*, the HFNY newsletter.

OCFS contracts with the Center for Human Services Research (CHSR), Rockefeller College of the State University of New York at Albany to manage the data system for HFNY and to assist with the evaluation of the program. A computerized management information system (MIS) is used to collect comprehensive, yet anonymous, information for managing the program and for evaluating outcomes. CHSR has a Director of Management Information and management information and evaluation staff, and is the third member, along with OCFS and the TSD, of the HFNY Central Administration.

The HFNY Central Administration (CA), composed of OCFS, PCANY TSD, and CHSR, establishes and maintains written program policies that address the 12 Critical Elements and govern and guide operation of the HFNY state system. The CA is also responsible for determining system response to research outcomes, attending to programs that are facing challenges, reviewing sites' research proposals, and identifying state system areas of emphasis and developing strategies and expectations for the direction of the program. The CA routinely solicits input from program sites, and communicates policy, research, and program direction updates with sites via regular Statewide Leadership and Regional Leadership meetings.

Statewide leadership meetings consisting of all program managers and the members of Central Administration occur two times a year. The goals of these meetings include sharing resources, and discussing training, multi-site policies, evaluation, technical assistance and quality assurance.

Regional leadership meetings are held four times a year. Regional meetings provide the opportunity for smaller groups of geographically closer program managers and regional representatives from Central Administration to meet. These meetings serve the same function as the larger meetings, but provide the additional opportunity to address regional concerns in a smaller group setting, and have more in-depth discussion and sharing among participants.

Section A: Service Initiation
Critical Elements 1-3

Critical Element #1 Services are initiated prenatally or at birth.

Intent: The overall intent of Critical Element #1 is to ensure that sites have a well- thought-out mechanism for the early identification of families in the community that could benefit from services.

SCREENING AND ASSESSMENT PROCESS
HFA Best Practice Standard 1-2.A

POLICY: Assessment staff or trained community partners conduct initial screenings and assessments, ensuring timely determination of eligibility.

Intent: Sites have a clearly defined Target Area and Target Population, and establish community relationships that support identification of and outreach to the target population so that services can begin prenatally or within three months (calculated in MIS as 92 days) of the birth of a baby.

The site measures annually the number of families in the *target population* that are identified and/or referred through its system of organizational relationships, and through review and analysis of this data, develops strategies to increase the percentage identified and screened, as well as recognizing need for services within the community.

Sites use the HFNY screening tool to identify potential participant families and have a system for identifying families prenatally and for processing referrals so that the determination of eligibility for the assessment occurs prenatally.

Sites assess screened families for participation prenatally or within 14 days of the birth of the baby. Efforts are made to assess families as early as possible prenatally; at least 80% of assessments occur within in 14 days of a baby's birth.

Sites systematically track, measure and analyze their efforts to reach, screen, and assess the Target Population in order to increase enrollment, especially early prenatal enrollment, and assess level of need in the community, including review and analysis of stage of pregnancy at assessment, families who left the process, either by actively declining or where the connection was lost after positive screens or positive assessments, and develop strategies, including community relationships and outreach materials, and a plan to increase the Acceptance Rate. Programs' efforts in tracking, measuring and analyzing are reflected in their Annual Service Review.

1. All sites use the HFNY screening tool. Staff review screens upon receipt and enter information from screens into the MIS within five business days of receipt from referral sources or from families who have self-referred.
2. Sites develop and maintain effective referral relationships with community agencies to encourage as many referrals as possible to be received as early as possible in the pregnancy or within the first two weeks of the infant's birth. These relationships have both informal and formal components. Formal relationships are reflected in Memoranda of Understanding (MOUs), which must be updated and signed annually.
3. Sites place emphasis on identifying referral sources that will help them identify potential participants early in their pregnancy.
4. Families with a positive screen are offered a comprehensive assessment using the Parent Survey to determine their strengths and needs. The assessment is conducted in the family's home, with assessment staff making every effort to offer the Parent Survey to both parents, and within two weeks of a positive screen being entered in the MIS. If staff is unable to contact the family, they will contact the referral source to verify contact data and determine alternative means to contact the family.
5. Families where the mother, father, or their partner scores 25 or higher on the Parent Survey are eligible for intensive home visiting services.
6. Sites give an update to the referral source within five business days of resolution of the family's enrollment status, unless the referral source does not want this information.
7. Referrals, screening outcomes, and assessments are tracked by the HFNY Management Information System (MIS) and monitored at least monthly by the Program Manager or designated administrative staff member, and these efforts are used to develop strategies for quality improvement.

MIS References:

Analysis/Elapsed Times Between Key Dates
Analysis/FAW Monthly Report
Analysis/Quality Assurance Report
Analysis/Screen Referral Source Summary
Analysis/Screen Referral Source Outcome Summary
Analysis/Screen/Referral Source Demographic and Outcome Analysis
Quarterly /Quarterly Pre-Assessment Engagement
Accreditation/1-2.C Assessment Information
Lists/Zip Code Report

Appendix:

HFNY Screen
Quarterly Report Guidelines
Annual Service Review Guidelines

HFNY Performance Indicators
HFNY General Talking Points
HFNY Prenatal Talking Points

Insert site-specific procedures that include:

1. The definition of the Target Area and description of the Target Population, including where the Target Population can be found and community relationships that have been developed to locate and engage the Target Population, including special efforts to reach families in the early prenatal period.
2. A description of the process for receiving referrals, and conducting screens and assessments.
3. A description of the mechanisms the site has in place to ensure timely determination of eligibility.
4. Timeframes between receipt of the referral or screen and contacting the family, and the timeframe from the contact to offering the assessment.
5. A description of the process for tracking process between the receipt of screens or referrals to when long-term home visiting services are offered.
6. Mechanisms for monitoring the processes and timeframes.

FIRST HOME VISIT
HFA Best Practice Standard 1-3.A

POLICY: For families that accept services, the first home visit occurs prenatally or within the first three months after the birth of the baby.

Intent: The first home visit that begins to establish a long term home visiting relationship (i.e. after the screening and assessment process), occurs within three months (calculated in MIS as 92 days) of a baby's birth, 95% of the time, as set by HFNY Performance Indicators.* Any instance when a family's first planned home visit falls outside these parameters must be discussed with and approved by the site's OCFS Program Contract Manager. Programs develop strategies to expand and maintain prenatal enrollment, and how they will achieve the HFNY Performance Indicator of at least 65% prenatal enrollment. Calculating the rate of families accepting services is a critical quality improvement practice, therefore programs systematically track, measure and analyze their efforts annually to reach this goal. Programs' efforts in tracking, measuring and analyzing are reflected in their Annual Service Review.

*This is a higher standard than is set by HFA Best Practice Standards. During the HFA accreditation process, HFNY program sites will be held to the HFNY standard.

1. Once a family is determined eligible for intensive home visiting services, a home visitor is assigned and immediately begins engagement efforts.
2. The first home visit as soon as possible after a home visitor has been assigned and no later than three months (calculated in MIS as 92 days) after the birth of the baby.
3. The family is considered to be enrolled when, during a home visit, they have signed the Service Agreement Form and Family Rights and Confidentiality Form. These indicate the family's informed consent to receive services. HFNY sets the date of signatures as the family's enrollment date
4. Engagement efforts and families' enrollment status are tracked in the site's data system and monitored at least monthly by the Program Manager, and these efforts are used to develop strategies for quality improvement.

MIS References:

Quarterly /Quarterly Pre-Intake Report
Tickler/Pre-Intake Tickler
Accreditation/ 1-3.B Timing of First Home Visit
Accreditation/1-4.A and B Acceptance Rate and Analysis

Appendix:

HFNY Performance Indicators

Sample Service Agreement Form
Sample Family Bill of Rights and Confidentiality Form

Insert site-specific procedures that include:

1. A description of the beginning of services, i.e. that they begin prenatally, or at birth.
2. A description and the source of the requirement that the first home visit must occur prenatally or within the first three months after the birth of the baby, and the specific standards to which the site is held.
3. A description of the process for tracking the timing of first home visit in relation to the child's date of birth.
4. A description of the process for monitoring and adhering to this standard.
5. A description of how and when Home Visitors are assigned after a positive assessment.

Critical Element #2 A standardized tool is used to systematically determine which families would benefit the most from intensive home visitation services.

Intent: The overall intent of Critical Element 2 is to ensure that sites have an objective, standardized process for identifying and assessing the strengths and needs of families at the onset of services.

ELIGIBILITY REQUIREMENTS
HFA Best Practice Standard 2-1.A

POLICY: Families are eligible for intensive home visiting services when they are determined at risk for poor family outcomes, as determined by the Parent Survey.

1. Staff review referrals within three business days of receipt of screen from health, education and human service agencies, as well as from families who self-refer.
2. For all positive screens a Pre-Assessment Form is completed.
3. A Screen is positive if any of the following are true about the PC1:
   a. Marital status is single, separated, divorced, widowed
   b. Late (started after the 12th week of pregnancy) or no prenatal care, poor compliance
   c. Inadequate income (TANF or Medicaid, employed without insurance or family financial concerns)
   d. Expectant/new parent is under 21 years of age at time of screen

   Or

   A screen is also positive if the marital status, prenatal care, and income are ALL unknown.
4. Families with a positive screen are offered a comprehensive assessment using the Parent Survey to determine their eligibility for intensive home visiting services.
5. Families where either parent scores 25 or higher on the Parent Survey are eligible for intensive home visiting services.
6. Screen and Assessment results are documented in the site's data system and monitored by the Program Manager at least monthly.

MIS References:

Analysis/FAW Monthly Report
Analysis/Program Synopsis
Quarterly/Quarterly Pre-Assessment Report
Tickler/FAW Tickler

Appendix:

HFNY Screening Form

Pre-Assessment Form

Insert site-specific procedures that include:

1. A description of the required criteria for determining eligibility for Healthy Families home visiting services.
2. Describe procedures for follow-up on assessment refusals.

ASSESSMENT NARRATIVES
HFA Best Practice Standard 2-2.A

POLICY: The Parent Survey is used to assess for the presence of factors that could contribute to increased risk for child maltreatment and/or other adverse childhood experiences, and is completed within the required timeframe set forth in 1-2.A.

Intent: No single factor can predict which parents face the high levels of stress that may lead to child abuse or neglect, nor when a child is at risk for developmental delays, poor childhood outcomes or adverse childhood experiences. Therefore, HFNY sites use the Parent Survey to objectively determine family strengths and needs, and identify families most in need of services and ensure that services are offered to families the model is designed to serve.

HFNY sites must ensure that all staff involved in the assessment process provides such service objectively and consistently. Sites state clear expectations for the documentation of the assessment narrative to ensure it conveys accurately the depth and detail of each family's strengths, risk factors, and needs, to provide home visitors with an understanding of each family, and afford the opportunity to provide individualized service that builds upon their strengths and is specific to their unique needs.

1. Families with a positive screen are offered a comprehensive assessment using the Parent Survey, to determine their eligibility for intensive home visiting services.
2. Families with either parent having a score of 25 or higher on the Parent Survey are eligible for intensive home visiting services.
3. Every effort is made for the Parent Survey to be completed with both parents, or primary caregivers.
4. Assessments are fully documented consistent with expectations outlined in HFA Parent Survey and Community Outreach (PSCO) Core training, with narrative detail for each of the ten domains for parents, or primary caregivers, using the HFNY Assessment Narrative Form.
5. Each parent or primary caregiver is rated 0, 5, 10 or Unknown in each domain of the Parent Survey using the Rating Scale.
6. The narrative includes details of the family's strengths, risk factors and needs as determined by the Parent Survey.
7. The HFNY Parent Survey narrative is completed by the assessment worker within 2 business days and submitted to the supervisor for review.
8. FAW supervisors review all Parent Survey narratives. These reviews may be completed outside of regular supervision times to ensure that the Supervisor

reviews them in a timely manner. Any subsequent changes to the narrative are reflected in a finalized Parent Survey that is completed and entered into the MIS within 5 business days of the assessment.

9. In order to ensure reliability in scoring the Parent Survey and quality of assessment practice, staff that complete assessments participate in regularly scheduled, protected supervision with their supervisor, and supervisors review and confirm scoring to assure inter-rater reliability. Supervisors observe workers conducting the Parent Survey at least once per quarter for the first year, and twice per year thereafter for each FAW who has completed assessments during the year.
10. All staff with responsibility for conducting the assessment must complete intensive, role-specific training offered by a certified Healthy Families America Assessment Trainer, that includes the theoretical background of the tool, hands-on practice, and scoring and documentation procedures, prior to offering the assessment.
11. HFNY does not accept stop-gap training for staff administering the Parent Survey.

MIS References:

Training/ 10-3 Intensive Role Specific Training for Staff
Accreditation/ 12-2.B Parent Survey Observation by Supervisor

Appendix:

HFNY Parent Survey Worksheet

Insert site-specific procedures that include:

1. A description of assessment criteria, including protocols for re-assessment.
2. The process for documenting assessments including:
   a. A description of who completes the narrative, including training required and that the HFNY Assessment Narrative Form is universally used to document the Parent Survey.
   b. The timeframe for completing the narrative.
   c. Language that supports that narratives accurately convey the detail of the families' strengths, risk factors and needs.
   d. Support for assessment practice that includes a description of: Routine review of assessments and timeframe for review, reflective supervision, the training required for the supervisor, practice observation for quality assurance, and inter-rater reliability practice.

Critical Element #3 Services are offered voluntarily, with positive, persistent outreach efforts to build family trust.
Intent: The overall intent of the standards in this section is to ensure that sites have a process for reaching out to and engaging families, both initially, and after enrollment.

VOLUNTARY NATURE OF SERVICES
HFA Best Practice Standard 3-1.A

POLICY: HFNY services are voluntary

Intent: Offering services voluntarily increases trust and receptivity. Research suggests that an important reason for voluntary services is that 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).

While HFA is very clear that services to families are offered voluntarily, there may be some external agencies that 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 accepts families that have active child welfare cases, staff may not monitor family's progress on behalf of the referral entity nor perform the job functions required by that entity. Sharing of information with child welfare and/or other service systems is bound by the confidentiality requirements of HFA and informed consent that indicates precisely what information is to be shared.

1. Parents are to be informed, verbally and in writing, of the voluntary nature of participating in HFNY services as early as possible and no later than when families consent to participate in services, including the assessment visit.
2. The Parent Survey visit is used as the first opportunity for families to make an informed and voluntary choice about participation in services offered by the program.
3. During the assessment visit, the assessment worker explains what Healthy Families is, what services are available, and the voluntary nature of services.
4. Assessment workers review a consent for assessment form, that indicates that services are voluntary, and the assessment proceeds after the parents have signed indicating their informed consent.

5. Family support workers review a service agreement form that includes a Participant Bill of Rights and a Confidentiality Form that indicates that program services for enrolled families are voluntary.
6. Each family choosing to participate in HFNY services signs and receives a copy of the Family Rights Handout.
7. In the event that any entity (child welfare or the court system, for example) attempts to mandate services for a family, staff ensure that both the agency and the family know that services will be offered voluntarily and that the family is free at any time to decide whether or not to participate.

MIS References:

None

Appendix:

Sample Family Bill of Rights and Confidentiality Form

Insert site-specific procedures that include:

1. Statement of commitment to services that are voluntary.
2. How families are informed of the voluntary nature of services and their right to refuse services.
3. The site's family rights form that clearly states the voluntary nature of services.

BUILDING TRUST AND ENGAGING FAMILIES
HFA Best Practice Standard 3-2.A

POLICY: HFNY staff use positive methods to build family trust, engage families in services, and maintain family involvement.

Intent: Staff needs to employ trust-building methods and tools, and have supervisory support, when establishing and maintaining relationships with families. Based on current circumstances or past experiences, families may have difficulty building trusting relationships and engaging in services. Therefore, staff must identify positive ways to establish a relationship with a family and keep families interested and connected over time. Using a family centered approach throughout the course of services allows staff to focus on what is important to the family. Supervision is an excellent place to strategize ways to build trust, engage families, and maintain family involvement.

1. Services are routinely provided to families in their homes. There may be occasional exceptions, for example, the family may request meeting at another location if there are confidentiality or safety concerns, or families that are socially isolated may benefit from a visit outside the home.
2. When home visit documentation indicates that child development and parent-child interaction are consistently discussed in home visits, one parent group meeting offered by the program per month may count toward the home visit rate with Level 1 and Level 2 families, if the home visitor is present at the group meeting.
3. At least 75% of visits are expected to take place in the family's home. Exceptions must have the approval of the program's Program Contract Manager.
4. Home visitors are trained to planfully use reflective strategies and active listening skills to build a trusting relationship with families, and encourage parents' healthy brain development.
5. When a family is reluctant to participate in home visiting or does not appear to be available, the home visitor discusses the family in detail with their supervisor to problem-solve the engagement difficulties and develop creative outreach strategies.
6. To build trust, staff will maintain a regular, predictable home visit schedule, always notifying the family if changes in the schedule must occur. Staff will also endeavor to always follow-through on what they say they are going to do.
7. Staff will use a variety of outreach and engagement activities including texting, phone messages, sending friendly notes, drop-by visits, invitations to parent group and leaving small token gifts like body, etc. to engage families and maintain engagement with families.

MIS References:

Analysis/Summary of Home Visit Log Activities
Analysis/Summary of Unique Families by Type of Home Visit Activities

Appendix:

None

Insert site-specific procedures that include:
A variety of positive outreach methods to be used to:

a. Build trust with families
b. Engage new families
c. Maintain family involvement

CREATIVE OUTREACH AND LEVEL X
HFA Best Practice Standard 3-3.A

POLICY: Home visitors offer Creative Outreach under specified circumstances for families who have received at least one home visit, for a minimum of three months, for each family before discontinuing services.

Intent: It is the site's responsibility to reach out to families who may benefit from services, yet, for a variety of reasons, may not have accepted an initial visit or have disengaged after initially enrolling and participating in services. In the latter case, families are changed to Level X. Often, families that 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. In any case, HFA's commitment to family-centered practice calls for persistent, respectful, and individualized outreach.

1) Creative outreach to families prior to enrollment is generally concluded after 30-45 days of efforts to engage the family.
2) A family that has enrolled in the program is placed on Level X status when:
   a. The family cannot be located.
   b. A family leaves the service area for an extended period of time and intends to return to complete the program. In this instance, a full review of the case with the Program Manager, Supervisor, and other relevant staff is held. This includes ideas for remaining in contact (such as sending age appropriate child development curriculum). If a family does not return within 6 months, their case is closed.
   c. Three consecutive scheduled home visits are missed while on Level 1-Prenatal, Level 1, Level 2 or Level 1SS.
   d. A family on Level 3 or 4 has missed one scheduled visit and there has been no communication. This does *not* include a family who calls prior to the missed visit to reschedule.
3) Level X status corresponds to the family's circumstances and not those of the home visitor or the program. For example, families may not be placed on Level X when a home visitor is on leave of absence or vacation, or when the program is having trouble filling a vacancy. It is the program's responsibility to visit the family according to the family's current home visit level.
4) Home visitors consult with their supervisor in determining Level X. The review is documented in the participant file and supervision documentation. When Level X status is assigned, discussions about the outreach efforts occur regularly in supervision.

5) Outreach efforts include phone calls, text messages, drop-by home visits, use of door hangers, friendly letters, and materials that may be of special interest to the family (e.g., ASQs, job announcements, social activities, etc.).

6) A family is taken off of Level X when they have received *two consecutive home visits*. The date of the second home visit is the date of level change, and this is documented using the HFNY Change Form.
7) The family remains on Level X status for a minimum period of three months (calculated in MIS as 92 days), as set by HFNY Performance Indictors. Level X status may be concluded prior to 92 days *only* under the following circumstances:
    a. The family has reengaged in services
    b. The family has refused services
    c. The family has moved from the service area
    d. Neither parent has custody of the child
    e. The pregnancy ended in miscarriage or termination
    f. Target child is deceased
    g. The primary care giver is deceased
    h. There are significant safety concerns that place the home visitor's health and well-being in jeopardy.
    i. The family has transferred to another program
8) Level X extends beyond 92 days if it is likely that the family will be re-engaged. Supervisors and home visitors discuss this circumstance and document the discussion. HFNY Performance Indicators set the maximum percentage of families on Level X at 10% or lower.
9) Families are returned to their same or a higher frequency of visits when they are taken off of Level X. This decision is made based on discussions between the supervisor, home visit and family (not necessarily at the same time).
10) If 92 days of outreach at Level X conclude without success, a letter may be sent to the family indicating that services will be closed, and inviting them to contact the program if their circumstances have changed and services as outlined in the Family Rights Handout would now be welcomed.
11) Whenever appropriate, home visitors and supervisors discuss transition planning for families being discharged from the program after being enrolled and at the conclusion of outreach efforts.
12) Sites use the MIS and informal methods, such as discussions with staff and others involved in program services, to track and analyze, at least annually, the length of time families remain in services to identify patterns and trends associated with families dropping out of services, and develop strategies for improving retention. Programs use the Annual Service Review to discuss strategies for increasing retention rates based on its analysis of programmatic, demographic, social and other factors that appear to impact retention of families for at least one year.
13) New sites without 2 full years of home visiting data will complete an annual measurement of retention based on 6-month retention data.

MIS References:

Accreditation/3-3.B Use of Creative Outreach
Accreditation/3-4.A and B Retention Rate Analysis
Analysis/Program Synopsis
Lists/Supervisor case list

Appendix:
Creative Outreach Activities/Checklist

Insert site-specific procedures that include:

1. A description of the circumstances under which a family is provided creative outreach:
    a. Pre-engagement creative outreach
    b. Creative outreach after the family has enrolled in the program
2. A description of activities to be carried out during the course of creative outreach, and highlights the site's commitment to individualized, family-centered practice and the home visitor's genuine interest in the family throughout the creative outreach period.
3. That creative outreach practices will not include ultimatums or threatening language to persuade families to engage or re-engage in services.
4. That creative outreach to re-engage a family is continued for a minimum of three months, and is concluded prior to three months only if the family has re-engaged in services, has moved from the service area, or has explicitly refused services.
5. Site-specific policies and practices for Level X when a family plans to leave the area for a period of time and intends to return to complete the program.
6. That creative outreach to families prior to enrollment is generally concluded after 30-45 days of efforts to engage the family.
7. Other allowable reasons for ending services (e.g., parent no longer has custody, pregnancy ended in miscarriage, target child or primary care provider is deceased, significant staff safety issues, transferred to another program, etc.).
8. The site's definition of retention, and its plan and time frames for reviewing and analyzing creative outreach efforts and Level X, and developing strategies for improving overall acceptance and retention.

Section B: Service Content
Critical Elements 4-7

Critical Element #4 Services are offered regularly and have well-defined criteria for decreasing services over time. Services are offered long term – 3 to 5 years.

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

INTENSIVE HOME VISITING
HFA Best Practice Standard 4-1.A

POLICY: Families are offered weekly home visiting services for a minimum six months (calculated in MIS as 183 days) after the birth of the baby or after enrollment, whichever is longer, excluding any time on Level X.

Intent: The first 6 months after a baby is born is a critical period for home visiting: The parent-child relationship is developing, newborn care and safety can be addressed, and parents are adjusting to their new role. Weekly visits during this time are essential for providing the greatest opportunity to address these topics, and at a time when the parents are most open to information and support. HFNY does not enroll families after the baby has reached three months of age (calculated in MIS as 92 days).

1. At least 90% of families on Level 1 receive home visits every seven days for at least 183 days after the birth of the baby if enrolled prenatally, and 183 after enrollment if enrolled postnatally.
2. HFNY Performance Indicators set the standard for enrollment prior to 92 days after the baby's birth.
3. HFNY Performance Indicators set the standard that at least 95% of families enroll prior to the child being 92 days.
4. On rare occasions, sites may want to enroll a family where the child is > 3 months. Sites must contact their Program Contract Manager at OCFS to request permission and these decisions are handled on a case-by-case basis.

MIS References:

Intensive Home Visitation Level after Target Child is Born
Level Change History Report
Case Home Page: Basic Information tab

Appendix:

None

Insert site-specific procedures that include:

1. The requirement that families are offered weekly home visit for a minimum of six months (calculated in MIS as 183 days) after the birth of the baby or date of enrollment, whichever is longer, excluding any time the family was on Level X
2. The requirement that at least 90% families receive the most intensive rate of home visits 183 days after the birth of the baby, or after enrollment, whichever is longer.
3. The requirement that families are enrolled only prior to the baby reaching three months of age (calculated in MIS as 92 days).

LEVELING CRITERIA
HFA Best Practice Standard 4-2.A

POLICY: The intensity of services is based on clearly defined levels of service and criteria for moving from one level of service to another.

Intent: A well-thought out system for determining service intensity is sensitive to the needs of each family, the changes in family needs and competencies over time, and the responsibilities of the home visitor. Families with higher needs receive more intensive services, while less intensive services are provided as family stability and progress increases. A level system also provides sites with a mechanism to monitor home visitors' caseload capacity more effectively, thus promoting higher quality services and staff retention. Home visitors and supervisors should share an understanding of the level system and the criteria for movement within it, and partner to ensure families receive the most appropriate level of support and intensity of home visits.

HFNY Performance Indicators set the standard for home visit completion rates of at least 75%, and that 75% of visits occur in the families' homes. Home visits typically last 60 minutes. A visit of at least 30 minutes can be logged and contribute to home visit completion rate only with the approval of the supervisor. Approval is based on home visit content and pertinent family circumstances.

HFNY Level System

Level	Case weight	Visits expected
1-Prenatal	2	1 visit every 14 days
1	2	1 visit every 7 days
1SS	3	1+ visits every 7 days
2	1	1 visit every 14 days
3	.5	1 visit every 28 days
4	.25	1 visit every 84 days
X	.5 – 2[1]	1 visit every 7-28 days[2]

Sites use level change forms which detail expectations for parent progress that indicate movement from one level to another, and the objective criteria for change to a different level. In general, these expectations include:

- Quality of responsive, nurturing parenting practices
- Engaging in child development activities with their children
- Providing a stimulating and safe home environment
- Negative depression screen or linked to appropriate mental health services

[1] Sites are encouraged to maintain a family's case weight while on Level X that is equal to the weight of their level prior to being placed on creative outreach to ensure space is retained to move family back to that level if re-engaged.
[2] Attempting visits is strongly encouraged, but Level X visits are not included in calculation of home visit rate.

- Working to accomplish individual/family goals
- Managing stress effectively
- Using nurturing and respectful discipline methods

HFNY State System expectations:

1. Families on Level 1-Prenatal, receive a visit every 14 days until the birth of the baby, however it is good practice to increase the visits to every 7 days in the third trimester.
2. Families experiencing temporary periods of intense crisis, and requiring a higher level of service and greater intensity of visits than one every seven days may be placed on Level 1 Special Services (SS). It is recommended that families be moved to Level 1SS only from Level 1. If they are on a level with less intensive home visiting, home visitors and supervisors discuss moving the family to Level 1 first, if appropriate, then to Level 1SS if it becomes clear that they need more than one visit every seven days, and/or the home visitor must devote a great deal more time to supporting or advocating for the family.
3. The time spent on Level 1SS should be less than 3 months. There may be situations in which Level 1SS extends beyond 3 months, such as multiple births or parental developmental disabilities. This requires the approval of the site's OCFS PCM.
4. Families moved to Level X from Level 1 return to Level 1 once they are re-engaged, and continue receiving a home visit every seven days until a minimum of six months (calculated in MIS as 183 days) on Level 1 has been completed. Families moved to Level X from any other level are returned to their previous level or a more intensive one, based on criteria for level assignment.
5. All level changes include discussion with the family regarding their evolving circumstances and any changes in visit frequency.
6. The supervisor and the home visitor formalize all level changes during regular supervision.
7. Sites monitor and analyze home visit rates on a monthly basis, and include the analysis and plans for improvement in their Quarterly Reports and Annual Service Reviews. These outcomes are discussed regularly in supervision in an effort to identify areas for professional development and strategize to provide the most effective support to families.

MIS References:

Supervisor Case List
FSW Case List
Program Caseload Summary
Home Visiting Completion Rate Analysis - Detail and Summary
Family Support Worker Home Visit Record - Detail and Summary

Case Home Page, Basic Info tab

Appendix:

HFNY Sample Level Change Criteria Forms

Insert site-specific policies and procedures that include:

1. A description of service levels and the criteria for moving families from one level to another.
2. Reference to level change forms with specific criteria for each level.
3. A description of the process and frequency for monitoring, analyzing, and addressing home visit completion rates, rate of in-home visits, and length of visits.

NOTE: 4-2.B is a SENTINAL STANDARD

PROCESS FOR LEVEL CHANGES
HFA Best Practice Standard 4-2.D

POLICY: The family, home visitor, and supervisor review family movement to a new service level.

Intent: It is important to ensure that families, home visitors, and supervisors are all involved in partnership to make level-change decisions. Supervisors and home visitors have conversations about potential level changes during routine supervisory sessions when family progress is discussed, and home visitors and families have conversations about family progress and any formal change that might be made to home visit frequency during home visits. Those conversations are documented in supervision notes and on the Home Visit Narrative. Sites ensure that decisions regarding level change are inclusive of all three parties - though not all must be present at the same time - and that level changes are not made according to arbitrary minimum time requirements, but reflect a shared perception of the families' real circumstances and progress.

1. During home visits, the home visitor and family discuss the family's achievements, their visit schedule, family circumstances, and readiness for a change in frequency of home visits. The family's receptiveness or resistance to the proposed level change is documented in the Home Visit Narrative.
2. Based on the Criteria for Level Change Form and discussion with the family, the home visitor and supervisor routinely review the family's progress towards meeting criteria for a level change to make a determination about each family's potential service level change. These discussions are documented in the supervision notes.
3. When a level change is made, it is documented on the Criteria for Level Change Form and on the Monthly Caseload Report.

MIS References:

HFNY Change Form
Home Visit Log
Home Visit Narrative
Supervisor Case List
FSW Case List

Appendix:

Criteria for Level Change Forms

Insert site-specific procedures that include:
1. The process for review of progress made towards meeting the criteria for a level change.

2. A description of how the home visitor, family and supervisor are involved in making the decision for moving from one level to another.

DURATION OF SERVICES
HFA Best Practice Standard 4-3.A

POLICY: Intensive home visiting services are offered to families for a minimum of three years after the birth of the baby.

1. HFA services are offered to families at least until the target child reaches three years of age, and up to age five, as needed.
2. All materials indicate that services are provided prenatally through age three.
3. The family rights handout used by the site, and sites' procedures ensure that families are made aware at the time of enrollment that services are provided through age three.

MIS References:

Participant in Program for at Least 3 Years as of Today

Appendix:

Criteria for Level Change Form

Insert site-specific procedures that include:

1. A description of the time frame for offering services to families, which must be prenatally until at least three years after the birth of the baby.
2. A discussion of the site's capacity to provide services through age five, relative to other services in the community, for families with children age three to five.

NOTE: 4-3.B. is a SENTINEL STANDARD

SERVICE CLOSURE AND TRANSITION PLANNING
HFA Best Practice Standard 4-4.A

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

Intent: As a family prepares to end services, efforts and time to plan for a smooth and successful transition should involve the family, the home visitor, and the supervisor. While the decision to develop a transition plan is based on the wishes of the family - the family may decline - sites are expected to be strongly proactive in transition planning. The site takes the initiative to explore suitable resources, contacts service providers, if the family has given their written consent, and follows-up on the transition plan.

1. Six months before completion of the program or when the family indicates they are planning to move from the service area or leave the program for any reason, the home visitor initiates formal transition planning by discussing ongoing goals the family has for their child and their family.
2. Special care should be taken with transition planning when the family ends their engagement in the program due to loss, i.e. death of the parents, loss of pregnancy, loss of target child, etc.
3. Whenever possible, a transition plan should be made with families leaving the program at the end of creative outreach efforts.
4. The home visitor and supervisor review and discuss the transition plan developed by the home visitor and the family in the context of progress the family has made while in the program, and this discussion, as well as the discharge plan, is documented by the home visitor and the supervisor.
5. The home visitor assists the family in identifying other services available to them in the community. This might include Head Start, childcare, or other community-based early childhood education program, or another HFA site, if the family is moving, and makes referrals as needed.
6. The home visitor and family update the Family Goal Plan to incorporate any additional family goals generated by the transition. The home visitor and the family revisit the transition plan when the family's departure from the program becomes imminent, and make contact with any new service providers.
7. Prior to closure, the home visitor follows-up on all referrals that have been made to determine availability of services and to assist with successful transition.
8. Whenever possible, the site conducts a family exit interview
9. The PSI is administered at discharge whenever possible
10. The Follow-Up Form is completed at discharge

MIS References:

None

Appendix:

Transition Planning/Discharge Form

Insert site-specific procedures that include:

1. The time frame for beginning transition planning, whether the family is graduating, moving from the target area, or planning to leave the program for any reason.
2. Procedures that ensure that the family, the home visitor, and the supervisor are involved in transition planning, though not required to be present at the same time.
3. Procedures for transition planning when the family is leaving the program as a result of loss of parent(s), pregnancy, or child.
4. That other collaborative service partners in the community will be notified that services are desired, with the family's written consent.•
5. The expectation that resources or services needed or desired by the family will be identified in a timely manner.
6. The steps that will be followed to obtain any resources or services that have been identified.
7. The expectation that the home visitor will follow-up on referrals prior to closure to determine availability of services, and to assist with successful transition.
8. How all steps in the transition planning process will be documented

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Critical Element #5 Services are culturally sensitive. Staff, and materials used by the program and sites, reflect the diversity of the population served.
Intent: HFNY works to ensure that sites are providing services that are culturally sensitive to each family's unique characteristics. For services to be effective it is imperative that cultural context is incorporated into program design and delivery.

Successful home visiting programs provide culturally sensitive services so that new skills and ideas being shared with families are respectful of each family's values and beliefs. Providing culturally sensitive services requires that knowledge of diversity be applied to policy and practice. Valuing diversity allows home visitors to establish strong relationships with families that are founded on mutual respect and understanding, and enhances the opportunity for providers and families to work together.

Families vary in many ways, so it is important that home visitors, and programs as a whole, understand differences among them. Diversity takes many forms: Cultural, linguistic, racial, religious, geographic, sexual orientation, and ethnic, for example. Family needs, beliefs about healthcare, coping mechanisms, and child-rearing practices vary by population; services need to reflect these variations.

While aspects of culture may be shared between families, each family is unique, and has its own definition of "family." When home visitors are non-judgmental and express curiosity, families have an opportunity to reflect and share, thus providing home visitors with greater opportunities to understand what is important to them.

MIS References:
Program Demographics
Culturally Sensitive Practices

Appendix:
Guidelines for Annual Service Review

Insert site-specific procedures that include:
1. A description of the cultural characteristics of the site's service population that includes numeric data and narrative detail.
2. A description of procedures that ensure that ethnic, racial, linguistic, demographic, and other cultural characteristics are identified by the site and inform all aspects of program and practice.
3. A description of procedures that ensure that staff receives annual training designed to increase understanding of and sensitivity to the unique characteristics of the service population.
4. A description of completing a Cultural Sensitivity Review every year. The review addresses program materials, and the training and service delivery

system, and integrates input on the program's cultural sensitivity obtained from families and staff.

5. A description of how the Cultural Sensitivity Review is used to assess services and contributes to planning for optimal cultural sensitivity throughout the program.

6. A description of how the Cultural Sensitivity Review is included in the Annual Service Review, and how it is shared with the site's Advisory Group to increase culturally sensitive practices.

Critical Element #6 Services should focus on supporting parents, promoting a healthy parent-child relationship and assuring healthy childhood development.

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

HFNY employs an Infant Mental Health (IMH) approach in which services are relationship-based, strength-based, and culturally sensitive, and informed by the Parallel Process. Home visitors develop an alliance with parents to help parents respond sensitively and in a nurturing manner with their young children.

REVIEWING AND ADDRESSING RISKS AND STRESSORS FROM THE ASSESSMENT

HFA Best Practice Standard 6-1.A

POLICY: Home visitors and supervisors review the risk factors and stressors identified by the Parent Survey Assessment, and address these issues during the course of services.

Intent: Supervisors and home visitors refer to the Parent Survey Assessment throughout the course of services to identify how the issues that place families at-risk for poor childhood outcomes are addressed over time, and how Protective Factors have contributed to mitigating risk. Supervision discussions are thoughtful and purposeful, and assist the home visitor to understand how early childhood trauma and the stressors experienced by the family impact parenting.

1. The supervisor and home visitor review the Parent Survey Assessment together at the beginning of services, identifying risk factors and potential stressors for the family, as well as Protective Factors.
2. The supervisor and home visitor develop and document a plan of activities to address each of the risk factors or stressors identified, and how Protective Factors can be acknowledged and employed.
3. The home visitor and family discuss the risk factors and stressors, and use activities from the plan to reduce them and build on the strengths of the family. These discussions continue throughout the course of service, and are documented in the Home Visit Narrative.
4. During supervision sessions, the supervisor and home visitor routinely review the activities that have been implemented, discuss the readiness of the family to address issues, reflect on the success of the activities, and discuss next steps. These discussions are documented in the HFNY Supervision Note.

5. Progress on reducing risk factors and stressors is discussed and celebrated on an ongoing basis with the family, and documented in the Home Visit Narrative.

MIS References:

None

Appendix:

HFNY Supervision Note

Insert site-specific procedures that include:

1. How the supervisor and home visitor work together to:
   a. Review each family's risk factors and stressors that are identified in the Parent Survey Assessment.
   b. Plan activities and strategies to address each of these factors, including the time frame for doing so, and the Protective Factors (i.e. strengths that are identified during the assessment process) that will contribute to the plan.
2. How the home visitor will engage the family in a collaborative relationship to implement the planned activities and strategies to reduce risk during home visits, both initially and throughout the course of services, and celebrate progress with the family.

FAMILY GOAL PLAN
HFA Best Practice Standard 6-2.A

POLICY: Home visitors and families work together to develop a Family Goal Plan.

Intent: Goal setting is designed to be a collaborative process between parents and the home visitor. Supervisors support the development and completion of goals by helping home visitors identify and resolve barriers families may be experiencing, and acknowledging progress they have made. The process of developing goals is an essential part of HFNY's Infant Mental Health approach. Supporting parents in achieving success changes the way they view the world, increases a sense of self-efficacy, enhances internal motivation, and builds Protective Factors.

A family's ability to develop and achieve goals can be life altering. The process is more important than the product, which means that the role of the home visitor and the supervisor in the goal setting and achievement process is critical to family success.

1. The home visitor employs a collaborative and strengths-based approach to creating the initial Family Goal Plan. This requires engaging the family in the process, and may include information gathered during the assessment process and other screening tools.
2. In addition to developing achievable family goals, the home visitor and family work together to develop detailed action steps for achieving the goals, building upon strengths and successes, as well as realistic timelines for completion.
3. The first Family Goal Plan process is completed within 45 days of enrollment. Subsequent plans are developed after the birth of the baby, if the initial plan was created prenatally, and at least twice per year until the family leaves or graduates from the program.
4. The Family Goal Plan is used to help determine home visit activities and identify resources for the family.
5. Every Family Goal Plan has at least one goal.
6. The Family Goal Plan is a "living document," i.e. it is expected that it will not remain static, but evolve and change along with the family. It is reviewed with the family during visits and with the supervisor during supervision on an ongoing basis. Review includes discussing progress on goals, identifying strengths and barriers, addressing any family concerns, and celebrating successes.
7. The home visitor works with the family to modify goals as needed, to retire goals that the family is no longer interested in pursuing, and to update the Family Goal Plan with new goals as goals are accomplished. There should always be a goal that families are actively working on, and that the home visitor is supporting.

MIS References:

None

Appendix:

None

Insert site-specific procedures that include:

1. The time frames and processes for developing, reviewing, and updating the Family Goal Plan that includes collaboration between the family and the home visitor, and the home visitor and supervisor.
2. The strategies and tools that ensure that the goals that are developed are meaningful to the family.
3. Tools and processes to be used to identify strengths and Protective Factors that support goal development.
4. How the Family Goal Plan process is supported in supervision.
5. How the Family Goal Plan is used to inform home visit activities and resources offered to families.
6. How achievement of goals is acknowledged and celebrated with families.

CHEERS: ASSESSING PARENT-CHILD INTERACTION
HFA Best Practice Standard 6-3.A

POLICY: Home visitors assess, address, and promote positive parent-child interaction, attachment, and bonding using CHEERS.

Intent: The promotion of parent-child relationships is a primary HFA and HFNY goal.

Many parents 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 use reasoning until their own basic needs for safety and trust are met. Home visitors are trained to use an Infant Mental Health approach, which supports building a partnership with parents, providing a platform for exploring parent-child interaction together. It is expected that the parent-child relationship is observed during each visit where the parent and child are both present using CHEERS as the framework for observations, and these observations are documented, discussed in supervision, and used in planning subsequent visits and other services.

1. During each home visit the home visitor observes parent child interaction using CHEERS, and uses the observations to identify areas of strength and concern.
2. The home visitor consistently uses teachable moments to reinforce the parents' positive interactions and address concerns, promote nurturing relationship skills, and provide coaching and redirection.
3. All observations are documented on the Home Visit Narrative using CHEERS at each home visit. Documentation is objective and behaviorally specific, and includes what went well as well as any concerns observed during parent child interactions.
4. The home visitor supports positive interactions between parent and child by using the HFA Reflective Strategies and curriculum, and helps parents practice skill building activities during home visits. At least one ATP will be documented in the HV log/narrative.
5. The home visitor and supervisor discuss parent-child relationships and parent-child interactions during supervision, and develop plans to address any needs or concerns, based on the observations of the home visitor.

MIS References:
Home Visit Narrative

Appendix:
None

Insert site-specific procedures that include:

1. How home visitors will use CHEERS to assess parent-child relationships on all home visits where interaction is observed.
2. How home visitors will document parent-child interactions observed during home visits, including a commitment to objectivity and using specific examples observed.
3. How supervisors will work with home visitors to develop plans for increasing positive parent-child interactions.
4. How strength-based intervention tools, i.e. the HFA Reflective Strategies, will be used to promote positive parent-child interactions.
5. How curriculum will be used to promote parent-child interaction, how it will be selected, and how often it will be used.
6. How home visitors will address any needs or concerns regarding the parent-child relationship and interactions.

NOTE: 6-3.B and 6-3.C are SENTINEL STANDARDS

PROMOTING CHILD DEVELOPMENT, PARENTING SKILLS, AND HEALTH AND SAFETY
HFA Best Practice Standard 6-4.A

POLICY: HFNY promotes child development, parenting skills, and health and safety practices with families

Intent: Home visitors observe family interactions, build skills, and share information on 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, and weaning, 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. Whenever possible, home visitors are encouraged to organize child development information into activities in which the parent is encouraged to play with the child. Home visitors are encouraged to take advantage of "teachable moments" to share appropriate information with families when it is most meaningful.

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, SIDS, "shaken baby" strategies, baby-proofing, feeding and nutrition, selection of child care providers or alternative caretakers, in addition to any other safety issues. It is expected that home visitors will address any health or safety concerns that could be detrimental to parents and their children. Additionally, home visitors support the development of a healthy and stimulating home environment.

It is important that the home visitor 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 is highly recommended.

Curriculum should always be culturally sensitive and supported by research. Curriculum should not become the primary focus of each home visit, but 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.

Curricula must contain:

- 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 share this in a strength-based manner.
- Content that is developmental in nature
- Strategies that strengthen families and their relationships
- Health and safety information

1. The Ages and Stages Questionnaire (ASQ) and ASQ-Social/Emotional (SE) are used to monitor child development status and as a teaching tool with parents to build knowledge and promote appropriate developmental expectations.
2. Child development and parenting skills are also promoted through the use of evidence-informed curriculum during every home visit.
3. Sharing health and safety information that addresses prevention strategies as well as areas of concern observed in the home.
4. All curriculum and handouts provided, and the family's response, are documented on the Home Visit Narrative.
5. Additional checklists, handouts and brochures that promote positive parent child interaction, knowledge of child development and health and safety practices, and that have been approved by the site, are used to supplement the use of curriculum.

MIS References:

None

Appendix:

None

Insert site-specific procedures that include:

1. How staff promote child development, including any curricula and/or tools to be used and the frequency for sharing this information
2. How staff promote parenting skills, including any curricula and/or tools to be used and the frequency for sharing this information
3. How staff promote health and safety related practices, including any curricula and/or tools to be used and the frequency for sharing this information

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USE OF EVIDENCE-BASED CURRICULUM
HFA Best Practice Standard 6-5.A

POLICY: Home visitors use HFNY-approved, evidence-informed, primary curricula during each home visit.

Intent: Curriculum materials are to be used in conjunction with teachable moments and parental interest, and shared with parents using a strength-based approach building on parental capacity. The curriculum helps home visitors 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 that the home visitor 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 them what they have noticed about their baby's development before teaching specific lessons or modules is highly recommended.

Curriculum should always be culturally sensitive, including being matched to the parents' literacy level, and supported by research. Curriculum represents just one piece of a comprehensive approach to working with families. The primary focus of each visit should be 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 relationship dynamics.

Curricula should include:

- Information on how to promote a nurturing parent-child relationship, be anchored in the baby's current and future development, build parental self-esteem, and encourage parents to have fun playing with their baby.
- Child development information across all developmental domains, and incorporate the use of developmental screens.
- Strategies that strengthen families and build relationships
- Health and safety information
- Guidance for planning and implementation, and materials for the family

The following is approved by HFNY for use by sites as primary curriculum:

- **Partners for a Healthy Baby** Florida State University Center for Prevention and Early Intervention Policy
- **Parents as Teachers** Parents as Teachers National Center, Inc.
- **Healthy Families: San Angelo Curriculum** Healthy Families San Angelo
- **Growing Great Kids** Great Kids, Inc.

The following is approved by HFNY for use by sites as supplementary curriculum:

- Partners for Learning Curriculum and Activity Cards Kaplan Press
- Helping Babies Learn: Developmental Profiles and Activities for Infants and Toddlers Setsu Furono, et. al.

1. Curriculum is used with all families to promote positive parent child interactions, healthy child development, and health and safety practices. It is expected that the curriculum is used at all home visits unless an assessment or another resource is being completed or discussed.
2. The home visitor uses information gathered from assessments, goals in the Family Goal Plan, and the developmental stage of the child to determine what material to cover with curriculum, and curriculum is used throughout the course of services.
3. The home visitor engages the parents in reviewing the information from the curriculum, using the handouts and activities recommended by the curriculum. The home visitor leaves handouts with the family.
4. All curriculum material used, and the parents' response to it, is documented on the Home Visit Narrative.
5. Additional checklists, handouts and brochures that promote positive parent child interaction, knowledge of child development and health and safety practices, and are approved by the site, are used to supplement curriculum.
6. All home visitors receive orientation to the use of curriculum and ongoing support in supervision.

MIS References:

None

Appendix:

None

Insert site-specific procedures that include:

1. Identifying the evidence-informed curriculum/parenting materials to be used.
2. Describing how and when the curriculum is to be used with the family, including how cultural sensitivity, literacy level, and learning style are considered when selecting and using curriculum.
3. A description of orientation training requirements for the use of the curriculum, when training is to be received, and how the training requirements will be met.

DEVELOPMENTAL SCREENING
HFA Best Practice Standard 6-6.A

POLICY: HFNY monitors the development of participating infants and children with the Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire SE, which are standardized developmental screens.

Intent: The ASQ and ASQ-SE screening tools are used as a means of partnering with parents in observing their child's development and to see the significance of their role in supporting that development, and to determine the need for further assessment, typically an in-depth developmental assessment by Early Intervention.

1. Home visitors use the standardized child development screening tool, Ages and Stages Questionnaire (ASQ) for all target children, unless developmentally inappropriate.
2. Developmental screens are administered within a 30-day window on either side of the test interval, and the screening schedule is revised based on prematurity
3. If the child is receiving developmental assessment through Early Intervention staff is not required to complete the ASQ during that time. Staff should coordinate services and obtain updates from Early Intervention, with signed parental consent.
4. The ASQ is required to be administered at 4, 8, 12, 18, 24, 30, 36, and 48 months, based on the age of the child.
5. The ASQ-SE is required to be administered at 6, 12, 18, 24, 30, 36, and 48 months, based on the age of the child.
6. The ASQ is used, in partnership with parents, during the home visit, and is administered in accordance with tool instructions to ensure accuracy, including adjusting for prematurity when needed and allowing no more than a 30-day window on either side of the administration due date.
7. A child development specialist reviews all ASQs and ASQ-SEs.
8. All administration dates and scores are entered into MIS to monitor completion for all target children, and to help track referral to Early Intervention when indicated by scores that fall below cut-off in any domain.
9. Staff must be trained before administering developmental screens, and training should include the critical function behind each of the developmental questions.

MIS References:
None

Appendix:
None

Insert site-specific procedures that include:

1. That the Ages and Stages Questionnaire and ASQ-SE are the developmental screening tools used.
2. That all target children are screened for development, and the special circumstances under which screens are not done.
3. The time frames for administration of the developmental screening tools
4. A description of how the tools are to be used with parents in home visits, unless developmentally inappropriate.
5. How staff is trained to administer the tools, and that training takes place prior to using the tools with families.
6. Protocol for the review of ASQs and ASQ-SEs by a child development specialist.

NOTE: 6-6.B is a SENTINEL STANDARD

TRACKING DEVELOPMENTAL DELAYS
HFA Best Practice Standard 6-7.A

POLICY: HFNY tracks child development, and follows up on all children who are suspected of having a developmental delay.

Intent: It is central to the goals of HFNY that child development is observed and monitored, and that any indications of delay are discussed with parents, and parents are supported in accessing more in-depth assessment from the child's primary care provider or Early Intervention. Follow-up on referrals is a significant support to parents and is, therefore, expected and tracked. Ensuring families' access to services is a team effort, so the program manager and supervisor should be aware of any challenges with referral sources for early intervention services, and assist by advocating with referral entities/partners to reduce these barriers.

1. The completed ASQ and ASQ-SE Summary Sheets indicate whether the child appears to be developing on target, or has any potential developmental delays.
2. In the event an ASQ or ASQ-SE indicates a possible delay in one or more developmental areas, the home visitor discusses the results with the parent and the supervisor. If deemed appropriate, the home visitor facilitates a referral to Early Intervention and/or the child's primary care physician, with parents' signed consent, unless the family declines the service.
3. Concerns about developmental delays are communicated and discussed during supervision between home visitor and supervisor. The supervisor ensures necessary follow-up, and that the home visitor is providing appropriate resources to the family.
4. The home visitor communicates with Early Intervention and/or the child's primary care physician, with parents' signed consent, regarding services being provided and how to best support the family with those services, and this communication is documented in HFNY Case Notes and HFNY Supervision Notes.
5. The supervisor ensures that all children with a suspected developmental delay are closely monitored and tracked. The tracking form documents referrals, follow-up, and the utilization of developmental resources, services and intervention.

MIS References:
HFNY Case Note

Appendix:
HFNY Supervision Note

Insert site-specific procedures that include:

1. A description of the process for follow-up when there is a suspected developmental delay.
2. Guidelines for identifying when to make a referral, the referral resource to be used, and how to make a referral.
3. A description of how referrals will be followed-up.
4. A description of how staff are to collaborate with families and service providers in the process of the family's receipt of services in a way that supports the family..

NOTE: 6-7.B is a SENTINEL STANDARD

THE FOLLOWING PARENTAL STRESS INDEX POLICY IS A HFNY SPECIFIC POLICY. It is not a requirement of the Critical Elements or Best Practice Standards; however, it is a required screening tool in HFNY.

PARENTING STRESS INDEX (PSI)

POLICY: HFNY sites use the Parenting Stress Index (PSI) in order to identify and assess the stress that parents experience in their role, and to inform planning services that attend to parental stress. This policy is HFNY-specific, and not mandated by the HFA Best Practice Standards.

The PSI is copyright protected and each copy is purchased by the Center for Human Services Research (CHSR). The PSI is administered to primary caretaker one (PC1). The program may administer the tool to the child's other parent or to a significant other, however the MIS only requires completion of the tool for the PC1.

Each PSI is answered with the target child in mind. For multiple births, the parent identifies one target child for the initial PSI, and continues to contemplate the same child for all subsequent PSIs. In order to ensure the most accurate reflection of the parent's feelings, the PSI is completed during one home visit, in the presence of the home visitor, who encourages parents to answer all questions openly and honestly, without fear of being judged or criticized.

Sites develop protocols for discussing the PSI. Typically, if the score does not warrant immediate attention, the home visitor and supervisor discuss the results during weekly supervision, and review the results with the family in a supportive, non-judgmental manner within two weeks of administration. If any domain or total stress is outside the normal range, appropriate referrals or resources are offered within 3 days. If it is determined that the family is in need of referral and resources but does not accept such service, the FSW works with his/her supervisor to explore how to proceed. The FSW documents that the family did not accept the referral in the participant record and on the service referral form.

The first PSI is administered within one month of the target child's date of birth. If intake is post-natal, the PSI is administered within one month of intake. Subsequent PSIs are administered according to the target child's age, at 6 months, 1 year, 2 years, 3 years, 4 years, and 5 years, and at discharge from the program.

Staff is trained to administer the PSI before administering it to families. Administration is planned according to the schedule, above. If the time window (30 days before the due date and 30 days after the due date) is missed, home visitors administer the PSI anyway, and as soon as possible. PSI results are included in supervision discussions, and documented accordingly.

Data from and analysis of PSI results in the program are included in sites' Quarterly Reports.

PSI Referral Criteria	
Defensive Responding	A Defensive Responding score of 10 or less indicates that the individual may be responding in a defensive manner, and caution should be exercised in interpreting the remainder of the scores.
Parental Distress Domain (PD)	When the PD scale is the highest among the three subscales it is recommended that further exploration be conducted. There may be signs or indications of the presence of depression, lack of social support, conflict with the child's other parent, etc. Appropriate referrals like parenting classes and parental support groups designed for helping to improve the parent's self-esteem and sense of parental competence are recommended.
Parental-Child Dysfunctional Interaction Domain (PCDI)	High scores in the PCDI may indicate an impaired relationship between the parent and child (i.e. child does not meet parent's expectations). Very high scores suggest potential for child physical abuse and neglect. Intensive services and support (i.e. preventive services and Level 1-SS, etc.) are recommended. Prompt intervention and additional assessment is required in these cases.
Difficult Child Domain (DC)	High scores in the DC often indicate a need for professional assistance. If the DC domain is above the 90th percentile and the other two domains are below the 75th, then a referral for parent education with a focus on behavioral management should help the situation.
Total Stress	The Total Stress Score provides an indication of the overall level of parenting stress an individual is experiencing. It reflects the stresses reported in the areas of personal parental distress, stresses derived from the parent-child interaction and the stresses that result from the child behavioral characteristics. It does not include stresses associated with other life roles and life events. A Total Stress score above a raw score of 90 (at or above the 90th percentile) indicates significant levels of stress. Individuals scoring above this level should be referred for closer diagnostic evaluation and professional assistance.

MIS References:

None

Appendix:

None

Insert site-specific procedures that include:

1. That the Parenting Stress Index is the tool used to assess and respond to parental stress.
2. Who is screened for parental stress.
3. The time frames for administration of the PSI
4. A description of how the PSI is introduced and administered to parents.
5. How staff is trained to administer the PSI, and that training takes place prior to using the tools with families.
6. How scores that indicate high parental stress are used to plan services and referrals to support parents.
7. How supervisors support home visitors in the administration of and use of results from the PSI, including protocols for follow-up.
8. How home visitors and supervisors document the work with the PSI.
9. How results of the PSI are tracked and analyzed by the site.

Critical Element #7 Families are linked to community programs and resources that can address their needs.
Intent: The overall intent of the standards in this section is to ensure that families are linked to providers for preventative health care and timely receipt of immunizations, and appropriately referred to additional community services based on each family's unique needs. Encouraging parents to access a variety of community resources is an essential part of our work, and empowering families to take action and advocate on behalf of themselves and their children in incremental steps based on parental capacity is critically important, and requires staff to strike a delicate balance between doing too little and doing too much for families.

LINKAGE TO MEDICAL PROVIDERS
HFA Best Practice Standard 7-1.A

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

Intent: It is important for each target child to have a medical home and caregivers that practice preventative health care for their child. Through sites' partnerships with primary health care providers, site staff can help parents to access routine well-child care, sick-child care, and specialty care, when needed.

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

MIS References:
TC Medical Form

Appendix:
None

Insert site-specific procedures that include:

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

IMMUNIZATION
HFA Best Practice Standard 7-2.A

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

Intent: While the US currently has record low cases of vaccine-preventable diseases, the viruses and bacteria that cause them still exist. According to the American Academy of Pediatrics, vaccines prevent disease in the people who receive them and protect those who come into contact with unvaccinated individuals (aap.org). Some children may be ill or have other reasons preventing them from receiving immunizations according the identified immunization schedule. Therefore, children may not necessarily receive their immunizations on time; however, it is essential to keep them up-to-date.

1. Home visitors provide information to parents regarding the importance of immunizations and encourage timely receipt of immunizations according to the immunization schedule recommended by the American Academy of Pediatrics.
2. Home visitors print and provide to parents the schedule of immunizations from the CDC individualized scheduler at http://www2a.cdc.gov/nip/kidstuff/newscheduler_le/.
3. Home visitors document all scheduled immunizations and well-baby care visits on the TC Medical Form in the MIS.
4. When immunizations are missed, home visitors record the explanation on the Home Visit Narrative and work with parents to reschedule and address any barriers to obtaining care.
5. Home visitors document the target child's health care provider on the Target Child Identification and Birth Outcomes form in the MIS, and after that, on the Follow-Up form. Programs also document the current medical provider for the Primary Caretaker 1 on the Intake form and after that, on the Follow-Up form. There is no need to wait for a Follow-up form to be due when a family has a new doctor. This change can be documented on the Change Form and on the Medical Provider tab of the Case Home Page in the MIS.
6. Programs are required to report on Primary Care Taker 1 and Target Child having a medical provider, a HFNY Performance Target, on a quarterly basis.

MIS References:

Quarter Performance Targets
Four Quarter Performance Targets
PC1/TC Medical Provider Listing

Appendix:

None

Insert site-specific procedures that include:

1. How information about immunizations is shared with parents
2. How immunizations are tracked
3. How home visitors work with parents when immunization appointments are missed

REFERRALS AND REFERRAL FOLLOW-UP
HFA Best Practice Standard 7-3.A

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

Intent: Sites are encouraged to provide information, referrals and linkages for all participating family members including the target child. Information could include smoking cessation support groups, free health clinics for adults, immunization clinics, flu shots, nutritional classes, dental care, and family planning, etc. Site staff needs to be knowledgeable of health care and other resources within the community, and be able to appropriately provide referrals and linkages to families. Families may be reluctant to access additional services, and home visitors are one way to bridge the gap.

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

MIS References:

Case Filter/Site Options

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

Appendix:

None

Insert site-specific procedures that include:

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

ADDRESSING CHALLENGING ISSUES: MENTAL HEALTH, SUBSTANCE ABUSE, INTIMATE PARTNER VIOLENCE, AND DEVELOPMENTAL DELAY OF PARENT
HFA Best Practice Standard 7-4.A

POLICY: Home visitors address challenging issues such as substance abuse, mental health challenges, intimate partner violence, and parents with developmental delay, using a strength-based empowerment approach to build Protective Factors.

Intent: Healthy Families sites serve many families who are struggling with challenging issues and multiple stressors such as poverty, inadequate housing, lack of education, and poor self-esteem. Home visitors can best address these challenges within a strong relationship built upon trust, honesty, mutual respect, and clear professional boundaries.

Home visitors are not counselors or therapists. Their most important role is to create the safe, accepting relationship within which to provide honest feedback and information, and assist parents in developing a vision of what they want. Staff should be trained and supported to use Motivational Interviewing (MI) tools and strategies, as MI is a key piece in building this kind of helping relationship.

In addressing challenging issues, protected, reflective supervision is critical in supporting the work of home visitors and preventing burnout. Due to the nature of these specific challenges, a safety manual containing information, guidance for practice, and response protocols is an important tool.

Home visitors work with families to build Protective Factors and reduce risks such as untreated disorders, unresolved trauma, and substance abuse. Information regarding these risks is gathered during the Parent Survey Assessment and throughout the course of service. Families may express needs and desires during home visits, and they may also come to light from maternal depression screens and the PSI, and during the development of the Family Goal Plan. Home visitors document these discussions on the Home Visit Narrative, and include them during supervision. At any time that staff find themselves in a situation where they feel they or someone else is in immediate danger, they are to follow the protocols for staff and family safety set forth in their site's policy manual Home visitors at all HFNY sites will use the following screening tools:PHQ-2 and PHQ-9 (depression)Parental Stress Index (stress)

1. HFNY sites that receive MIECHV funding will use the following additional screening tools
    - HOMES Inventory (parenting and home environment)
    - HITS (intimate partner violence)
2. Home visitors and their supervisors discuss all screening results and identify referral resources or services for further evaluation, as needed. Referrals are offered to the family, and home visitors work with families to overcome any barriers to accessing services.
3. Home visitors use Motivational Interviewing techniques and HFA reflective strategy, Problem Talk, as needed in encouraging the family to access services.
4. Home visitors encourage families to identify others (professionals and non-professionals) that will help and support them in times of crisis, during the course of treatment, and in the recovery process.
5. Developmentally delayed parents, or those suspected of having a developmental delay, are referred to community supports as needed. The supervisor and home visitor work together to adapt curriculum and home visiting activities based on the needs of the parents. This may include use of supplemental curriculum, adapting or repeating curriculum as needed, and identifying tools that assist with parenting.
6. HFNY Performance Targets require that when challenging issues such as substance abuse, mental health challenges, and intimate partner violence, are identified, referrals to services in the community are offered within six months of identification.

MIS References:

Parent Survey Pending Issues Report

Appendix:

None

Insert site-specific procedures that include:

1. Strategies home visitors use to build trusting relationships so they can address challenging issues.
2. Screening tools to be used to identify challenging issues, and how home visitors will be trained and supported to use them.
3. How home visitors are supported in supervision regarding their role in supporting families experiencing critical issues.
4. How home visitors make and follow-up on referrals to address challenging issues.
5. How the site attends to the safety of families and staff, including crisis response protocols

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DEPRESSION SCREENING
HFA Best Practice Standard 7-5.A

POLICY: Home visitors conduct depression screening with all families using the PHQ-2 and the PHQ-9, standardized instruments.

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

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

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

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

PHQ-9 scores are interpreted as follows:

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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

1. Home visitors conduct depression screening with all families to assess for risk of perinatal depression, in accordance with the tool developer guidelines, using the PHQ-2 and PHQ-9 Depression Screens.

2. The PHQ-2 is administered during the assessment process and is incorporated into the Parent Survey form. Screenings are documented on the Home Visit Narrative and in supervision notes.
3. The PHQ-9 is administered:
    a. Within 30 days of the first prenatal home visit (if serving the family prenatally), and documented on the Intake Form
    b. Within the first three months of the baby's birth for families enrolled post-natally, and documented on the Target Child Identification and Birth Outcomes form.
4. Additional depressions screening is administered:
    a. Any time during home visiting services if a parent is displaying or reports depressive behavior or symptoms. This includes fathers as determined necessary by the home visitor and supervisor.
    b. For each subsequent pregnancy and/or birth that a family has while receiving home visiting services is highly encouraged.
5. Families receive education on risks for, and signs and symptoms of perinatal depression during the course of home visits, and specifically when the PHQ-9 is administered.
6. If a participant's score on the PHQ-9 indicates depression, they are referred to mental health resources in the community (or provider of family's choice) for a follow up mental health assessment. If a participant scores 20 or above, the home visitor must consult immediately with the supervisor for emergency treatment referrals.
7. In the instances where the depression screening is done as a part of a collaborative process with other service providers involved with the family, the site must be in receipt of a copy to show that the screen was completed on time and to make and track any necessary follow-up referrals or interventions for the family.
8. The home visitor and supervisor discuss the results of depression screens and develop plans to assist the family as needed.
9. Home visitors promote stress reduction, and support parents to be responsive to their child's physical and emotional needs
10. Home visitors share community resource information with all families when they enroll in the program. For families at risk of depression, home visitors highlight community resources that specialize in depression, and encourage and assist families to access these resources. All families are given the suicide prevention hotline number, as well as contact information for mental health clinics.

MIS References:

Intake Form
TC ID

Appendix:

None

Insert site-specific procedures that include:

1. That the PHQ-9 is used to screen for depression
2. How the depression screening tool is to be used
3. When the depression screening tool is to be used
4. Community resources information for agencies and programs that provide services to address depression
5. Activities appropriate for home visitors to do with families to address stress and depression.
6. That staff is trained prior to administering the tool, and who administers the training.

NOTE: 7-5.B is a SENTINEL STANDARD

Section C: Governance and Administration
Critical Elements 8-GA

Critical Element #8 Services are provided by staff with limited caseloads to assure that adequate time is spent with each family.
Intent: The overall intent of the standards in this section is to ensure site staff has limited caseloads to allow them the necessary time with families to build trusting, nurturing relationships.

CASELOAD SIZE AT MOST INTENSIVE LEVEL OF SERVICE
HFA Best Practice Standard 8-1.A-B & 8-2.A

POLICY: Home visitors have limited caseloads, with a maximum of 15 families served at Level 1. The maximum caseload size is 25 families, and the maximum case weight is 30, with any combination of services levels, for full time home visitors. Supervisors monitor caseloads at least monthly.

Caseloads are limited to ensure that home visitors have sufficient time and resources to serve families most effectively. Sites may set lower caseload expectations and serve fewer families under special circumstances. Any decisions regarding case weights that are higher or lower than expected must be discussed with the OCFS program contract manager. These conversations should be documented in supervisor notes or team meeting notes, wherever most appropriate.

1. The supervisor and home visitor monitor caseload size during supervision.
2. A full time home visitor will have no more than 15 families at the most intensive level, and no more than 25 families at any combination of service levels.
3. The ideal caseload is no more than 20 families and case weight of 24.
4. The site will prorate caseload size based on the home visitor's full-time equivalency.
5. There may be temporary periods when case weights exceed maximum size (for example, a home visitor leaves the program and the caseload is dispersed among existing home visitors until another home visitor is hired). When this occurs, the reason is clearly documented and includes the amount of time that the case weights were out of adherence with this policy, and sites ensure that the time period does not exceed three months.
6. When making caseload assignments, the supervisor will take into consideration the following:
    a. Experience and skill level of the home visitor assigned
    b. Nature and difficulty of the problems encountered with families
    c. Work and time required to serve each family
    d. Number of families per service provider which involve more intensive intervention
    e. Travel and other non-direct service time required to fulfill the service providers' responsibilities

f. Extent of other resources available in the community to meet family needs
g. Other assigned duties of the home visitor

MIS Reports:

FSW Case List
Enrolled Program Caseload Information
FSW Home Visit Narrative
Supervisor's Case List
Home Visiting Completion Rate Analysis

Appendix:

Home Visiting Levels Table

Insert site-specific procedures that include:
Describe your program's specific process for managing caseloads related to the following criteria:

1. Experience and skill level of the home visitor assigned
2. Nature and difficulty of the problems encountered with families
3. Work and time required to serve each family
4. Number of families per service provider which involve more intensive intervention
5. Travel and other non-direct service time required to fulfill the service providers' responsibilities
6. Extent of other resources available in the community to meet family needs
7. Expectations regarding caseloads that temporarily exceed maximums
8. Other assigned duties of the home visitor

Critical Element #9 Service providers are selected because of their personal characteristics and skills, and their willingness to work with culturally diverse communities.
Intent: The intent of the standards in this section is to ensure staff is selected because they possess characteristics necessary to build trusting, nurturing relationships with families, and work with families with different cultural values and beliefs than their own.

A stable, qualified workforce is known to contribute to improved participant outcomes and family retention. Therefore, sites strive to hire staff that is well qualified and suited to their roles, and management monitors factors associated with staff turnover.

Strategies to increase staff retention can be developed by having an understanding of the circumstances and characteristics of staff that stays versus those that leave. Factors that may be associated with staff satisfaction and retention include: Staff demographics, role clarity, acknowledgement of work performed, satisfaction with supervision, salary and benefits, reasonable workload, autonomy, and opportunities for advancement and career development.

Sites must work to ensure the safety of the families and children it serves by conducting criminal background checks on all prospective employees, interns and volunteers who will come in contact with families, i.e., assessment staff, home visitors, supervisors and program managers. At a minimum, all sites are to conduct legally permissible criminal background checks (at any point during employment) in order to be in adherence with the standard.

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 are part of the licensing process, and that these staff members have a valid and current license.

STAFF SELECTION
Screening and selection of **Program Managers** includes, but is not limited to:

- Master's degree in public health or human services administration or fields related to working with children and families, or Bachelor's degree with 3 years of relevant experience.
- A solid understanding of and experience in managing staff
- Administrative experience in human service or related field, including experience in quality assurance and improvement, and site development;
- Experience with and commitment to reflective practice. Infant mental health endorsement level III or IV a plus.

- Final selection for Program Managers must be approved by the HFNY Central Administration.

Screening and selection of **Supervisors** includes, but is not limited to:

- Master's degree in human services or fields related to working with children and families, or Bachelor's degree with 3 years of relevant experience.
- A solid understanding of and/or experience in supervising and motivating staff, as well as providing support to staff in stressful work environments
- Experience with and commitment to reflective practice
- Knowledge of infant and child development, and parent-child attachment
- Experience with family services that embrace the concepts of family-centered and strength-based service provision
- Knowledge of maternal-infant health, and the dynamics of child abuse and neglect
- Experience in providing services to culturally diverse communities and families
- Experience in home visiting, with a strong background in prevention services to the 0-3 age population
- Infant mental health endorsement level III or IV a plus
- An Associate's Degree with a minimum of five years working in Healthy Families New York with the development and implementation of a professional development plan, and prior HFNY Central Administration approval.

Note regarding HFA Accreditation: Program Managers and Supervisors hired prior to July 1, 2014 will need to demonstrate at least a Bachelor's degree. Additional criteria above will be applied to staff hired July 1, 2014 or after. Also, please note that 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.

Screening and selection of **direct service staff** (including volunteers and interns performing the same function as paid staff) includes, but is not limited to:

- Minimum of a high school diploma or equivalent
- 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 that are present among the site's target population
- Knowledge of infant and child development
- Openness 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 level I or II a plus

Any exceptions to these staff screening and selections requirements must be discussed with and approved by HFNY Central Administration prior to hire.

MIS Reports:

Quarterly Worker Characteristics

Appendix:

Sample interview Questions
Rating Scale

Insert site-specific procedures that include:

1. The site's system for screening and selection of all staff that ensures that it considers all of the personal characteristics of job candidates as listed above, and staff meet the criteria.
2. That 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.
3. How 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.
4. The site's recruitment and selection practices are in compliance with applicable law or regulation and must include:

- Internal job postings of available positions before or concurrent with external recruitment
- Use of standard interview questions that comply with employment and labor laws, and address knowledge and skills needed for the job, and demonstrate ability to establish and maintain a strengths-based program culture.
- Verification of 2-3 references and/or letters of recommendation and credentials. If hired from within the organization, performance appraisals may suffice.

5. How the site will ensure that all employed site staff have had legally permissible background checks completed at the time of employment, including criminal background checks. State child abuse and neglect registries may have been checked in addition. The site is knowledgeable about what is legally permissible and usable in screening applicants, and it carefully follows all mandates. (HFA BPS 9-3.B) NOTE: This is a Safety Standard
6. How the site monitors and analyses staff retention and satisfaction at least every two years, and evidence that it develops and implements strategies to address any issues discovered through this process. 7. Include job positions, selection criteria and duties for other positions not listed above, such as assistant program manager, child development specialist, fatherhood advocate, or others.

Critical Element #10 Service providers receive intensive, role-specific training. This includes Assessment Staff, Home visitors, Supervisors and Program Managers.
Intent: The overall intent of the standards in this section is to ensure staff receive training specific to their role.

ORIENTATION TRAINING
HFA Best Practice Standards 10-1.A-F

Staff receives Orientation training separate from intensive role specific training, prior to direct work with families or supervision of staff, to familiarize them with the functions of the site, the priorities of the program, and the site in the context of the community.

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.

There are six required orientation topics to be received by all staff prior to work with families:

1. All staff members are oriented to their roles as they relate to the site's goals, services, policy and operating procedures, data collection forms and processes, and philosophy of home visiting/family support prior to direct work with families or supervision of staff.
2. All staff members are oriented to the site's relationship with other community resources (e.g., organizations in the community with which the site has working relationships) prior to direct work with families or supervision of staff.
3. All staff members are oriented to child abuse and neglect indicators and reporting requirements prior to direct work with families or supervision of staff.
4. All staff members are oriented to issues of confidentiality prior to direct work with families or supervision of staff.
5. All staff members are oriented to issues related to boundaries prior to direct work with families or supervision of staff.
6. All staff members are oriented to issues related to staff safety prior to direct work with families or supervision of staff.

MIS Reports:

Training/10-1 Orientation Training
Training/Shadowing
Training/Required Topics

Appendix:

None

STOP-GAP TRAINING

HFA Best Practice Standard 10-2.A

POLICY: All staff must receive training specific to their position. HFNY does not allow stop-gap training as a temporary or long-term solution to the need for role-specific training for any role but supervisor. For a supervisor, stop-gap training may be used only as a short-term solution.

Stop-gap training may be provided to supervisors so that they can begin to support staff prior to attending Supervisor Core only if all of the following conditions are met:

1 The supervisor has attended either ISHV or PSCO core, or both, depending on which roles they will be supervising.
2 They have not had an opportunity to attend their role-specific training prior to the site's need for the supervisor to begin supervision practice.
3 Stop-gap training is provided by someone who has completed Supervisor Core.
4 Stop-gap training for the supervisor must include the following for each role the supervisor will be supervising:
   a Theoretical background of the role of supervisor: general background on the importance of the role why the role is critical to the model
   b Shadowing of other supervisors
   c Training on forms used by supervisors
   d Hands-on practice, with observation and feedback
   e Inter-rater reliability related to documentation
   f Use of a strengths-based approach when working with others
5 The supervisor attends the next available Supervisor Core training provided by the Training and Staff Development Team.

MIS Reports:

Training/Required Topics
Training/Shadowing
Training/Data Training

Appendix:

None

Insert site-specific policies and procedures that include:
A description of how stop-gap training is provided to supervisors: when it is used, how it is delivered and by whom, and how it is documented.

ROLE SPECIFIC CORE TRAINING
HFA Best Practice Standards 10-3.A-C
Note: 10-3.A-C are Sentinel Standards

Intent: Intensive training fosters the knowledge and skills necessary to achieve program 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. Intensive training allows staff to link theory to practice by developing and implementing practical approaches to real-life situations, to share information and experiences, and to learn from one another.

All staff receives Core training that is provided by a HFA certified trainer.

Program Managers hired after July 1, 2014 must attend all three HFA Core trainings within six months of hire, as well as attend HFNY Program Manager Orientation at the next available training date. Program Managers hired prior to July 1, 2014 will be "grandfathered," and do not need to demonstrate evidence of receipt of HFA Core training. They are, however, strongly encouraged to attend HFA Core training.

Supervisors must complete the HFNY Supervisor Core Training within six months of hire. While supervisors may begin supervising staff without having attended the HFNY supervisor core training, HFNY policy requires that supervisors must have attended the role specific core training (ISHV or PSCO) prior to supervising staff in that role. Supervisors hired after July 1, 2014 are required to attend both ISHV and PSCO training 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. Supervisors hired prior to July 1, 2014 must, at minimum, have attended HFA Core Training for all roles they directly supervise prior to providing supervision.

FAWs begin assessing families only after PSCO Core training has been completed.

FSWs make home visits unaccompanied by other staff only after ISHV Core training has been completed.

Cross-Trained Staff are expected to receive additional core training specific to their new or added role before providing services specific to that role.

Returning Staff
A training plan is developed by the Program Manager and the Training and Staff Development Director for each returning staff person prior to the staff person providing services to families. * *Any staff person returning to the state system*

after an absence from HFA program practice of 3 or more years is to attend the entire HFNY training process for new staff.

All training requirements also apply to interns, volunteers, or others working directly with families when serving in the FSW, FAW or other program-specific roles.

MIS Reports:

Training/10-3 Intensive Role Specific Training for Staff
Training/2-2.C Kempe (Parent Survey) Training
Training/ No Home Visits before FSW Core Training
Training/Required Topics

Appendix:

None

No-program specific policy and procedures required here.

Critical Element #11 All service providers receive basic training in areas such as cultural competency, child development, family systems, intimate partner violence, substance abuse, etc.
Intent: The overall intent of the standards in this section is to ensure staff receives the support and training, and has the skills necessary to fulfill their job functions and achieve the site's goals with diverse families and in diverse situations. Training must be specific, practical, and culturally sensitive, and take into account each staff member's skills and needs.

TRAINING PLAN AND POLICY
HFA Best Practice Standard 11-1

POLICY: Sites have a comprehensive training plan that assures access to and ongoing tracking and monitoring of required trainings in a timely manner for all staff.

Intent: The training plan guides the site towards meeting training expectations in a timely manner with specified timeframes, and clearly identifies how the training is provided and by whom, topics that will be covered in each training, and the site's processes for supervisory follow-up. Additionally, the site addresses how they ensure that the training provided is of high quality.

1. The training plan addresses all topics and subtopics included in HFA Best Practice Standards 10 and 11, as well as the training that is required to administer other tools that are used with families: Depression screens, developmental screens, PSI, etc., as well as training on effective use of curriculum.
2. Training may be provided by various qualified individuals, including Program Manager, Supervisor, community agency, HFA online training modules, and use various modalities, including video, reading materials, self-study modules, etc.
3. Training tracking includes supervisory verification of all required training received.
4. The tracking form includes date of hire, date of first direct service contact or supervision of staff, and date of first administration of tools.
5. Sites track training even when training was received outside of the required timeframe.
6. Learning formats can include: attendance at trainings, workshops, and in-services; on-line training; current formal education; certification; licensure; and competency-based testing.
7. There are circumstances when staff may be exempt from wrap-around trainings only, that must be documented in MIS and back-up documentation maintained for review by peer reviewers. Professional experience and previous formal education can qualify as training when coupled with competency based testing and/or supervisory follow-up to assure successful knowledge acquisition and understanding of concepts and/or materials.

8. Returning Staff: A training plan is developed by the Program Manager and the HFNY Staff Development and Training Director for each returning staff person prior to them providing service to families. **Any staff person returning to the state system after an absence from HFA program practice of 3 or more years is to attend the entire HFNY training process for new staff.*
9. Formal education, previous training, and previous experience must have occurred within three years prior to hire, and apply directly to the topics identified in order to be counted.
10. Supervisors, home visitors and assessment staff hired prior to July 1, 2014 must receive at least a majority of the topics listed in the 11-2, 11-3 and 11-4 standards.
11. All staff, including program managers, hired on or following July 1, 2014, must receive all of the training topics listed in the 11-2, 11-3 and 11-4 standards. Program Managers hired prior to July 1, 2014 are "grandfathered" and not required to show evidence that wrap-around training topics were received, however it is recommended they obtain and document this training, even if received outside the required timeframes.
12. Role-specific Core training cannot be used to satisfy the 3, 6 and 12-month training requirements.
13. All interns and volunteers who perform the same duties as assessment workers, home visitors and supervisors receive the same type of training as paid staff.

Required training for all staff[3]			
All staff receive Orientation Training regarding their role, the site's relationship with community resources, child abuse and neglect indicators, confidentiality, boundaries, and staff safety – prior to direct work with families			
Screening and assessment tools (PSI, ASQ, ASQ-SE, PHQ-2, PHQ-9, HITS, Home, and Audit-C) – prior to administration			
Within 3 months	**Within 6 months**	**Within 12 months**	**Ongoing training**[4]
Infant care • Sleeping • Feeding • Physical care of baby • Crying and comforting baby	Infant and child development • Language and literacy • Physical and emotional • Identifying developmental delays • Brain development	Child abuse and neglect • Etiology of child abuse and neglect • Working with survivors of abuse	The staff and supervisors identify training needs and determine what additional training topics would be most beneficial in enhancing job performance, and training is offered
Child health and safety • Home safety • Shaken baby syndrome • SIDS • Well-child visits and immunizations • Appropriate child care • Car seat safety • Failure to thrive	Supporting the parent-child relationship • Supporting attachment • Positive parenting strategies • Discipline • Parent-child interactions • Observing parent-child interactions • Strategies for working with difficult relationships	Family violence • Indicators of family violence • Dynamics of family violence • Intervention protocols • Strategies for working with families with family violence issues • Effects of family violence on children • Referral resources for family violence	Annual child abuse training • Updates on child welfare policies, practices, trends in the community
Maternal and family health • Family planning • Nutrition • Pre- and post-natal health care • Pre-natal and post-partum depression • When to call the doctor	Staff related issues • Stress and time management • Burnout prevention • Personal safety • Ethics • Crisis intervention • Emergency protocols	Substance abuse • Etiology for substance abuse • Culture of drug use • Strategies for working with families with substance abuse issues • Smoking cessation • Fetal Alcohol Spectrum Disorders • Street drugs • Referral resources for substance abuse	Annual Cultural Sensitivity Training
HFNY Family Goal Plan training • Purpose and importance of the FGP process • Helping families identify strengths and needs • Supporting the family to set and achieve meaningful, measurable goals, and build independence • Development of FGPs based on the home visitors' knowledge about the family (including the Parent Survey Assessment), as well as tools completed by the family	Mental health • Promoting positive mental health • Behavioral signs of mental health issues • Depression • Strategies for working with families with mental health issues • Referral sources for mental health	Family issues • Life skills management • Engaging fathers • Multi-generational families • Teen parents • Relationships • HIV and AIDS	
	HFNY Prenatal training • Fetal growth and development • When to call the doctor • Activities to promote the parenting role during pregnancy • Preparing for baby • Promoting parental awareness of and sensitivity to the baby's needs	Role of culture in parenting • Working with diverse populations (age, religion, gender, sexuality, ethnicity, poverty, fathers, teens, gangs, disabilities, etc.) • Culture of poverty • Values clarification	

[3] In addition to training prescribed in 10-1 and 10-3

[4] Takes into account the staff members' knowledge and skill base, and assumes Prenatal and Family Goal Plan trainings

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 supervisory follow-up. Sites may use the HFA online trainings (TLC) in conjunction with site-based supervision/training to assure successful knowledge acquisition and understanding of concepts. If not using TLC, sits need to maintain training agendas to demonstrate adherence to the standard. Reports printed from the TLC demonstrating that all staff successfully completed each module will satisfy all evidence required for these standards.

MIS Reports:

- **Training/Required Topics**
- **Training/5-3 Culturally Sensitive Practices**
- **Training/6-6 ASQ/ASQ-SE Training**
- **Training/7-5D PHQ 2/9 Training**
- **Training/10-1 Orientation Training**
- **Training/10-3 Intensive Role Specific Training for Staff**
- **Training/11-2 Wraparound Training for All Staff by 3 months of Hire**
- **Training/11-3 Wraparound Training for All Staff by 6 months of Hire**
- **Training/11-4 Wraparound Training for All Staff by 12 months of Hire**
- **Training/11-5B Prenatal Training for All Staff by 6 months of Hire**
- **Training/11-5D Annual Child Abuse & Neglect Training for all Staff**
- **Training/Data Training**
- **Training/Shadowing**
- **Training/FGP/IFSP Training**
- **Training/Training Tickler**
- **Training/Training Resume**

Appendix:

- **Site Training Record**
- **TLC Certification**

Insert site-specific procedures that include:
A description of how the site insures that:

1. Staff discusses their annual training goals with their supervisor during their introductory period and as part of annual performance evaluations.
2. All training is documented in the MIS.
3. The site's administration monitors and approves training received to ensure timely access to and receipt of all required training.
4. Supervisors provide new staff orientation prior to direct work with families or supervision of staff.

5. Sites track training on these topics and insure that staff receive training within required time frames.
6. If the site has received approval from Central Administration to administer additional screening and assessment tools, include expectation that staff is trained to use these tools prior to administration.

Critical Element #12 Service providers receive ongoing effective supervision. Intent: The overall intent of the standards in this section is to ensure that direct service staff and supervisors collaborate effectively to support the professional growth of staff to facilitate healthy growth in families. A supervisor's primary role is to create an environment that encourages staff to grow and change, and to provide motivation and support, maintain ideals, standards, quality assurance, and safety, and facilitate open, clear communication. Reflective supervision is provided within protected time each week to enable staff to increase self-awareness, identify and build on parental competencies, become more effective in their interactions with families, and become more familiar with their own feelings and values and how these impact their work.

ON-GOING SUPERVISION FOR DIRECT SERVICE STAFF
HFA Best Practice Standard 12-1.A - 12-1.D

POLICY: All direct service staff, including interns and volunteers who work directly with families, receive regular, ongoing supervision, are provided with skill development and professional support, and are held accountable for the quality of their work.

1. Full-time staff and part-time staff that are at least .75 FTE participate in regular, individual supervision for a minimum of 1.5 to 2 hours a week (over a seven-day period of time). For part-time staff that is .25 FTE to .74 FTE, the requirements are 1 hour weekly (over a seven-day period of time). HFNY Performance Indicators set the expectation that this frequency and duration of supervision is achieved at least 75% of the time.
2. For staff that works less than .25 FTE, supervision may be provided according to role and occurrence of services.
3. The ratio of supervisors to direct service staff is one full time supervisor to five full time direct service staff.
4. Volunteers and interns who are performing the same functions as FSWs or FAWs must receive the same type and amount of supervision as paid staff.
5. Supervisors document the dates, duration, and content of all supervisory sessions, and this is tracked in the MIS to ensure staff is receiving supervision according to the threshold established in the standard.
6. The only acceptable reason for missing a supervision session the supervised staff person's absence for an entire week.
7. Group reflective supervision is not officially recognized at this time as contributing to expectations for reflective supervision, and will remain unrecognized until the HFNY system encompasses the Infant Mental Health Endorsement.
8. It is required that staff has access to a supervisor at all times when they are in the field.

MIS Reports:

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

Appendix:

Supervision Forms

Insert site-specific procedures that include:
A description of the procedures and practices that insure that policy expectations are met

12-1.B Measure supervision frequency and duration is a *Sentinel Standard*

PROFESSIONAL SUPPORT AND SKILL DEVELOPMENT:
ADMINISTRATIVE, CLINICAL, AND REFLECTIVE SUPERVISION
HFA Best Practice Standard 12-2.A

POLICY: All direct service staff are provided with professional support and supervision that includes administrative, clinical, and reflective components in order to continuously improve the quality of their performance.

1. Supervisors focus on:
   a. Feedback on strengths-based approaches and interventions
   b. Integration of results of tools and assessments used
   c. Guidance on curriculum, techniques and approaches
   d. Identification of areas for growth and boundary issues
   e. Sharing of information related to community resources
   f. Exploring and reflecting on the impact of the work on the worker
   g. Assistance in implementing new training in practice
   h. Guiding cultural sensitivity practice
   i. Strengthening engagement techniques
   j. Supporting parent-child interaction work and CHEERS observations
   k. Reviewing Family Goal Plan progress and process
   l. Reviewing family progress and level changes including:
      - Addressing issues identified during the initial assessment
      - Using a curriculum that promotes attachment and child development
      - Conducting developmental screening
      - Supporting parents in building healthy support systems
      - Reducing parental stress
      - Advocating for nurturing discipline techniques
      - Collaborating with families to develop meaningful goal plans
      - Conducting depression screening
      - Making referrals based upon family needs
      - Completing assessments required by the site

   1. m. Providing feedback on documentation

2. All home visitors are provided with feedback on the results of quality assurance activities and reports.

3. Level 1 and 2 families are to be reviewed weekly, with in-depth discussion at least once per month. Level 3 and 4 families are to be reviewed as needed, and at least after home visits have occurred.

MIS Reports:

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

Appendix:

None

Insert site-specific procedures that include:
A description of the procedures and practices that insure that policy expectations are met

12-2.B Reflective, Clinical and Admin supervision provided is a *Sentinel Standard*

SUPERVISION OF SUPERVISORS
HFA Best Practice Standard 12-3.A

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

1. Supervisors receive supervisory support at least twice a month from the Program Manager or other qualified designated consultant or staff member. At least one session per month should be individual supervision.
2. The Program Manager documents topics discussed and strategies developed in supervision.
3. Supervision of supervisors is documented in the MIS.
4. Topics may include:
   a. Addressing personnel issues
   b. Feedback and reflection regarding team development and agency issues
   c. Review of documentation, statistics and reports
   d. Review of progress towards meeting goals and objectives
   e. Strategies to promote professional development and growth
   f. Shadowing of supervision

MIS Reports:

Listing of Supervision records

Appendix:

None

Insert site-specific procedures that include:

1. That supervisors receive supervision at least of at least twice a month
2. How supervisors are held accountable for the quality of their work
3. How supervisors are provided skill development and professional support
4. Procedures for addressing:
   a. Addressing personnel issues
   b. Feedback/reflection on team development; agency issues
   c. Review of site documentation
   d. Site statistics
   e. Progress towards meeting site goals and objectives
   f. Strategies for professional development
   g. Quality oversight – shadowing

SUPERVISION OF PROGRAM MANAGERS
HFA Best Practice Standard 12-4.A

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

1. The Program Manager receives regular ongoing support from his or her direct supervisor at least monthly.
2. Supervision is documented, including topics discussed and strategies developed during supervision.
3. Accountability can be addressed through quarterly reports, annual performance reviews, regularly scheduled meetings with the Program Manager's Supervisor.

MIS Reports:
None

Appendix:
None

Insert site-specific procedures that include:
1. That the Program Manager receives supervision at least once a month, who provides their supervision, and how their supervision is documented
2. How the Program Manager is held accountable for the quality of his or her work
3. How the Program Manager is provided skill development and professional support

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GA Governance and Administration. The site is governed and administered in accordance with principles of effective management and of ethical practice.
Intent: The overall intent of the standards in this section is to ensure that sites have feedback and oversight mechanisms that ensure high quality services to families.

ADVISORY GROUPS
HFA Best Practice Standard GA-1.A

POLICY: The site's advisory/governing group is an effectively organized, active body, which meets at least quarterly and advises/governs the activities of planning, implementation and assessment of site services.

Intent: Advisory groups serve important functions in community-based agencies as advocates for the site in the community, and representing the site and agency in other venues and settings, which can bring more recognition and visibility. Advisory Group members bring different skills and perspectives, can share ideas or strategies that facilitate growth for sites, and may have access to resources to strengthen the site or agency. It is important that the group has the community connections to understand the needs of the participant population.

Advisory Group involvement may be more intense during sites' start-up phase when community leadership is critical to the launch of the site, however well-established sites benefit from Advisory Group involvement as well, and a well-formed advisory committee with strong member relationships is an asset to the continuation of a shared vision and the realization of intended program impacts.

Advisory Groups are informed when state system policies or practices change. The Advisory Group helps insure that program policies are implemented in a way that matches the mission of the site and the needs of the community.

MIS Reports:
None

Appendix:
None

Insert site-specific procedures that include:
1. How the Advisory Group is formed in order that it provides a heterogeneous mix of skills, strengths, community knowledge, professions, and cultural characteristics.
2. A list of Advisory Group members, their affiliations, and Advisory Group demographics (Ex: age, race, amount of time in the Advisory Group, etc.).

3. That the Advisory Group will meet at least quarterly, with agendas set and meetings facilitated by the Program Manager, or other designated site representative.
4. The site's strategy for ensuring that the Program Manager, or other designated site representative, and the Advisory Group work as an effective team in planning responsive services in the community.

FAMILY SATISFACTION FEEDBACK
HFA Best Practice Standard GA-2.A

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

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

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

MIS Reports:
None

Appendix:
None

Insert site-specific procedures that include:
1. A description of the mechanisms used to obtain feedback from families.
2. How feedback from families is compiled and used

PARTICIPANT GRIEVANCES
HFA Best Practice Standard GA-2.C

POLICY: All families are notified of the participant grievance procedure during the first home visit.

1. Families are informed of the grievance process during the first home visit as part of the process of reviewing the Family Rights handout. They are invited to contact the supervisor if they have any concerns, and are provided contact information for the home visitor's supervisor.
2. Any grievances received are immediately discussed with program management and agency leadership, and appropriate action is taken, including contact with the family to ensure there is clear understanding of the family's concern. The Advisory Group may be called upon to help resolve grievances.
3. The family is made aware of the strategy to resolve the issue as soon as the strategy has been determined. The family has the right to appeal any decision they believe does not adequately resolve their issue.
4. Families may request a change in home visitor at any time. The site honors these requests whenever possible.
5. Staff members are removed from work with families immediately pending resolution of a grievance involving allegations that, if true, would endanger families' safety and well-being.
6. The site works with staff named in grievances through coaching in supervision, and takes any additional personnel actions needed to ensure the safety of families.
7. Documentation that the grievance procedures were reviewed with families is placed in the participant file, and a copy of the procedure is provided to the family so that they have the pertinent information.

MIS Reports:
None

Appendix:
Sample Grievance policy
Sample Family Rights and Confidentiality

Insert site-specific procedures that include:
1. A description of how families are informed about how to make a complaint or share a grievance.
2. The specific steps and time frames for reviewing and acting on any grievances received.

3. The follow-up mechanisms used to address identified areas of improvement based on the grievance received.

QUALITY ASSURANCE
HFA Best Practice Standard GA-3

POLICY: The site has a Quality Assurance Plan, and monitors and evaluates quality of services

Intent: To help ensure accountability and support skills development of site staff, sites develop a Quality Assurance Plan that includes internal observation of practice for direct service and administrative staff, satisfaction surveys, file reviews, and analysis of reports related to program activities, and state system QA activities. Collectively, these activities contribute to sites' overall plan to address the quality of services to families: what is working well, areas for improvement, and methods of follow-up.

1. Sites use a variety of methods to monitor the quality of all of the services offered to families.
2. The state system's goals and objectives are contained in the HFNY Performance Indicators and HFNY Performance Targets.
3. The QA plan has specific internal quality assurance strategies, and includes monitoring assessment, home visiting, and supervision practice, according to the HFNY Performance Indicators and HFNY Performance Targets.
4. The QA plan includes working with the Center for Human Services Research to monitor quality and completeness of the data.
5. The Quality Assurance Plan includes:
    a. Cultural Sensitivity Review (5-4 standards)
    b. Analysis of family engagement/acceptance (1-2 standards), family retention (3-4 standards), and prenatal enrollment
    c. Analysis of sites' Performance Targets and Performance Indicators are included in evaluation of quality.
6. Sites use information gathered through all QA activities to continue effective practices and develop mechanisms to identify and address areas for improvement.

HFNY QUALITY ASSURANCE TABLE

<table>
<tr><th colspan="4">Sites' Internal QA Activities</th></tr>
<tr><td colspan="4">MIS data completion</td></tr>
<tr><td colspan="4">Quarterly narrative and data reports (also regularly reviewed and addressed by OCFS Contract Managers)</td></tr>
<tr><td colspan="4">Annual program-wide participant satisfaction survey</td></tr>
<tr><td colspan="4">Every 2 years staff satisfaction and retention survey</td></tr>
<tr><td colspan="4">Quarterly Performance Targets</td></tr>
<tr><td colspan="4">Performance Indicators – twice per year</td></tr>
<tr><td>Practice QA: All practice QA activities are reviewed in supervision to acknowledge practice strengths and support practice improvement. All QA follow-up is documented by the supervisor.</td><td>FSW
One home visit observation per quarter
One participant file review per quarter
Two participant surveys per quarter (Program manager should review all participant satisfaction surveys that are conducted by the supervisor)
Annual performance review and professional development plan</td><td>FAW
One assessment observation per quarter in the first year of FAW practice, then twice per year, including "inter-rater reliability" of the observed assessments.
One Assessment refusal call or observation of assessment calls per quarter
Annual performance review and professional development plan</td><td>Supervisor
One supervision observation per quarter
One review of supervisor binder/notes by supervisor of supervisors per quarter
Annual performance review and professional development plan</td></tr>
<tr><td colspan="4">Annual Service Review The ASR represents the culmination of all of the site's QA activities, and is shared with the site's advisory board and funder. The ASR is studied by the site and used as a tool to develop a specific plan for program enhancement and improvement.</td></tr>
<tr><th colspan="4">External QA Activities</th></tr>
<tr><td>PCANY Quality Assurance and site support visits</td><td colspan="2">2-day FSW: Observation of home visitor and FSW supervisor practice; site-specific support/training.

Occur every 24 months, and follow PCANY protocols for planning, expectations, and follow-up for the visit</td><td>2-day FAW: Observation of assessment and FAW supervisor practice; site specific support/training

Occur every 24 months, and follow PCANY protocols for planning, expectations, and follow-up for the visit</td></tr>
<tr><td>Technical Assistance Visits</td><td colspan="2">Offered by PCANY in conjunction with Central Administration partners</td><td>Scheduled as needed with initial request made to/by OCFs</td></tr>
<tr><td>OCFS site visits</td><td colspan="3">OCFS Program Contract Managers visit sites approximately every 12 months (at least twice a year for new programs). PCMs provide follow-up documentation and support sites in developing specific plans and time lines for quality improvement.</td></tr>
<tr><td>HFA Accreditation</td><td colspan="3">While HFA accreditation occurs every 5 years, sites update their Self-Assessment Tool annually</td></tr>
</table>

MIS Reports:

Quarterlies /Quarterly 4 Quarter Performance Targets

Accreditation/3-4.A and B Retention Rate Analysis
Accreditation/1-2.C Assessment Information
Accreditation/1-3 .B Timing of First Home Visit
Analysis/Quality Assurance Report
Training/10-1 Orientation, 10-3 Intensive Role Specific Training for Staff, Shadowing and FGP/FAMILY GOAL PLAN
Training/11-2. Wraparound 3 months, 11-3 Wraparound 6 months and 11-4 Wraparound 12 month reports
Accreditation /4-2.B. HFA Home Visiting Completion Rate Analysis – Summary
12-2A. Home Visit Observation by Supervisor and 12-2B. Kempe (Parent Survey) Observation by Supervisor
Quarterly Program Information for 8 quarters
Accreditation/ 12-1.B Regularly Scheduled and Protected Supervision – Summary

Appendix:

ASR
PCANY QA Protocols
OCFS Tools for site visits, quarterly and ASR
Performance Indicators
Quarterly Performance Targets
Sample Participant Survey

Insert site-specific procedures that include:
A description of the site's Quality Assurance Plan, including quarterly and annual contractual reporting, and any external and internal QA activities. Description should include:

Who is responsible for scheduling, developing, and completing the QA activities in the plan.

How QA activities are documented, used, and followed up to improve program quality.

How the QA plan supports the site's commitment to continuous quality improvement (CQI).

RESEARCH PROPOSALS
HFA Best Practice Standard GA-4

POLICY: Any proposals to conduct research studies involving HFNY program staff or participants, past or present, must be presented to Central Administration for review and approval.

Intent: In order to protect the safety and privacy of families and program staff, and to ensure that the standards of effective practice are maintained, this policy establishes the procedures necessary to obtain approval to conduct research with HFNY program staff or families who are currently receiving services or have received HFNY services in the past.

1. Only bona fide researchers may conduct research that involves families served by or those employed by the HFNY program. To be eligible to conduct research, the Researcher must be a faculty member or graduate student at an accredited institution of higher education, or hold a research position at a reputable research organization or at a government agency. Sites should follow their own agency and/or program policies with regard to whether or not they will to allow bona fide researchers to engage in research activities with families receiving services from HFNY programs. Once the agency and/or program has indicated that the researcher may use their program for research purposes and provided the researcher with a letter of support to indicate their willingness to participate, the prospective researcher must submit their proposal for review by HFNY Central Administration

2. Prospective researchers must submit a proposal that meets all of the requirements of the OCFS Research Approval Policy to the HFNY Program Coordinator who will put the research proposal on the agenda for review at the next Central Administration meeting. These meetings occur at least 6 times per year.

3. Central Administration will review the proposal on the basis of the following standards: 1) relevance to the HFNY mission or contribution to the body of literature in the field; 2) methodological adequacy; 3) procedures for ensuring confidentiality; 4) potential risks and benefits to participants; 5) impact on HFNY or program operations; and 6) support from involved parties. Central Administration will also assess the extent to which the program is providing services with fidelity to the HFNY model. In order to ensure that any research results are relevant to the state system, the program in which the research will be conducted must be meeting state performance standards. Exceptions may be allowed if the research is being conducted to specifically address areas in which the program is deficient.

Researchers should be sure to address the following questions within their proposals:

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

4. Once Central Administration has reviewed the research proposal, the researcher will be contacted to address any concerns that were expressed by Central Administration or told that their study is conditionally approved pending review by the OCFS Research, Evaluation, and Performance Analytics (BREPA). If the researcher is unable to address all of the concerns raised by Central Administration, the study will be rejected. After all concerns are addressed to the satisfaction of Central Administration, the HFNY Program Coordinator will provide a letter of support indicating approval of the research study by HFNY.

5. Upon receipt of the letter of support from the HFNY Program Coordinator, the researcher may proceed with the OCFS Research Approval process and should submit a complete research proposal to:

Rebecca Colman
Bureau of Research, Evaluation, and Performance Analytics
NYS Office of Children and Family Services
Email: rebecca.colman@ocfs.state.ny.us
Phone: (518) 474-9426

6. Any final reports or findings should be shared with OCFS and HFNY prior to dissemination so that OCFS and HFNY may confirm that the safety and privacy of families or program staff has been protected and so that OCFS and HFNY may benefit from the research results. A minimum of 5 business days shall be required to review and approve draft posters, presentations, journal abstracts, and manuscripts. Researchers should also notify OCFS and HFNY in advance of any media, publicity, or other public presentation related to the research study.

MIS Reports:
None

Appendix:
None

Insert site-specific procedures that include:
How any research proposals that would involve past or current participants, or past or current staff, will be reviewed. Including a description of who will conduct the review, protocols for conducting the review, a timeline for completing the process, and who will make the determination to approve or deny the research.

FAMILY RIGHTS AND CONFIDENTIALITY
HFA Best Practice Standards GA-5.A, GA-5.B, GA-5.C

POLICY: Families are informed of their rights, and that the confidentiality of information that families share with the program - during the intake process as well as during the course of services – is assured.

Intent: A family-centered approach to service delivery requires that practices reflect a profound respect for personal dignity, confidentiality and privacy. When a request for confidential information about a family is received, or when a release of confidential information is necessary for the provision of services, sites must obtain the family's informed, written consent prior to releasing the information. Informed consents are time-specific and do not include open-ended timeframes such as.

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.

1. All families enrolled in HFNY have the right to be treated with dignity and respect and to know the scope and limitations of the services offered. Home visitors inform families of their rights and provide them with the Family's Rights and Confidentiality Form on or before the first home visit. The form includes:
   a. The right to refuse service (i.e. the voluntary nature of the program)
   b. The right to referral to other service providers
   c. The right to participate in the planning of services they will receive and the right to an individualized Family Goal Plan.
   d. The right to private and confidential interaction with staff; any information shared between the family and staff is protected and treated in a confidential manner.
   e. The manner in which information is used to make reports to funders, evaluators, Central Administration and/or researches (in aggregate format)
   f. The manner in which consent forms are signed to exchange information
   g. The circumstances when information would be shared without consent (i.e., need to report child abuse and neglect)

2. HFNY sites adhere to the following confidentiality standards:
   a. All HFNY staff sign a confidentiality agreement to keep participant information confidential including the acceptable use of HFNY MIS. Staff keeps their MIS password confidential.
   b. Sites that maintain paper participant files store the files in locked cabinets.
   c. Files are not left open on home visitors' desks.

d. Home visitors log off of the MIS when leaving desk or office.
e. Home visitors discuss information related to families only with site staff and administration, and the evaluation team, if the site is participating in an evaluation project.
f. A family's information cannot be discussed with an outside provider unless Consent for the Release of Information form has been signed. Consent to release information forms will only list one agency per form in order to maintain confidentiality related to the various services that a family might receive. Release of Information forms that list multiple entities on the same form are not acceptable for use. Consent forms must include:
    - A signature of the person whose information will be released or parent or legal guardian of a person who is unable to provide authorization.
    - The specific information to be released
    - The purpose for which the information is to be used
    - The specific date the release takes effect
    - The timeframe or date the release expires. *No release agreement can exceed a period of 12 months.
    - The name of the person to whom or agency to which the information is to be released.
    - The name of the HFNY site providing the confidential information.
    - A statement that the person/family may withdraw their authorization at any time.
g. Home visitors do not talk about the families being served with friends or family members.
h. Home visitors do not use the name of a family member (or any identifying information) in any public area.
i. Staff who breach confidentiality commitments face disciplinary action, up to and including dismissal.

3. Should families be asked to participate in any research project, they will be informed of the scope and intent of the research and sign consent to participate. Families will be assured that their participation is voluntary, without pressure to participate, and that they have the right to refuse to participate without effect on the services they receive.

MIS Reports:

None

Appendix:

Sample Acceptable MIS Use Agreement
HFNY Data Request Needing OCFS Approval Form
MIECHV-Only Informed Consent

Informed Consent
Sample Consent to Share Information with External Source

Insert site-specific procedures that include:
A description of how and when the Family Rights and Confidentiality practices are implemented, and how the practices are documented by the site.

GA-5.B and GA-5.C are Sentinel Standards

REPORTING CHILD ABUSE AND NEGLECT
HFA Best Practice Standard GA-6

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

Intent: A clear understanding of child abuse and neglect indicators and the state's definitions of child abuse and neglect will assist staff with knowing how and when to report it. It is important for staff to know whom to contact for support when abuse or neglect is suspected, and that site leadership is notified in advance of a CPS report being made, unless there are imminent child safety concerns.

All direct service staff, including supervisors, should adopt a "mandated reporter philosophy," even if their site does not identify them as mandated reporters. Therefore, it is important to familiarize all staff with mandated reporting laws, the OCFS paperwork involved in reporting suspected abuse and neglect, and the sites' protocols for reporting to the State Central Register.

Sites' protocols should include:

1. Families are informed of the limits of confidentiality at intake.
2. When staff, including home visitors, are mandated reporters they are obligated to make a report when they become aware of suspected child abuse, or credible threat of harm to self or others, including homicide or suicide. They are expected to:
    a. Contact the State Central Register hotline immediately.
    b. Complete the appropriate OCFS form to document the call and if the report was accepted by the State Central Register.
    c. Report to his/her supervisor and/or program manager that a call for suspected child abuse/neglect was made to the SCR.

3. When a home visitor is not a mandated reporter and suspects abuse, they are expected to:
    a. Immediately speak with his/her supervisor. If imminent danger is threatened, the home visitor is to call 911 prior to calling supervisor.
    b. Complete the child welfare abuse reporting form, which includes all necessary information the State Central Register will request when the report is made.
    c. Contact the State Central Register hotline immediately.
    d. Document the observation of suspected abuse or neglect and next steps taken, including the time of the call to the SCR and the person to whom it was reported on the Child Welfare Abuse Reporting form.

4. All Program Managers, FAW and FSW supervisors, FSWs and FAWs, interns and volunteers receive orientation *prior to direct services with families or supervision of staff.* This orientation, BPS 10-1.C, must ensure that staff

clearly understands how to identify child abuse and neglect indicators, fully understands the State's definition of child abuse and neglect, and is aware of the legal limits of confidentiality. Additionally, as per BPS 11-5.D, all staff receive annual training related to child abuse and neglect in order to stay updated on current child welfare policies, practices, and trends in their community.

5. A report to the State Central Register must be made if a staff member suspects that a child has experienced one of the following types of abuse:
   a. Serious physical injury
   b. Serious mental injury
   c. Sexual abuse or exploitation, including underage pregnancy
   d. Serious physical neglect
   e. Imminent risk

6. Whenever possible, home visitors inform the family that a report is going to be made. When circumstances make informing the family prior to reporting impossible, they are informed by the home visitor as soon as possible after the report has been made. This practice is an important use of the home visitors' relationship with the family; it removes the additional stress on the family of not knowing who made the report, and models respectful, trust-building relationships.

MIS Reports:

None

Appendix:

None

Insert site-specific procedures that include:

1. That families are informed at intake of the site's expectations for reporting child abuse and neglect and the limits to confidentiality, and how this sharing of information is documented.
2. Criteria to be used to identify and determine when to report suspected child abuse and/or neglect (this may be a reference to where the criteria can be found)
3. Requirement that the Program Manager and/or supervisor must be notified immediately when abuse or neglect is suspected.
4. Who is expected to report to whom regarding reports to the State Central Register, and times frames for this communication.
5. How all observations of suspected abuse and neglect, and any next steps are documented.
6. How the family will be informed of any report made to the State Central Register.

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

CRITICAL INCIDENT POLICY
HFA Best Practice Standard GA-7

POLICY: Home visitors must immediately notify the Program Manager and/or supervisor in the event of a participant or participant's household member's death, critical injury, or other critical incident. The OCFS Program Contract Manager (PCM) must be notified within 48 hours. Affected participants and staff are offered counseling when a participant death or critical incident occurs.

Intent: Critical incidents that affect the program staff and participant families, including the death or critical injury of a program participant, staff witnessing a violent incident, an assault of program staff, threats against the program or program staff, and natural disasters, may create a deep sense of loss for the families and staff. This policy assures that both staff and family members are supported through the grief/loss process, or to address their sense of safety.

1. In the event of critical incident, including the death or critical injury of a participant household member, threats against the program or program staff, serious injury of staff on duty, the staff that becomes the first one aware of the incident immediately informs the Program Manager and/or supervisor. The OCFS PCM should be notified as soon as possible, but within a maximum of 48 hours of the program becoming aware of the incident. This notification is to include preliminary information such as name and age of the participant and a brief description of the incident.
2. Support is offered to the family, including services for grief counseling or other therapeutic services, if desired by the family, and short-term transitional home visits in the case of the death of the target child.
3. Appropriate support should also be provided to the home visitor(s) and supervisor, including additional reflective supervision, and counseling or access to an Employee Assistance Program (EAP).
4. If the program staff suspect that death or critical injury of the target child or other child in the home may be the result of child abuse or neglect, staff follow the agency's procedures consistent with the child abuse reporting policy and cooperates fully with any investigation.
5. Critical Incidents are documented on the OCFS Critical Incident Report form. (see Appendices).
6. If a report is made to the State Central Register concerning the death or critical injury, documentation on the OCFS Critical Incident Report includes: who made the initial report to the Statewide Central Register, if known; the contact information for the CPS worker or supervisor, if known; the notifications that followed the initial report; whether follow-up HFNY services will be provided to the remaining household members, and length of time they will be provided.
7. A preliminary written report of the critical incident, with available information, will be made

to OCFS using the OCFS Critical Incident Report ASAP, but within one week of the program becoming aware of the incident at most. A final OCFS Critical Incident Report, with all required information included, is submitted to the OCFS PCM within two weeks of the program becoming aware of the incident.

MIS Reports:

None

Appendix:

Critical Incident Report

Insert site-specific procedures that include:

1. Immediate notification of the program manager and/or supervisor
2. That staff is offered grief counseling when a death or critical injury occurs
3. Expectations for communication and documentation of the death or critical injury of a participant
4. The support that will be offered to the family who experienced the loss
5. Protocols for when multiple participating families are impacted by a critical incident.

Section D: GLOSSARY

ACCEPTANCE RATE: definition from MIS formula

ADVISORY GROUP:
An organized, voluntary group with responsibilities to advise on aspects of the HFA site's 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.

CASELOAD:
The total number of families assigned to a direct service staff person.

CHALLENGING ISSUES:
Standard 7-4 refers to parental capacities and/or behaviors that potentially place their children at especially high risk and can be particularly challenging for home visitors to address. These include parental substance use, mental illness, and developmental delay, and intimate partner violence. Support from a supervisor, use of reflective consultation groups (where available) and additional training are critical, as are protocols for worker safety and addressing family safety concerns.

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 and/or expanded to address the specific concerns of each location or situation. Supervisory 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 home visitor fears for his/her safety. The safety of the home visitor is of utmost importance.

CHEERS:
CHEERS is an acronym used to support home visitors in observing and understanding 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. Home visitor are expected to make CHEERS observations and document their observations for each home visit. Training on CHEERS is also a significant part of HFA Core – Integrated Strategies for Home Visitors training.

CRITERIA:
Rules upon which judgment or decisions are based.

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.

CULTURAL SENSITIVTY REVIEW:
A process the site undertakes to examine critically and deliberately its current ability to provide culturally sensitive services. The Cultural Sensitivity Review (CSR), as a final product, is a written document that summarizes the strengths and needs for improvement in all areas of the service delivery system. The CSR includes recommendations/suggestions for how the site might advance its current level of cultural sensitivity. Sites are encouraged to reference the Cultural Sensitivity Workbook as a resource tool when compiling a CSR.

ENGAGED FAMILIES:
Families, including all primary caregivers (i.e., mother, father, significant other, grandparents, etc.) participating in services, who are interested in, 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:
Parenting curricula should be evidence-informed, meaning that the information contained within it is based on scientific knowledge and/or research. Strategies employed, or goals of a curriculum, may also be grounded in scientific research i.e. - 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, relevant and credible information versus materials that are opinion-based vs fact-based, or outdated and no longer accurate.

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

GRADUATE:

A Healthy Families participant who has completed the program in its entirety, I.E. 3 or 5 years, as defined by program.

HANDS-ON PRACTICE:
Actual use of practice tools during training. This may include role-play, videotaping assessments, or scoring a videotaped or shadowed assessment.

HFA CORE ASSESSMENT TRAINING:
In-depth, formalized training which outlines the specific duties of the assessment 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.

HFA CORE HOME VISITOR TRAINING:
In-depth, formalized training which outlines the specific duties of the home visitor'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 home visitor, communication skills, and crisis intervention, etc. The trainer is certified by the HFA National Office and has been trained to train others.

HFNY 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 assessment staff and home visitors, effective supervision, reflective practice, quality management techniques, crisis management, understanding the site's policy and procedures; and case management, etc.

HOME VISIT:
A face-to-face interaction that occurs between the family and the home visitor. 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 family's home, last a minimum of an hour, and the child is present. Sites are permitted to count one group meeting per month as a home visit while families are on Level 1, however to do so requires that the home visitor 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. The focus during home visits may include, but are not limited to:

<u>Promotion of positive parent-child interaction/attachment</u>:

- 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 birth date 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.

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*).

INTIMATE PARTNER VIOLENCE (IPV):
The current nomenclature used in referring to Domestic Violence.

MEDICAL/HEALTH CARE PROVIDER:
The primary individual, provider, medical group, public and/or private health agency, or culturally recognized medical professional where participants can go to receive a full array of health and medical services.

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 possibly 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 and/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 (MI):
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

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.

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 SURVEY:
Current HFA nomenclature for the family assessment.

PARENT GROUP MEETING:
HF 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 HF site hosted parent group meeting per month may be counted as a home visit if the home visitor is present for the group meeting and the goals of a home visit are met.

PLANNING, IMPLEMENTATION, AND ASSESSMENT (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 program faces, such as striving for early enrollment, engaging fathers, etc. Assessment relates to feedback from the group related to the analyses, cultural sensitivity reviews, and other performance measures developed by the program.

POLICY:
Written statements of principles and positions that guide site operation and services. The governing body, the host agency, and/or the appropriate administrative body typically approves policies. Policy and Procedure Checklist and Sample Policy and Procedure Template/Guide

PROCEDURE:
The step-by-step methods by which broad 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:
Program managers (PM) are responsible for the day-to-day, hands-on management of the program, and are involved in program planning, budgeting, staffing, training, 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 Home Visitors and/or Assessment workers 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 is encouraged to also access free online Protective Factors training made available by the National Alliance of Children's Trust and Prevention Funds.

QUALITY ASSURANCE PLAN:
A plan to monitor and track the quality of all aspects of implementation that includes performance measures, screening process, program acceptance, family retention, satisfaction surveys, case file reviews, shadowing, quality assurance phone calls, supervision rates, etc.

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

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.

REFLECTIVE PRACTICE:
The use of "safe space" where trust has been established, for regularly scheduled meetings to collaboratively examine thoughts and feelings about work experiences. The practice includes active listening and thoughtful questioning to

gain a better understanding of the reasons for the thoughts and feelings, thus determining the best strategies 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?

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 6) Problem Talk. The Reflective Strategies are taught and practiced during HFA Core *Integrated Strategies for Home Visitors* training.

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.

RESEARCH:
Scientific research refers to a systematic examination of information to answer address a specific 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.

REVIEWS (QUALITY ASSURANCE):
The process a site undertakes to examine or study judicially, to go over or examine critically or deliberately an aspect or aspects of the site. The review (as a final product) should be in a narrative format and identify areas for improvement. For “routine review” see 4-2.D and 6-1.A

RISK FACTORS (FROM PARENT SURVEY ASSESSMENT):
- Childhood history of abuse and/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 and/or physically available to child

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.

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 Evidence (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 POPULATION:
The individuals that are currently enrolled and receiving services.

SERVICES:
When referenced in the Best Practice Standards, "services" includes 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 brings professional experience and education to the job. Training and self-study are added to broaden the knowledge base and expertise. Each staff member brings 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. The staff member and supervisor then develop a plan to support ongoing staff development. This can occur during regular supervision and often is formalized during an annual review process.

SUPERVISOR:
Supervisors provide weekly, individualized supervision to the home visitors and assessment workers within a Healthy Families site that incorporates administrative, clinical and reflective practices. The supervisor assures 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.

Three Elements of Supervision

- **Administrative**: *Was it done? Did it happen when it was supposed to happen?*
- **Clinical**: *How was it done? What can we try?*
- **Reflective**: *How did it feel? How does the emotional experience affect the work? What is the impact?*

This is an example of how all three components of supervision may be integrated and part of the same conversation on a particular topic.

Home visitor and supervisor, Family Goal Plan (FGP)

Administrative: Are the FGPs developed and reviewed during home visits?
Clinical: How is the home visitor facilitating the FGP process? What tools are used (motivational interviewing, solution-focused questions)? How are goals broken down into achievable steps?
Reflective: How does it impact the home visitor when families are not achieving their goals? How does the home visitor feel when families choose a goal that is not meaningful to the home visitor?

TARGET POPULATION:
Collectively, the group of people 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, and/or community needs. The Target Population is clearly defined in the sites' contract to provide services in the HFNY state system.

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).